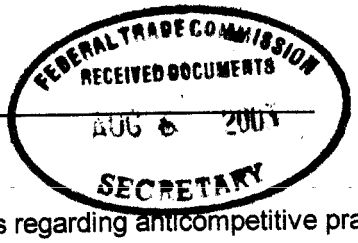
Lynne Odell-Holzer



Dear Secretary Clark;

This is in response to the FTC/Dept of Justice hearings regarding anticompetitive practices in healthcare industry.

I believe that the structure of our current health care reimbursement system continues to breed more barriers to health care services to the patients. This belief has come from my experiences both as a consumer and a provider of health care services.

My practice has additional barriers to delivering health care services within the current flawed system. I am an Nurse Practitioner who is dually certified as a Family Nurse Practitioner and as a Nurse Practitioner in Psychiatry with national ANCC certification as a Clinical Nurse Specialist in Child and Adolescent Psychiatric and Mental Health. My first Masters degree is in Community Health Nursing Administration and I have 30 years practice in that field. My reason for returning for the second master's was to provide comprehensive services-mostly preventive and primary care for those people whom I had only partially been able to serve as an RN in a home care agency. Many (approximately 90%) of my home care clientele insisted that they were not depressed or anxious. They then would spend as much time as I would allow telling me their problems & issues. Many of these issues inhibited their rehabilitation and continued their dependency upon our governmentally administered social and health care systems.

Once I obtained my second master's as a Nurse Practitioner in Psychiatric/Mental Health, I planned to return to the field (Community health) to help address this issue. The FNP was a bonus that was to make my visits to the patients more acceptable due to the stigma of Mental Health issues. I planned for the dual NPs to cover the whole range of primary care to reduce the numbers of visits patients had to make and the cost on the health care system. Theoretically, I could treat their anxiety, depression, and other basic mental illnesses as well as their high blood pressure, diabetes, or assess and treat their reproductive health needs as some examples. Little did I know that the reimbursement systems for mind and body are totally different and that numbers of insurances refuse to cover house calls or NP services. Many insurances prefer to pay the higher rates to continue to use MDs rather than to look at models of health care delivery that improve the health of their 'covered lives'.

During my two years of developing Comprehensive Holistic Health and House Calls, I have run into a number of barriers to providing services. Some of these are:

1. Payment confusions and delays because some insurances do not recognize NPs as providers and require payments to go to the collaborating physician. The collaborator then has to have a separate system to track my clients, pay me the amount for those services, track the co-pays and record those when they come in. This is quite necessary so that he/she can 'pass through' the money rather than be liable for the taxes as his/her income. I also need to have a record of this information in order to properly pay my taxes.

Some insurances pay me for the service I provide where others pay a reduced rate for the fact that I have a different license.The ones that pay me the same rate for the same service are actually covering the costs that my collaborator incurs for the tracking process. Even this convoluted process has its follies.

As an example, I have billed Blue Cross/Blue Shield for house calls. These payments have gone to my collaborator at his downtown office (he has no record of that client in his caseload), to that collaborator at my practice address, and to me at my practice address. No one at Blue Cross can tell us why. This also occurs with insurance requests for further information and with denials of services. Therefore, my practice and reputation is dependent upon the business skills of my collaborator, not upon my business acumen. Payments are delayed or denied, cash flow is compromised and I have a person dedicated to spending hours tracking these payments down for what is currently a part-time practice.

2. While on contract as a CMS intermediary in Upstate New York recently, BC/BS paid my direct claims for Medicare clients while at the same time denying that I qualify as a provider through the private BC/BS system for those exact same services. Their comment is that the various BC/BS 'products' are independent, much like McDonald's restaurants. This is a hollow argument because all the McDonald's franchises have the same framework with only peripherals different in the different franchises.

3. I am unable to hire more NPs for my house call business because of the limitations

on the collaborating physician to collaborate with no more than four NPs who are not directly practising in the same office/vicinty. There is also the complication of hiring NPs who have collaborators who are willing to 'allow' the NP to work for my agency and who are willing to agree to my agency policies. I cannot directly hire physicians to be collaborators for the NPs who might work for my house call agency. That also means separate tracking of the insurances under which that NP and his/her collaborator may bill and the additional billing confusion of where the claims may be paid (my agency who billed or the collaborator's office who is not responsible for the patient).

Another NP in my house call practice further confuses the issue of 'whose patient is it anyway?' If the NP collaborates with the physician and is not recognized as a direct provider by that insurance, the insurance attributes responsibility for the outcomes for that patient to the physician. Yet the patient is a member of my house call practice and is followed by an NP whom I have hired. My housecall practice 'should' be responsible for that patient if my housecall practice is billing for that patient. Where is the responsibility and where is the liability?

4. Insurances allowing only collaborating MDs to be listed on their provider panels. This is especially egregious because these same insurers already credential and list separately psychiatric clinical specialists, physical therapists, and occupational therapists. I wonder about this being a restraint of trade.

In the least, patients cannot find me as their NP when they prefer this level of service. When it is the collaborator only who is listed, many potential patients are told by the insurer that they do not know/cover my services. Other times, if the patient knows I work with one physician and calls that collaborator's office, they are told that the physician is not accepting new referrals and they do not know to ask for the NP. This also breeds suspicion on the part of some of the patients who wonder if I am a legitimate service/organization if their insurance does not know of or recognize my services.

5. Risk of shut down of services if my collaborator becomes incapacitated. I cannot provide services in New York state unless I have a collaborative agreement in place. If my collaborator has a serious illness/injury that makes him/her unavailable, I cannot provide services to my clientele-putting me at risk for abandonment of my patients.

6. Problem of finding appropriate backup NPs for on-call services if I am incapacitated--including the home visits is a corollary problem. This is not only because of my dual credentials, but also because of the reimbursement issues. Would the covering NP use my collaborators? Would the covering NP use his/her own collaborator? How would the billing occur? What if the covering NP is not credentialled with that insurance?

7. Problem of some insurances requiring that services be provided in offices, not reimbursing by type of service irrespective of its venue. For example, Aetna, who does recognize NPs for direct reimbursement, requires an office which can supply seating for at least 5 patients at a time, has capacity for pelvic exams, is handicap accessible, etc. Primary care in the home setting is an unacceptable venue for service for them even though I can do pelvics in the home. They will not credential me on the office requirement alone, irrespective of my ability to provide the same services as an office-based practice.

8. A corollary problem is that of some insurances requiring hospital privileges even though I currently use hospitalists because of their specialized skill level. Using hospitalists allows me to concentrate my retraining and continuing education courses on my two community specialties rather than dilute my training time. Using hospitalists maintains my ability to concentrate on those who are without services in the community so I don't have to divide my time and resources providing to both community and hospitalized patients.

9. Funding assistance and program development via HRSA is unavailable because eligibility is based upon geography as a definition of underserved populations without consideration of their inaccessibility to health care services because of their immobility. For example, we have pockets of patients who are poor and rural scattered throughout our county. They do not have reliable transportation-public or private, to get to the few clinics in the county. Many poor mothers have no capacity for babysitting the other children when one child needs health care. Other people are agoraphobic and cannot access the few buses that are available for public transportation. The medicaid taxi systen is antiquated and breeds many missed clinic appointments. (A side example is the rule that the medciad taxi cannot pick up the mother at home and the child at school for the child's mental health visit at the clinic).

10. For those insurances that require collaborators, I can only use the insurances that my collaborator uses and I am dependent upon his/her personal economic decisions about whether he/she will participate in an insurance or not. If my collaborator decides that he/she no longer will accept BC/BS for example, I have to drop my caseload who have this insurance, putting me at risk of abandonment on one hand or providing free services if I am suddenly without a payment source. Most

of my patients can/will not pay full fee privately.

11. New York Medicaid reimbursement is antiquated. Standard medicaid allows $30.00 for a visit for FNP type services in an office setting but only $7.00 (not a typo) for house calls. Medicaid officials have written to me to state that bringing house call visits in line with office visits would be an expansion of their services and requires legislative action! In addition, insurances accept the UB82 or the CMS1500 forms for claims. Medicaid currently requires a different form and different data collection creating necessity for two methods of billing and the extra time that involves.

12. New York Medicaid cannot reimburse me for the services I provide because they have no schedule for reimbursement of those codes for NPs. They do not recognize NPs as having any specialties which has shut out my services to Medicaid clients for whom I was providing mental health services. I have 80+ unbillable Medicaid visits. This population is in intense need of services in the home from the multi-systemic, multi-problematic, and the transportation standpoints.

13. I do contract work in a sub-acute nursing unit, a private child and adolescent psychiatry office, and with a private mental health services company until I can surmount the financial barriers enough to have a full time house call practice. The billing process is a nightmare- dependent upon four different billing systems, medical and psychiatric coding and documentation. Not just in the instance cited in # 1 where BC/BS has sent reimbursements in at least three different ways, but also in the refusal of Medicare to pay for two different types of services in the same calendar day by the same provider. Two examples are:

A.) Ventilator dependent patient for whom I am providing psychiatric counseling for his depression and pain control for his chronic pain. At one visit where I walk in to provide counseling, I find him with nausea, vomiting, diarrhea, and fever. Doing a physicial, I diagnose probable pneumonia, initiate treatment for that, and then continue on with some attenuated instructions for mental health 'homework' practice and some therapy. Although they are two separate services for two different diagnoses, the more expensive of the two services was rejected based on the same day by same provider regulation.

B.) In another household, I provided an hour's individual psychotherapy to the agoraphobic patient. When the spouse came home, I provided another hour and one half couples counseling regarding their marital stresses. This also was rejected, even though clearly documented as the two distinct services with distinct foci. It would have been covered if I went back after midnight for the second visit.

I think that this may give you some indication of the numbers of insurance issues that are barriers to my provision of the care I was trained to provide. A health economist named Jeffrey C. Bauer, Ph.D has written cogently about the barriers to practice that NPs must currently endure. His book is: *"Not What the Doctor Ordered"* 2nd edition. 1998 McGraw-Hill. This book may speak more to the issue on behalf of all NPs.

Finally, you are all invited to come and audit my practice to get a feel for the daily work involved and where 2/3 of my time is spent on insurance and paperwork to document for insurances.

Sincerely yours,
Lynne Odell-Holzer RN, MSN, FNP, NPP, CNS-BC