

MEDICARE PRESENTATION

12/16/96

Agenda

1. The President's and Republicans' FY97 Medicare proposal
2. What has changed?
3. Discussion on the Trust Fund
 - A. Reinstatement of home health policy
 - B. Impact on providers and total savings
4. Base proposal
5. Moving parts
6. Possible changes to the base proposal

President's and Republicans' FY97 Medicare Proposals

(In Billions)

	<u>CBO Scoring</u>				<u>Administration Scoring</u>				
	<u>5 years</u>	<u>6 years</u>	<u>5th year</u>	<u>6th year 2002</u>	<u>5 years</u>	<u>6 years</u>	<u>5th year</u>	<u>6th year 2002</u>	<u>Trust Fund Exhaustion*</u>
FY97 Budget¹	\$82	\$116	\$29	\$34	\$87	\$124	\$31	\$37	2006
GOP FY97 Budget Resolution	\$114	\$168	\$42	\$53	\$134	\$196	\$49	\$62	2005?

*We achieved the 2006 Trust Fund exhaustion date through a combination of Part A savings and the reallocation of home health care expenditures. Republicans achieved their 2005 exhaustion date with their 6-year Part A traditional savings plus some very large cuts achieved in the 2003 – 2006 budget window.

¹ Our FY97 budget submission saved \$124 billion over 6 years off the OMB baseline. After submitting our proposal, we had to amend it to ensure that CBO Medicare savings came closer to our \$124 billion number. The revised proposal, which achieved \$116 billion in savings off the CBO baseline, would score \$135 billion in savings off of our baseline. In general, Medicare proposals produce less savings off the CBO baseline than of the OMB baseline.

Medicare Trust Fund

- **Need approximately \$160 billion in Part A savings between 1998 and 2002 to extend life of Trust Fund to 2006.**
- **Can achieve savings in 3 ways:**
 - (1) Traditional Part A Savings**
 - (2) Transfers of Part A liability out of Trust Fund**
 - (3) Transfers of revenue/savings from outside of Part A**
- **Absent some reliance on some non-traditional Part A savings, two problems arise:**
 - (1) Much larger provider cuts are necessary or**
 - (2) The number of years of extended life of the Trust Fund is eroded.**

Reinstating Home Health Policy

Arguments for:

- **It is our current policy.**
- **Home health costs in excess of 100 visits are rising at alarming rates.**
- **Simply reinstates pre-1980 law's allocation of expenditures -- a policy that virtually every House Republican voted for in 1995.**
- **Significantly strengthens the Trust Fund and its absence makes this goal more difficult.**
- **Allows for moderation of provider and beneficiary cuts, which is why the hospitals & nursing homes will strongly and quietly support.**

Reinstating Home Health Policy

Arguments against:

- Key Republicans will criticize.
- Elite reaction.
- Distribution of savings.
- Home health industry will strongly oppose.

Medicare In a New Environment

Pressures to Increase Medicare Number:

- 2002 deficit reduction target
- Desire to extend Medicare Trust Fund
- Reports that conclude hospitals and managed care are overcompensated
- Overall health policy priorities: Medicaid/investments
- Private sector growth rates declining

Pressures/Policies that Argue for Moderation:

- Republican savings streams from last Congress
- Beneficiary policy
- Provider policy
- Home health policy

Alternative Savers

Policy	5 years	2002
Income-Related Premiums:		
(1) Health Security Act: began at \$90k/\$115k (3% of beneficiaries); at least 25% subsidy	\$5 billion	\$1 billion
(2) 1995 GOP Budget: began at \$60k/\$90k (5% of beneficiaries); eliminates subsidy at top	\$8 billion	\$2 billion
(3) Coalition Budget: begins at \$50/\$75k (7% of beneficiaries); eliminates subsidy at top	\$13 billion	\$3 billion
Include Home Health Transfer in Part B Premium:	\$17 billion	\$4 billion \$75.10/month (up \$9.00 from \$66.10/month)
		1995 GOP Budget: \$88.90/month (3/95 CBO baseline) \$84.60/month (12/95 CBO baseline)
Expand Medicare Coverage to All State and Local Government Employees	\$7 billion	\$1 billion
Additional Managed Care Savings	\$8 billion	\$3 billion
Additional Hospital Savings: Option 1	\$5 billion	\$1 billion
Additional Hospital Savings: Option 2	\$15 billion	\$4 billion
Begin Respite Benefit In FY98	- \$2.2 billion	- \$0.5 billion
OPDs (coinsurance buydown)	- \$21.8 billion	- \$10.1 billion
Federalize Coverage of Low-Income Medicare Beneficiaries' Cost Sharing (i.e. buy down state share)	-	-
Other Programmatic Improvements	-	-

Facsimile Cover Sheet

To: CHRIS JENNINGS

Phone: _____

Fax: _____

From: **Bill Vaughan**
Committee on Ways and Means

Phone: 202-225-4021

Fax: 202-225-5680

Date: _____

Pages including this
cover page:

4

Comments:

WENT TO DEM HOUSE
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COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES
WASHINGTON, DC 20515

SUBCOMMITTEE ON HEALTH

December 6, 1996

adr~

Dear name~:

Over the next several months, the Administration--to extend the life of the Medicare Part A Trust Fund and, coincidentally, to balance the budget--is going to have to propose some fairly large Medicare cuts. Their last budget offer was \$116 billion and since then we have lost a year of savings.

Because the Republicans refused to take the President's \$116 offer which would have extended the life of the Trust Fund till 2006, Congress will now have to obtain the same level of savings at a faster rate.

If the Republicans were to offer a Medicare package with a balanced budget, their past statements show that their cuts would be much larger than ours. But with the President going first with a budget offer, undoubtedly the Republicans, conservative seniors' groups, and some in the media will attempt to confuse the public that our Medicare proposals are not greatly different than last year's Republican proposals.

I urge you to prepare now with your local media to explain that whatever the budget dollar figure, there remains a fundamental difference between the Democratic and Republican approaches. Attached are two very thoughtful articles on why the Republican plan would have radically altered the nature of Medicare in ways that the public (and media) have never understood. Send these to your editorial writers with a cover letter! We have not been demagogues on this issue and should take exception to those in the media who never understood the radical Republican changes.

December 6, 1996

Page 2

The Republican structural changes:

- would have pressured doctors to move into managed care plans (thus forcing their patients to follow) where the physicians could charge billions of dollars beyond the Medicare fee amounts;
- would have set arbitrary, hard budget caps on Medicare that would have been disastrous if inflation increased and which would not have kept up with reasonable rates of medical inflation--leaving beneficiaries with the equivalent of vouchers that bought less and less.
- failed to provide adequate consumer protections in managed care plans even though studies show that the low-income and frail elderly are not currently well-served in these plans.
- threatened the low-income assistance programs so vital to the 18% of seniors living below the poverty level.

You have two months to educate your editorial writers that our concerns of last year were real and much more important than the few billions of dollars* that will separate us in the coming budget fight. The attached pages from CRS Report 96-866 EPW is also useful in showing how we forced the Republicans to moderate their Medicare budget cuts.

Sincerely,

Pete Stark
Ranking Democrat

CONGRESS OF THE UNITED STATES
HOUSE OF REPRESENTATIVES
WASHINGTON, D.C. 20515

December 10, 1996

Dear Democratic Colleague:

During the coming months, you will endlessly hear the mantra "Medicare restructuring."

Sounds good; sounds innocent.

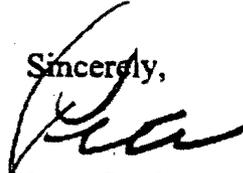
It is a codeword for shifting costs onto retirees and the disabled. It may be good budget policy, but it is bad health policy--because as lower income Medicare beneficiaries face higher and higher out-of-pocket costs, they will be less and less likely to seek care and their health will suffer.

Medicare beneficiaries already spend an average of \$2,605 per person on their own health care expenses--that's 21% of family incomes (up from 15% in 1987). 18% of Medicare beneficiaries live below the poverty line.

Please, let's not restructure Medicare (allow doctors to charge extra and turn the program into a vouchered/defined contribution plan that doesn't keep pace with inflation).

Whenever you hear the term "let's restructure Medicare," substitute the reality: "shifting costs to the poor." Medicare can be saved and improved, without pushing millions of seniors and disabled into deep poverty and ill-health.

Sincerely,

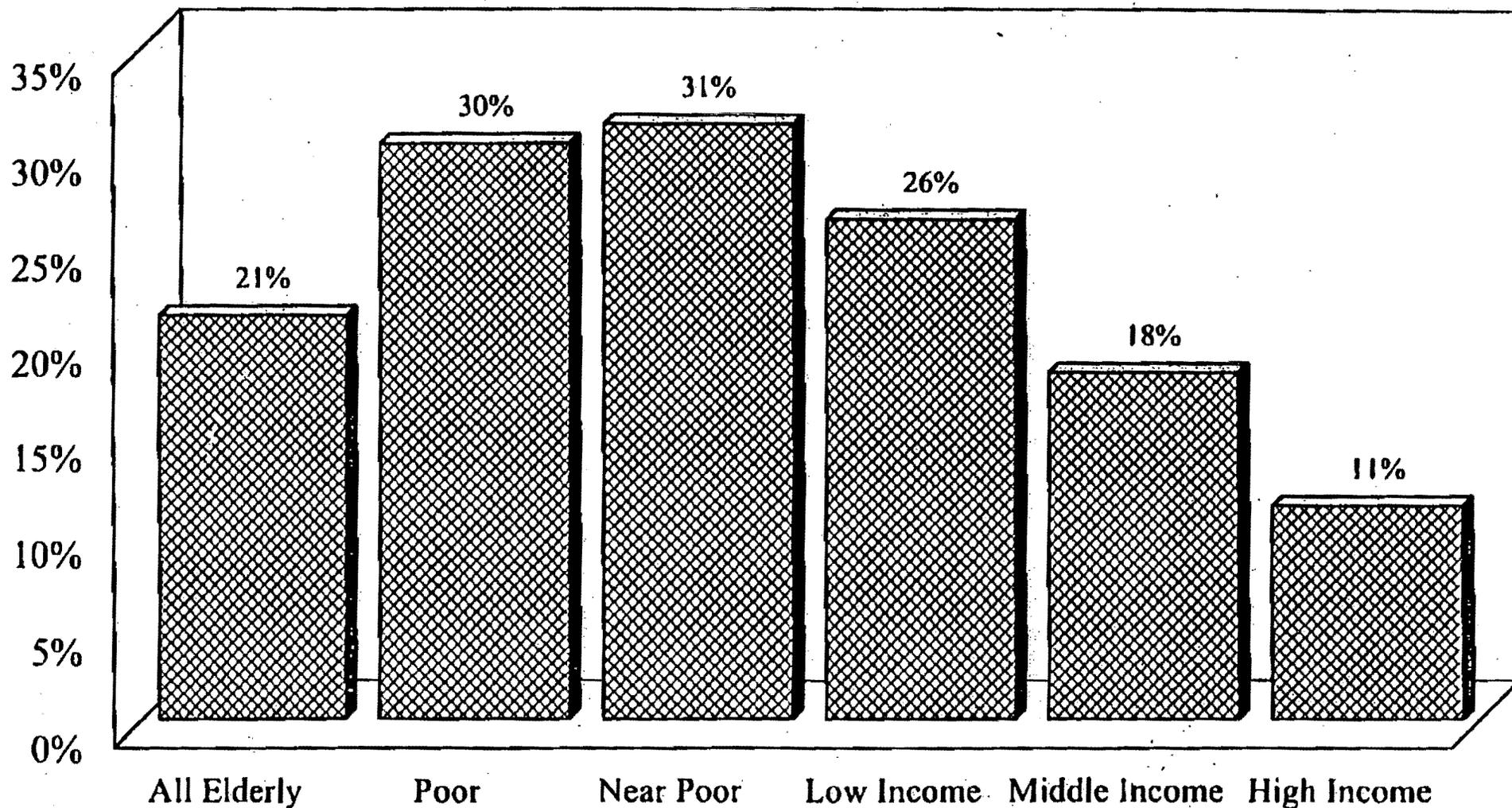


Pete Stark
Member of Congress

**MEDICARE
RESTRUCTURING=
CODEWORDS FOR
SHIFTING COSTS TO
RETIRES AND
DISABLED**

Figure 3

Total Health Spending by the Elderly as a Percent of Family Income, 1996



Poverty status definitions: poor=<100% of poverty; near poor=100-125%; low income=125-200%; middle income=200-400%; and high income=400%+
Source: Author's simulations using National Medical Expenditure Survey

Thinking About Balancing:

Budget Strategy for

1998 - 2002

Thinking About Balancing:

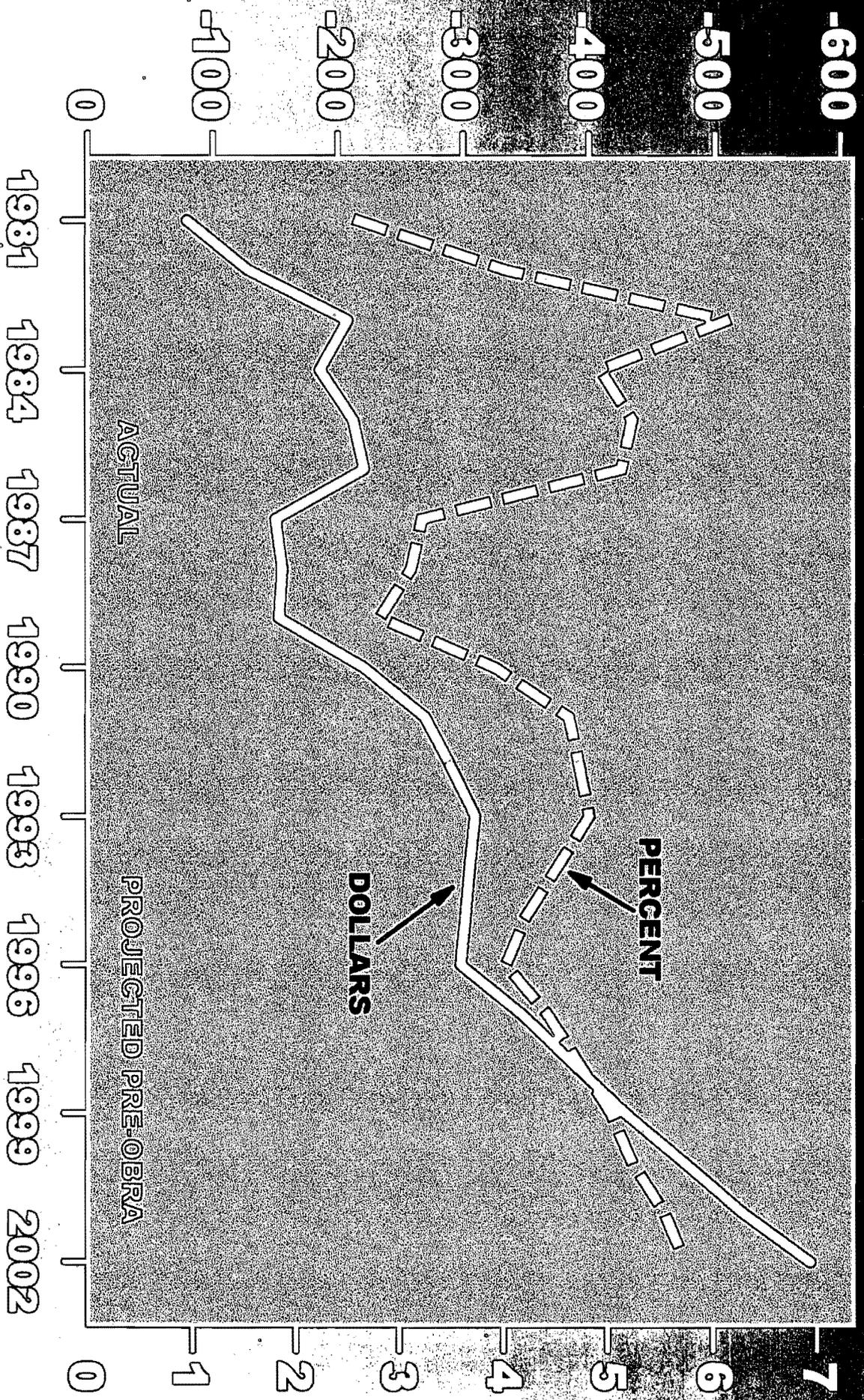
Progress from 1992 - 1996

WHAT YOU INHERITED IN 1993

ACTUAL AND PROJECTED DEFICITS

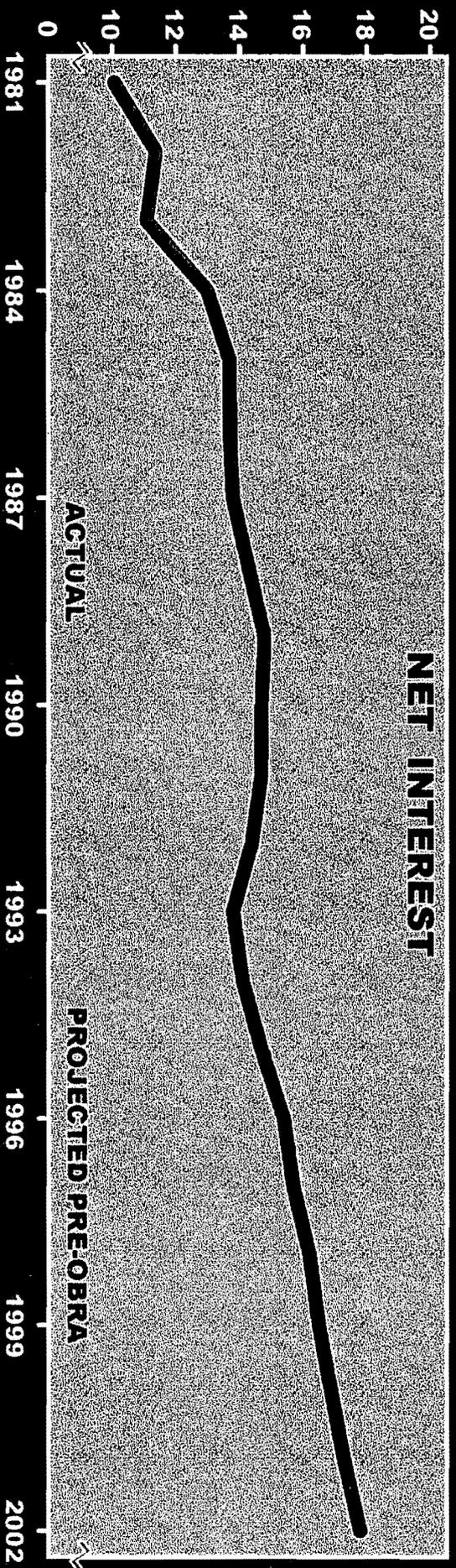
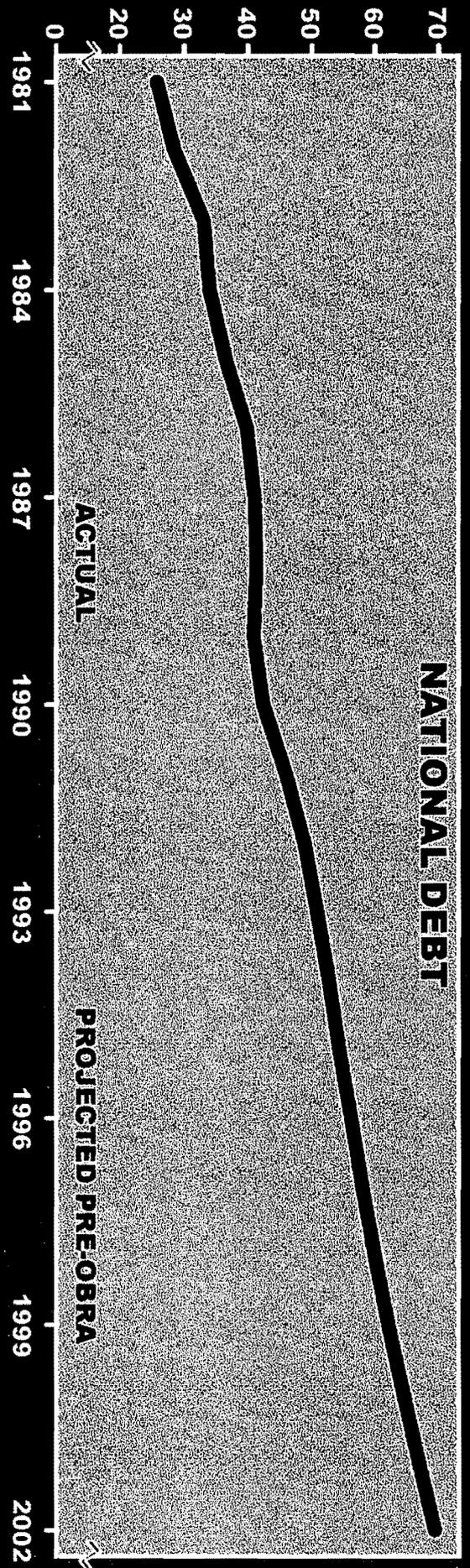
DOLLARS IN BILLIONS

PERCENT OF GDP



WHAT YOU INHERITED IN 1993

PERCENT OF GDP

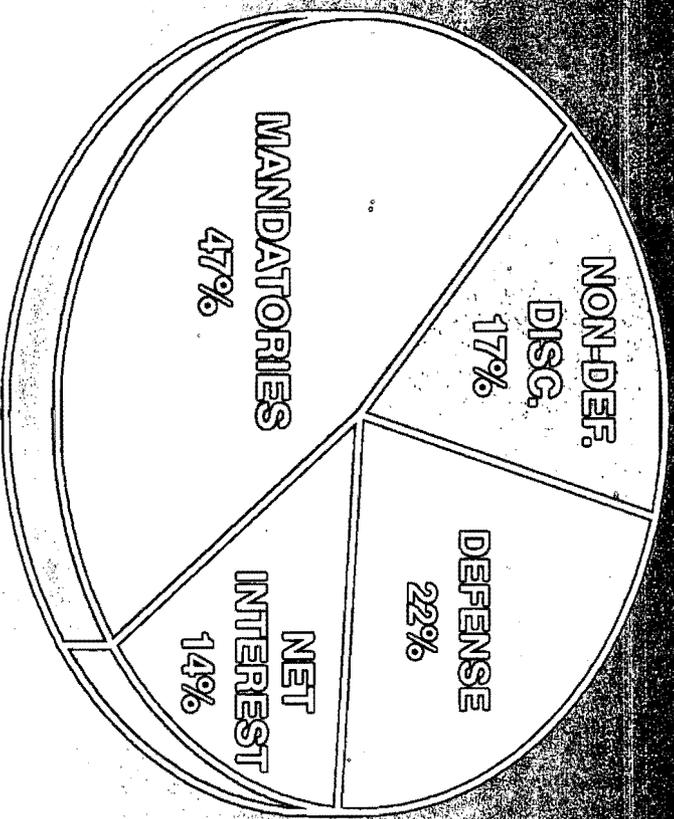


WHAT YOU INHERITED IN 1993

SHARES OF THE BUDGET

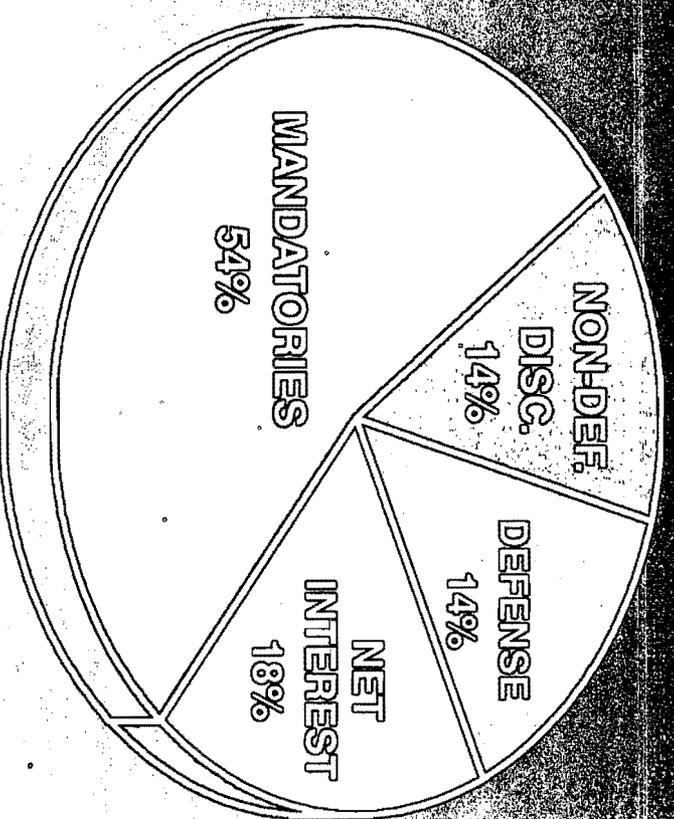
ACTUAL

1992



PRE-OBRA BASELINE

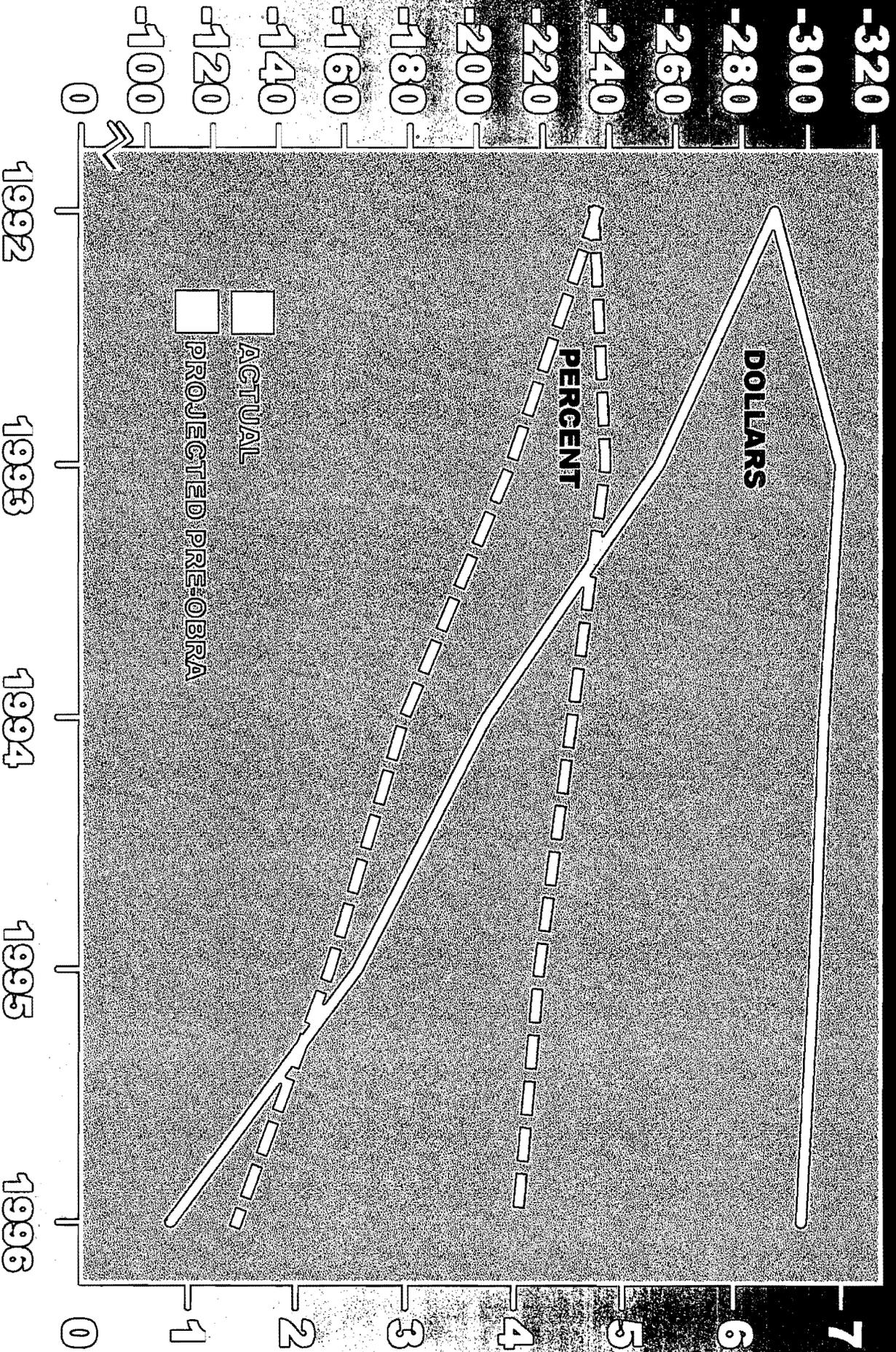
2002



WHAT HAPPENED

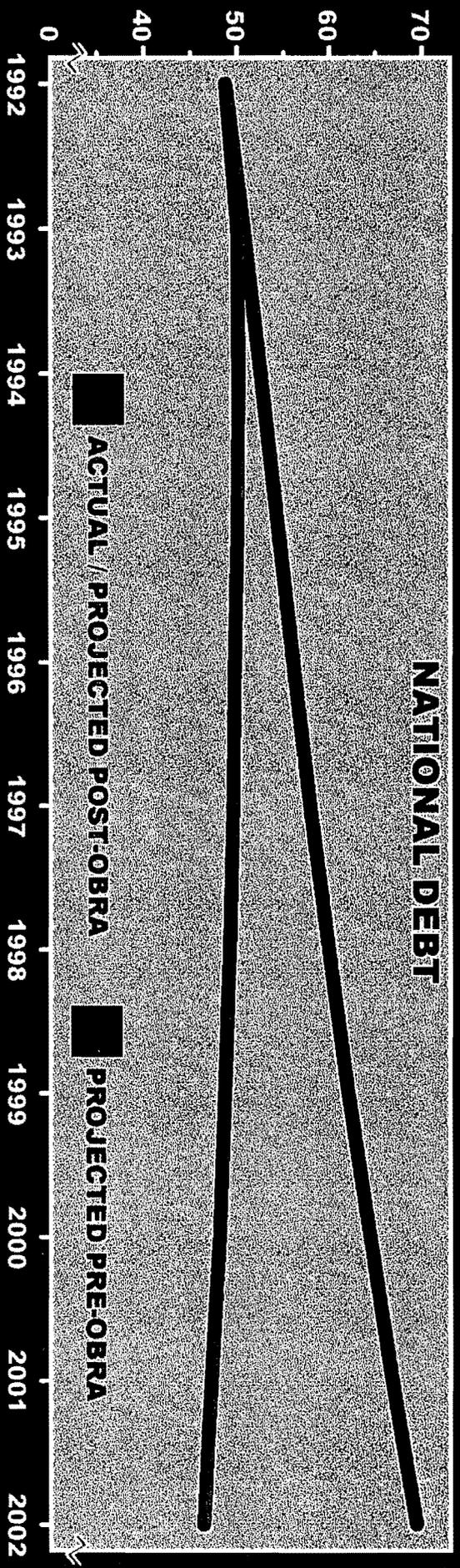
DEFICITS IN BILLIONS

PERCENT OF GDP

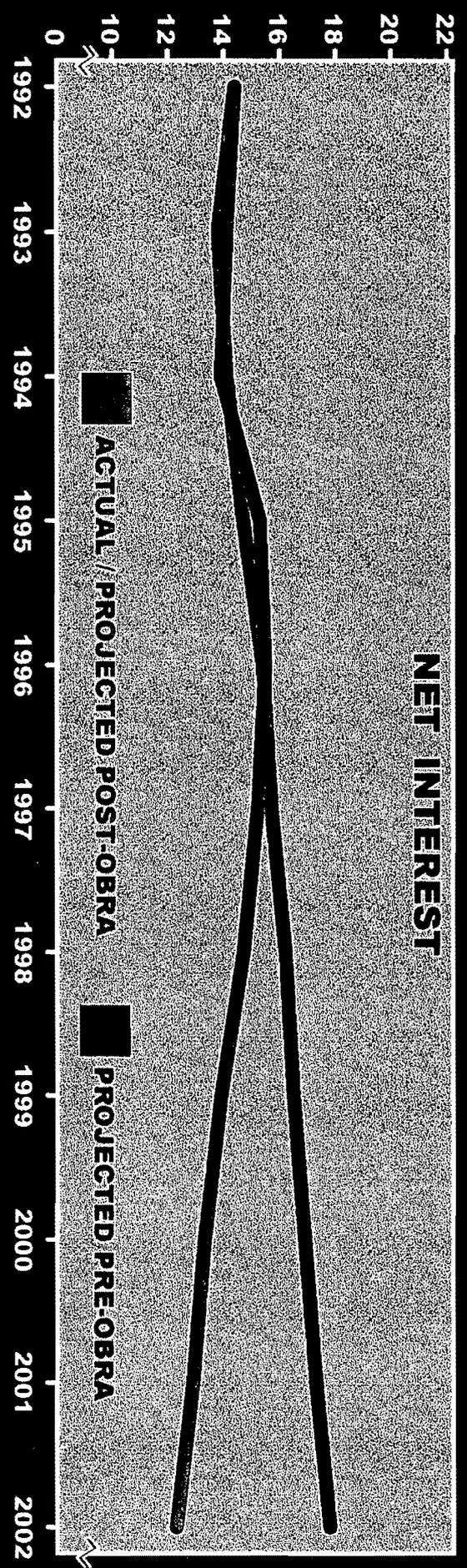


WHAT HAPPENED

PERCENT OF GDP



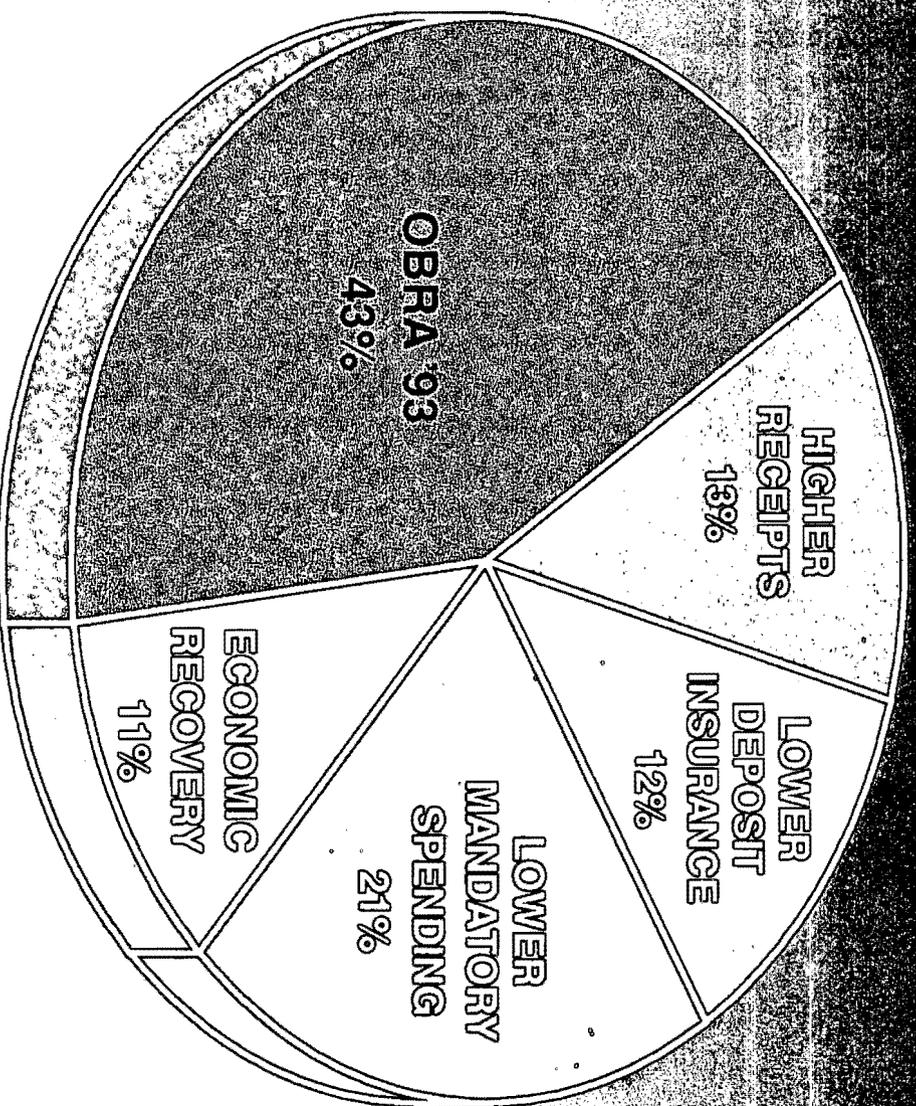
PERCENT OF BUDGET



WHAT HAPPENED

CONTRIBUTIONS TO \$485 BILLION REDUCTION

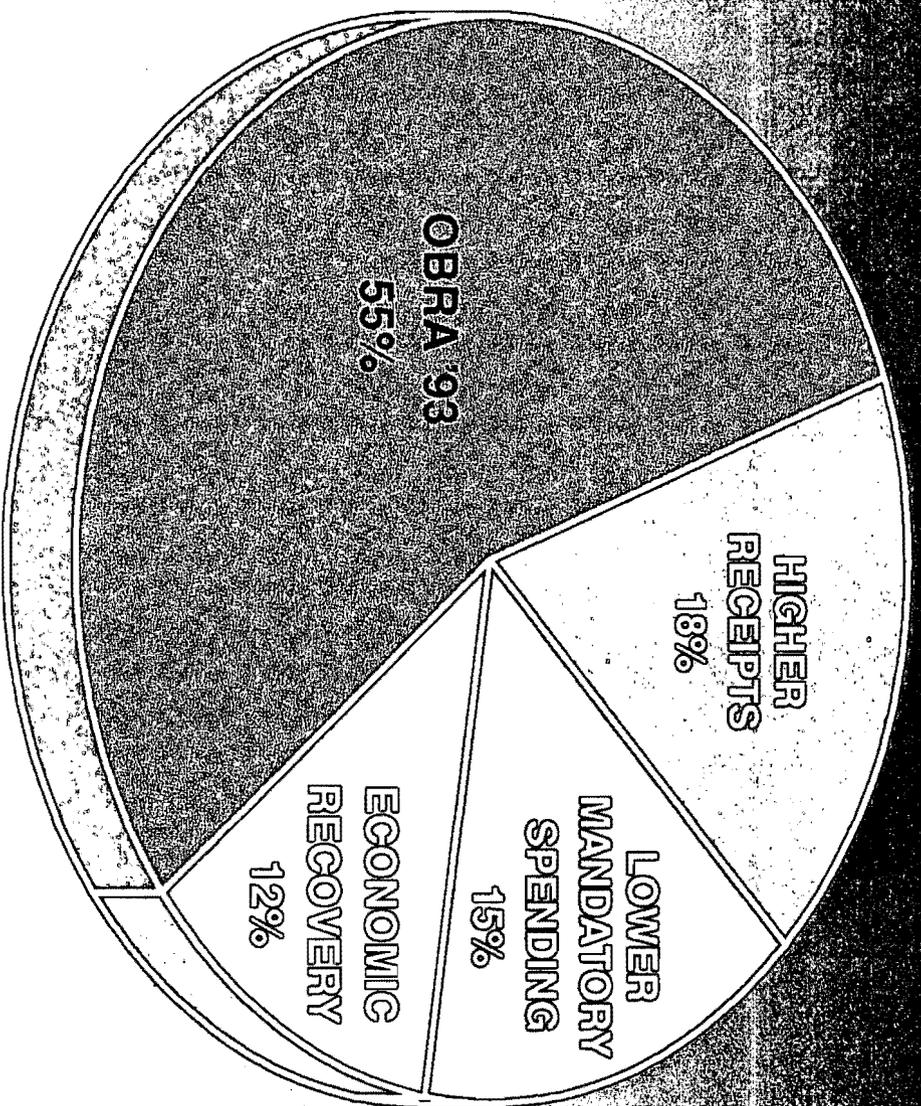
1993 - 1996



WHAT HAPPENED

CONTRIBUTIONS TO \$190 BILLION REDUCTION

1996

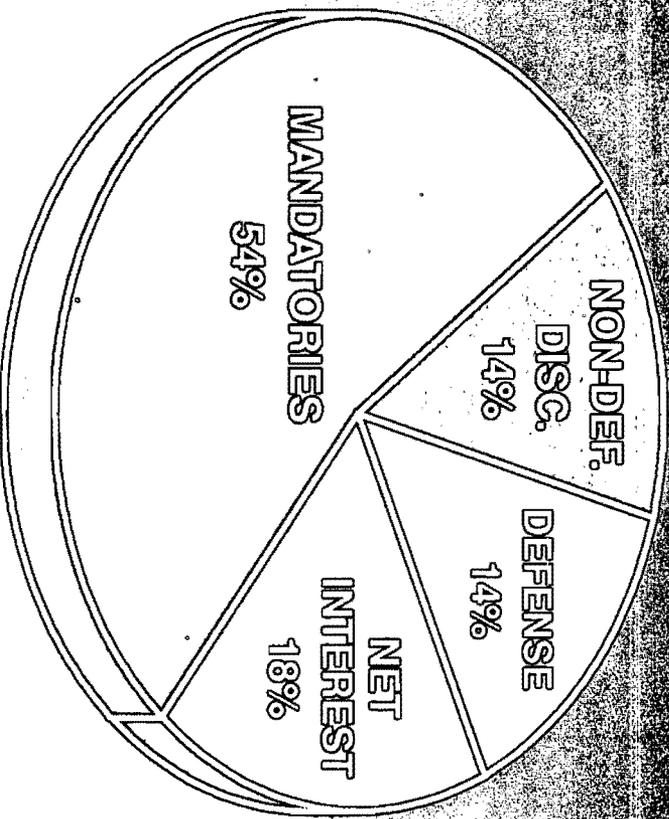


WHAT HAPPENED

SHARES OF THE BUDGET

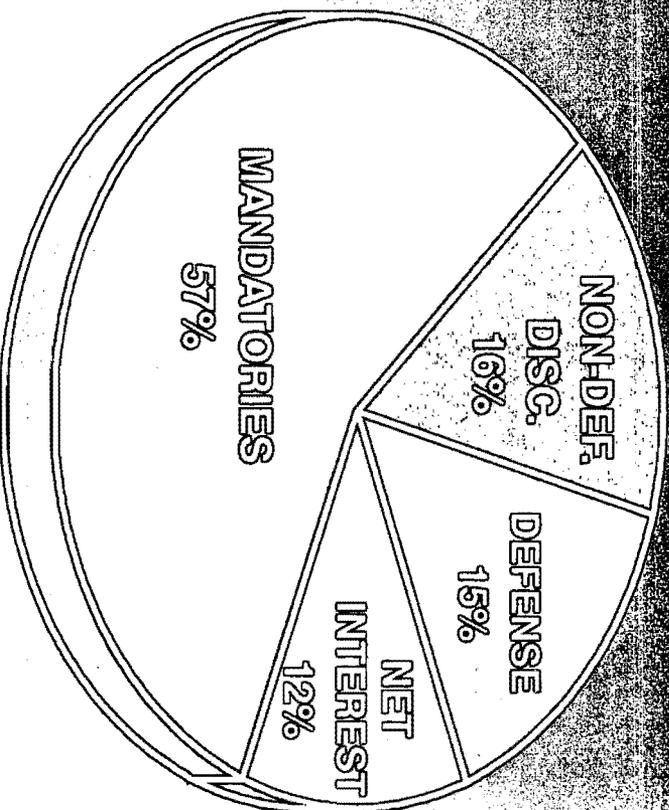
PRE-OBRA BASELINE

2002



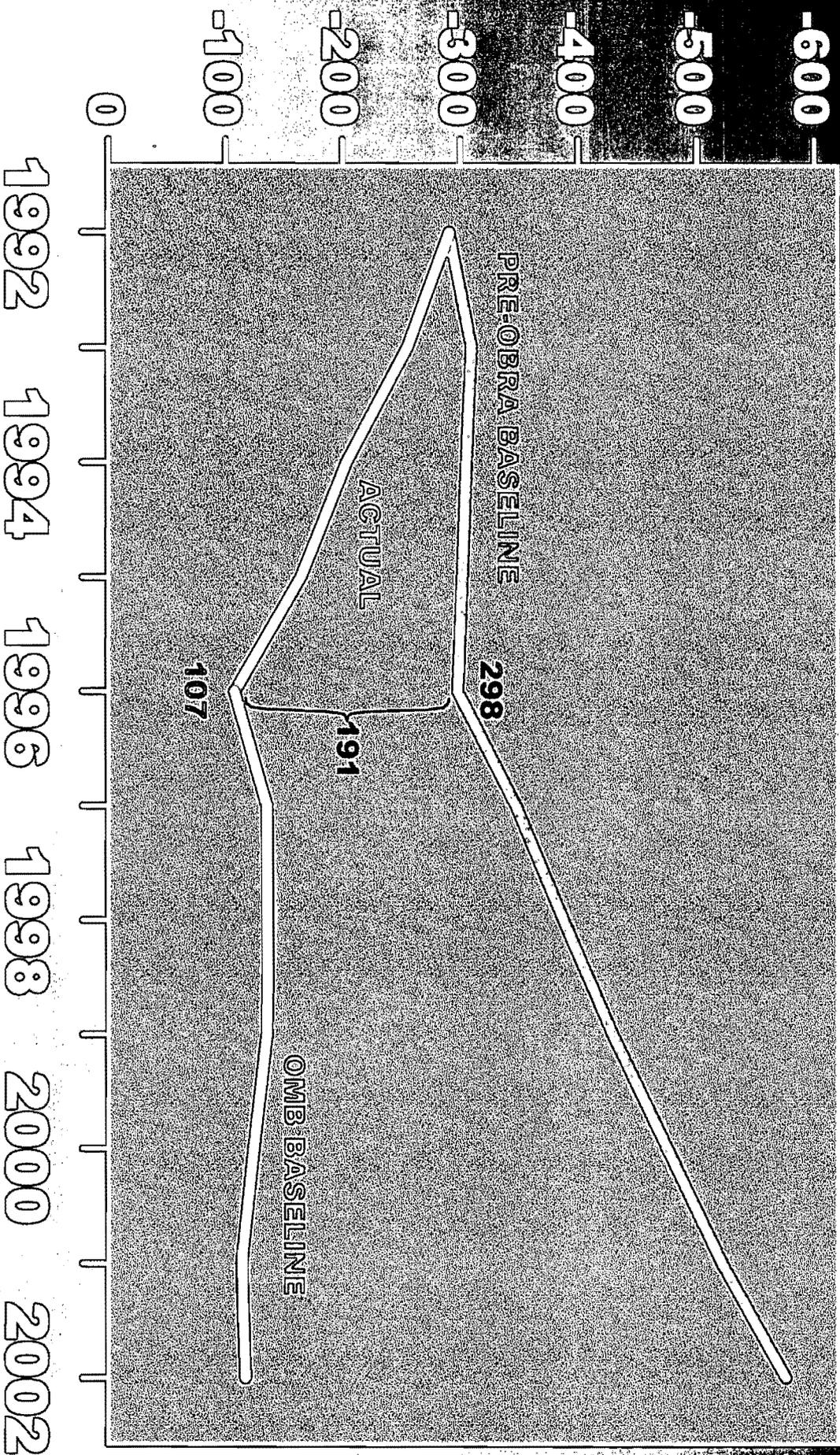
CURRENT BASELINE

2002



ONE THIRD LEFT TO GO (OMB ECONOMICS)

DEFICITS IN BILLIONS



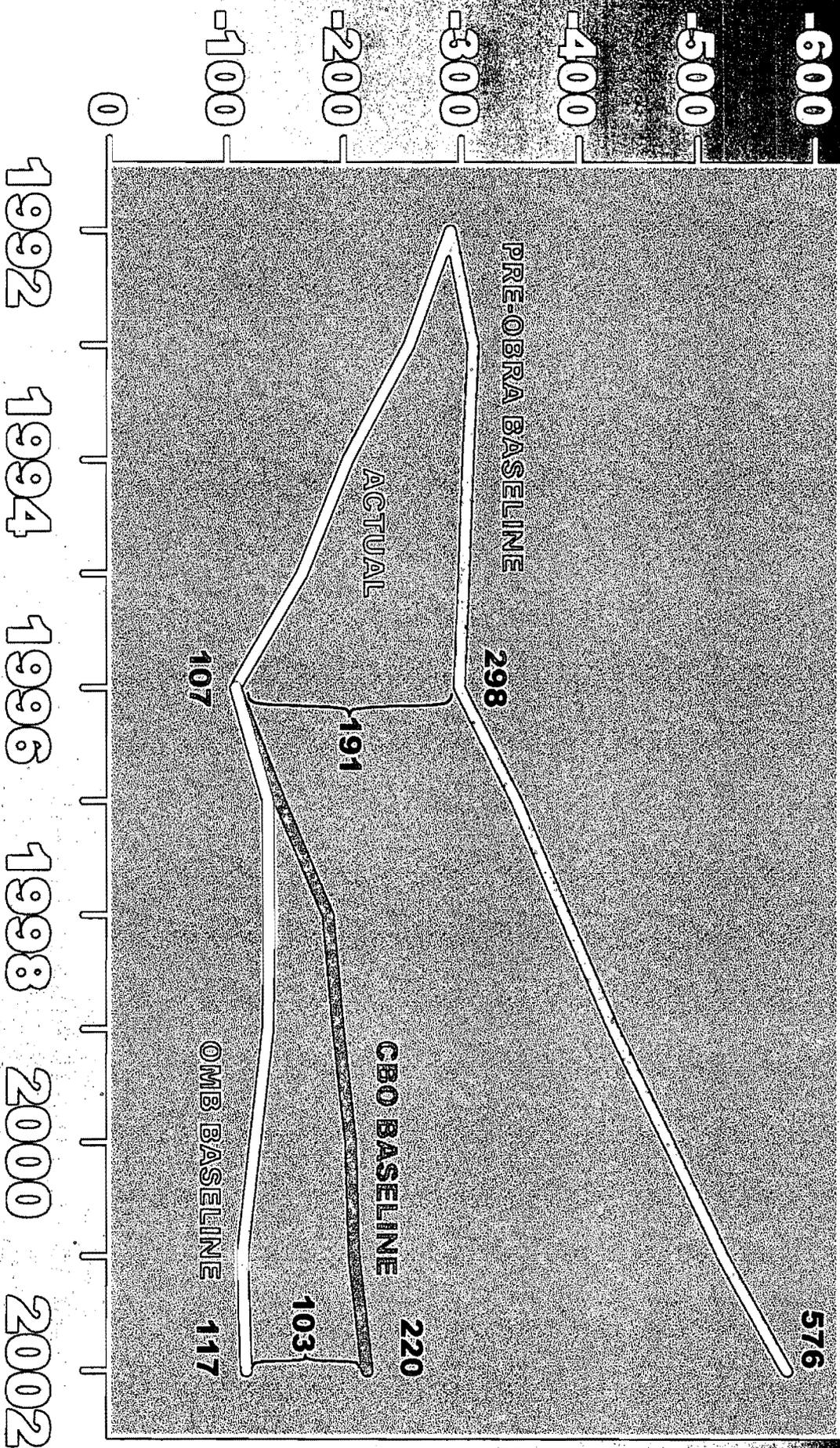
Last Third Harder Than First Two-Thirds

Special Contributions to 1996 Deficit Reduction

- 55% OBRA 1993
- 18% Unexpected Higher Receipts
- 15% Unexpected Lower Mandatory Spending
- 12% Economic Recovery

CBO PROJECTS BIGGER GAP

DEFICITS IN BILLIONS



OMB vs. CBO

\$103 billion difference

(billions)

	1997	1998	1999	2000	2001	2002
OMB	135	137	135	124	113	117
CBO	145	186	195	206	209	220

Difference between OMB and CBO

103

CBO Slightly More Pessimistic 2002

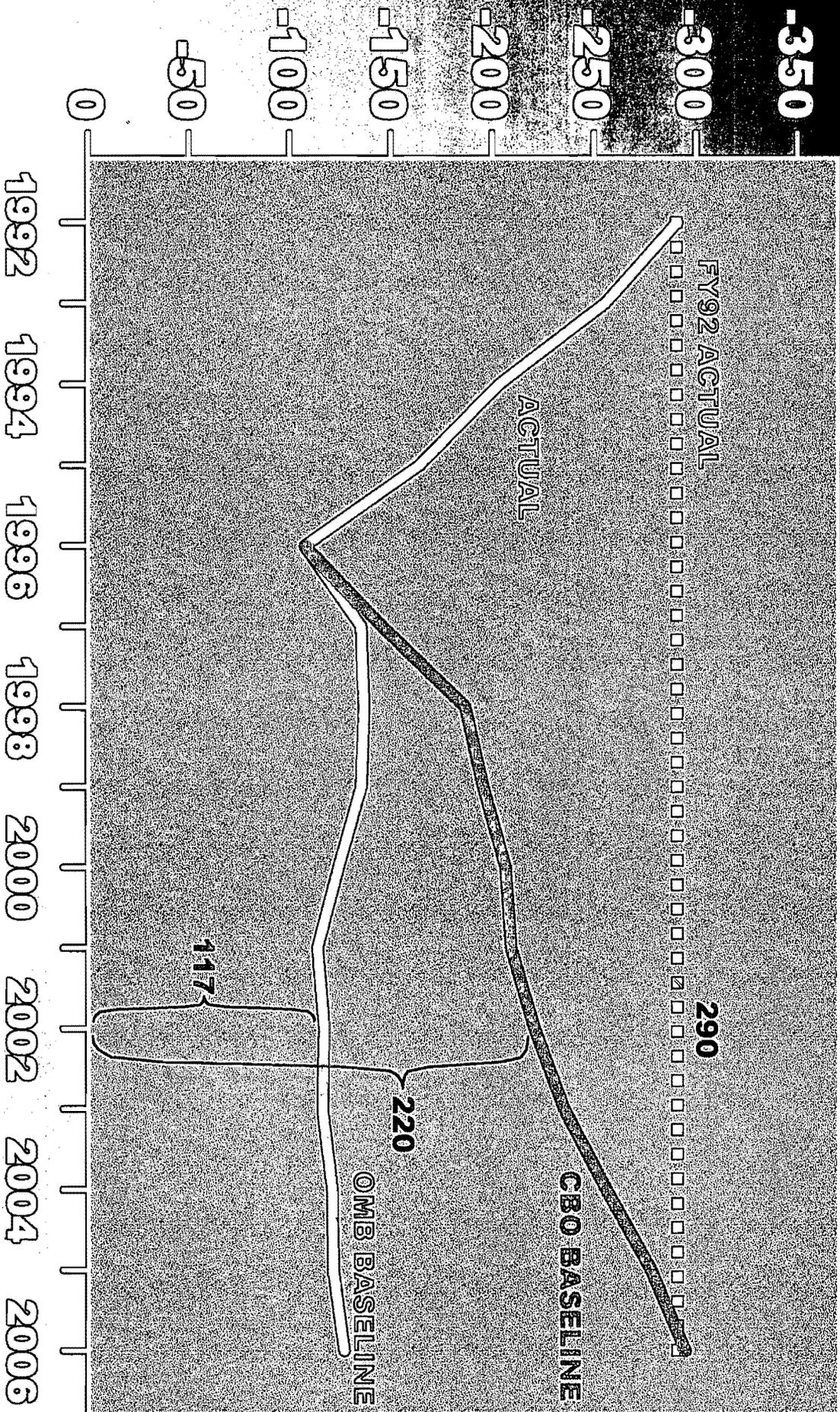
	OMB	CBO	Blue Chip
Real Growth	2.3%	2.2%	2.3%
Unemployment	5.5	5.8	5.7
Interest Rates (10-yr)	5.2	5.3	N.A.
Inflation	2.8	3.0	3.0
Taxable Income Share	76.4	75.5	N.A.

Small Differences = Big Dollars in 2002

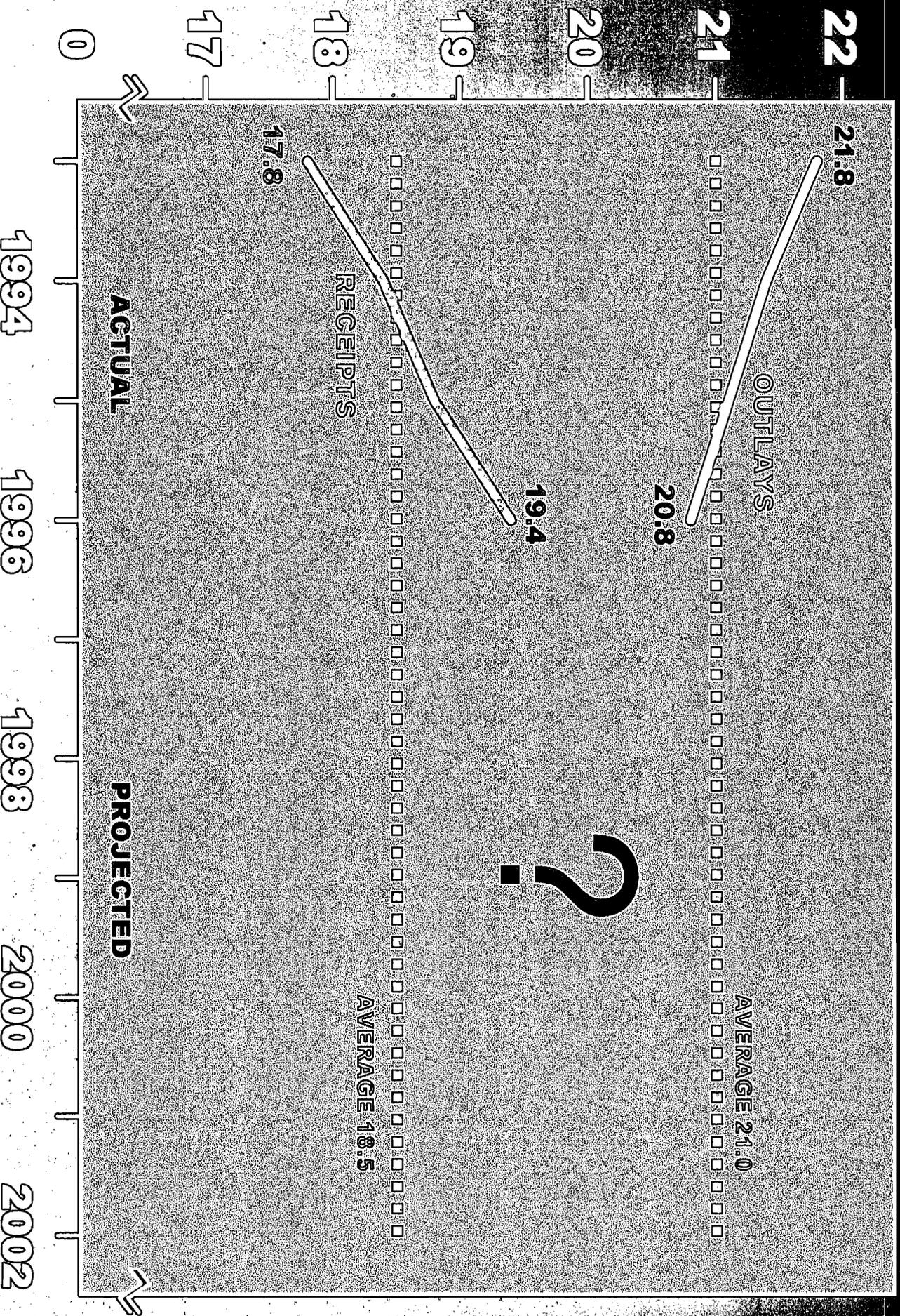
\$49 billion	--	Income shares
\$19 billion	--	Inflation
\$17 billion	--	Real growth
\$13 billion	--	Interest rates
\$ 3 billion	--	Unemployment
\$16 billion	--	Debt service and other
<hr/>		
\$118 billion	--	TOTAL

WHAT'S LEFT TO DO ?

DEFICITS IN BILLIONS



BALANCE AS A PERCENT OF GDP ?



Solution is bounded by schedule

- Legal requirement to submit President's budget by Feb 3
- CBO numbers available late January
- If we want to balance under CBO, we have to aim at an unknown target
- We will not know if our budget balances under CBO until it's too late

Solution also bounded by policy

- Commitment to balance by 2002
- Commitment to balance under CBO
- Commitments to domestic priorities, defense, and welfare fixes
- Medicare and Medicaid cuts limited
- No general tax increase

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

MEMORANDUM

TO: Rich T., Jack E., John C., Bruce V.
FROM: Debbie Chang *Debbie*
DATE: December 5th
RE: Materials for White House meeting on Medicare

The attached is for use at the White House meeting on Medicare at 6:15 pm today. Please treat confidentially. Due to sensitivity of White House, I am only giving it to principals.

Please call me or Ira Burney if you have questions.

DETERMINED TO BE AN
ADMINISTRATIVE MARKING

INITIALS: 17 DATE: 6-23-05 Medicare Options

~~CONFIDENTIAL~~

OPTIONS

- (1) Last year's package, slipped by one year, with adjustments. (See specifications in Attachment A).
- (2) Same as option (1) but with \$10 billion more in savings, primarily through managed care plans.
- (3) Same as option (1) but with an income related premium similar to the Health Security Act provision. The savings from the income related Part B premium would be transferred to Part A.
- (4) Same as option (1) but with adjustments made to achieve savings of \$44 billion in FY 2002.
- (5) Same as option (4) but with additional benefit improvements (See Attachment B) and with a Part B premium increase as a result of the home health care shift from A to B.

INFORMATION PRESENTED WITH THE OPTIONS

Each option would be priced on the Administration's FY 1998 baseline with the following information with each option, in addition to the year-by-year savings streams:

- (a) Trust Fund Solvency Exhaustion Date
- (b) Savings in FY 2002
- (c) Total 5 year and 6 year savings
- (d) Distribution of savings for Part A and Part B
- (e) Part B premium:
 - o Part B premiums assuming 25% costs of Part B
 - o Net increase in premiums compared to current law

In addition, we would present:

- o Current law Part B premiums through 2002, and
- o 1995 Conference Agreement Premiums using the March 1995 and Dec 1995 and CBO baselines.

DETERMINED TO BE AN
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INITIALS: DF DATE: 6-23-05

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Attachment A

Specs for Last Year's Package Slipped One Year

The overall description is to slip all policies in last year's package by one year. However, there are a number of policies that have "date certain out-year effective dates" which should not be slipped and there are other policies for which detailed specification is useful. Following are specifications for each proposal from last year's package.

Two versions of the pricing are needed, one including the savings from the OPD formula driven overpayment (FDO) policy, the other without it.

- o PPS and Non-PPS Updates. MB-1 for FY 1998-2000 and MB-1.5 for FY 2001-2002.
- o PPS Capital. Last year this policy gave the FY 1996 capital update to PPS capital rates that applied on 9/30/95. This resulted in savings of a specific amount in FY 1998. Slipping the policy one year would mean applying the FY 1996 and FY 1997 capital updates to the PPS capital rates that applied on 9/30/95. The savings stream would not be shifted by one year.
- o Non- PPS Capital. The 15 percent reduction would apply for FY 1998 to FY 2002.
- o LTC Hospital Moratorium. Continues to be effective upon enactment. Assumption of enactment slipped one year to FY 1998.
- o Centers of Excellence. Effective FY 1998.
- o IME. 6.5% in FY 1998, 6.3% in FY 1999 and 6.0% beginning in FY 2000.
- o GME Reform.
 - + IME. For discharges beginning with FY 1998, the total number of residents and total number of non-primary care residents would not exceed the number in the hospital for the cost reporting period ending on or before 12/31/95. Cap IRB ratio at FY 1996 level.
 - + IME for interns and residents providing off-site services. Effective for discharges beginning with FY 1998.
 - + GME Limit on number of residents. For cost reporting periods beginning with FY 1998, the total number of FTE residents would not exceed the number of FTE residents in the cost reporting period ending on or before 12/31/95.
 - + GME for non-hospital providers. Effective for cost reporting periods beginning with FY 1998.
- o Eliminate Add-On for Outliers. Effective for discharges beginning with FY 1998.
- o Treatment of Transfers. Effective for discharges beginning with FY 1998.
- o Sole Community Hospitals. The alternative base year would be the average of 1994 and

ADMINISTRATIVE MARKING

INITIALS: DA DATE: 6-23-05**CONFIDENTIAL**

1995 cost reporting periods. Effective for cost reporting periods beginning with FY 1998.

- o RPCH Expansion. Effective on enactment.
- o Medicare Dependent Hospitals. Effective for discharges occurring during portions of cost reporting periods beginning on or after FY 1998.
- o Home Health Freeze Extension. Last year this policy extended the savings stream from expiration of the OBRA-1993 temporary freeze. This resulted in savings of a specific amount in FY 1998. Slipping the policy one year would now mean a further reduction in the home health cost limits under the interim system to achieve the savings that would have occurred beginning in FY 1998 if the OBRA-1993 fee freeze had been extended. The savings stream would not be shifted by one year.
- o Home Health PPS. Still effective FY 2000 (not slipped).
- o HH Elimination of PIP. Still effective FY 2000 (not slipped).
- o Transfer Certain Home Health to Part B. Effective FY 1998.
- o SNF Freeze Extension. Last year this policy extended the savings stream from expiration of the OBRA-1993 temporary freeze. This resulted in savings of a specific amount in FY 1998. Slipping the policy one year would now mean a reduction in the SNF payment amounts in FY 1998 to achieve the savings that would have occurred beginning in FY 1998 if the OBRA-1993 fee freeze had been extended. The savings stream would not be shifted by one year.
- o SNF Interim and Full PPS Systems. The effective date for the SNF PPS is still FY 1998 (not slipped). The policy for FY 1998 would incorporate the savings that would occur beginning in FY 1998 from the interim and full PPS policies from last year if both were effective beginning in FY 1998. Consolidated billing effective FY 1998.
- o Therapy guidelines. Effective for FY 1998.
- o Medicare Choice. All policies shifted one year, including floor beginning in 1998 equal to \$325 increased by 1998 index factor.
- o Remove GME, IME and DSH from AAPCC. Removed from AAPCC formula beginning with 1998 (40 percent in CY 1998 and 100 percent beginning in CY 1999). Payments from the savings would be made to directly to HMOs, teaching hospitals, and DSH hospitals, subject to a cap equal to 100 percent of net savings.
- o Medicare secondary payor extenders. Effective beginning with FY 1999 (not slipped).
- o MSP Insuror Reporting and Court Case.

- + All third party payers to gather information and report to the Secretary on Medicare Secondary Payor (MSP) situations, effective 180 days after enactment.
- + Court case fixes effective 1/1/91, except double billing penalty effective upon enactment.
- o Fraud and Abuse. Drop proposals since these provisions were enacted in HIPAA.
- o Physician Single Conversion Factor, Revised Targets/Updates.
 - + Establish single conversion factor in 1998 at 1997 primary care conversion factor updated by overall 1998 update.
 - + Cumulative expenditure targets, real gross domestic product per capita plus one percentage point, eliminate pricing offset for update changes from the target, increase the maximum reduction in updates due to performance from 5 to 8.25 percentage points and set limit on annual bonuses at 3 percentage points, effective for targets beginning with FY 1997.
 - + Anesthesia services would have the same as the update as for surgical services in 1997 and for all physicians' services beginning in 1998.
- o Reduce Physician Overhead Payments. Effective 1/1/98.
- o Single Payment for Surgery. Effective 1/1/98.
- o Incentives to Control the Volume of In-Hospital Physicians' Services. Effective 1/1/00.
- o Physician Assistants, Nurse Practitioners and Clinical Nurse Specialists. Effective 1/1/98.
- o Eliminate FDO. Effective beginning with FY 1998.
- o OPD extenders. Effective beginning with FY 1999.
- o OPD PPS. Effective 1/1/02.
- o DME, Oxygen, Prosthetics and Orthotics. Oxygen 10 percent cut effective 1/1/98 and freeze updates for DME and orthotics and prosthetics for FY 1998 through FY 2002.
- o Reduce Updates for Ambulatory Surgery Centers (ASCs). CPI-2 applies for FY 1997 through FY 2002.
- o Preventive Benefits. Waive mammography cost-sharing, annual mammogram, colorectal screening, diabetic education and strips and flu shot administration effective 1/1/98.
- o Respite Care. Effective FY 2002.
- o Part B premium at 25 percent extension (effective beginning with 1999). (The Part B premium offset to be recomputed).

DETERMINED TO
ADMINISTRATIVE MATTER
INITIALS: DT DATE: 6-23-05

CONFIDENTIAL

Attachment B

Expanded Medicare Benefits (billions)
(Estimated Administration Pricing 1/)

	<u>5-year</u>	<u>6-year</u>	<u>2002</u>
<u>Base Package</u>			
Waive Mammogram Cost-Sharing	\$0.3	\$0.4	\$0.5
Annual Mammogram	\$0.5	\$0.6	\$0.1
Colorectal	\$0.6	\$0.8	\$0.2
Flu Shot Administration	\$0.5	\$0.6	\$0.1
PA's, NA's, CNS's	\$1.4	\$1.8	\$0.4
Respite (begins in FY 02)	\$0.0	\$0.5	\$0.5 <u>2/</u>
Subtotal	\$3.3	\$4.7	\$1.8
<u>Additional Benefits</u>			
ESRD Facility Rate	\$1.8	\$2.4	\$0.4
Free-Standing IHS Clinics	\$0.1	\$0.2	\$0.0
No Chiropractic X-Ray Required	\$0.1	\$0.3	\$0.1
OPDs (coinsurance buydown)	-\$0.2	\$2.4	\$1.4 <u>3/</u>
Respite Care (begin in FY 98)	\$2.2	\$2.2	\$0.0 <u>4/</u>
Federalize State QMB Costs			
Premium	\$11.3	\$14.0	\$2.6 <u>5/</u>
Cost Sharing	\$21.5	\$27.1	\$5.2 <u>5/</u>
Subtotal	\$36.8	\$48.6	\$9.7

1/ Estimated Administration pricing before premium offset and before managed care interaction based on FY 1997 Administration baseline.

2/ The Part B premium did not apply to the respite care benefit.

3/ The figures shown are the Federal budget impact. Reduction in beneficiary coinsurance saves beneficiaries the following amounts: 5-year, \$21.8 billion; 6-year, \$36.1 billion and \$10.1 billion in FY 2002. The hospital impact is: 5-year, \$25.9 billion; 6-year, \$38.9 billion and \$9.9 billion in FY 2002.

4/ These figures are the marginal costs of respite care relative to the base package where the respite benefit begins in FY 2002 at a cost of \$0.5 billion

5/ Net Federal budget costs. Assumes Federal payment of current state costs for QMBs. However, these figures are not cost estimates and they exclude: (a) Part B premium costs for extension of the 25 percent rule; (b) the drug portion for dual eligibles; and (c) behavior changes.

If Federalization of QMBs becomes a Medicare benefit, then these figures exclude the transfer to Medicare from Medicaid of current Federal spending under Medicaid for Medicare premiums and cost sharing. This would increase Medicare costs for both premiums and cost-sharing by \$44 billion over 5-years, \$55 billion over 6-years and \$10 billion in FY 2002.



555 West 57th Street / New York, N.Y. 10019 / (212) 246-7100 / FAX (212) 262-6350
Kenneth E. Raske, President

December
Two
1996

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

Dear Mr. President:

During the arduous Medicare and Medicaid debates of 1995 and early 1996, Greater New York Hospital Association (GNYHA), working collaboratively with the New York Congressional Delegation, 1199 National Health and Human Service Employees Union and District Council 37 (AFSCME), enjoyed an excellent working relationship with your Administration. Former White House Chief of Staff Leon Panetta showed a particular interest in addressing our concerns and directed members of your staff to work with us. Through this relationship our member hospitals and continuing care members gained a better understanding of the Administration's priorities, and your original Medicare and Medicaid proposals were modified to reflect many of the concerns we raised on behalf of the health care community of metropolitan New York.

As you and your staff begin to consider Medicare and Medicaid proposals for the fiscal year 1998 budget, we would like to continue to work with your Administration to ensure that the health care needs of New Yorkers are adequately addressed and that earlier progress continues. To this end, I have attached to this letter summaries of GNYHA's Federal priorities for our hospital and continuing care members, as well as a description of GNYHA's very exciting public education campaign on the uninsured designed to help gain the public support necessary to solve this extremely important issue.

We would welcome the opportunity to meet with you or your staff to discuss these priorities. If your staff members have any questions, please have them call David Rich, Vice President of Government Affairs, at (212) 246-7100. Thank you for your consideration and attention.

My Best.

Sincerely,

Kenneth E. Raske
President

Attachments

GREATER NEW YORK HOSPITAL ASSOCIATION

MEDICARE PRIORITIES FOR FY 1998:

HOSPITALS

- Graduate Medical Education Trust Fund: GNYHA strongly supports Senator Daniel Patrick Moynihan's "Medical Education Trust Fund Act of 1996" (S. 1870) and urges the President to include Senator Moynihan's bill in his FY 1998 budget proposal.
- Medicare Managed Care "Carve-Out": During the FY 1997 budget negotiations, President Clinton agreed to remove 100% of direct graduate medical education (DGME), indirect graduate medical education (IME), and disproportionate share (DSH) payments from the adjusted annual per capita cost (AAPCC) for Medicare managed care enrollees and to continue to make DGME, IME, and DSH payments to hospitals directly for such costs associated with care provided to managed care enrollees. The President dropped an earlier proposal under which the Federal government would have retained 25% of the amount removed from the AAPCC for deficit reduction purposes. GNYHA strongly supports President Clinton's final "carve-out" proposal (i.e., no cut) with the caveat that hospitals should be reimbursed using the current DGME, IME, and DSH payment methodologies. In addition, GNYHA urges that, to the extent the AAPCC methodology is reformed, DGME, IME, and DSH payments be removed from the current AAPCC before any new methodology (e.g., "blending") is applied to the AAPCC. This would avoid a geographic redistribution of DGME, IME, and DSH funds. Also, to the extent the AAPCC methodology is reformed, it must not be undertaken in such a manner as to disadvantage Medicare beneficiaries in the metropolitan New York area.
- Disproportionate Share (DSH): During the FY 1997 budget debate, President Clinton agreed to eliminate all Medicare DSH payment cuts from his Medicare proposals. GNYHA strongly supports President Clinton's final DSH position (i.e., no cut) and urges the President to maintain this position throughout future budget negotiations.
- Direct Graduate Medical Education: GNYHA urges the President to oppose proposals to (a) mandate the number and mix of residents in training; (b) change the DGME payment methodology from the hospital-specific per resident amount methodology to a national average methodology; (c) cap the number of residents for which DGME payments will be made; (d) discriminate against international medical graduates (IMGs); and (e) extend the freeze on DGME payments for specialty residents. GNYHA supports President Clinton's proposal to allow the Secretary to make DGME payments to certain non-hospital providers who incur the costs of medical education.

- *Indirect Graduate Medical Education:* GNYHA urges the President to oppose proposals to (a) reduce the IME adjustment factor; (b) weight residents "beyond the initial residency period" at 50% for purposes of calculating the IME adjustment; and (c) cap the intern and resident to bed ratio (IRB) at a base year level. GNYHA strongly supports President Clinton's proposal to allow hospitals to count residents in non-hospital settings in their IRB ratio if they continue to pay the resident's salary.
- *Reform of the Medicare Program:* GNYHA strongly supports increasing the health plan options available to Medicare beneficiaries through the authorization of provider-sponsored organizations (PSOs) and the elimination for PSOs of the enrollment composition and minimum enrollment rules now applicable to health maintenance organizations and competitive medical plans so long as the PSO can make other assurances regarding the mix of patients served.
- *Reclassification of Discharges to PPS-Exempt Facilities and SNFs:* GNYHA strongly opposes proposals to reclassify discharges from hospitals to facilities that are exempt from the Prospective Payment System (PPS) and skilled nursing facilities (SNFs) as transfer cases, and urges the President to oppose such proposals throughout future budget negotiations.
- *Incentive Payments for Long Term Hospitals:* GNYHA strongly opposes proposals to eliminate incentive payments for long term hospitals who keep costs below the target rate limits set by the Medicare program and urges the President to oppose such proposals throughout future budget negotiations.

GREATER NEW YORK HOSPITAL ASSOCIATION

MEDICARE PRIORITIES FOR FY 1998:

CONTINUING CARE PROVIDERS

- **Prospective Payment System (PPS):** GNYHA supports the development of a prospective payment system for post-acute care services so long as such a system truly recognizes the costs and resources necessary to provide quality care to skilled nursing facility residents and home health care beneficiaries at all levels of acuity. Great care needs to be taken in the implementation of a PPS for continuing care services. While the Prospective Payment Assessment Commission (ProPAC) has documented increases in aggregate Medicare spending on post-acute services, ProPAC has clearly stated that the reasons for such increases are poorly understood. ProPAC has also provided no estimates of how much faster Medicare spending may have increased without the substitution of continuing care services for acute care services. In addition, it is extremely important that Federal policymakers take into account the significant qualitative benefits associated with the shift from acute care to subacute and continuing care. For all of these reasons, the development of a PPS should be undertaken with care and only after sufficient data have been gathered.
- **Interim Payment System:** GNYHA has serious concerns about many of the proposals considered during the FY 1997 budget negotiations which would have changed Medicare SNF payment rules prior to the implementation of a PPS. In particular:
 - Routine Cost Limit Exceptions, Exemptions:** GNYHA strongly opposes proposals to completely eliminate routine cost limit exception payments and routine cost limit exemptions, and urges the President to oppose such proposals throughout future budget negotiations.
 - Ancillary Service Payment Reductions:** GNYHA strongly opposes proposals to arbitrarily reduce payments for ancillary services or to reduce the volume of ancillary services prior to the development of a PPS and without adequate qualitative data on the need for such services.
 - Hospital-Based SNFs:** GNYHA strongly opposes proposals to eliminate the hospital-based SNF differential by basing regional cost limits on the costs of free-standing SNFs only, and urges the President to oppose such proposals throughout future budget negotiations.
- **Reclassification of Discharges to SNFs:** GNYHA strongly opposes proposals to reclassify discharges from hospitals to PPS-exempt facilities and SNFs as transfer cases, and urges

the President to oppose such proposals throughout future budget negotiations.

- *Distinct Costing*: GNYHA strongly supports the ability of SNFs to set up "distinct costing" areas for high and low intensity patients, and urges the President to direct the Health Care Financing Administration (HCFA) to allow this.

GREATER NEW YORK HOSPITAL ASSOCIATION

MEDICAID PRIORITIES FOR FY 1998

- Medicaid Reform: GNYHA strongly supports the President's position that Medicaid must remain an entitlement program for low-income families and individuals and urges the President to oppose any attempts to deny Medicaid coverage to current or future eligibles. GNYHA also strongly opposes any changes in the formulas used to reimburse states for Medicaid costs that would have the effect of redistributing Medicaid funds from New York to other states. GNYHA strongly supports proposals to increase New York's Federal medical assistance percentage (FMAP).
- New York's 1115 Medicaid Managed Care Waiver: GNYHA strongly supports Governor Pataki's proposed 1115 Medicaid managed care demonstration project, and urges the President to direct the Secretary of Health and Human Services to approve the waiver without further delay.
- Coverage for Legal Immigrants: GNYHA strongly supports the President's position, supported by the bipartisan political leadership of New York State, that the new limits placed on Medicaid coverage for legal immigrants, contained in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, should be repealed. At the very least, permanent residents under color of law (PRUCOL) who resided in the United States prior to the enactment of the welfare reform law should be exempt from the new limitations.
- Boren Amendment: GNYHA strongly opposes efforts to repeal the Boren Amendment, which requires states to reimburse hospitals and skilled nursing facilities at reasonable and adequate rates. In addition, GNYHA supports the application of the Boren Amendment to Medicaid managed care capitation rates. At the very least, the public comment provisions of the Congressional Balanced Budget Act should be enacted.
- Disproportionate Share: GNYHA is extremely concerned about any reforms to the Medicaid disproportionate share (DSH) program which would jeopardize New York State's carefully crafted indigent care pools. If reforms are necessary, GNYHA recommends capping each state's DSH payments at 12% of total Medicaid spending.

GREATER NEW YORK HOSPITAL ASSOCIATION'S

PUBLIC EDUCATION CAMPAIGN:

"THE UNINSURED: FACES THAT AMERICA MUST SEE"

The number of Americans who have no health insurance has reached over 40 million, and another 29 million Americans are reported to be underinsured. Although this issue has been on the back burner of late, it remains one of our nation's most pressing challenges.

The purpose of GNYHA's national media campaign, which we hope to launch in January of 1997, is to rekindle interest in this critical problem. The media campaign will consist of radio, television, and newspaper advertisements. Steve Karmen, the songwriter who is best known for dozens of nationally recognized commercial jingles (and who composed "If Medicare and Medicaid Get Cut" for GNYHA last year), has composed a theme song for the campaign (audio tape enclosed).

The campaign does not offer specific solutions; it simply seeks to bring this issue back to the forefront of the national health policy agenda, pending proposals from President Clinton and Congress.

GNYHA is seeking to forge a national coalition to help launch the campaign and is asking corporations, labor unions, trade associations, foundations, and others who are concerned about the growing ranks of the uninsured to join the coalition.

Notes to Tables

- (1) These tables illustrate various Medicare savings packages to get to \$34 billion, \$39 billion and \$44 billion in total savings in FY 2002. The tables show the Part A Trust Fund exhaustion date, and the 5, 6 and 7 year savings totals for Part A, Part B and total Medicare.
- (2) The base is last year's package slipped one year. Fraud and abuse savings have been dropped because they were enacted in HIPAA. The repricing does not slip the effective dates for three extender provisions (the Part B premium, MSP and OPD extenders) because these occur on specific out-year dates. The Part B premium offset was repriced to be consistent with the Part B premium revenue stream. Not slipping the extenders and repricing the premium offset has the effect of increasing the 6-year savings from last year's (\$135 billion) package to \$146 billion now. (Last year's CBO pricing of \$116 billion (which includes the FDO proposal) compares to Administration pricing of \$135 billion (including the FDO proposal). The Administration's pricing of \$124 billion excluded the FDO proposal and compares to CBO pricing of \$103 billion).
- (3) In all packages, adding an income-related premium and transferring the revenues to Part A are considered as alternative ways to reduce Part A outlays.
- (4) Packages to get \$34 billion in FY 2002 could be achieved by increasing last year's Part A package and with a Part B package comprised of minimal Part B savers and the Part B spenders.
 - o The minimal Part B package contains: extension of the Part B 25 percent premium, the physician single conversion factor and revised target/update system, the Part B impact of proposals that also have Part A impact (e.g., Medicare Choice, MSP, etc.), the preventive benefits, respite care beginning in FY 1998, an increase in the ESRD facility rate, elimination of the x-ray requirement for chiropractors, payment of free-standing IHS clinics, an actuarially determined Part B premium late enrollment surcharge, and a hospital outpatient department proposal that is budget-neutral over 7-years (eliminates FDO in 1998, begins PPS in 1999, uses FDO savings to buy-down coinsurance which would transition to 20 percent over 15 years).
 - o While the minimal package displays less total Medicare savings, if the spenders are taken out, then the gross savings are deeper. A likely early criticism of the package will focus on the gross Medicare cuts before offsetting them for the spending provisions.

- (5) Packages to get \$44 billion in FY 2002 would need to use last year's Part B package slipped one year and a deep Part A cut that would extend exhaustion to 2008 or 2009. This approach would bring total Medicare savings to \$131 to \$141 billion over 5-years and \$243 to \$254 billion over 7-years.
- (6) There are two different types of packages to get \$39 billion in FY 2002.
- o The first would use last year's Part B package slipped one year and a small increase in last year's Part A cuts. This approach would be more consistent with the balance of cuts between Part A and Part B used last year.
 - o The other strategy would be to use the minimal Part B package but much larger Part A cuts. This approach has the advantage of extending the Trust Fund further and also allows for the spending provisions (including beginning to fix the OPD problem). The disadvantages are that it skews the distribution of cuts to Part A and requires deeper gross cuts to pay for the spenders.

Alternative Medicare Savings Streams

	<u>FY 98</u>	<u>FY 99</u>	<u>FY 00</u>	<u>FY 01</u>	<u>FY 02</u>	<u>5-years FY 98-02</u>	<u>6-years FY 98-03</u>	<u>7-years FY 98-04</u>	<u>Trust Fund Exhaustion</u>
<u>Last Year Slipped One Year c/</u>									
A = FY 97 Slipped 1 Year	\$5.4	\$10.0	\$13.3	\$19.4	\$22.9	\$ 71.0	\$ 97.9	\$127.4	12/05
B = FY 97 Slipped, w/FDO	\$1.5	\$ 3.6	\$ 6.0	\$ 9.3	\$12.4	\$ 32.8	\$ 48.4	\$ 67.5	
Total	\$6.9	\$13.6	\$19.3	\$28.7	\$35.3	\$103.8	\$146.3 d/	\$194.9	
<u>\$34 Billion in FY 2002</u>									
A = LY Slipped + \$10bil b/	\$6.2	\$11.4	\$15.2	\$22.1	\$26.1	\$ 81.0	\$111.6	\$145.2	10/06
B = Minimal B Sav w/Spend	\$0.2	\$ 1.5	\$ 3.4	\$ 5.1	\$ 7.4	\$17.6	\$ 27.1	\$ 40.1	
Total	\$6.4	\$12.9	\$18.6	\$27.2	\$33.5	\$ 98.6	\$138.7	\$185.3	
A = LY Slip + 3% PPS hit	\$8.0	\$12.9	\$16.4	\$22.7	\$26.5	\$ 86.5	\$117.3	\$151.0	2/07
B = Minimal B Sav w/Spend	\$0.2	\$ 1.5	\$ 3.4	\$ 5.1	\$ 7.4	\$17.6	\$ 27.1	\$ 40.1	
Total	\$8.2	\$14.4	\$19.8	\$27.8	\$33.9	\$104.1	\$144.4	\$191.1	
<u>\$39 Billion in FY 2002</u>									
A = LY Slipped + \$10bil b/	\$6.2	\$11.4	\$15.2	\$22.1	\$26.1	\$ 81.0	\$111.6	\$145.2	10/06
B = FY 97 Slipped, w/FDO	\$1.5	\$ 3.6	\$ 6.0	\$ 9.3	\$12.4	\$32.8	\$ 48.4	\$ 67.5	
Total	\$7.7	\$15.0	\$21.2	\$31.4	\$38.5	\$113.8	\$160.0	\$212.7	
A = LY Slip + 3% PPS hit	\$8.0	\$12.9	\$16.4	\$22.7	\$26.5	\$ 86.5	\$117.3	\$151.0	2/07
B = FY 97 Slipped, w/FDO	\$1.5	\$ 3.6	\$ 6.0	\$ 9.3	\$12.4	\$ 32.8	\$ 48.4	\$ 67.5	
Total	\$9.5	\$16.5	\$22.4	\$32.0	\$38.9	\$119.3	\$165.7	\$218.5	
A = LY Slip + 7.2% PPS hit	\$11.7	\$17.0	\$20.8	\$27.4	\$31.6	\$108.5	\$146.8	\$186.4	1/09
B = Minimal B Sav w/Spend	\$ 0.2	\$ 1.5	\$ 3.4	\$ 5.1	\$ 7.4	\$ 17.6	\$ 27.1	\$ 40.1	
Total	\$11.9	\$18.5	\$24.2	\$32.5	\$39.0	\$126.1	\$173.9	\$226.5	

\$44 Billion in FY 2002

A = LY Slipped + \$27bil b/	\$7.5	\$13.8	\$18.4	\$26.8	\$31.6	\$ 98.0	\$135.1	\$175.8	7/08
B = FY 97 Slipped, w/FDO	\$1.5	\$ 3.6	\$ 6.0	\$ 9.3	\$12.4	\$ 32.8	\$ 48.4	\$ 67.5	
Total	\$7.7	\$15.0	\$21.2	\$31.4	\$44.0	\$130.8	\$183.5	\$243.3	
A = LY Slip + 7.2% PPS hit	\$11.7	\$17.0	\$20.8	\$27.4	\$31.6	\$108.5	\$146.8	\$186.4	1/09
B = FY 97 Slipped, w/FDO	\$ 1.5	\$ 3.6	\$ 6.0	\$ 9.3	\$12.4	\$ 32.8	\$ 48.4	\$ 67.5	
Total	\$13.2	\$20.6	\$26.8	\$36.7	\$44.0	\$141.3	\$195.2	\$253.9	

a/ All estimates assume refined pricing of the home health transfer. All packages deleted savings from fraud and abuse since they were enacted in HIPAA.

b/ Additional money is added in proportion to savings stream. It may be difficult to develop policies to match this savings stream.

c/ Last year's Medicare package priced by CBO at \$116 billion contained a proposal to eliminate hospital outpatient formula-driven overpayment (FDO). However, the savings from that proposal were excluded in the Administration's priced \$124 billion Medicare package. If the FDO proposal was included in the Administration pricing, then the 6-years savings total would have been \$135 billion. Following are the savings stream from last year's package slipped one year excluding FDO. The 6-year total is now \$135 billion (rather than \$124 billion) because slipping the package one year also requires that certain extender proposals that occur on an out-year date certain not be slipped.

A = FY 97 Slipped 1 Year	\$5.4	\$10.0	\$13.3	\$19.4	\$22.9	\$ 71.0	\$ 97.9	\$127.4	12/05
B = FY 97 Slipped, w/oFDO	\$0.5	\$ 2.3	\$ 4.4	\$ 7.2	\$ 9.9	\$ 24.3	\$ 36.8	\$ 52.1	
Total	\$6.9	\$12.3	\$17.7	\$26.6	\$32.8	\$ 95.3	\$134.7	\$179.5	

d/ The 6-year total of \$146 billion compares to last year's estimate of \$135 billion. The difference is due to several extender proposals not being slipped one year (i.e., the Part B premium, OPD extenders and MSP extenders) because they occur on a out-year date certain.

Note: These Trust Fund exhaustion estimates are sensitive to assumptions about treatment of some parameters from last year's package. These Trust Fund exhaustion figures should be considered preliminary estimates "plus or minus a few months"; the estimates are likely to change as the package is specified, when the new baseline is available or with official actuary pricing.



FAX COVER SHEET

OFFICE OF LEGISLATIVE & INTER-GOVERNMENTAL AFFAIRS

Number of Pages: 4

Date: _____

To: <i>Chris Jennings</i>	From: <i>IRA B</i>
Fax: _____	Fax: <u>202 690-8168</u>
Phone: _____	Phone: _____

REMARKS: _____

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

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COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES
WASHINGTON, DC 20515

SUBCOMMITTEE ON HEALTH
November 21, 1996

Mr. Christopher Jennings
The White House
Washington, DC

Dear Chris:

Re: Medicare Savings

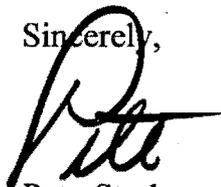
As you consider budget proposals to save Medicare monies and extend the life of the Trust Fund, I hope you will consider favorably the following items:

- 1) Abuse of seniors in hospital outpatient departments must be stopped. The HCFA actuaries estimate that the rate of inflation in hospital OPD copayments is about 20% a year, and by 2003 the beneficiaries will be paying 65% of the total amount. Correction of the Formula Driven Overpayment can be used to make the correction of this problem revenue neutral for Medicare. While this does not save the Treasury money, it is essential for closing an egregious loophole in the Medicare benefit. To save Medicare money, we should encourage the wider use of ambulatory surgical centers, either through payment reform or beneficiary education.
- 2) Most of the nation's hospitals continue to have massive excess capacity, and Medicare capital payments, for a variety of reasons, were very large last year. Reduced capital payments would be appropriate in the future.
- 3) Hospitals continue to purchase and then shift costs onto physician practices, rural health clinics, and other entities which are reimbursed on a cost-basis. The result is also increased utilization: a study last month found that urban hospitals that owned home health agencies referred 57% more patients for home health services than hospitals that had no such ownership. Legislation should immediately provide that no purchased entity paid on a cost basis can assume any of the costs of the hospital. The budget proposal should also call for bundling, as soon as possible, of total costs for various diagnoses. If an entire system cannot be developed immediately, at least start the process as data is developed on a diagnosis-by-diagnosis basis.

- 4) The attached GAO report lists many shortcomings in Medicare's purchase of pharmaceuticals. By either administrative action or legislative request, you should move to an acquisition cost reimbursement system (including EPO).
- 5) Many Part A entities employ or contract with therapists and bill outrageous hourly amounts for their services. Part A therapy should be reimbursed at the Part B fee schedule rates and not allowed a higher reimbursement rate.
- 6) Hospitals are often being paid too much for organ acquisitions. The enclosed legislation and speech describes the problem and potential savings.
- 7) Occupational and physical therapy services provided in a doctor's office do not meet standards or limits that apply to OT and PT services provided by an independent contractor. Physician offices should be held to the same standards and payment limits as the independent provider. In the past the OIG has estimated that this change would result in some savings.
- 8) Expand the Centers of Excellence contracting idea to other areas as rapidly as possible. Burn centers, for example, would be an excellent addition to the list and would provide a higher quality of bundled services.
- 9) Repeal revenue losing anti-fraud provisions included in Kennedy-Kassebaum, in particular the advisory opinion provision worth approximately \$300 million.

Thank you for your consideration of these recommendations.

Sincerely,

A handwritten signature in black ink, appearing to read "Pete Stark", written over a large, stylized initial "P".

Pete Stark
Member of Congress

Identical letter to Donna Shalala
Bruce Vladeck
Nancy-Ann Min



Health, Education and Human Services Division

B-274728

October 11, 1996

The Honorable Fortney H. (Pete) Stark
Ranking Minority Member
Subcommittee on Health
Committee on Ways and Means
House of Representatives

Dear Mr. Stark:

In 1995, Medicare part B allowances¹ for drugs, nutrients, and nutrient-related supplies totaled over \$2.2 billion. For outpatient drugs alone, Medicare part B allowances rose from over \$1.3 billion in 1994 to over \$1.6 billion in 1995, an increase of over 26 percent. Your May 8, 1996, letter requested that we examine the reasonableness of Medicare's payment levels for outpatient drugs and liquid nutrients. Specifically, you asked that we gather information on (1) the Medicare allowances for outpatient drugs and liquid nutrients, (2) the cost at which Medicare providers and suppliers acquire these items, (3) the prices paid by other large purchasers, and (4) potential areas of fraud and abuse in Medicare billings for outpatient drugs and nutrients. This letter summarizes the information we have gathered to date, identifies the reasons why we have suspended our work, and informs you of our follow-up plans.

We reviewed Medicare regulations with officials of the Health Care Financing Administration (HCFA) and a HCFA contractor to determine how they set the Medicare payment levels for drugs and liquid nutrients. We reviewed reports on Medicare pricing for drugs and nutrients by the Office of the Inspector General (OIG) in the Department of Health and Human Services (HHS). We also obtained information compiled by a home infusion and nutritional service provider.

MEDICARE PAYMENT LEVELS FOR OUTPATIENT DRUGS

Medicare part B generally pays only for drugs that are incident to physician services and are not self-administered, unless specifically authorized by law.

¹Medicare allowances include the 80 percent Medicare pays directly to suppliers and the 20 percent copayment by the Medicare patient.

Medicare coverage includes certain drugs used in conjunction with medical equipment, such as inhalation drugs used with a nebulizer pump. In setting payment levels, HCFA established a policy to reimburse outpatient drugs on the basis of estimated acquisition costs or national average wholesale prices (AWP). If a drug has multiple sources, Medicare payment levels are based on the median of the AWP for all generic sources.

The information we gathered provides three indications that Medicare payment levels for drugs may be too high. First, HCFA officials said that because of the difficulty of collecting acquisition cost data, Medicare contractors have been using AWPs to set Medicare payment rates. In contrast, under the Medicaid program, HCFA does not allow the states to routinely use AWPs to establish upper limits on their reimbursements for certain drugs.² In its instructions to the states, HCFA notes that "...there is a preponderance of evidence that demonstrates that such AWP levels overstate the prices that pharmacists actually pay for drug products by as much as 10 to 20 percent...."³

Second, the home infusion and nutritional service provider that we contacted had collected and analyzed Medicare and industry drug pricing data. Information from that provider indicated that for some drugs the Medicare payment levels, based on AWPs, are much higher than acquisition costs. The information collected by that provider, however, is now part of an ongoing Department of Justice matter under court seal. We decided to accede to the Justice Department's strong preference that we refrain from pursuing use of the data.

Third, reports issued in May and June 1996 by the HHS OIG show that HCFA's use of AWPs results in excessive Medicare payment rates for the drugs studied.⁴ In the May report, the OIG compared Medicare payment levels for 17 drugs with the prices paid by state Medicaid programs for the same drugs. The Medicare allowances, based on

²These drugs include brand-name drugs certified as medically necessary by a physician and drugs not marketed or sold by more than one manufacturer.

³The quoted material is from HCFA's State Medicaid Manual, Part 6, section 6305.1.

⁴Appropriateness of Medicare Prescription Drug Allowances, HHS OIG, OEI-03-95-00420 (Washington, D.C.: May 1996); A Comparison of Albuterol Sulfate Prices, HHS OIG, OEI-03-94-00392 (Washington, D.C.: June 1996); Suppliers' Acquisition Costs for Albuterol Sulfate, HHS OIG, OEI-03-94-00393 (Washington, D.C.: June 1996).

AWPs, were almost 15 percent higher than the state Medicaid allowances, which were based on a discounted AWP drug reimbursement formula. In June, the OIG reported that suppliers pay an average of \$0.19 per milliliter (ml) to purchase albuterol sulfate (a nebulizer drug), though Medicare's allowed reimbursement ranged from \$0.40 to \$0.43 per ml. The OIG concluded that Medicare could have saved \$94 million during the 14-month period of the OIG review if HCFA had based Medicare payment rates for albuterol sulfate on the average of surveyed supplier invoice costs.

HCFA concurred with the HHS OIG's recommendation that the agency reexamine its Medicare drug reimbursement methodologies with the goal of reducing payments for prescription drugs. HCFA has not yet acted to change the Medicare drug payment levels but is considering alternatives to the current reimbursement method.

HCFA has issued a revision to the Medicare Carriers Manual on the dispensing and billing of prescription drugs used in conjunction with medical equipment.⁵ This revision stipulates that pharmacies dispensing these prescription drugs, such as nebulizer drugs, should bill and receive Medicare payments for those drugs. Nondispensing suppliers who furnish the medical equipment, such as nebulizer pumps, are prohibited from billing Medicare for these drugs. These requirements will be enforced beginning December 1, 1996.

MEDICARE PAYMENT LEVELS FOR LIQUID NUTRIENTS

Medicare covers enteral products (tube-fed liquid nutrients) for patients who cannot ingest food orally or whose digestive systems are impaired. In May 1996, the HHS OIG issued a report⁶ recommending reduced Medicare payment levels for enteral nutrition. (The OIG is also planning a study on Medicare payment levels for parenteral nutrition, which is administered intravenously.) The OIG based its May 1996 recommendations on a survey of pricing information obtained from Medicare and non-Medicare payers and 140 retail pharmacies between September 1994 and August 1995.

For two types of enteral products commonly stocked by larger retail pharmacy chain stores, the OIG found that almost all 140 pharmacies surveyed charged less than the Medicare allowance. For example, for one type of enteral product, 98 percent of the pharmacies

⁵This revision also applies to some nutrition products that are considered drugs.

⁶Payments for Enteral Nutrition: Medicare and Other Payers, HHS OIG, OEI-03-94-00021 (Washington, D.C.: May 1996).

charged less than the Medicare allowance, and almost half charged 10 to 20 percent less.

For some enteral products, the OIG also obtained the prices paid by nine other payers, including Medicare risk-contract health maintenance organizations (HMO), the Veterans Administration, a Blue Cross/Blue Shield plan, a private HMO, and state Medicaid agencies. For three products, the OIG reported that the other payers reimbursed on average 48, 23, and 17 percent less than Medicare's fee-for-service program. For example, a Medicare risk-contract HMO paid \$.68 to \$.78 for an enteral product that fee-for-service Medicare reimburses at \$1.09. All the payers that negotiated contracts with suppliers had lower payment rates for enteral products than Medicare fee for service.

HCFA concurred with the OIG that the Medicare payment levels for enteral products were too high but noted that the methodology for setting payment rates for enteral products is mandated by legislation. HCFA is considering alternatives to the current reimbursement method for liquid nutrients. For example, HCFA plans to include enteral products in a competitive pricing demonstration project, which is allowed under its statutory authority. The demonstration project has been delayed until 1997, however. Also, HCFA reported that the administration had a budget proposal to freeze Medicare payment levels for enteral and parenteral nutrition at 1993 levels until 2002, but this proposal was not enacted.

REASONS FOR SUSPENDING FURTHER WORK

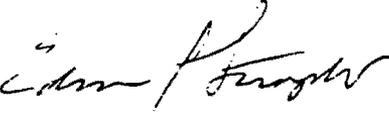
Some of the information we have gathered has led us to suspend further work on your request at this time for the following reasons: (1) The drug pricing information collected by the home infusion and nutritional service provider is part of an ongoing Justice Department matter under court seal. (2) The HHS OIG has recently completed reports on drugs and enteral nutrition pricing and plans additional work on parenteral nutrition pricing. Finally, (3) HCFA has concurred with the OIG's recommendations. Therefore, as agreed with your staff, we are suspending further work on your request. We are monitoring actions taken by the Justice Department and HCFA. We will periodically review their actions with your staff and discuss whether we should consider additional work.

HCFA and Justice Department officials have reviewed a draft of this correspondence for accuracy, and we have incorporated their suggestions.

B-274728

If you would like any additional information on these matters, please contact Edwin Stropko at (202) 512-7114 or William Reis at (617) 565-7488.

Sincerely yours,



William J. Scanlon
Director, Health Financing
and Systems Issues

(101516)

DRAFT

MEDICARE BILL INTRO. STATEMENT

Mr. Speaker, today I rise to introduce a bill which will save Medicare millions of dollars each year. This savings will not involve a decrease in coverage for Medicare beneficiaries. It simply allows us to stop paying someone else's laundry bill, and I mean that literally.

Medicare was established to provide basic protection against the costs of health care while providing quality services. As organ transplants became a medical reality, Medicare became a full insurer for kidney, heart, lung, and liver transplants. Hospitals must apply for certification to perform each type of transplant and receive Medicare reimbursement. There are approximately 160 hospitals across the country which hold such contracts.

We seem to be under the impression that because we have approved these facilities, all of the items in their bills to Medicare are justified. But this is not the case; hospitals add on approximately 25% of an imported organ's acquisition cost to cover a portion of administrative and general overhead costs, such as laundry, housekeeping services, rent, and utilities. This add-on system cost Medicare 22 million dollars in 1995.

Let me back up for a moment and put this in context. Under the Diagnostic Related Group system, Medicare pays hospitals a set rate for each type of injury or illness. The DRG payment covers all items and services provided by the hospital to the patient, and includes an allocation for overhead associated with each service rendered. Organ acquisition is covered separately from the DRG for organ transplants. In this case, Medicare separately reimburses transplant centers for the acquisition cost of each organ. It is this cost to which hospitals make the add-on. The problem lies particularly with cases in which the organ is imported from an organ procurement organization.

Mr. Speaker, I don't mean to imply that hospitals have acted inappropriately. This add-on to cost centers which are not covered by DRGs is a normal practice. Overhead costs are allocated across the board to all possible cost centers. However, the DRG for organ transplantation already includes an allocation for overhead. Since no medical service is associated with simply acquiring an organ from an outside agency and then billing Medicare for the organ, adding a portion of unrelated administrative and general costs is unreasonable.

This add-on of 25% raises the cost of acquiring an organ for transplant from \$10,000 for the hospital to \$12,500 for Medicare. It cheats the system of millions every year by charging Medicare more than its share of the overhead costs associated with transplants. The 25% add-on is not associated with

medical services to the patient, nor administrative or general services other than billing Medicare. If we allow this practice to continue, Health and Human Services estimates suggest that this will cost Medicare as much as \$35 million in 1999.

Mr. Speaker, I propose that we change the nature of this spending from wasteful to beneficial. I am sure we can find a better way to spend \$22 million than on new mop heads and fabric softener.

This bill would amend Title XVIII of the Social Security Act to provide for savings in the Medicare program by reducing overhead payment for Medicare transplant centers. It states that hospitals may not allocate their general or administrative costs to the acquisition cost of organs imported for transplant as they determine costs to be reimbursed by Medicare. This is a bill to improve the efficiency of the Medicare program, an objective I believe we all would like to accomplish.

104TH CONGRESS
2D SESSION

H. R. _____

IN THE HOUSE OF REPRESENTATIVES

Mr. STARK introduced the following bill; which was referred to the Committee
on _____

A BILL

To amend title XVIII of the Social Security Act to reduce the medicare payment for general overhead costs of transplant centers in acquiring organs for transplant from organ procurement organizations.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

1 SECTION 1. REDUCTION IN MEDICARE PAYMENT TO
2 TRANSPLANT CENTERS FOR GENERAL OVER-
3 HEAD COSTS OTHERWISE ALLOCATED TO
4 ORGAN PROCUREMENT.

5 (a) IN GENERAL.—Section 1861(v)(1) of the Social
6 Security Act (42 U.S.C. 1395x(v)(1)) is amended by add-
7 ing at the end the following new subparagraph:

8 “(T) In determining such reasonable costs, of a hos-
9 pital that is a transplant center, for the acquisition of or-
10 gans for transplant purposes from an organ procurement
11 organization, no administrative and general service costs
12 of the hospital (other than overhead directly attributable
13 to acquiring such organs) may be allocated to the cost cen-
14 ter for the costs of acquiring such organs.”.

15 (b) EFFECTIVE DATE.—The amendment made by
16 subsection (a) shall apply to cost reporting periods begin-
17 ning on or after October 1, 1997.