Donald S. Clark
Office of the Secretary
Federal Trade Commission
600 Pennsylvania Ave NW
Washington DC 20580

Healthcare@ftc.gov + 6 Hard Copies Subject: Comments Regarding Hearings on Healthcare Competition Law & Policy

Dear Mr. Clark;

I am a consulting engineer with an MBA, so I have some idea how a business is supposed to run. I also happen to be married to a Nurse Practitioner with specific licensure in NY state in BOTH Family Medicine and Psychiatry, with Board Certification as a Child & Adolescent Mental Health provider, and a long history of Public Health Nursing. The last of these formed the basis for her awareness of the woefully underserved population of homebound, and those whose child-care responsibilities make it extremely difficult to obtain healthcare at a traditional medical office, to say nothing of the costs of doing so. Additionally she observed that much of the population typically served by Public Health was unable to obtain ANY psychiatric therapy due to the lack of qualified personnel providing services in the home. Lastly, and as we have repeatedly observed especially with child mental health, familial interactions are much more likely to be observable as contributory to condition in a familiar setting like the home than in a traditional office, where almost every child will be at least withdrawn, to say little of their agitation state from inactivity for the typical hour in a waiting area before the provider sees them.

For these reasons, Lynne Odell-Holzer NP stopped paid work as an RN for almost four years to additionally absorb the costs of getting her licensure as an NP and attempt to start her practice, **Comprehensive Holistic Health and House Calls** div. Holzer Enterprises; professional medical & psychiatric treatment and med management care via a MOBILE office, within which she transports all the equipment she would otherwise expect to utilize in a traditional office to a location most appropriate for the patient's needs. To prevent duplicative costs for only partial usage she does not maintain a fixed office for visits, only an administrative one. Thankfully, my income allowed our family to continue to live normally through that period. And since completing services to my last client in Nov 2002, I have been serving as her office manager to allow her to become HIPAA compliant and get caught up on the administrative side of her business. I would like to emphasize that last word, as she is every bit the successful entrepreneur any small business-person is, with one glaring exception explained below.

She has provided care to many patients; Medicare, Medicaid, private insurers and private payers. Of these, certainly least-hassled are the private payers, as she receives payment right up front, or with a relative certainty on a time payment schedule. However, none of the other payers is quite so business-like. Obviously, where required, she obtains pre-authorizations. Note that this is at the least a tedious process whereby ANY medical provider must absorb costs to chase down the funding source even before they can determine whether their services are appropriate to the patient needs or not, and although coordination of care and extensive administrative costs are involved, no compensation is available for those activities. But that was at least understood going in.

What was not understood was the level of absurdity practiced by almost all the third party payers, and especially aggravating in the case of Medicare and Medicaid; to deny payment, after services have been rendered in good faith, for nitpicking interpretations. Some examples: Lynne cannot even BILL Medicaid for the dozens of Psychiatric therapy and med management visits she has made, because their interpretation is that NP's have no specialties, and so reject any 908XX CPT code. This despite the fact that Medicare DOES pay for those services so billed. What THEY do not do is accept the idea that a provider supplies TWO services when they find a patient with both a physical ailment as well as a mental health issue in a single visit. Medicare "bundles" them, and pays the LOWER of the service values. This results in the reality that, as a business-person, Lynne must insist that the patient suffer until the next time she visits to treat whichever is the "less urgent" problem. Is this really serving the CUSTOMER best? And doubly frustrating when realized that two DIFFERENT providers on the same calendar day would have no problems with payment whatsoever, but a single provider with the capability of optimizing care which recognizes the interrelationship between the two conditions (or more) is expected to give the insurer this capability gratis. Do YOU absorb costs for NOTHING? Additionally, until the first of this month, Medicaid allowed $30 plus the cost for transport for a client to a traditional office, but limited the payment for home visit to $7. For all the extensive reading, having an EQUALLY participating collaborator etc., required by Medicaid, they still think providers have no idea of the realities of business? Small wonder Medicaid cannot find providers. But who suffers most?

And perhaps the most galling refusal to pay, and especially in light of the recent Supreme Court decision requiring a Tenn HMO to pay anyone qualified who accepts their fee schedule, has been the insurers who claim that care provided in the home is not what they mean when they refer to covering outpatient "office" visits, unless the person is "homebound", and further by implication, requiring a homebound patient who recovers mobility to find a DIFFERENT provider than the one who helped them GET such mobility. And of course, this all happens AFTER the services have already been rendered, so the providers are forced to eat the costs while the insurers continue to collect premiums and show added profits to THEIR investors. But what about OURS? And this is merely scratching the surface where Blue Cross Blue Shield is concerned. THEY refuse to accept ANY NP, nor even to make payment to an NP as a Secondary Insurer for Medicare. That results in their putting all Lynne's patients at risk if her collaborator gets fed up with them, as with Medicaid, and creates a seeming double-payment for 1099 for IRS, as the provider's TIN is reported as having been paid by BC/BS, but the check is made out to the Collaborator, which except for the requirement that the collaborator review her cases on a statistical sampling basis would be a violation of HIPAA, and certainly violates Medicaid rules for payment ONLY to the actual provider. He then must pay Lynne, absorbing added administrative costs, and ALSO report her payment as a 1099 for her TIN. It may not yet be a red flag at IRS, but it won't be long as more electronic reporting occurs. And when queried about WHY they do such practice, BC/BS responds unapologetically that "they must protect their member physicians". If that isn't uncompetitive cronyism, I cannot wait to see a better example. And with the Excellus buyouts in NY, they are almost a monopoly.

This is not to say that all insurers have such practices. United Behavioral Health for one has requested Lynne to take some cases PRECISELY because she DOES provide home visits, and can therefore determine where the real problems lie instead of interpreting inputs from a filtering environment, and provide the BEST care to alleviate the issue, thereby REDUCING overall cost. Innovation in providing for a customer base which has not received adequate service in the traditional marketplace IS competition.

The simple truth is that NP's represent a potential means to reduce the staggering growth of health care costs, but only if allowed to BE competitors on the playing field. As things are, the costs for NP's exceed the potential revenues available when providing for the unserved populations, but not because they should; rather because of inconsistent application of interpretation by insurers whose charters at core require them to be profitable and pay no more than reasonable for services to their customer base, while providing for the medical treatments which are appropriate. It takes no genius to observe both that short term screwing of innovative providers who are willing to accept the EXPECTED fee schedule may save a small amount up front, but it will drive ALL the costs up because both the provider and the insurers must waste resources arguing the issues, to the benefit of noone, and the providers will simply opt out of providing as soon as they ethically can do so. Providers are expected to assume responsibility for helping patients to find other providers if they are unable or unwilling to continue. But what is the insurer's similar liability, especially when THEY are the CAUSE? And does noone realize that the ultimate result is that the unserved eventually require MORE complex and costly care? Care that could have been minimized through preventive action, but they frequently can get that care at only the place of last resort; hospital emergency rooms, the most costly care resource available. SOMEone must pay for the care, so costs skyrocket for we taxpayers. But competitive it certainly is NOT.

Respectfully,

Joe Holzer
7751 Treadmill Cir
Liverpool NY 13090
315-622-9241 Voice or Fax

**Idea Man** div Holzer Enterprises

www.holzerent.com

im@holzerent.com