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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. letter	Gil Garcetti to Hillary Clinton (2 pages)	9/23/96	P6/b(6)

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Health Security Act)
OA/Box Number: 8993

FOLDER TITLE:
Correspondence [1]

gf66

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advise between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

THE WHITE HOUSE

WASHINGTON

December 30, 1996

Ms. Mary J. McLaughlin

P6/b(6)

Dear Ms. McLaughlin:

Thank you for writing about the amount physicians may charge under the Medicare program. I appreciate having the benefit of your thoughts.

In order to give your concerns the appropriate attention, I have forwarded your letter to Dr. Bruce Vladeck, Administrator of the Health Care Financing Administration, for review. You can be sure that he will give your thoughts careful consideration.

Again, thank you for writing,

Sincerely,

Christopher C. Jennings
Special Assistant to the President
for Health Policy

cc: Bruce Vladeck

P6/b(6)

November 17, 1996

The White House
Chris Jennings/White House Aide
1600 Pennsylvania Avenue
Washington, D. C. 20500

Dear Mr. Jennings,

Re: Medicare

Are you aware that charges submitted to Medicare by doctors are not checked by Medicare.

My research has shown that there is nothing in print for Medicare patients to use showing what the doctor can charge for the initial office visit in their area, and the follow up visits depending upon the time spent with the doctor, and the treatments received.

I have brought this to the attention of Rep. Richard Gephardt, AARP, Donna Shalala, and Medicare.

A quote from AARP. "Seeing the allowable amounts for various services would likely confuse patients rather than help them."

A quote from Medicare. "Doctors know or could reasonably have been expected to know, that the services were excluded from coverage." I was given a document to sign, just incase Medicare doesn't pay. It cost me over $400 dollars out of my pocket.

A quote from Medicare. "It doesn't make any differance what the doctors charge Medicare." (It does make a differance if the wrong code is used for office visits alone.) That's an overcharge to Medicare, and the patient, be it a typing error, or mis understanding the instructions in the manual.

There should be a separate pamphlet for Medicare patients, something that can be picked up at the doctors office that both the patient, and the billing clerk can use, following treatment guidelines by The National Institute of Health since 1991.

Is there a tax write off for doctors that charge above the approved amount?

Why not just charge the approved amount in their area for office visits, and treatments. The right computers would pick up any mistakes made by the billing clerks.

A sample enclosed of mistakes made. Medicare is checking all the charges. This is 2 doctors (oncologists) in two different areas.

Sincerely,

Mary J. McLaughlin

Mary J. McLaughlin

Doctors seem to be only interested in lining their own pockets. They do not follow the guidelines set by The National Institute of Health since 1991.

That's why it is important to get out a pamphlet showing the treatments to be received for a specific illness, and showing the Medicare approved amount.

This will save money for both Medicare, and the patient.

Example: Oncologists. One doctor will treat you with 100mg. of Iron Dextron twice a week for a low blood count. Another will treat you with 200 mg. every day for 2 weeks, plus Epoetin, but only after you sign a document that you will pay, if Medicare doesn't pay.(According to Medicare, they know inadvance if Medicare will pay for Epoetin.

Example: Allergists know that around 70 years old,tests will show negative, but they insist on taking the tests, and charge Medicare some $1,600.

Example: Pulmanary doctors should know that there is no need to use the Nebulizers, but continue to sell the equipment to you, along withthe medication. The medication alone is some $300. dollars a month to Medicare, and $30.00 to the patient.

ONCOLOGISTS

P6/b(6)

	Initials	Date
Prepared By		
Approved By		

		Medicare Code Off. Visits	Charge To Medicare	Medicare Approved	80% Paid To Doctors	20% Paid by Patient	
1	Newport	99245	20053	17437	13950	3487	
2	La Jolla	—	—	—	—	—	
3							
4	Newport	99211	1703	1481	1185	296	
5	La Jolla	99211	4000	1454	1163	291	
6							
7	Newport	99213	4234	3682	2946	736	
8	La Jolla	99213	7100	3652	2922	730	
9							
10	Newport	99214	6471	5627	4502	1125	
11	La Jolla	99214	8800	5612	4490	1122	
12							
13	Newport	99215 } 7	9806	8507	6802	1705	
14	Newport	99215 } 1	10211	8879	7103	1776	
15	La Jolla	99215	13100	8865	6908	2857	
16							
17	Newport	99214	6000	5693	4554	1139	} Pulmonary Doctor Newport
18		99213	4000				
19		99213	4500	3772	2978	744	
20		99213	4500	3722	2978	744	
21							
22							
23							
24							
25		THE MEDICARE APPROVED AMOUNT					
26		IS WITHIN PENNIES FROM ONE					
27		AREA TO ANOTHER.					
28							
29							
30		THEY CHARGE FOR AN OFFICE VISIT					
31		THEY CHARGE FOR THE WORST GIVING YOU THE INJECTION					
32		" "		" "	KNOW DOCTOR		
33		" "		" "	SAKINET (IT'S .99 CENTS AT DRUG STORE		
34		" "		" "	AUTOMATIC HEMOGLOBIN		
35							
36							
37							
38							
39							
40							

TREATMENT IN ADDITION TO office VISIT CHARGE

	Initials	Date
Prepared By		
Approved By		

		1	2	3	4	5	6	7	8
			CHARGE TO MEDICARE	MEDICARE APPROVED	80% PAID TO DOCTORS	20% PATIENT PAYS			
1	P5024	(AUTOMATED HEMOGLOBIN)							
2	Newport		1198	1198	958	240			
3	La Jolla		2100	1198	958	240			
4									
5									
6	85030	(AUTOMATED HEMOGLOBIN)							
7	Newport		—	—	—	—			
8	La Jolla		1000	643	514	129			
9									
10									
11	90780	(INFUSION THERAPY)							
12	Newport		5180	4504	3603	901			
13	La Jolla		12500	4218	3374	844			
14									
15									
16	J1760	(IRON DEXTRAN)							
17	Newport	(1)	3966	(1) 3449	2759	690	(1) (100 mg 2cc)		
18	Newport	(2)	7932	6898	5518	1380	(2) (200 mg 4cc)		
19	La Jolla	(1)	6400	(1) 3630	2904	726			
20									
21									
22	J7040	(SALINE) MIX WITH IRON DEXTRAN							
23	Newport		600	—	—	—			
24	La Jolla		1650	1144	915	229			
25									
26									
27		I may be missing a point here.							
28									
29		It could be so simple if they							
30		would change the Medicare							
31		Approved Amount.							
32									
33		It has to be a tax write off							
34		for the Doctors. * (why confuse							
35		the patients							
36									
37									
38									
39									
40									

COVER STORY

Controls remain 'nonexistent'

Continued from 1A

Part of the problem is that in nine states, anyone can open a home health agency, regardless of background or experience. In many other states, the few rules that do exist are lax and do little to weed out potential criminals.

"It's just fraught with fraud," says June Gibbs Brown, inspector general for the U.S. Department of Health and Human Services, where she heads a anti-fraud campaign in which home health care is a chief target.

"There are so many benefits to home health care — the person is in their own environment, they have their support system — and in theory, it should also be cheaper than a full-care facility, so we support the concept," Brown adds. "But when care is provided in the home it's very difficult to ... see whether a patient really gets the care, or what the quality is."

The numerous loopholes beckon

John Watts Jr. pushed through all the loopholes.

His conviction in a million-dollar cocaine sales scheme wasn't an issue when he applied for and received a California license to run a home health-care agency. No one asked whether he had a criminal record; no one was required to check. His experience as a nightclub owner was deemed sufficient to qualify him as the agency's administrator.

Watts and a partner got their first patients by paying a local doctor to send them patient referrals — kickbacks that are illegal. But soon they decided they didn't even need real patients, and they began billing Medicare for services they never provided, using names of dead people or people never seen.

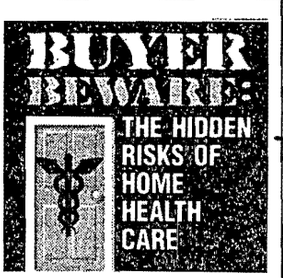
Watts' company, United, was allowed to send in claims via computer, no paperwork required, so it was "easy for us to submit Medicare claims for patients to whom we never provided any services," Watts testified.

United was "paid millions of dollars for fraudulent claims before Medicare even began to ask for any documentation that the services were ... actually performed," he added.

When Watts finally was asked for paperwork on home-care visits, he and his partner simply forged it. With no one actually checking to see that the visits had been made, investigators were fooled for months longer.

Watts, who pled guilty and was ordered to pay restitution in the case, has had his sentencing delayed while he shares his story with prosecutors and policy makers looking for insights on how fraudulent home-care providers work.

"We were making so much money," he testified, "that I was able to have a custom-built home for $2.5 million of which I put down $1.2 million."



SPECIAL REPORT

- One good home health aide makes a difference
- How one of the nation's largest home health companies defrauded the government for more than $1 million

Stories, Page 7A

The biggest victims of home-care fraud are the nation's two health insurance programs: Medicare and Medicaid.

Together, the two will cover about 60%, or $22 billion, of the $36 billion Americans will spend on home care in 1996. Government investigators estimate that 10% of the claims paid by the programs are fraudulent or improper — $2.2 billion.

"Although we have been reporting on program weaknesses over the last 15 years, controls over the Medicare home health benefit remain essentially nonexistent," says a March report by the U.S. General Accounting Office, Congress' investigative arm. "Few home health claims are subject to medical review and most claims are paid without question."

The most common scams: billing for fictitious visits, billing for care that's unnecessary, over-billing, or using low-skills care givers for work that's billed as skilled nursing care.

Now, there are new efforts to root out bad providers.

Home health care, along with nursing homes and medical equipment suppliers, is a chief target in Operation Restore Trust, the crackdown by the Department of Health and Human Services. So far, the 19-month-old effort has focused on the five states believed to have the most problems — New York, Florida, Illinois, Texas and California.

A flood of recent cases suggest home care's fraud problems are not overblown:

▶ A random federal audit of Medicare claims by home health agencies in Florida found 26% of billings were bogus. Federal investigators said that at St. Johns Home Health Agency in Miami Lakes, improper claims, often for services not rendered, accounted for 75% of the agency's $45 million in Medicare charges for 1993.

▶ Robert "Jack" Mills, head of ABC Home Health Services Inc., one of the nation's largest home care chains, was convicted last February in a massive Medicare fraud case. Investigators said Mills billed Medicare for more than $14 million in bogus expenses, for everything from fancy jewelry to a luxury beach condominium. **(Story, 7A)**

▶ Rony Flores, owner of Casa Care Services in New York, was convicted last year of bilking Medicaid for $1.25 million. Flores billed Medicaid for care provided to dozens of patients by untrained, unqualified home-care aides, many of them illegal immigrants. He spent eight months in jail and was ordered to pay restitution.

Home health care "is an industry that contains all of the components for disaster," says Tom Temmerman, who heads Medicaid fraud prosecutions at the attorney general's office in California. "It is unregulated in the traditional medical sense, multiple agencies are involved with large amounts of government money and it is attractive to the consumer."

No one counts how much private insurers lose

But Medicare and Medicaid aren't the only victims of fraud. The damage also has reached the ranks of private insurers, who pay about 13%, or more than $4 billion, of the nation's home care tab.

How much do they lose? No one knows.

"We know that it's very fast growing," says Bill Gradison, president of the Health Insurance Association of America. "Fraud and abuse are problems. Care given in the home is just much harder to monitor than care given in a hospital."

The National Association for Home Care, the industry's largest trade group representing 6,000 of 17,000 providers nationwide, has adopted a "zero tolerance" stance on billing fraud.

"A significant amount of what we see in terms of (fraud charges) is a result of home-care agencies either not understanding the rules or having the rules applied differently" state-to-state, agency-to-agency, says Stephen Delfin, the association's public relations director. "Often, it's the unintentional misuse of (Medicare or Medicaid) funds."

State and federal officials acknowledge there are some inconsistencies in how states and agencies rule on claims.

But the big problem, most agree, is that it's too easy for bad people to get into the business.

"The industry itself is showing a great interest in keeping (home care) clean," says Brown, the inspector general. "It's a matter of tightening up (on) the experience and certifications people need to get into the business. It's just too easy."

COVER STORY

Those who get caught say it's 'just too easy'

Home health care 'an industry with all the components for disaster'

By Peter Eisler
USA TODAY

LOS ANGELES — Just 13 months after John Watts Jr. finished his prison term for cocaine dealing, he launched his next money-making venture: United Care Home Health Services Inc.

But his new business turned out to be no more legal than the first. He's now awaiting sentencing after pleading guilty last year to using the home care agency to defraud Medicare of at least $1.5 million.

"We didn't start out to do this," Watts testified last fall to a Senate committee investigating health-care fraud. "But it was just too easy."

A USA TODAY investigation finds Watts' story is all too common in the behind-closed-doors business of home health care, where shady operators easily can set up shop and start billing taxpayer-paid Medicare and Medicaid for services never rendered.

Home care's booming popularity — it's now the nation's fastest growing industry — has combined with loose licensing laws and lax oversight to make the business ripe for thieves, thugs and scam artists.

Some work as caregivers, abusing and stealing from the elderly and disabled patients who turn to them for help.

Others gravitate to the business side. This year, Medicare and Medicaid, the government insurance programs for the elderly, poor and disabled, will lose an estimated $2.2 billion to fraudulent home-care providers. Private insurers will lose millions more.

Scheming for profits

Managed-care provider organizations are scheming health-care systems foisted on American people seeking health care outside of Medicare. The bottom line for managed-care organizations is profit first, quality health care a distant second.

Unlike Medicare, which requires federal process to make necessary regulation changes, managed-care regulatory changes can and are made at will to adjust for profitability at the cost of patient health concerns.

I would rather trust my physician with my health concerns than profit-chasing managed-care organizations.

Santo Arduino
Garden Grove

THE WHITE HOUSE

WASHINGTON

December 30, 1996

Ms. Arlene Rakoncay
Executive Director
Chicago Artists' Coalition
11 East Hubbard Street, 7th Floor
Chicago, Illinois 60611

Dear Ms. Rakoncay:

Thank you sharing your thoughts about health care for artists. I appreciate having the benefit of your views.

As you noted in your letter, the Clinton Administration has fought long and hard over the past few years for health care reform. The President was pleased to sign into law the Kassebaum-Kennedy bill that will help as many as 25 million Americans, who today live in fear of losing their health insurance when they change or lose their jobs. This bill will also eliminate the discriminatory tax treatment of the self-employed, making health care more affordable for the 3 million self-employed Americans now purchasing health care. Still, we must continue our efforts on behalf of the millions more who live without adequate health care coverage.

I am grateful for your interest and involvement.

Sincerely,

Christopher C. Jennings
Special Assistant to the President
for Health Policy

Chicago Artists' Coalition

November 25, 1996

Mr. Chris Jennings
Aide to President Clinton
The White House
1600 Pennsylvania Avenue
Washington, DC 20500

Dear Mr. Jennings:

I was happy to see the article in the N.Y. Times informing readers that President Clinton hasn't abandoned the health care issue for the American people.

While you are putting together agendas, please consider the plight of the artist. Most are self-employed, well educated, but financially unable to pay for excessive premiums charged by greedy insurance companies. Our organization, Chicago Artists' Coalition, does have an assortment of health plans that we offer our 2,500 members. The major problem is that the premiums are too high for our membership to take advantage. Also, beware if you have a pre-existing condition. Coverage for most these conditions are so expensive that even in your wildest dreams you could not afford them, or, no company will cover you.

Putting it bluntly, Mr. Jenings, the little guy is being "screwed!" In a country as rich as ours, citizens should not have to go without health care. I hope that somewhere in your agendas you can address the issues of those people who are middle-class, but just don't make enough money to afford health insurance, and those citizens being discriminated against because of pre-existing conditions.

Sincerely,

Arlene Rakoncay

Arlene Rakoncay
Executive Director

11 E. Hubbard Street, 7th Floor • Chicago, IL 60611 • (312) 670-2060

THE WHITE HOUSE

WASHINGTON

December 30, 1996

Dr. Nancy L. Purcell
President
Washington State Medical Association
2033 Sixth Avenue, Suite 1100
Seattle, Washington 98121

Dear Dr. Purcell:

Thank you for your letter in support of Dr. Peter M. McGough to serve on the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry.

Dr. McGough's background and credentials are currently being reviewed. Clearly, he would have much to contribute to the Advisory Commission. You can be assured that his candidacy will be given every consideration.

I appreciate having the benefit of your views.

Sincerely,

Christopher C. Jennings
Special Assistant to the President
for Health Policy

2033 Sixth Avenue
Suite 1100
Seattle, Washington 98121
206-441-9762
1-800-552-0612
Fax 206-441-5863
e-mail: wsma@wsma.org

1800 Cooper Point Road SW
Bldg 7, Suite A
Olympia, Washington 98502
360-352-4848
1-800-562-4546
Fax 360-352-4303

WashingtonStateMedicalAssociation

December 12, 1996

Mr. Christopher Jennings
Special Assistant to the President for Health Policy
The White House
1600 Pennsylvania Avenue, NW
Washington, DC 20500

Dear Mr. Jennings:

I am writing, on behalf of the Washington State Medical Association, to endorse the nomination of Peter M. McGough, MD, for appointment to the Advisory Commission on Consumer Protection and Quality in the Health Care Industry.

Dr. McGough has a wealth of experience that would benefit the work of the commission. He is a family physician who practices medicine in West Seattle, Washington. He also serves as medical director for legislation and business liaison for Medalia, a physician-directed component of the Sisters of Providence Health System. Dr. McGough recently served as president of the 8,000 member Washington State Medical Association, and as chair of its Executive Committee, and has helped guide the profession in his state through a tumultuous period of change.

He is very astute politically, and has a broad working knowledge of the issues affecting patients, physicians, insurers, hospitals, and others. He has been closely involved for several years in a wide variety of state health care issues – legislatively and otherwise. I understand he has recently been named to the strategic planning committee of the state hospital association.

Dr. McGough daily acts on his professional and personal commitment to providing access to high quality health care for all people. He understands managed care, and works well with those in and outside of managed care systems. He is held in high regard by his colleagues.

President Clinton and the commission would benefit from Dr. McGough's involvement as a member of the commission. He is eminently qualified to help define and resolve the issues associated with the provision of quality health care for all.

Please call me at (206) 656-4048 if you have any questions about this outstanding physician.

Sincerely,

Nancy L Purcell MD

Nancy L. Purcell, MD
President

mcgough

(G)

September 23, 1993

1~
2~
3~

Dear 4~:

Thank you for taking the time to write and share your thoughts with me on 5~. It is very important that this Administration hear from individuals like yourself (or groups) who have valuable information to contribute. I have shared your letter with staff members of the Domestic Policy Council.

Again, thank you for writing.

Sincerely,

Carol H. Rasco
Assistant to the President for
Domestic Policy

CHR:rk

THE WHITE HOUSE

August 8, 1996

Ms. Mary Ellen Schattman

P6/b(6)

Dear Mary Ellen:

Thank you for sharing your thoughts about health care in Tarrant County, Texas. I have forwarded your letter to Bruce Vladeck, Administrator of the Health Care Financing Administration.

As you noted in your letter, the President and I have fought long and hard over the past few years for health care reform. We are pleased that Congress has taken the first steps by passing legislation that will help as many as 25 million Americans, who today live in fear of losing their health insurance when they change or lose their jobs. We must continue our efforts on behalf of the millions more who still live without adequate health care.

Again, I thank you for your words of encouragement and wish you the best of luck in your ongoing efforts in Tarrant County.

Sincerely yours,

Hillary

Hillary Rodham Clinton

cc: Bruce Vladeck

Chris
Jennings

THE WHITE HOUSE

WASHINGTON

October 28, 1996

W. Thompson Bachmann

P6/b(6)

Dear Dr. Bachmann:

Thank you for taking the time to write and share your thoughts with me on managed care. It is very important that this Administration hear from individuals like yourself who have valuable information to contribute. I have shared your letter with staff members of the Domestic Policy Council.

Again, thank you for writing.

Sincerely,

Carol H. Rasco

Carol H. Rasco
Assistant to the President
for Domestic Policy

John L
managed care
OCT 21 1996

W. THOMPSON BACHMANN, M.D., F.A.C.P.
39 EAST AVENUE
WESTERLY, RHODE ISLAND 02891-3195
TELEPHONE (401) 596-2021
FAX (401) 596-0431

October 18, 1996

Ms. Carol H. Rasco
Assistant to the President for Domestic Policy
The White House
1600 Pennsylvania Avenue N.W.
Washington, D.C. 20500

Dear Ms. Rasco:

The biggest problem with managed (capitated) health care is that an individual primary care physician gets a yearly bonus if he spends less money referring patients, ordering tests, and admitting to the hospital. Referring patients and admitting them to the hospital is work for the doctor (referring is somewhat humbling -- asking for help). If there is an additional financial disincentive, then there is a real risk of no referral, test, or admission, resulting in the wrong diagnosis.

It is not surprising that only two people at the San Diego debate (the area with the most managed care in the country) raised their hands when asked by the President, "Do you like managed care?"

Since kickbacks for referrals are illegal, bonuses for non-referral should be illegal. Referral, admission, and testing decisions should be revenue neutral for all physicians.

If the President wants to win California, he needs to understand this serious flaw in managed care, and come out in opposition to it, just as he did with the less destructive gag rule.

Sincerely,

W. Thompson Bachmann, MD

WTB/clw

Thank you for sharing your views regarding health care reform.

My Administration remains committed to helping working Americans succeed in the modern economy. Our strategy has always been to create opportunity for all, demand responsibility from all, and to work to come together in a great American community. In response to these challenges, recent legislation has included a number of reforms which will help keep American families healthy and strong.

Last August, I was very pleased to sign into law the Kennedy-Kassebaum bill, which will enable as many as 25 million Americans to keep their health insurance coverage when they change jobs. Workers will no longer fear losing their health insurance if they or a family member have a pre-existing condition. Another bill we enacted prohibits health plans from establishing separate lifetime and annual limits for mental health coverage.

I am firmly committed to assuring quality in health care. I recently established the "Advisory Commission on Consumer Protection and Quality in the Health Care Industry" to review changes in the health system and make recommendations on how best to promote and assure consumer protection and quality in all health plans.

I was pleased to sign into law protections for mothers and their newborns by signing into law legislation that will require health plans to let new mothers remain in the hospital for at least 48 hours following most normal deliveries and 96 hours after a Caesarean section.

While these are important steps, we should continue to build on these insurance reforms by helping to assure that previously insured people who are looking for a new job can afford to keep their health insurance and retain their portability protections. In addition, I believe we should enact legislation to prohibit health plans from restricting medical communications with their patients.

My Administration is also working to improve Medicare by expanding choice, combating fraud and abuse, offering new preventive benefits, and extending the solvency of the Medicare Trust Fund for 10 years from today without imposing new cost increases on beneficiaries. My plan will also preserve Medicaid as a safety net while reforming it to work more efficiently.

As I continue to pursue these much needed reforms with Congress, I am grateful for your interest and involvement.

F

September 23, 1993

1~
2~
3~

Dear 4~:

Thank you for taking the time to write and share your thoughts with me on the issue of health care reform. It is very important that those of us working on health care reform hear from individuals like yourself who have valuable information to contribute.

Again, thank you for writing.

Sincerely,

Carol H. Rasco
Assistant to the President for
Domestic Policy

CHR:ram

Please Fax to Chris Jennings

THE WHITE HOUSE

WASHINGTON

December 13, 1996

Jack Ebeler
~~Health Policy Deputy~~ Asst Asst Secretary,
Planning and Evaluation
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Jack:

I am forwarding to you a report I received from Dr. Stephen McDonough on expanding health coverage to children.

I hope that you can help address Dr. McDonough's concerns. Please call me if you have any questions or need any additional information.

I appreciate your assistance in this matter.

Sincerely,

— Thanks —

Christopher C. Jennings
Special Assistant to the President
for Health Policy Development

To. Chris -
Dr. McDonough sent this
to me as well and we are
looking at it -
Thanks 12/16
Jack

September 24, 1996

Ms. Sissy Clinton

P6/b(6)

Dear Sissy:

Thanks for writing to inform me about the exciting new projects at the University of Arkansas for Medical Sciences. As you requested, I sent a letter to Dr. Lipschitz in support of your efforts.

The President and I are firmly committed to programs that promote the health and well-being of older Americans. As our population ages, we are presented with both new opportunities and new challenges. I am confident that your efforts, including the establishment of a Center on Aging, will play an important role in meeting the needs older persons in Arkansas and the nation.

Again, I wish you the best of luck in your work at the University of Arkansas. Please keep me apprised of your efforts.

Sincerely yours,

Hillary Rodham Clinton

September 24, 1996

Mr. David Lipschitz
Director, Center on Aging
4301 West Markham, Slot 748
Little Rock, AK 72205-7199

Dear Mr. Lipschitz:

I am pleased to learn about the establishment of the Center on Aging at the University of Arkansas for Medical Sciences. I am confident that your efforts will play an important role in meeting the needs of older persons in Arkansas and the nation.

As you know, the Clinton Administration is firmly committed to programs that promote the health and well-being of older Americans. As our population ages, we are presented with both new opportunities and new challenges. The research, education and training conducted at the Center will likely prepare us for any such changes in the future.

I wish you the best of luck in your work at the University of Arkansas. I hope that you will keep me informed of your efforts.

Sincerely yours,

Hillary Rodham Clinton

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Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. letter	Gil Garcetti to Hillary Clinton (2 pages)	9/23/96	P6/b(6)

This marker identifies the original location of the withdrawn item listed above. For a complete list of items withdrawn from this folder, see the Withdrawal/Redaction Sheet at the front of the folder.

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Health Security Act)
OA/Box Number: 8993

FOLDER TITLE:
Correspondence [1]

gf66

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advise between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

PATH LAB, INC.
New England's
Diagnostic Laboratory

October 2, 1996

Hillary Rodham Clinton, First Lady
The White House
1600 Pennsylvania Avenue, N.W.
Washington, D.C. 20500
Attention: Pam Cicetti, Executive Assistant

Dear Mrs. Clinton:

I very much enjoyed the opportunity to hear you and then meet with you privately in New London last week. Sam's wife Betsy called very excited last night that the picture you graciously took with us had arrived and they look just great. Every one of us appreciated the time and interest you showed in our work.

While you have endured the brunt of unfair, unjustified criticism on the healthcare issue, you have done more than any other person to bring about what is in most cases justified and positive change. I appreciated your willingness to examine our position on issues related to continuity of care and regulatory policy.

As promised, I am enclosing information on the complex and costly regulatory policies health care providers must labor under which do not improve patient care and frequently result in uneven benefits to Medicare beneficiaries.

I look forward to the opportunity to meet with you again.

With every good wish, I am

Sincerely,

Mary Jane Burt

MJB;mjb

P.S. I am looking forward to seeing the President on Monday in Stamford!

Regional Laboratory:
Burt Medical Laboratory
24 Rossotto Drive
Hamden, CT 06514
Tel: (800) 300-4638
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ACLA

American
Clinical Laboratory
Association

Laboratory Billing Reforms

The American Clinical Laboratory Association (ACLA) believes it is necessary to implement sensible reforms that will bring greater fairness to beneficiaries while reducing administrative costs and making compliance easier for all parties involved with the program.

Today's policies have led to inequities for Medicare beneficiaries and have imposed costly administrative burdens on physicians, laboratories and the Medicare program. Further, the widely varying, complex and restrictive policies that exist today make compliance extremely difficult.

ACLA members and HHS share the common goal of providing quality, cost-effective health care for all patients. We request the Secretary to establish reasonable, understandable, and uniform national payment and review policies for clinical laboratory testing paid for by the Medicare program.

ACLA Recommendations

- In order to fix the current problems, the Secretary should direct the Health Care Financing Administration (HCFA) to engage in a negotiated rulemaking to establish reasonable, understandable, and uniform national coverage rules for payment and review of laboratory testing services to replace today's widely varying systems of coverage policies.

- The process should begin immediately and be completed no later than March 1997.

1250 I Street, N.W. • Suite 880 • Washington, D.C. 20005 • (202) 637-9466 • Fax: (202) 637-2050 • David N. Sundwall, M.D. • President

ACLA
American
Clinical Laboratory
Association

September 27, 1996

The Honorable Donna E. Shalala
Secretary, Health and Human Services
200 Independence Avenue, SW
Washington, DC 20510

Dear Secretary Shalala:

Thank you for meeting with me and Board of Directors of the American Clinical Laboratory Association (ACLA) on Tuesday morning, September 24th. We very much appreciate your attention to matters of great importance to the clinical laboratory industry.

As you requested, I am enclosing a partial compendium of communications between Medicare Part B carriers and our member companies during this calendar year. Also included are examples of responses from the clinical laboratory companies to their clients, informing them of changes in payment policies. Together, they illustrate the extraordinarily complex and costly regulatory burdens we are currently laboring under. Consequently, we are hopeful you will consider our request to establish national uniform payment and review policies for clinical laboratory testing paid for by the Medicare program. As we discussed, this will address current problems of unfair and uneven access to such services by Medicare beneficiaries, and enable laboratories to be compliant with federal rules and regulations.

Thank you again for meeting with us. ACLA, and our member companies, look forward to working with you and your colleagues in the Administration to promote appropriate utilization of laboratory testing through regulatory reform.

Sincerely yours,

David

David N. Sundwall, M.D.
President

1250 I Street, N.W. • Suite 880 • Washington, D.C. 20005 • (202) 637-9466 • Fax: (202) 637-2050 • David N. Sundwall, M.D. • President

Documentation of Recent Changes in Rules and Regulations Related to Payment for Clinical Laboratory Services Under Medicare

The following is a partial listing of directives from Medicare Part B carriers, published in their monthly or bi-monthly bulletins, or special notices, in 1996.

To illustrate the regulatory burden described by Ms. Eileen Aird (CEO - LifeChem) during our meeting, she has prepared a chronology of publications from Xact, Medicare Services in Camp Hill, PA, and LifeChem's response to the changing policies or requirements. [Appendix I - in LifeChem binder]

Additional documentation is provided for Corning Clinical Laboratories [Appendix II] and SmithKline Beecham Clinical Laboratories [Appendix III] in the lists of carrier bulletins which included clinical laboratory specific directives and/or policy changes. We have copies of all bulletins and communications on file.

Please note: Each of these labs deal with Xact, and receive the same bulletins outlined in the LifeChem document. Therefore, they were not included in the CCL and SBCL lists.

Attachments:

Appendix I	LifeChem Requirements and Response
Appendix II	Corning Clinical Laboratories (CCL) Requirements and Response
Appendix III	SmithKline Beecham Clinical Laboratories (SBCL) Examples of Requirements
Appendix IV	Path Lab, Inc. Response to Change in Requirements - Communciations with Clients and Changes in Requisition Forms

APPENDIX II

CORNING CLINICAL LABORATORIES (CCL)

AETNA - Georgia

January, 1996	•	Published revision of codes acceptable for coverage of tests previously published in September, 1995.
March, 1996	•	Published explanation of policies governing limited coverage and additional acceptable codes.
July , 1996	•	Published additional changes in codes acceptable for coverage of certain tests.
July, 1996	•	New Local Medical Review Policies for additional tests are proposed.

BX/BS - Michigan

June, 1996	•	New limited coverage policies are issued for cholesterol, glycolated hemoglobin and glycolated protein.
July, 1996	•	New policies issued for allergy tests, renal dialyses patients, and limitations of liability.
August, 1996	•	New policies issued related to coverage of pap smear screening.

MetraHealth - Connecticut

January, 1996	•	Local Medical Review Policies issued for PSA.
April, 1996	•	New policies published related to coverage of automated multichannel tests.

Transamerica - California

January, 1996	•	New policies related to medical necessity documentation for several specific clinical lab tests.
March, 1996	•	New policies related to payment for lipid panels.
May, 1996	•	Revisions in previously published policies related to coverage of lipid panels.

BX/BS - Florida

March/April, 1996	•	New rules issued for automated laboratory testing and limited coverage policies for several additional tests.

TrailBlazer Medicare Part B Bulletin - MD

February 23, 1996	•	Correct Coding Initiative (CCI) policies, coverage limitations for lipoproteins, LDL cholesterol, glycolated protein. New policies related to coverage of automated multichannel testing, including new fee schedule.
March 18, 1996	•	Publication of policies related to GB modifier and information about the Correct Coding Initiative (CCI).
March 15, 1996	•	Policies related to MediGap coverage of services not paid for by Medicare, e.g., clinical lab testing.
April, 1996	•	Announcement of coding edits available though National Standard Format, a program designed to reduce denied claims.
May 31, 1996	•	Automated Multichannel Test correction announcement of QP modifier , used to identify tests ordered individually or as a CPT-recognized panel.

June, 1996	•	Various directives related to specific coding requirements, e.g., ID required with provider name, how to identify location of lab facility, etc.
July 19, 1996	•	Updated list of several limited coverage tests. Description of waiver of liability and patient responsibility for payment.
July 22, 1996	•	Announcing HCFA's proposal to pay for lab service only if ordered by the physician or consulting physician beginning in 1997. Clarification that limited coverage is determined by carrier NOT location of physician.

General American - St. Louis

January, 1996	•	New policies for coverage of automated multichannel tests.
February, 1996	•	Update of limited coverage for several clinical laboratory tests.
April, 1996	•	Limited coverage policies for glycemia tests in Diabetes Mellition Thyroid function testing.
May, 1996	•	Acceptable codes for iron studies, blood counts, leukocyte differentials, cholesterol and lipid determinations.
July, 1996	•	Limited coverage of routine preventive tests. Description of acceptable form advising patient of Medically Unnecessary Service (MUS).
July, 1996	•	Limitations on payment for glucose monitoring. Acceptable CPT Billing Codes for organ system panels.

CIGNA - Tennessee

February	•	Announcement of new limited coverage tests.

Nationwide - Ohio/West Virginia

January, 1996	•	Announcement of several new limited coverage tests. New policies on coverage of automated multichannel tests.
June, 1996	•	Limited coverage for additional tests.
July,1996	•	New policies for Digoxin, Prothromibin, and thyroid function tests.

BX/BS - Buffalo

April, 1996	•	Prostate Specific-Antigen (PSA) limited coverage
June, 1996	•	Clinical lab pricing policies coding changes. Requirement for higher levels (not truncated) for ICD-9 codes.
July, 1996	•	Limited coverage updates of certain lab tests.

Cambridge, Mass.

April, 1996	•	Lipid panels - limitations in coverage.

BX/BS - Montana

July, 1996	•	Limited coverage policies for thyroid tests. Complete Blood Counts (CBCs), Prostate Specific Antigen (PSA), Carcino Eubryonic Antigen (CEA), automated multi-channel tests, "general health panel", and thyroid testing.

AETNA - Arizona

April, 1996	• Limited coverage for PSA's iron studies, platelet counts and ESR's.

AETNA, Portland

January, 1996	• Limited coverage policies for Glucose, urinalysis, blood counts, occult blood in feces.
March, 1996	• ICD-9 coding policies.

BX/BS - Colorado

March, 1996	• Waiver of liability policies and use of GA modifier.
July, 1996	• Limited coverage policies for PSA's.

Empire BX/BS - New York

January, 1996	• Limited coverage for ESR's, blood lipid monitoring.

AdminaStar Federal - Indiana

March, 1996	• Policies related to automated multichannel testing, lipid panel testing, PSA's, CEA's.

CCL'S RESPONSE TO CHANGING POLICIES PROMULGATED BY CARRIERS

- CCL had had to develop separate physician education materials depending on the location of the facility which will perform the testing. This is because of variation among the carriers (see following examples).

- Modify CCL order entry forms to incorporate the new requirements. (There is a minimum 60-90 day time period required to obtain new forms and introduce the new forms to CCL clients. Ongoing changes to the limited coverage requirements require us to repeat this process, and waste the obsolete forms.)

- Employ outside consultants to conduct market research with our clients in order to develop a new requisition form.

- Develop training and educational materials and train all of CCL employees and clients on the new requirements. Examples of the types of material include: Employees procedures, client procedures, long terms care/nursing home procedures, and specimen collection procedures for CCL phlebotomists.

- Reprogram billing systems software in all of our sites (20+).

- Retrain billing employees on the new software.

- Modify lab systems to pass order data to billing systems.

- Conduct many meetings with carriers to clarify implementation questions.

APPENDIX III

SMITHKLINE BEECHAM CLINICAL LABORATORIES (SKCL)

A majority of SmithKline Beecham Clinical Laboratories Medicare claims are processed by Xact. The remainder are handled by the following carriers:

Blue Cross/Blue Shield - Texas

March, 1996	• Published policies related to Medigap coverage of services not covered by Medicare; e.g., coverage for laboratory testing.
July, 1996	• Published notice that claims for lab services will be returned is unprocessable when ICD-9 CM code is invalid and that codes must be coded to highest degree of specificity, i.e., to the fourth or fifth digit. Published updates to fee schedule.

New York

June, 1996	• Published clinical labs pricing update and no longer covered new diagnostic codes.
July, 1996	• Special bulletin announcing updated ICD-9-CM diagnostic codes including a higher level of specificity must accompany claims submitted beginning January 1, 1997.

Nationwide Insurance Enterprise

(See CCL documentation - page 5)

BX/BS - Kansas, Nebraska, Western Missouri

January, 1996	• Notification of changes in HCFA-1500 claim form billing instructions.
March, 1996	• Information on correct coding initiative and electronic media claims • Implementation of the National Provider Identifier

- First of invalid codes effective January 1, 1996.

April, 1996

- Notification of QP modifier.

AETNA - Georgia

(See CCL description - page 2)

General American Life - Missouri

(See CCL documentation - page 4)

Palmetto Government Benefits Administrators - South Carolina

February, 1996

- Instructions on HCFA -1500 claim filings.

BC/BS - Alabama

March, 1996

- Notice of compliance with National Standard Format