Speak

Sept. 26 ~~27~~
Mon ~~Tues~~.

OK
(Mon. 9:30 am Sept.)

9:30 am Mon Sept. 26
(or Tues eve 4-6:00 Recep. SH-208)
informal remarks

at Hyatt Reg
on Hill

Tues: 8:00 am speak
(8:10 latest can do)

$3,000

will be flexible

NAMES

August 1, 1988

The Honorable Robert Dole
United States Senate
141 Hart Senate Office Building
Washington, DC 20510

Attention: Betty Meyer

Dear Senator Dole:

On behalf of the officers and directors of the National Association of Medical Equipment Suppliers (NAMES), I would like to invite you to address our annual Legislative Conference to be held September 26th and 27th in Washington, D.C. Our members provide durable medical equipment (DME) for millions of elderely and disabled Americans in the home care setting.

Each year, approximately 250 industry leaders gather in Washington to meet with their elected representatives. We have found this to be extrememly effective for educating our members about the political process which takes place in Washington.

Because of your continued interest in, and influence over, home care issues, we feel that your views are critical to our members' understanding the complexity of issues facing the health care community today.

We realize that your schedule is very tight and subject to constant change, therefore, we are prepared to accomodate you in anyway. A simple "stop by" visit would be very acceptable. The conference is being held at the Hyatt Regency Washington on Capitol Hill. We recognize the value of your time and are prepared to pay an honorarium.

Senator, we hope you will be able to honor us with your presence and appreciate your consideration of this request.

8/26 Advised Patrick C. Sen. would do at 9:30 am Mon. Sept. 26

Sincerely

Patrick J. Cacchione
Director of Legislative Affairs

8-2 Interim letter

National Association of Medical Equipment Suppliers, 625 Slaters Lane, Suite 200, Alexandria, Virginia 22314, (703) 836-6263

Joyce

Sept. 26
mon.

NAMES

August 26, 1988

The Honorable Robert Dole
United States Senate
141 Hart Senate Office Building
Washington, D.C. 20510

Attn: Betty Meyer

Dear Senator Dole:

On behalf of the officers and directors of the National Association of Medical Equipment Suppliers (NAMES), I would like to thank you for accepting our invitation to address our Legislative Conference.

The address is scheduled for September 26, 1988 from 9:30 a.m. to 10:00 a.m. at the Hyatt Regency Washington on Capitol Hill. The topic of your presentation is totally within your discretion. As some guidance, however, you should know our members are health care providers, and your thoughts on Congress' likely health agenda next session would be timely. More specifically, you may want to consider two issues which are of significant interest to our members. Those issues are: (a) physician ownership of health care facilities to whom they refer patients (H.R. 5198); and (b) long-term health care (S.2681 and S.2305).

Again, thank you for accepting our invitation. If I can be of any assistance on this or any other matter, please feel free to contact me.

Sincerely,

Patrick J. Cacchione

Patrick J. Cacchione
Director of Legislative Affairs

National Association of Medical Equipment Suppliers, 625 Slaters Lane, Suite 200, Alexandria, Virginia 22314, (703) 836-6263

NAMES

National Association of
Medical Equipment Suppliers
625 Slaters Lane, Suite 200
Alexandria, VA 22314

National Association
of Medical
Equipment Suppliers

NAMES

...Strength Through Unity

The National Association of Medical Equipment Suppliers (NAMES) was organized in 1982 as a non-profit trade association representing the collective interests of the home medical equipment industry.

Today, NAMES is the only organization in the country dedicated *solely* to meeting the needs of a competitive, chang-

Industry representation and professional development are the essential cornerstones of NAMES.

ing HME industry... a rapidly growing industry facing increasingly complex issues.

Simply stated, NAMES' primary mission is to make a positive and lasting impact on the HME industry... to help *individual* HME companies stand up to the changing forces affecting our industry by assembling the collective strengths of thousands of HME companies into a single, unified voice.

...The "Spokes Organization" For the Industry

NAMES was founded to enable individual HME companies to better respond to the reimbursement, regulatory and competitive pressures facing our industry. Today, guided by a Board of Directors comprised of HME executives who have direct experience with the problems and issues affecting our industry, NAMES has become *the* "spokes organization" for the industry... the largest, most effective national organization representing HME professionals.

...A Diversified Membership

The members of an association are literally and figuratively the heart and soul of the organization... in reality, they determine what, where and how NAMES can best serve the needs of the membership.

NAMES has a current and diversified membership of over 2,000 HME dealers, 30 state associations and 100 HME manufacturers. This membership represents a broad range of HME companies, from small local dealers to large regional and national chains. As new companies have entered the HME industry, NAMES' membership has grown to include pharmacies, hospitals, HMOs, PPOs, and independent business people... with sales volumes ranging from $1 million to over $100 million annually.

...A National Resource

NAMES functions as a national resource organization for our members. By joining forces with a national association, small and large HME companies alike are able to participate in a broader range of programs and services than they could otherwise obtain alone. The result is NAMES... providing a comprehensive range of services designed to help our members stay abreast of the changing forces in our industry ...to gain a competitive edge.

And...Most of All... Membership Services

In many ways, NAMES *is* service. Every function and activity at NAMES is considered and designed to provide a specific service to the members of the association. These services fall into four general categories.

Legislative Services: Through its legislative activities, NAMES offers its members the benefits of unity and group action...a collective voice that helps mold the external forces affecting the HME industry.

By responding to all legislative and regulatory issues affecting the industry, NAMES insures that Congress and HCFA know and understand the concerns and positions of HME professionals. NAMES also sponsors NAMESPAC, a Political Action Committee designed to support elected representatives favorable to our industry. And finally, the NAMES annual Legislative Conference enables our members to meet face-to-face with the key Congressional representatives and government officials who influence policies affecting the HME industry.

Educational Services: Continuing education for our members is an essential component in maintaining quality standards and insuring their maximum profitability. Typically, NAMES educational programs

NAMES members realize tangible benefits through member services such as RMS (Reimbursement Management System).

enhance the productivity and performance of NAMES members and their key staff.

Through two major programs — the NAMES Annual Convention and HELP (Health Education Leadership Program) College (regional programs offered throughout the year), NAMES offers numerous opportunities for professional growth, personal enrichment and continuing education. Topic areas include:

- Reimbursement Management
- Voluntary Accreditiation
- Customer Service
- Human Resource Management
- Sales and Marketing
- Accounts Receivable Management
- Retail Merchandising
- Inventory and Materials Management
- Communications Skills
- Financial Strategic Planning

Communications Services: NAMES' basic communications philosophy is to be *the* source of up-to-date news and information needed in today's rapidly changing HME environment.

NAMES features an organized system for disseminating information to members about industry trends and new developments through regular newsletters, plus special articles and executive briefings. In addition, NAMES distributes press releases and conducts media relations, plus initiates public relations and marketing activities to enhance the overall effectiveness of the organization and the industry.

Member Services: NAMES offers a wide range of special services which reflects our constant commitment to meeting the growing and changing needs of our members. These services include:

- **NamesGuard Insurance Programs:** Complete product and professional liability insurance, plus employee health, life and dependent coverage at competitive rates.
- **RMS (Reimbursement Management System) Manual:** A comprehensive explanation of the Medicare program as it relates to the HME industry, including detailed descriptions and guidelines concerning insurance claims processing, reimbursement policy and managing medicare appeals.
- **Spring Buying Show:** The latest in HME technologies and products at the *only* HME show sponsored by the HME industry for HME professionals.
- **Resource Library:** NAMES serves as a clearinghouse for information concerning the HME industry, including an up-to-date library of current legislative and regulatory documents.
- And many, many more.

For many members, NAMESGUARD has put an end to the "insurance crisis."

NAMES IS... A Special Advantage... An Edge On Success

As thousands have already discovered, NAMES gives each member a special advantage... an edge on success. For the hundreds of companies that will join NAMES this year, NAMES membership means they will get:

- A larger voice in Washington where reimbursement and regulatory policies are created.
- Access to a vast array of professional training and development programs that can make a strong, positive impact on the success of their companies.
- Up-to-date, reliable information which will enable them to make informed decisions about the future of their companies.
- Frequent contact with industry leaders and other members in sharing new ideas.
- Access to shared services and resource arrangements that can save them time and money.

For more information on NAMES, contact us at: 625 Slaters Lane, Suite 200, Alexandria, VA 22314 (703) 836-6263.

NAMES is committed to addressing legislative and regulatory issues at their source... Washington D.C.

since we produced the first NHHCE has been very strong and steady. It is readily apparent that two major national shows will be needed to meet the demands of home health care suppliers in 1989 and thereafter."

NMH SCHEDULED FOR JCAHO SITE INSPECTIONS

National Medical Homecare (NMH) has been scheduled for site inspections under JCAHO's new home care accreditation program.

NMH, which will be officially changing its name to Homedco as of June 1, has signed an agreement for the Joint Commission to survey all 139 of its offices during the summer & early fall.

The Joint Commission is currently reviewing other HME applications and planning to conduct additional site inspections commencing in June.

JCAHO official and HELP College faculty member Anne Rooney, R.N., stated that applicants are scheduled on a first-come, first-served basis.

TAMED AND NAMES CO-SPONSOR SIX POINT PLAN PROGRAM

NAMES and TAMED will be co-sponsoring a "Getting Ready for the Six Point Plan" seminar at the Dallas Fairmont Hotel from 1:00-5:00 p.m. on July 20, the day before TAMED's Annual Convention and Exposition begins. When calling for hotel reservations, participants must indicate that they are with TAMED in order to get a discounted room rate.

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NAMES NEWS

Editor: Mistie W. Hurwitz May 26, 1988

NAMES News is published to keep NAMES members informed of industry news and legislative and regulatory developments.

CONGRESS SCRUTINIZES INCOME OF TAX-EXEMPT HOSPITALS

Congress is considering taxing non-profit hospitals on the income they derive from the sale or rental of home medical equipment (HME).

Given the current national fiscal environment, which includes record deficits and the Graham-Rudman-Hollings law, Congress is desperately trying to raise new revenue without raising taxes for the general population or cutting existing programs. One way of achieving this, while also promoting fair competition for small businesses, is to expand the scope of the unrelated business income tax (UBIT), explained Patrick Cacchione, NAMES director of legislative affairs.

Enacted in 1950, UBIT is a way of taxing trade or business income of ex-exempt organizations; specifically income derived from operations that are not substantially related to the organization's exempt or charitable purposes.

(For further information on possible changes to the tax status of non-profit organizations, see the Spring 1986 issue of Resources.)

Recently, the Ways and Means Subcommittee on Oversight, which is chaired by Congressman J.J. Pickle (D-TX), held hearings to consider a number of revenue options, including applying UBIT to the income non-profit hospitals receive from the sale or rental of HME. Exceptions would be made for 1) inpatients, continuous-care outpatients, or emergency treatment outpatients and 2) items not available in the immediate geographical area.

The purpose of the Subcommittee hearing was to review options prior to making recommendations to the full Ways and Means Committee (probably in the early fall). At that time, the full Committee will determine whether legislation should be drafted, and if so, which measures should be included.

Cacchione said Names will continue to follow this issue closely and report periodic updates when appropriate.

OIG TO GET TOUGH ON ROUTINE COPAYMENT WAIVERS

In a General Session at NAMES '88 New Orleans, U.S. Inspector General (IG) Richard Kusserow announced that the Office of Inspector General in the Department of Health and Human Services (DHHS) will be getting tougher with HME suppliers found quilty of routinely waiving copayments.

NAMES

HELP College '88 is proud to present . . . .

GETTING READY FOR THE SIX POINT PLAN

ST. LOUIS
THURSDAY, JUNE 9

8:00 a.m. — Noon
Sheraton-West Port Inn
314-878-1500

LAS VEGAS
FRIDAY, JUNE 10

8:00 a.m. — Noon
Sahara Hotel & Casino
702-737-2111

BOSTON
THURSDAY, JUNE 23

8:00 a.m. — Noon
Park Plaza Hotel & Towers
617-426-2000

DALLAS
WEDNESDAY, JULY 20

1:00 — 5:00 p.m.
TAMED Annual Convention & Exposition
Fairmont Hotel
214-720-2020

(See reverse side for additional information)

GETTING READY FOR THE SIX POINT PLAN

NAMES HELP College is proud to present a **"help yourself seminar"** . . . designed to:

- Help you thoroughly understand the new reimbursement system that will go into effect January 1, 1989.
- Assist you in planning for the changes that will be necessary to your internal systems and operations.
- Teach you how to insure that the base calculations being made this year by your carriers are correct.

EXPERT FACULTY

This all-important seminar will be presented by three HME professionals intimately involved with the development and passage of the Six Point Plan.

- **Albert Deckter**, Abbey Medical, member of the NAMES Board of Directors, and chairman of NAMES Legislative and Regulatory Committee.
- **Susan Bowlby**, National Medical Homecare, member of the NAMES Board of Directors, and chairman of the NAMES Education and Communications Committee.
- **Cynthia Bentley**, Primedica, Inc., a member of NAMES Legislative and Regulatory Committee.

THE SIX POINT PLAN'S IMPLEMENTATION MANUAL

A special implementation manual has been developed and includes all of the information, documents and forms necessary to prepare you for the implementation of the new reimbursement system.

REGISTRATION IS AS EASY AS 1 — 2 — 3 !

Just fill in the registration form below and mail it along with your check to NAMES; or call NAMES (703-836-6263) and charge your registration fee to VISA, Mastercard, and American Express.

Please, register me for the "Getting Ready for the Six Point Plan" seminar being presented in

_____ **(location).**

NAME _____

COMPANY NAME _____

ADDRESS _____

CITY/STATE/ZIP _____

PHONE (____) _____.

_____ $25—Member and all Dallas Attendees

_____ $50—Non-Member

_____ Free—Registrants of the HELP College '88 Mini-series, Boston and St. Louis.

For hotel reservations, please call the hotel directly.

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_____	_____	x	_____	=	$_____

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SUNDAY, MAY 8, 1988

_____NAMS-01 Executive Education.....$20.00

MONDAY, MAY 9, 1988

_____NAMS-02 Preparing for the Six Point Plan.....$20.00
_____NAMS-03 Joint Ventures and Other Contractual Relationships.....$10.00
_____NAMS-04 White Collar Stress--A Professional Crisis.....$10.00
_____NAMS-05 Selling Yourself With A Professional Image.....$10.00
_____NAMS-06 HME and AIDS--Rendering the Product Safe.....$20.00
_____NAMS-07 Customer Relations Techniques.....$10.00
_____NAMS-08 How To Shop For Your Best Insurance Package.....$10.00
_____NAMS-09 Trends In New Technology: Oxygen Conserving Devices.....$10.00

TUESDAY, MAY 10, 1988

_____NAMS-11 Solving People Problems in the Family Owned HME Business.....$20.00
_____NAMS-12 Managing Quality Throughout Your HME Chain.....$20.00
_____NAMS-13 Five Steps To Better Listening.....$10.00
_____NAMS-14 Managing Employee Stress.....$10.00
_____NAMS-15 Ask The Lawyer--An Open Forum.....$10.00
_____NAMS-16 Conquering Medicare Part B.....$10.00
_____NAMS-17 HME's Inspector General/Voluntary Accreditation..$20.00

WEDNESDAY, MAY 11, 1988

_____NAMS-18 Beat the Clock--Make Every Minute Count.....$10.00
_____NAMS-19 For Salespeople Only: Medicare Part B.....$10.00
_____NAMS-20 Dealing With HCFA--Trials and Tribulations.....$10.00
_____NAMS-21 HCFA's Repsonse to the Six Point Plan.....$10.00

Please allow 2-3 weeks for delivery. Please incluse $3.50 (USA) or $6.00 (foreign) for shipping and handling.

For Texas residents only: please include 8% for sales tax.

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NAMES

NAMES 1988 Legislative Conference
September 26-27, 1988

Hyatt Regency on Capitol Hill
Washington, D.C.
Agenda

Monday, September 26, 1988

7:30 a.m. - 5:30 p.m. Outside Columbia B	Registration
8:15 a.m. - 8:30 a.m. Columbia B	Welcome - James Liken, Chairman of the Board
8:30 a.m. - 9:30 a.m.	Keynote Address - The Long-Term Care Assistance Act of 1988 Senator Max Baucus, (D-MT) Senate Finance, Subcommittee on Health
9:30 a.m. - 10:00 a.m.	Senator Robert Dole (R-KA)
10:00 a.m. - 12:00 p.m.	Implementing the Six-Point Plan: An Update Moderator: Thomas Antone, VI, NAMES President Marty Haver, Empire Blue Cross/Blue Shield Association Representative from HCFA Albert Deckter, Chairman, NAMES Legislative and Regulatory Committee

12:00 p.m. - 1:30 p.m. Regency A	Luncheon - Les Francis, Francis, McGinnis & Rees, Washington, D.C. A Political Commentary on the November Election
1:30 p.m. - 2:30 p.m. Columbia B	Legislative/Regulatory Committee Update Moderator: Albert Deckter, Chairman, Legislative and Regulatory Committee Thomas M. Antone, IV, President, NAMES Timothy Redmon, Director of Regulatory Affairs, NAMES Patrick Cacchione, Director of Legislative Affairs, NAMES
2:30 p.m. - 2:45 p.m.	Break
2:45 p.m. - 4:15 p.m.	Both Sides of the Venice Florida Case Moderator: Charles J. Steele, Esq., Partner, Pierson, Ball & Dowd, (NAMES General Counsel) Christopher K. Kay, Esq., Swann & Haddock William G. Kopit, Esq., Epstein, Becker & Green
4:15 p.m. - 5:30 p.m. Columbia B	State Leadership Forum - Carrier Relations; How to Lobby Your Carrier Moderator: Timothy Nightingale Ruthann Roy, President, FAMED Angie Cullimore, Manager of Part B DME, Blue Cross/Blue Shield of Florida
6:00 p.m. - 7:30 p.m. Ticonderoga	PAC Thank You Reception Congressman Ron Wyden, (D-OR) House Energy and Commerce Committee, Subcommittee on Health and Environment; and the Select Committee on Aging

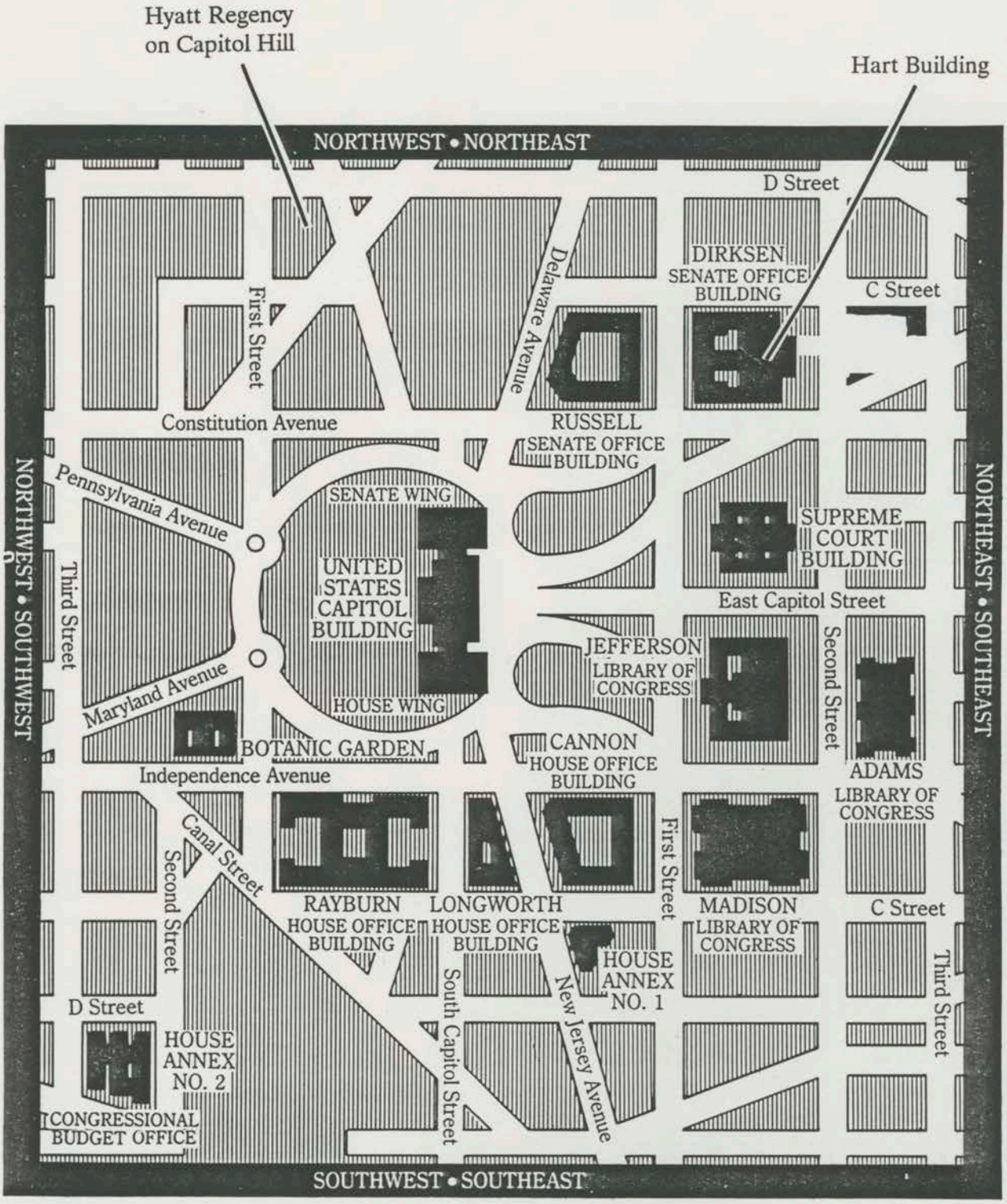
Tuesday, September 27, 1988

8:00 a.m. - 11:00 a.m. Outside Columbia B	Registration

8:30 a.m. - 9:30 a.m. Columbia B	UBIT and Doctors in HME Congressman Beryl Anthony, Jr., (D-AR) House Ways and Means Subcommittee on Health
9:30 a.m. - 11:00 a.m. Columbia B	Hill Briefing - The Fine Art of Lobbying Moderator: Thomas M. Antone, IV, President, NAMES Bill Butler, President, CAMPS Wayne Sale, President, VADMEC Patrick Cacchione, Director of Legislative Affairs, NAMES
11:00 a.m. - 4:00 p.m.	Hill Visits
4:00 p.m. - 6:00 p.m. Hart Senate Office Building Room 708	Congressional Reception

For Hill Appointments, Call (202) 224-3121

Map of Capitol Hill



Directions from the Hyatt to the Hart Building:
Exit the hotel on New Jersey Avenue, take a right on New Jersey and follow to Constitution Avenue. Take a left on Constitution Avenue and continue for approximately 4 blocks. The Hart Visitor's Entrance is on Constitution, between First and Second Streets. The Reception is on the seventh floor, room 708. The Reception is from 4:00 - 6:00 p.m. on Tuesday, September 27.

NAMES

ISSUE BRIEFS

1988 LEGISLATIVE CONFERENCE

WASHINGTON, D.C.

This package contains briefing papers on issues of importance to the Home Medical Equipment Industry. NAMES is a non-profit organization which represents about 1,500 suppliers in over 3,000 sites nationwide. Our members provide the equipment and services necessary for maintaining elderly or disabled patients in the home, rather than in the more expensive institutional settings. A substantial proportion of the users of these medically necessary items and services are Medicare beneficiaries, and home medical equipment suppliers accept assignment in over ninty percent of their Medicare claims.

THE SIX-POINT PLAN

Section 4062
Public Law 100-203

CURRENT LAW

The Six-Point Plan was passed as part of the Omnibus Budget Reconciliation Act of 1987 (OBRA '87) and goes into effect on January 1, 1989. This legislation eradicates many of the inequities that plagued the Medicare reimbursement system for over 20 years, and institutes a consistent, stable, and administratively efficient home medical equipment benefit.

Congress eliminated the cumbersome and error-prone rent/purchase decision for most items and substituted a cap on aggregate rental payments. This solves the problem of unlimited rentals. Moreover, Congress phased in a regional fee schedule which allows for reasonable geographic variations but eliminates unjustified disparities in reimbursement for the same equipment provided in different localities. The new program will be more cost effective because it does away with the costly item-by-item, dealer-by-dealer, carrier-by-carrier reimbursement calculations involving literally millions of data bits. Claims may be processed under 10 carriers, one for each HCFA region, rather than the current system of 56 carriers, which is expensive to operate and virtually ensures that no single carrier has enough DME claims to warrant the large overhead costs of processing them.

The Six-Point Plan is estimated to save the Medicare program $60 million in the first year of its implementation and over $120 million in two years. Beneficiaries and suppliers benefit from increased program stability and administrative efficiency.

NAMES POSITION

NAMES would like to thank Congress for their foresight in understanding and recognizing a troubled and failed system and for their diligence in taking the needed steps to correct those problems.

Furthermore, NAMES is prepared to work closely with Congress and the Health Care Financing Administration (HCFA) to ensure the optimal implementation of the Six-Point Plan. Some of the gray areas of the legislation which remain to be worked out are outlined and discussed on the next page.

THE SIX POINT PLAN

o The legislation requires the Secretary of Health and Human Services (HHS) to make available the data and other information used in computing payment amounts under the Six-Point Plan. Section 4062 states:

> The Secretary shall, upon written request, provide the data and information used in determining the payment amounts for covered items under section 1834 (a) of the Social Security Act.

NAMES POSITION

NAMES believes this is a very important provision and would like to ensure that it is strictly enforced. Because of it, industry and beneficiary representatives can review Carrier calculations and identify any errors before they become operational.

Furthermore, NAMES strongly encourages that information involving local screens, parameters and computer edits used in identifying claims for medical review be made available under this section.

o The legislation also provides that:

> The secretary is authorized to require, for specified covered items, that payment may be made under this subsection with respect to the item only if a physician has communicated to the supplier, before delivery of the item, a written order for the item. (Emphasis supplied).

NAMES POSITION

NAMES does not oppose this provision and agrees that it has merit as a targeted response to a known but narrow problem. Congress intended this provision as a tool to assist the Department in dealing with specific equipment and not as a rule of general applicability for all DME across-the-board.

Generally, equipment is first placed with patients pursuant to a physician's verbal order with written documentation following. This standard process ensures care is initiated only on a physician's order, but that such care is not delayed while awaiting confirming paperwork through the mail. To require written orders for all equipment prior to initiating treatment would delay hospital discharges and seriously impair care for all patients, whether discharged from a hospital or not.

QUALITY ASSURANCE

Section 411
Public Law 100-360

The Medicare Catastrophic Coverage Act of 1988, which became law on July 1, 1988, contained Technical Amendments to the Omnibus Budget Reconciliation Act of 1987 (OBRA '87). One of the Technical Amendments provides:

> ...such term (DME) does not include such equipment furnished by a supplier who has used, for the demonstration and use of specific equipment, an individual who has not met such minimum training standards as the Secretary may establish with respect to the demonstration and use of such specific equipment.

NAMES POSITION

NAMES supported this technical amendment. Prior this amendment, the Secretary of Health and Human Services (HHS) was mandated to develop training standards for all durable medical equipment (DME), thus including such items as walkers, bedpans, wheelchairs, etc. Our feeling is that Treasury dollars spent on quality assurance for such items is money poorly spent, because these are not "high-risk" items. However, we strongly support DME quality assurance focused on high-risk items, such as ventilators and parenterals (e.g. nutrition, chemo, and antibiotic therapies).

The Secretary is authorized (but not required) to recognize compliance with the standards of private accrediting bodies (such as the Joint Commission on Accreditation of Healthcare Organizations) as evidence of compliance with the Secretary's own standards. In effect, a supplier accredited by the JCAHO could be "deemed" to be in compliance with any Federal standards that might be drafted. This mechanism is known as "deemed status", and we urge Congress and the Secretary to accord deemed status to private accrediting bodies as a credible approach to quality assurance without increasing Federal costs.

PHYSICIAN OWNERSHIP OF DURABLE MEDICAL EQUIPMENT (DME)

The Ethics in Patient Referrals Act of 1988 (H.R. 5198)
Action not expected until 1989

CURRENT LAW

The Medicare Catastrophic Coverage Act of 1988, which became law on July 1, 1988, provided Medicare coverage for home intravenous (IV) drug therapy. The IV therapy provision also states:

> In general...a home intravenous drug therapy provider may not provide home intravenous drug therapy services under this part to an individual if the individual's referring physician...or an immediate family member of the physician - (i) has an ownership interest in the provider, or (ii) receives compensation from the provider.

Several weeks ago, Congressman Stark introduced H.R. 5198 which would expand the physician ownership principles of the IV therapy benefit to a much larger array of health services, including DME. Action on H.R. 5198 is not expected until next year.

NAMES POSITION

Similar to congressional action in the IV therapy provision, Congressman Stark's recently introduced bill, H.R. 5198, would prohibit DME and other suppliers from accepting patients if the referring physician, or an immediate family member of the physician, has a financial interest in the supplier. Action is not expected until next year, but during your Hill visits you may be asked for your thoughts, views, and supporting examples on this issue. Congressional staff will want your personal experiences, and you should begin to think now about how you will respond if this question is asked.

UNRELATED BUSINESS INCOME TAX (UBIT)

Hearings were held by:
House Ways and Means Oversight Subcommittee
House Small Business Committee

CURRENT REVIEW/PROPOSALS

Through the House Small Business Committee and the House Ways and Means Committee, Congress is in the process of reviewing and possibly expanding the scope of the unrelated business income tax (UBIT). The unrelated business income tax was enacted in 1950 as a way of taxing trade or business income of tax-exempt organizations that is not substantially related to the organization's exempt or charitable purposes. Congressional action on this issue might have tax implications for medical equipment provided by non-profit organizations.

The Small Business Committee is now in the process of holding hearings. In addition, Ways and Means Oversight Subcommittee has made the following recommendations to the full Ways and Means Committee:

> Income derived from the sale or rental of medical equipment and devices (including hearing aids, portable X-ray units, and oxygen tanks), the sale of pharmaceutical drugs and goods, and the performance of laboratory testing should be treated as income derived from an unrelated trade or business.

There are two exceptions to this recommendation. The first is that income derived from a patient of the tax-exempt organization is not taxable. The second is that such income would not be taxed if such items or services were not otherwise available in the immediate geographical area.

No legislative action is expected on UBITs until next year.

NAMES POSITION

Various hearings this Fall suggest Congress may be contemplating further legislative action next year. Therefore, it is quite possible that Congressional staff will want you to share your personal experiences with them regarding this issue. It is important that you begin formulating your thoughts and views now so you will be prepared to respond if the question is asked.

NAMES

THE ETHICS IN PATIENT REFERRALS ACT OF 1988
(H.R. 5198)

Introduced by Congressman Pete Stark on August 10, 1988

NOTE: ANY CONSIDERATION GIVEN THIS BILL WILL NOT OCCUR UNTIL SPRING/SUMMER 1989 AT THE EARLIEST. NAMES PROVIDES THIS SUMMARY OF H.R. 5198 ONLY TO LET MEMBERS KNOW OF AN ISSUE THAT MAY ARISE IN 1989.

The Ethics in Patient Referrals Act of 1988

Introduction

In recent years, competition and reduced reimbursement compelled health care providers and suppliers to consider new alliances and arrangements with each other. Consequently, there has emerged a proliferation of joint ventures, contracts, consulting fees and other connections between physicians, who order services, and the entity filling that order. The patient care involved includes laboratory services, IV therapies, PEN, and others, including, of course, durable medical equipment.

As a result of an increasing economic alliance between referring physicians and providers, Congress is questioning whether physicians are increasingly less likely to exercise unbiased judgement in making referral decisions. If so, patients may not be referred to the highest quality provider available. Moreover, Congress is also very concerned about the possibility of over- utilization, fraud and unfair competition.

Due to these concerns, Congressman Pete Stark (D-CA) introduced H.R. 5198 on August 10, 1988. The bill has been jointly referred to the Ways and Means Committee and the Energy and Commerce Committee. It is unlikely that any action will be taken this year on H.R. 5198. We will keep you advised as this legislation develops next year.

Summary of Legislation

H.R. 5198 would prohibit a provider of Medicare-covered services from accepting patients from a referring physician who (a) has a direct ownership or other indirect ownership or financial interest in the provider or (b) receives compensation from the provider. The prohibition also applies in the case of arrangements involving the referring physician's immediate family.

Exceptions are made for services typically provided as an integral part of the physician's own professional service. Thus physicians could be part owners of hospitals or ambulatory surgery centers (ASCs) since these facilities often serve as work-place for physicians. In addition, a physician or physician group practice could provide in-office lab testing and x-rays. Furthermore, consulting physicians, such as radiologists and pathologists could own their own facilities because they generally do not make patient referrals. However, it appears that as drafted, durable medical equipment would <u>not</u> fall into one of these exceptions. As a result, physicians would in effect be prohibited from referring patients to a company in which they or a family member have an equity interest.

Due to concerns about access, sole community providers would be exempted from this law. Also, ownership of publicly-traded stock would be excepted since such ownership cannot involve covert payment of a referral fee. Finally, HMOs would be excepted because they have no incentive to encourage over-utilization of referral services.

H.R. 5198 also addresses contractual arrangements for professional services or for rent or purchase of facilities, supplies, or equipment. The bill sets forth a number of strict tests to ensure that any payments made are for legitimate purposes.

Providers and physicians would have one year after passage of this legislation to bring existing ownership or compensation arrangements into compliance. After this time, intentional violations by physicians or providers would be subject to civil penalties of up to $15,000, assessments equal to two times the dollar value of any improper referrals, and/or exclusion from participation in Medicare.

Copies of this bill are available at the registration desk

NAMES

LONG-TERM CARE ASSISTANCE ACT OF 1988
(S.2305)

Introduced by Senator George Mitchell on April 11, 1988

NOTE: CONGRESS MAY NOT CONSIDER LONG-TERM CARE AT ALL. ANY CONSIDERATION GIVEN LONG-TERM CARE WILL NOT OCCUR UNTIL SPRING/SUMMER 1989 AT THE EARLIEST. NAMES PROVIDES THIS SUMMARY OF S.2305 ONLY TO LET MEMBERS KNOW OF AN ISSUE THAT MAY ARISE IN 1989.

Introduction

When the Pepper-Roybal bill (H.R. 3436) was voted down in the House of Representatives on June 8, 1988, attention was immediately focused on Senator George Mitchell's (D-ME) bill, S.2305.

Although the Mitchell bill is similar to the Pepper-Roybal bill in terms of expanding Medicare coverage for home care services and relying on an individual's ability to perform activities of daily living as one standard for determining eligibility for coverage, the Mitchell bill goes considerably further to establish new benefits and new provider requirements.

S.2305 would expand coverage of Medicare Part B to include respite care services, chronic home care services, and chronic nursing home services for chronically ill individuals. The bill also includes funding provisions, new requirements for state Medicaid programs, a section protecting the income and resources of institutionalized individual's spouses, and tax incentives to promote the expansion of private long-term care insurance.

S.2305 is currently under consideration by the Senate Finance Subcommittee on Health. Although the Subcommittee has held two hearings on the bill, no further action is expected until next Congress (1989) at the earliest. We will keep you advised if this legislation develops.

Summary of Legislation

The provision of the bill which is of greatest interest to the HME industry is the section which addresses chronic home care services.

"Chronic home care services" include medical supplies and durable medical equipment, homemaker and chore aid services, and other items and services within the definition of "home health care". The bill covers such items and services without regard to any limitation on the duration of the care or services provided and without regard to any requirement that the individual be homebound." The covered items and services would be required to be furnished on a case-managed basis; however, the bill makes no mention of who these case managers would be.

In order to qualify for this benefit, an individual must be unable to perform at least two of five daily living activities: eating, bathing, dressing, toileting, and transferring in or out of a bed or chair. The individual must also be under the care of a physician, who must review and certify that the services are furnished according to the case management plan.

To qualify for Medicare coverage, chronic home care services must be furnished by a "qualified home care service provider." These providers include home health agencies and "any other organization or agency that meets such conditions of participation as the Secretary of Health and Human Services (HHS) shall by regulation establish to assure the safe and efficient provision of chronic home care services." In addition, the home organization must have a new provider agreement in effect with HHS covering chronic home care services.

S.2305 uses many vague terms whose meaning and intent will be clarified through further debate if Congress considers long-term care next year. The HME industry must ensure that they are qualified to become "chronic home care providers". Moreover, the HME industry must insist that a chronic home care provider need only supply some and not all of the covered services under this bill.

Copies of this bill are available at the registration desk

NAMES

TECHNOLOGY-RELATED ASSISTANCE FOR INDIVIDUALS WITH DISABILITIES ACT OF 1988
(S. 2561)

Signed into Law on August 19, 1988

(Public Law 100-407)

Technology-Related Assistance for Individuals with Disabilities Act of 1988

Introduction

A major frustration for disabled individuals and NAMES members alike is the lack of coverage for assistive technology that could dramatically enhance the well-being of individuals with a wide variety of disabilities. A major stumbling block to creating a program for such individuals has been the lack of data, demonstrations, and experiments to guide Congress and other policy makers in drafting legislation for such a program.

Recently, the House and Senate have passed, and the President has signed, S. 2561, the Technology-Related Assistance for Individuals with Disabilities Act of 1988. The bill, which received strong bipartisan support, was introduced in the Senate by Senator Tom Harkin (D-IA) and in the House by Congressman Jim Jeffords (R-VT).

NAMES is a very strong supporter of this legislation and worked closely with the Coalition on Technology and Disability to ensure its passage. The Coalition includes over 90 national health groups including the United Cerebral Palsy, Paralyzed Veterans of America, The American Foundation for the Blind, etc. NAMES believes that this legislation is an important step in the development of Federal funding to help the disabled get the assistive technology they may need to live independent and productive lives.

The studies and demonstrations funded by this legislation will produce data and other information that for the first time will define the parameters of the problem and shed light on the proper approach for Congress to take in fashioning a legislative solution. This bill is, of coarse, brand new. In the coming months we will keep you advised as implementation gets under way.

Summary of Legislation

Title I of the bill authorizes $9 million in 1989 and "such sums as necessary" for the following four years for a competitive state grant program. The grants would allow states to develop programs to help the disabled learn more about and obtain assistive technological devices and services. Such technologies include anything from a simple flashing light that alerts a deaf person to a ringing telephone or doorbell to computers that paralyzed people can control with eye movement.

Title II authorizes $6.5 million in 1989 and "such sums" as needed thereafter for a variety of discretionary activities and studies. Studies include the financing of assistive technology and services and the feasibility and desirability of establishing a national information and programmatic referral network on technology-related assistance. Title II money also supports training and public awareness grants to increase the knowledge and effective use of assistive technology devices and services, demonstration and innovation projects related to model projects for delivery of technology-related assistance, applied research and development in assistive technology devices and services, and a loan program for assistive technology devices.

The grants would be awarded to the states on a competitive basis. Ten states will be funded the first year, twenty states the second year and remaining states the third year. Funding per state would be $500,000 to $1 million in each of the first two years, and up to $1.5 million in the third year.

Copies of this bill are available at the registration desk

September 7, 1988

Mr. Charles R. Booth, Director
Office of Reimbursement Policy
6325 Security Boulevard
Room 181
East High Rise
Baltimore, Maryland 21207

Dear Chuck:

Our thanks for the copy of the draft Manual instruction regarding implementation of the new DME fee schedule. We have attached a copy of the draft transmittal and have numbered the pages at the bottom to facilitate cross-referencing our comments to the text.

PAGE 1

No Comments

PAGE 2

B. Geographic Basis: The current wording is unclear on the issue of localities within a given Carrier's jurisdiction. From our earlier conversations, we had thought you planned to eliminate localities now, preparatory to regional pricing. We are simply requesting that this section clearly address the issue of whether Carriers should maintain or eliminate locality pricing; we believe the term "service area" is somewhat ambiguous.

A. Inexpensive or Other Routinely Purchased DME: The first sentence simply states, "...pay for rentals or purchases." The statute specifies that purchases in this class are to be made "...in a lump-sum amount...", and we believe the "lump-sum" concept should be worked in here to avoid later confusion. If this is not clarified at the outset, many Carriers will erroneously set-up their systems to pay for purchases on an installment basis. This is particularly likely to happen since elsewhere you have created a purchase option which provides for installment payments.

Perhaps the best way to accomplish this is simply to incorporate the actual statutory phraseology:

> For this type of equipment pay on a rental basis or in a lump-sum amount for the purchase of the item.

PAGE 3

2. Other Routinely Purchased DME: Item "b", center page sets forth a 10 step calculation to "compute the percent of purchase." In our meeting of July 12th, HCFA and industry agreed that items rented-to-cap following a rent/purchase decision would count as rentals. We're still concerned that while logical and correct, this decision may not be self-evident to all Carriers and should be specifically addressed. Any mistake in accounting for items rented-to-cap could lead us into serious mistakes in assigning equipment to the proper class.

On a similar point, we remain concerned that discarding all rental payments preceding a purchase improperly weights the tally toward purchases. Particularly during the base period, many Carriers found it essentially impossible to forecast the length of a beneficiary's need, and therefore simply chose to purchase most equipment. This is clearly documented in the GAO studies, and of course had the effect of inappropriately increasing program outlays.

In our earlier meetings and correspondence, HCFA and industry have discussed Congress' clear intent that items such as hospital beds and wheelchairs would fall in the capped rental category. Any methodology that produces a different result is flawed and such results should be disregarded.

As you said in our joint meeting with BPO, "Let's wait and see if we have a problem before discussing solutions", and we certainly agree with your logic. Still, we did want to highlight our continuing concern over this issue. To further assist the debate, we are sending under separate cover a listing of items identified by major suppliers which were "routinely purchased" during the base period.

3. The Fee Schedule: Items "b" and "c" recognize new, used, and rented DME. We assume that in retaining the "used" category from the rent/purchase rules you will also retain the accompanying provisions for waiving patients' copayments and requiring warranties that are one-half the length of warranties on new equipment. Since this would be a continuation of existing rules for used items, it will be easier actually for Carriers and suppliers alike. However, we believe it should be specified here since the question will invariably arise.

PAGE 4

B. Items Requiring Frequent and Substantial Servicing: This class (and oxygen equipment) are the only two where rental payments continue for the duration of the patient's need. If this point isn't made clear, we believe some carriers will conclude they should apply the 15 month cap or some other approach borrowed from another class. The point is we have an opportunity to head-off potential confusion and should take advantage of it. We suggest simply amending the first sentence as follows:

> For this type of equipment, you will generally pay on a rental basis for as long as the patient's need continues.

3. Maintenance and Service: Most warranties cover only parts, others cover parts and labor, and still others cover parts and labor but for different terms. The current language in the draft could be better worded to reflect this reality. To protect the beneficiary, we suggest:

> In the event the beneficiary purchased the equipment, you may pay for any parts and labor not covered under the manufacturer's warranty.

This language also has the advantage of consistency with the "parts and labor" statutory language concerning service and maintenance in the capped rental class.

We also believe it is important for all parties to know more specifically when service and maintenance payments on purchased items commences. Therefore, we recommend rewording the second sentence:

> Payment should be on a lump-sum, as needed basis, commencing when title transfers to the beneficiary.

Under the various Uniform Commercial Codes adopted by the States, title may transfer at slightly different times depending on the State. This language is broad enough to encompass that result.

C. Certain Customized Items: The draft identifies items in this category as equipment not covered by a HCPCS code. This is a reasonable and prudent approach, but there is one very important exception. Most Carriers maintain one or more "dump codes" (a HCPCS number) that is specific for customized equipment of all types. Such codes include: E1220, E1225, E1226, E1227, E1228, E1296, E1297, E1298 and possibly others. Carriers who maintain such "dump codes" should be alerted that the wide variety of items in these codes should continue to be reimbursed on the basis of individual consideration.

Also, we believe the definition of items in this category should be expanded to include equipment which has a HCPCS code but which is substantially modified for a given patient and is therefore unusable by any other patient. This practice is not uncommon and simply emerged as Carriers and suppliers tried to make maximum use of the HCPCS. Where it occurs, reimbursement has always been negotiated, so we're not proposing a change in current practice.

Finally, we believe Carriers and suppliers alike would benefit from some additional guidance clarifying that in applying "individual consideration" they should continue to use current procedures. We recommend rewording the last sentence:

> Payment for these items should be made in a lump-sum based upon your individual consideration of suggested retail prices and an appropriate allowance for parts and labor required to modify the item.

D. Other Prosthetic and Orthotic Devices: It might be prudent to insert a reminder to Carriers here that these rules do not apply to PEN which continues to fall under the legislation applying LCL, nor to IOL's.

PAGE 5

b.: Because the submitted purchase price is divided by 10 and then limited by the 85% and 115% parameters, these calculations must be absolutely accurate to ensure both government and suppliers come out where Congress intended. We recognize the first sentence includes the word "new", but in context and to avoid any possible mistake, we believe the second sentence should be reworded:

> Include in your calculations the purchase prices for new equipment submitted on rental claims that were used in making rent/purchase decisions as well as the submitted purchase prices for new equipment on purchase claims.

PAGE 6

3. Charges After 15-Month Period: We of course understand the suppliers' broad continuing obligation to patients after the 15-month cap is reached. But there are two legitimate exceptions that must be noted. The supplier, of course, does not have to continue supplying equipment at no charge after the patient's need or coverage ends. We suggest rewording the second sentence of the first paragraph:

> After 15 months of rental have been paid, the supplier must continue to provide the item without any charge, other than for the maintenance and service fee (see 4. below) until medical necessity ends or Medicare coverage ceases (e.g. the patient enrolls in an HMO).

In view of the penalties provided, it is crucial that Carriers and suppliers alike correctly understand the scope of obligations following the 15th month.

Also in section 3., but in the second paragraph, line three, the draft employs the phrase, "...rental period in which need ceased...". We are concerned that some Carriers will incorrectly construe "rental

period" to mean the 15-month period. For that reason we suggest rewording:

> "...rental month in which need ceased..."

Finally, in the Example you might want to change the word "hospitalized" to "institutionalized" to reflect nursing home stays, etc.

a. Change of Address: Congress, the Administration, and industry grappled with this issue separately and together for months in an effort to fashion a valid and equitable policy. Certainly Medicare shouldn't be exposed to more than 15-months of payments because a patient chose to move. By the same token it is equally inequitable to expect the second (receiving) supplier to furnish equipment -- perhaps for many months or years -- for what may only be a month or two of reimbursement, again because the patient chose to move. Compounding the debate is the issue of how the receiving supplier (and for that matter, the receiving Carrier) will even know of the patient's prior experience which may have occured thousands of miles away.

That said, as a practical matter we know the House Conference Report language leaves little latitude on this issue. We do, however, recommend the following:

- If the second supplier accepts the patient on a Medicare basis and medical necessity subsequently continues past the 15th month, we assume that second supplier becomes eligible for the service and maintenance payments. If you agree with our analysis, we think it is an important point to include here since it provides an incentive to accept Medicare transfer patients;

- The receiving supplier and the patient could, of course, agree to enter into a private commercial transaction not involving Medicare. The question is, can the patient still recoup whatever months remain in his/her 15th month allotment from either the original or the receiving Carrier? If so, the transmittal should probably explain which Carrier is appropriate and how the patient should approach them. If not, that conclusion should also be spelled out briefly. These questions will arise and it seems better that Carriers are prepared to handle the issue from the outset.

We would note that permitting the patient to collect the remaining months balances the equities of all three parties: the program is exposed only for 15 months, the patient collects his full 15-month entitlement, and while the second supplier does not receive any Medicare reimbursements, at least he is not liable for service, etc., in perpetuity.

PAGE 7

b. Modifications or substitutions of equipment: The most accurate and least disruptive way of identifying modified or substituted equipment is by reference to the HCPCS codes. Carriers and suppliers alike are familiar with this nomeclature, and for that reason we suggest rewording the first sentence:

> If the beneficiary changes equipment either through additions to existing equipment or a change to similar equipment with a different HCPCS code, refer the claim to your medical review unit.

We understand your need for medical review under these circumstances. However, as you know, medical review can be a very lengthy process. Frankly, we would prefer imposing a 60-day limit on medical review, with automatic coverage of the new item in the event the process takes longer. At a minimum, however, we believe that Carriers should be instructed to provide reimbursement for the "old" equipment while they are evaluating the appropriateness of the modified or substituted item.

In the same paragraph, the next to last sentence potentially is of grave concern to us. The sentence prohibits payments after the 15th month, but in context and as a matter of grammar, it is unclear to us whether it is meant to modify the preceding sentence ("Otherwise, continue to count...") or whether it states a rule applicable to the whole paragraph.

If you intend it to apply to the whole paragraph, we have a major problem. If a patient reaches the 15th month with one item and subsequently improves or deteriorates so that a modification or substitution is medically necessary, we cannot find any policy or legal grounds for denying reimbursement. If, however, you intend this sentence simply to modify the preceding sentence (with which we agree) we suggest rewording to remove any ambiguity:

> Otherwise, continue to count against the current 15-month limit and base payment on the least expensive medically appropriate configuration of equipment unless the 15-month period has already expired, in which case make no additional rental payments.

Finally, the words "substantially changed" seem to unnecessarily and inappropriately invite Carriers to consider not only whether the patient's new condition warrants different equipment, but also to debate whether the change in the patient's condition is "substantial".

We absolutely agree the patient's new condition must warrant different equipment, but believe that criterion alone is the appropriate test and therefore recommend deleting the words "substantially changed".

c. Change in suppliers: This raises essentially the same issues as a. Change of Address discussed earlier, and our same comments apply here.

d. Continuous use after the 15-month period: We cannot find statutory support for this position. Moreover, in establishing an obligation on the original supplier to provide equipment in perpetuity, it overlooks the fact that there can be years between the original and subsequent need during which the supplier may have gone out of business, the patient moved, the second period of need is for a totally different condition, etc. Thus, as written, the provision unnecessarily incorporates the same difficult problems that we all agree plague the change of address and change of supplier areas. The difference is that these problems are unavoidable where the address or supplier changes; here they are avoidable simply by adopting a slightly different policy.

As written, this provision will literally leap off the page to the press and our members, receiving a disproportionate amount of attention. The actual situation probably will not arise with great frequency; however, where it does the confusion and ill-will will be considerable. Taken together, these two facts suggest it is well worth our time to find a compromise position which is not costly to the government but which is defensible to patients and to our members.

Obviously, we believe the best approach is to apply here the same policy enunciated for breaks in service prior to the 15th month. You set that break at 60 days plus those days remaining in the last rental month, and we agree that is on target and fair to patients, government, and suppliers alike.

This policy would not only have firmer statutory grounding, than the current proposal, but has the added virtue of consistency and therefore administrative simplicity. And given the presumed small number of cases affected, we would not expect it to be costly to the program. Most importantly, it will help patients, Medicare, and suppliers alike by eliminating most of the problems and anomalies that will arise when patients move, change suppliers, etc., as they surely will given the large number of years and changed medical conditions that may follow the 15th month for most patients.

This is a very important issue for us and, unlike the change of address/supplier issue, one where there appears to be some flexibility in the legislative and report language. We very much hope to find a compromise that minimizes the problems of patients moving, suppliers going out of business, etc., and would welcome the opportunity to discuss our proposal or others with you.

4. Maintenance and Service: We are deeply concerned that Carriers will establish grossly inadequate maintenance and service fees given the wide discretion and lack of guidance provided in this transmittal. Frankly, we had expected a national maintenance and service fee schedule, but we realize the short timeframe coupled with the volume of items may make it impossible to accomplish this by January 1, 1989.

If a national fee schedule is impossible, we believe that at a minimum Carriers require more guidance. A month's rental is a modest amount and absent evidence to the contrary, we believe Carriers should be instructed to set the maintenance and service fee at that amount.

In the example, second bullet, 1/5/89 should be 1/5/88.

Finally, we believe the "MS" near the bottom of the page should employ the exact statutory language to avoid any possibility for confusion. We recommend:

> MS - 6-month maintenance and service fee for parts and labor which are not covered under any manufacturer or supplier warranty.

PAGE 8

5. Replacement: Purchased equipment may be replaced, but the current language gives Carriers no guidance for exercising this discretion. We recommend adding the following sentence to protect beneficiaries:

> Purchased equipment may be replaced where you determine the cost of necessary repairs would be 50% or more of the purchase price.

Obviously this issue arises in all classes of equipment and we recommend this change throughout.

F. Oxygen and Oxygen Equipment: Item 1 indicates that Exhibit 6 will contain a listing of Oxygen HCPCS codes, presumably compiled by Central Office. This is a sensitive and somewhat complicated area for Medicare and suppliers alike for the following reason. As you know, most Carriers developed an array of purely local codes relative to Oxygen and associated equipment. Accuracy and equity for all parties requires that Carriers be scrupulous in including data from all Oxygen codes (local and HCPCS) in calculating the fee schedule. This issue is so crucial that we believe it warrants special, highlighted mention in item 1. Again, if we can avoid confusion or inaccuracy with a few words early-on, it is well-worth the effort.

The "*" paragraph near the bottom of the page contains a technical error. "1987" should be "1986" since the statutory data period is "the 12-month period ending December 31, 1986."

The same "*" paragraph also sets forth a proposed ratio for allocating charges in combined portable/stationary codes. This formula may work where Carriers have maintained valid data bases. Unfortunately, in some Carriers it will produce patently illogical results.

To give you a specific example, in Pennsylvania charge class area one, the allowable for a combined portable/stationary system (E0435) is $168.50; the stationary system alone (E0440) is allowed $58.50. Thus the proposed ratio would allocate $58.50 to the stationary system, and $110.00 to the portable system, an obviously illogical result.

Such anomalies will also arise in other Carriers, and while they all have a common root (corrupt data), the solutions will necessarily vary from jurisdiction to jurisdiction. For this reason, we recommend modifying the "*" paragraph to note the proposed formula is offered only as one possible approach, and that where it produces inaccurate or illogical results Carriers must work with industry to devise an equitable apportionment.

The example at the bottom of the page cites a $90/$100 relationship between stationary and combined systems. A more typical example is a $70/$100 relationship. We recommend ascribing $70 to the stationary system in the first bullet and making the corresponding change in the third bullet.

PAGE 9

3. Adjustments: We believe the second sentence does not clearly capture the statutory language. We recommend:

> You should increase the fee schedule amount by the higher of either of the following add-ons if they apply:

Substituting "should" for "may" reflects the fact that the add-on is not discretionary if the high litre flow or portable criteria in the statute are met.

PAGE 10

A. Items Not Included in the Data Base: The last sentence refers to "comparable equipment". There will be instances -- given developing technology -- where no reasonably comparable equipment with an assigned HCPCS exists. It seems prudent to provide for this now and to add a new last sentence:

> Where no reasonably comparable equipment exists among current codes, establish a fee based on the suggested retail price or submitted price.

C. Transcutaneous Electrical Nerve Stimulator: The statute clearly provides that reimbursement for the two-month evaluation period is in addition to the full purchase price. We fear that if this is not made clear from the outset, some Carriers will reduce the purchase price by the rental amount. In the same paragraph, we are perplexed by the reference to "II.B. above." Is this a correct cite?

D. Written Order Prior to Delivery: We very much appreciate your listening to our concerns about the mischief across-the-board application of this provision would entail. And we understand your need to reach questionable practices that may have emerged in the field with respect to certain items. At the same time, we are confident that this provision -- even as drafted -- will raise a number of questions which have not been explored and which may have unexpected and undesirable consequences.

For example, in the hospital during morning rounds a physician may write in the patient's floor chart, "discharge to home with penecillin and power chair". The ward clerk then transcribes these orders from the chart and sends the drug order to the pharmacy for filling and the equipment order to the hospital discharge planner to arrange for the equipment. This process is absolutely standard, and more importantly ensures physician input at the outset as you would wish. However, it would not appear to pass muster under this provision as written and could well delay the patient's discharge.

This is but one example, and many others could be listed here. The point is, absent informed comment and advice from physicians, discharge planners and administrators (as well as Carriers and suppliers) we fear this rule will impose burdens on all parties with no off-setting gain in terms of program integrity since the physician will have been involved at the outset.

We want to stress our concern is not so much with the items you've identified, but rather the lack of broad input that would enable you to spot and provide for situations where the physician is involved at the outset in an appropriate manner, but where the transmission of the order -- while also performed appropriately -- is slightly different depending on the facts and circumstances.

For this reason we urge you to forego including this issue in this transmittal and instead publish a prompt NPRM or Interim Final notice available for wide public comment. We assume you intend to follow this transmittal with some more formalized rulemaking in any event, and we believe that would be an appropriate vehicle to first surface this issue for all concerned parties.

We also suggest that in the rulemaking document you identify the specific items by HCPCS as well as name since there can be a number of specific HCPCS embraced by a single generic name.

F. Coordination Between Intermediaries and Carriers: The third and fourth sentences repeat each other.

PAGE 11

A. Rent/Purchase Decision: "October 1, 1989" should be "October 1, 1988". However, we agree with the policy and agree further that months of rental following October 1, 1988 should count toward the 15-month cap.

B. The 15-month Ceiling: Several months ago, the press carried hints that you might adopt this stance, and since then lawyers we've never even heard of have called to "volunteer" their assistance! Doubtlessly your lawyers take a different view. For purposes of this discussion, let's put all of that aside for the time being since there may be a number of legally defensible and mutually agreeable positions.

As noted earlier, we can agree to counting toward the 15-month cap any rental payments made following the cessation of rent/purchase on October 1, 1988. Legal issues aside, this position is analytically sound since there is a visible and balancing quid pro quo. For similar reasons, we could also agree to counting toward the cap any rental payments made in 1988 following a rent/purchase decision. Together, these two situations will encompass the vast majority of equipment whose use spans the January 1, 1989 effective date.

Thus, as a practical matter measured by the amount of equipment affected, we are much in agreement. However, we have no choice but to strenuously object to counting toward the cap pre-1989 rentals on the small amount of equipment not falling into the two areas where we agree with you. As to this class of items there is simply no readily apparent rationale for such a policy, and it will be viewed by industry and press alike as an attempt to arbitrarily and retroactively apply the new law to 1987 or earlier, even though the statute was not enacted until December of 1988 and bears an effective date of January 1, 1989.

Again, this is an important and highly visible issue for us, and we would welcome the opportunity to discuss it further with you.

ADDITIONAL COMMENTS

I. Many of the experts we asked to review this draft commented on how clearly and simply it is written. Our sincere compliments.

II. The earlier BERC/BPO document on compiling a data base instructed Carriers against releasing fee screen data for the time being. This document, of course, is silent on the issue of data release.

We renew our request for release of data underlying the fee screens here. Permit us to reiterate our reasoning. In the meetings, correspondence, and general candid back-and-forth we have shared in the past two months or so, we have not seen anything remotely suggesting bad faith on anyone's part; that is not the root of our urgent concern. However, we -- as you -- have spotted areas of potential innocent confusion (particularly by Carriers) that could

pose enormous problems if not spotted and corrected early on, far prior to implementation. The general data area is rife with this potential, and all of us would benefit from early review of the data as provided for in the statute.

III. There is no mention of the regional pricing to come later. Was this deliberate?

IV. The Exhibits containing equipment by class were not attached. Obviously, the entire classification issue is of vital concern to us and we would appreciate the opportunity to review and comment on even a preliminary draft.

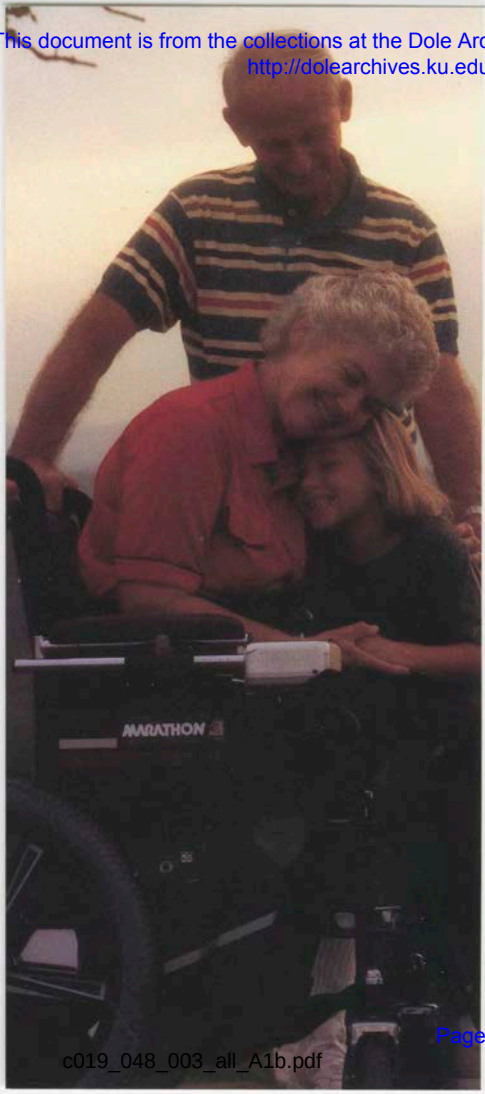
As always, thank you for your candor and cooperation. If we have been unclear or you want further development on any issue we raised, please do not hesitate to contact us.

Sincerely,

James E. Stover
Executive Vice President, HIDA

Frank E. Samuel Jr.
President, HIMA

Thomas M. Antone, IV
President, NAMES



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Date: Tuesday, September 27, 1988
Place: Hart Senate Office Building
Time: 4:00 - 6:00 p.m.

R.S.V.P.

NAMES
625 Slaters Lane, Suite 200
Alexandria, VA 22314
(703) 836-6263

A Milestone Event...
An Unmatched Opportunity

With great pleasure, the National Association of Medical Equipment Suppliers would like to invite you to a very special informal Congressional Reception on Capitol Hill.

Join us. Learn why the home medical equipment industry is a vital part of the American health care scene, providing services which enable millions of Americans annually to recover from an illness in the comfort of their own home. And meet the HME professionals who make this important service possible. Come to learn; come to relax.

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Speak

Sept. 26 Mon

OK
Mon. 9:30 am speak

O.K. 9:30 am - Mon Sept 26

at Hyatt Reg

NAMES

August 1, 1988

Tues: on Hill
8:00 am speak
(8:10 latest can do)

will be flexible

The Honorable Robert Dole
United States Senate
141 Hart Senate Office Building
Washington, DC 20510

Attention: Betty Meyer

Dear Senator Dole:

On behalf of the officers and directors of the National Association of Medical Equipment Suppliers (NAMES), I would like to invite you to address our annual Legislative Conference to be held September 26th and 27th in Washington, D.C. Our members provide durable medical equipment (DME) for millions of elderely and disabled Americans in the home care setting.

Each year, approximately 250 industry leaders gather in Washington to meet with their elected representatives. We have found this to be extrememly effective for educating our members about the political process which takes place in Washington.

Because of your continued interest in, and influence over, home care issues, we feel that your views are critical to our members' understanding the complexity of issues facing the health care community today.

We realize that your schedule is very tight and subject to constant change, therefore, we are prepared to accomodate you in anyway. A simple "stop by" visit would be very acceptable. The conference is being held at the Hyatt Regency Washington on Capitol Hill. We recognize the value of your time and are prepared to pay an honorarium.

Senator, we hope you will be able to honor us with your presence and appreciate your consideration of this request.

8/26 Advised Patrick C. Sen. would do at 9:30 am Mon. Sept. 26

Sincerely

Patrick J. Cacchione
Director of Legislative Affairs

8-2 Interim letter

September 23, 1988

M E M O R A N D U M

TO: SENATOR DOLE

FROM: SHEILA BURKE

SUBJECT: REMARKS TO THE NATIONAL ASSOCIATION OF MEDICAL EQUIPMENT SUPPLIERS

You are scheduled to speak to members of the group on Monday morning at 9:30 a.m. You may recall that you spoke with this same group two years ago and were a big hit. You have been asked to give brief remarks and answer a few questions. They are having a number of other speakers, including Senator Baucus, so you will not be expected to go into any detail on their narrow issues. They are interested in your views on the November elections and the possible health agenda for next year.

They are expecting about 200 to attend the meeting. Their membership generally represents small home medical equipment suppliers. These companies are often family owned rather than large chain operators. Kansas will be represented but they were unsure specifically who would be there.

As a general matter, the group is principally interested in medicare reimbursement. In last year's reconciliation bill, the Congress agreed to radically alter the way we pay for durable medical equipment (DME). Under current law, medicare pays for DME in a fashion similar to that used for physician services, prevailing or actual charges. Under the new methodology, the Secretary must develop a fee schedule for each of six categories of service.

The industry has been working with HCFA in the development of the new system. The regulations have not been published to date so there is no basis for complaint yet. I'm sure we'll hear from them when they are given the final details.

SENATOR BOB DOLE

NATIONAL ASSOCIATION OF MEDICAL EQUIPMENT SUPPLIERS (NAMES)

THE HEALTH AGENDA FOR 1989

O HAVING COMPLETED THE WORK ON THE MEDICARE CATASTROPHIC BILL, WE MUST NOW LOOK TO THE FUTURE AND THE OTHER PROBLEMS THAT CONFRONT THE NATION'S HEALTH CARE SYSTEM.

O THE 101ST CONGRESS WILL FACE SOME VERY DIFFICULT ISSUES ON THE HEALTH FRONT REGARDLESS OF WHO SITS IN THE WHITE HOUSE -- BUT THE SOLUTIONS TO THESE PROBLEMS WILL BE RADICALLY DIFFERENT DEPENDING ON WHETHER WE HAVE PRESIDENT BUSH OR PRESIDENT DUKAKIS.

O THE ISSUES THAT WILL NO DOUBT CONFRONT US INCLUDE; THE NEED FOR A NEW MEDICARE PAYMENT SYSTEM FOR PHYSICIAN SERVICES, THE LACK OF A REAL LONG-TERM CARE PROGRAM; THE INCREASING NUMBER OF THE UNINSURED; INCREASING ACCESS TO PRIMARY CARE SERVICES BY PREGNANT WOMEN

AND CHILDREN; THE ESCALATING FINANCIAL AND EMOTIONAL DILEMMA CAUSED BY AIDS; AND THE TRAUMA TO OUR SOCIETY CAUSED BY SUBSTANCE ABUSE -- BOTH DRUGS AND ALCOHOL.

O NONE OF THESE PROBLEMS WILL BE SOLVED BY QUICK, EASY FIXES; NOR CAN THEY ALL BE SOLVED BY GOVERNMENT ALONE.

- MICHAEL DUKAKIS AND MANY OTHER DEMOCRATS CONTINUE TO TURN TO THE SOLUTIONS OF OLD INCLUDING MANDATES ON EMPLOYERS AND EXPANDED OR NEW GOVERNMENT PROGRAMS.

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- GEORGE BUSH AND THE REPUBLICANS LOOK TO INCENTIVES AND PARTNERSHIPS BETWEEN GOVERNMENT AND THE PRIVATE SECTOR.

O A GOOD MANY OF YOU MAY WELL BE SMALL BUSINESS OWNERS AND KNOW ONLY TOO WELL THE DANGERS INHERENT IN A GOVERNMENT POLICY THAT SIMPLY MANDATES NEW BENEFITS OR PROGRAMS. SUCH A POLICY CAN QUICKLY BANKRUPT A SMALL BUSINESS OR MAKE IT BARELY COMPETITIVE WITH LARGER OPERATIONS.

O REPUBLICANS ARE WELL AWARE OF THE VERY REAL PROBLEMS FACED BY THOSE WHO ARE IMPOVERISHED BY A STAY IN A NURSING HOME OR WHO CANNOT AFFORD TO VISIT A DOCTOR OR STAY AT HOME AND RECEIVE CARE. BUT THE SOLUTION IS NOT SIMPLY A MANDATE.

O WE BELIEVE IN GIVING PEOPLE CHOICES -- CHOICES ABOUT THEIR PROVIDERS, CHOICES ABOUT WHERE THEY WANT TO BE CARED FOR, AND CHOICES ABOUT HOW THEY WANT THEIR WAGES SPENT. THE DEMOCRATS WOULD REMOVE MANY OF THOSE CHOICES.

O ANOTHER WHOLE SERIES OF ISSUES THAT RELATE TO YOU MORE DIRECTLY WILL BE THE CONTINUING ATTEMPTS OF THE CONGRESS AND THE ADMINISTRATION, TO REVISE THE WAY WE PAY FOR ALL SERVICES UNDER THE MEDICARE AND MEDICAID PROGRAMS.

- MODIFICATIONS TO THE HOSPITAL PPS SYSTEM WILL CONTINUE TO RECEIVE OUR ATTENTION BUT MORE IMPORTANTLY WE WILL FINALLY TRY TO RESOLVE THE WAY WE PAY OTHER PROVIDERS INCLUDING DOCTORS. ALL THE STUDIES ARE DUE AND WILL LIKELY BE THE BASIS UPON WHICH MUCH OF WHAT WE PROPOSE IS FOUNDED.

0 HEALTH CARE COST ESCALATION CONTINUES TO CONFOUND US ALONG WITH THE EVER-CHANGING FACE OF THE DELIVERY SYSTEM. WE NEED TO ACCOMMODATE THESE CHANGES -- AND LET OUR HEALTH CARE SYSTEM DO WHAT IT DOES BEST -- PROVIDE THE FINEST CARE IN THE WORLD, BUT WE CAN'T DISREGARD COST.

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MEDICARE PROGRAM CHANGES

O FINALLY TOUCHING BRIEFLY ON THIS YEAR'S ACTIVITIES, OUR ACTION ON THE CATASTROPHIC HEALTH INSURANCE BILL MARKED THE MOST SIGNIFICANT CHANGE IN THE MEDICARE PROGRAM SINCE ITS INCEPTION IN 1965. AND WHILE WE DID A GREAT DEAL OF GOOD WE ARE GOING TO HAVE TO WATCH WITH CARE THE ACTUAL IMPLEMENTATION.

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