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Improve patient safety through better department communication

Nursing and pharmacy staffs have operated independently for years, thus creating a communication gap that can be difficult to overcome.

Communication gaps cause departments to blame each other when an error occurs instead of working together to solve the problem, says Yolanda Smith, RN, MSN, CCRN, a member of the New York State Board of Nursing and president of YGS Medical Legal Consulting in Brooklyn.

“What I’m seeing right now is that nursing is doing its own thing and pharmacy is doing its own thing,” said Smith. “It’s definitely an advantage to have the pharmacy as part of the process. They have expertise that others don’t have.”

She recently presented a seminar titled, “Medication Administration and Patient Safety: Error Prevention for Nurses.”

Hospitals can prevent medication errors and improve treatment if they encourage collaboration between the pharmacy and other staff members.

Departments should communicate with pharmacy and nursing staff whenever a

Medication quality: Patients bend borders to cut costs on scripts

Pharmacists can often recommend generic alternatives to patients in an effort to reduce costs. The problem occurs when generic drugs do not exist for the prescribed products.

This drives costs up and forces the uninsured and those who don’t receive coverage for all medications to look for cheaper alternative sources, says Susan Winckler, RPh, JD, vice president of policy and communications and staff counsel for the American Pharmacists Association. Those alternative sources tend to be in the form of imported medications.

Imported medications are a scary prospect for pharmacists. They cannot accurately check for drug interactions when patients order prescriptions from foreign sources. They also cannot verify whether the drug is the correct strength or made from the correct ingredients. This poses a serious threat to a patient’s health.

“One [pharmacist] described
Pharmacy communication

- physician writes a medication order
- patient’s age is a factor
- nurse gives out medication for the first time

Pharmacists and doctors need to talk, too
A pharmacist should always look at a physician’s orders for possible drug interactions or problems, Smith says.

Case: A patient has known allergies to penicillin and a physician prescribes ampicillin to treat an infection.

Solution: The pharmacist should alert the prescriber because ampicillin could cause some of the same allergic reactions.

In this case, the pharmacy staff should review what occurred with the medical staff. They should examine why the pharmacist intervened and what can be done in the future to prevent the need for interventions. Staff knowledge increases as a result of the interdisciplinary meetings.

Physicians should communicate a patient’s age to the pharmacy, as younger patients often require a reduced medication dosage because they cannot metabolize adult doses as quickly, Smith says.

Pharmacists should ensure that the physician prescribes the correct dose for the patient’s age and

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A committee can focus on medication error reduction

Organizing an interdisciplinary committee is one of the best ways to prevent medication errors and increase staff collaboration and patient safety at your facility.

Maine Medical Center in Portland has a pharmacy and therapeutics committee that governs medication use. The committee includes physicians, nurses, pharmacists, dietitians, financial analysts, and other hospital staff members. It delegates various tasks to subcommittees, all of which report findings that allow the hospital to decide which medications to stock.

The subcommittees include the following:

- **Drug selection.** Staff members look at data to ensure each drug is safe and appropriate for the services provided at the hospital.

- **Adverse drug events.** Staff members analyze data from anonymous adverse drug event reporting systems, such as the U.S. Pharmacopoeia program. They check any problems that have occurred with the drug, including side effects and interactions with other drugs, treatments, or foods.

- **Financial risks.** Staff members assess the financial aspects of the drug, including costs, liability issues, and whether the hospital can use the drug effectively to meet its needs.

- **Prescribing.** Two groups evaluate how physicians will order the drug. Maine Medical Center uses a computerized physician order entry system, so the committee must make sure the system can recognize possible drug interactions, patient allergies, or other adverse drug events.

Source: John Jurczyk, RPh, director of pharmacy services, Maine Medical Center.
weight, if appropriate, to prevent complications.

Fatal lessons
Potential problems exist when nurses give out medications for the first time. Two patients died within one week at a New York hospital because they were given too much medication. The same physician wrote the orders for both, the pharmacy wasn’t given any background, and the nurse didn’t have enough experience to ask questions and know what warning signs to look for. The nurse should have checked with the pharmacy to ensure the correct dosage, Smith says.

✔ TIP: Tell pharmacists to instruct nursing staff on how to properly administer medications, from ensuring that the medication is correct for the patient to making sure that the dosage is accurate. Tell the nursing staff to consult the pharmacy if they have any questions regarding the medication.

Making the rounds
Bridge the communication gap among departments by urging pharmacists to make rounds through the units. The pharmacist can check laboratory data to make sure the patient is receiving the correct antibiotic or switch a patient from intravenous to oral therapy, if possible, for more effective and less costly treatment.

Pharmacists currently do not make rounds with nursing staff at Maine Medical Center in Portland, but it is something the hospital is considering in order to acquire Magnet status, says John Jurczyk, RPh, BS, MBA, director of pharmacy services. The American Nursing Credentialing Center awards Magnet status to high-quality nursing programs through a process similar to hospital accreditation.

There are 82 Magnet-recognized hospitals in the United States, according to the ANCC Web site, www.nursingworld.org/ancc.

If pharmacists start making rounds at Maine Medical Center, they will work with nursing and medical staff on patient care from admission to discharge. They will focus on monitoring the drugs rather than only compounding and mixing, and how to move patients from one care level to another, such as from surgery to rehabilitation, Jurczyk says.

Pharmacists can also provide valuable education to staff members in almost every department, says Jurczyk. Maine Medical Center’s clinical pharmacists specialize in cardiology, pediatrics, renal transplants, infectious diseases, and ambulatory care, among other areas.

Those pharmacists can educate staff members on selecting the correct medication for a patient and identifying possible complications that could arise from using a certain drug. They do a lot of teaching,” Jurczyk says. “That’s a big piece of being proactive.”

Jurczyk hopes making rounds will help his
Pharmacy communication

pharmacists appear more accessible to staff members, perform more order reviews, and act as liaisons among patients, hospital staff, and the pharmacy.

Safety by committee
Bridging a long-standing communication gap can be difficult, but forming an interdisciplinary committee is a good place to start. The committee should include pharmacists, nurses, physicians, and administration, Smith says.

In working together, the committee should draft safety policies and review incident reports when errors occur, Smith says. The group should review adverse drug events and develop ways to fix problems, rather than let individual departments blame each other for the error.

“A lot of errors could have been prevented had all the disciplines been working together,” Smith says. “They’ve got to get past [blaming each other] and focus on patient safety.”

✔ TIP: Involve staff members in the decision-making process. Allow them to participate in interdisciplinary committees and help plan the hospital’s policy regarding the level of pharmacy/medical staff cooperation. Staff members will buy into the plan more if they assist in its creation, Jurczyk says.

Medication quality

it as working in the dark,” said Winckler.

Drug importation made headlines recently when Springfield, MA, reimbursed city employees who purchased medication from Canada, and leaders in California, Illinois, and Iowa considered similar programs. State and local governments have considered drug importation programs to reduce costs to their insurance plans, in turn reducing the burden on taxpayers, who foot the bill for government employees’ health insurance.

In addition, at press time Congress is negotiating a Medicare reform bill with a provision that would allow Americans to import drugs from nearly 25 countries (see the prescription drug plan update on p. 12 for more about this bill).

Be inquisitive
Consumers do not receive pedigree papers for the prescription drugs they purchase. Pedigree papers outline the drug’s sales and shipment history. Without these papers, it is impossible to tell where a drug has been or whether it was shipped and stored properly, says Marv Shepherd, PhD, professor of pharmacy administration at the University of Texas at Austin.

This is a problem for pharmacists and consumers when drugs are imported. Consumers do not know whether the drug they are taking is correct and will help them, and pharmacists cannot perform an accurate interaction check because they can only base the check against FDA standards, which imported drugs do not usually meet, Winckler says. “They’re
pretty limited in the checks they can do,” Winckler says of pharmacists. “It’s important to understand that it may not be the same product you get in the United States.”

Most of the drugs consumers purchased from Canada are for chronic care, such as arthritis or other ailments, Winckler says. If consumers need urgent acute treatment for an illness and go to a local pharmacy or hospital to fill a prescription, they should tell the pharmacist that they receive medications from Canada.

A recent FDA inspection of packages at Miami, New York, San Francisco, and Carson, CA, mail facilities turned up 1,019 imported drug products that violated FDA standards. Of those drugs, 16% were from Canada, 14% from India, and 13.8% from Thailand. The remainder were from other countries.

✔ **TIP:** Pharmacists do not normally ask patients whether they use drugs from Canada, but they should always have patients identify all medications they use, including over-the-counter medications and herbal supplements, says Kathleen Cantwell, director of federal legislative affairs and government affairs counsel at the American Society of Health-System Pharmacists. This can help the pharmacist conduct a more accurate interaction check.

**Different standards for different countries**

Proponents of the Medicare reform bill call the prescription drug importation process “reimportation.” That is not what happens, Winckler says. Although it seems as simple as a U.S. manufacturer making and shipping drugs to Canada, and then Americans purchasing them from Canadian vendors, it’s not that cut and dried.

The FDA maintains strict regulations over manufacturing, labeling, and shipping, among other things. If a drug is manufactured in what the FDA considers substandard facilities, the drug may not be of the same quality as drugs made in the United States.

American drug companies manufacture and label medications to Canadian standards,

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**Importing medications: Your questions answered**

The American Pharmacists Association provides the following advice to consumers regarding imported medications. You may want to provide customers with the following information to alert them about the risks associated with imported drugs:

1. **Are you getting what you ordered?** Once a product leaves the U.S. regulatory system, it risks contamination. Understand that other distributors are not held to certain storage standards or product labeling. You could be consuming a product that has become faulty due to temperature conditions or one that is simply the wrong product.

2. **Do your local doctors and pharmacists know what you are taking?** Drug interactions with other medications are something doctors and pharmacists consider before prescribing and dispensing prescription medications to patients. You may be taking a medication that will become ineffective or cause harm when taken with another medication.

Patients often see different doctors for different examinations, creating the potential for drug interactions. To protect against this risk, patients should use one pharmacy for their medication needs. Pharmacists ensure that a patient receives the right medication for the right dose. Pharmacists also check for interactions by maintaining a patient’s medical history, thus protecting the patient from receiving the wrong medication. If you choose to import your medications, be sure to discuss those medications with your doctor and pharmacist.

Medication quality < p. 5

meaning some drugs are of a different strength or form than they would be in the United States.

Whereas the FDA could require something to be a capsule in the United States, Canadian regulation could require the same drug to be tablet form, says Winckler.

Such drugs do not comply with FDA standards because of labeling and other differences. They are considered illegal, Winckler says. FDA-approved drugs must have labels that explain, in English, proper use, dosage, and potential side effects. Many unapproved drugs are not labeled in English or omit information about side effects or safe use.

The FDA has not prosecuted individual consumers because they might not know they are breaking the law, Winckler says.

The FDA has acted against companies that facilitate drug importation, including warning CanaRx Services, Inc., of Detroit—the company that provides prescription drugs for Springfield, MA, and its importation program—to stop violating U.S. law. If companies do not respond and comply, the FDA can take legal action, including seizing property and seeking injunctions to stop importation activities, according to the FDA.

Some companies simply ship medications from another country through Canada and into the United States. Health Canada, the Canadian equivalent of the U.S. Department of Health and Human Services, only regulates drugs sold in Canada. It does not approve those imported with the intent to export to other nations, increasing the risk that Americans could receive counterfeit or defective drugs, Shepherd says.

Nearly 60% of all counterfeit medications do not have the active ingredients to make the drug work as it should, which can lead to further complications or death because the disease remains untreated, Shepherd says.

Yet drug importation appeals to many legislators because Canadian controls reduce drug prices, which looks good to someone trying to save money, he says. “Someone’s going to get hurt,” Shepherd says. “As a legislator, you’re trying to correct your budget and finances at the expense of the lives of other people.”

What’s next?

If the Medicare reform bill passes and allows consumers to import drugs, U.S. pharmacies would not be able to compete with the international prices and would see more business go overseas, Winckler says.

The government might have to allow pharmacies to purchase drugs overseas and maintain two inventories, one of which would be imports for those who cannot afford the higher prices.

In another scenario, the prescription drug benefit provision of the Medicare reform bill could reduce the importation need. Seniors might be able to afford more drugs in the United States, allowing them to purchase drugs domestically instead. The U.S. government should sit down with pharmaceutical manufacturers and negotiate some type of price concessions, such as an inflation index or a plan not raise prices multiple times a year, he says.
Don’t drop the bottle: Handle hazardous medications properly

Unstable medications such as chemotherapy medications and intravenous mixtures may become ineffective if mixed improperly or may pose a danger to patients and staff if handled incorrectly. Check out how one New Jersey hospital mixes medications to ensure patient and staff safety.

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requires all hospitals to safely prepare medications, including admixed medications, to comply with medication standard MM.4.20, pharmacies safely prepare medications, especially those considered to be hazardous and unstable, such as chemotherapy drugs.

Keep an eye on the clock
Pharmacists at Warren Hospital in Phillipsburg, NJ, mix medications a few hours before a nurse gives them to a patient, says Priti Merchant, PharmD, clinical pharmacy coordinator.

This ensures that the medication will be available when it needs to be given to a patient. One exception would be if an admixture has a short stability.

These mixtures are delivered immediately prior to administration, otherwise the medication will become less effective and possibly harmful to the patient.

Any unstable medication can form a precipitate—cloudiness or crystallization—if it is not used in a certain period of time. Pharmacists must make sure no unknown matter or products are in the medication.

“If the end product is supposed to be clear, make sure it is clear,” Merchant says. Pharmacists also check on the medications’ compatibility before they are mixed and sent to the floor.

For example, methylprednisolone sodium succinate and intravenous cipro can form a white cloudiness when administered through the same line, Merchant says.

✔ TIP: Use a reference book to check compatibility before mixing any medications. This will prevent waste and ensure the patient receives the most effective treatment.

Safety first
The person who mixes the chemotherapy order must be knowledgeable in chemotherapy, pass the American Society of Health-System Pharmacists’ chemotherapy competency exam, and work in a sterile clean room in the pharmacy wearing gloves, a gown, and protective shoes, Merchant says.

The hospital closely follows JCAHO requirements by using a vertical laminar flow hood to contain any contaminants that could escape while mixing the medication.

The hospital also discards vials and syringes once the medications have been mixed to prevent exposure to pharmacists, nurses, physicians, and housekeeping staff.

Even with the precautions, accidents can happen. Warren Hospital maintains standard procedures to deal with spills and other accidents, Merchant says. For example, if someone
Standard MM.4.20
Pharmacies safely prepare medications.

Elements of Performance
1. When a licensed pharmacy is available at the hospital, the pharmacy mixes all sterile medications, intravenous admixtures, or other drugs unless an emergency or other situation dictates otherwise (for example, if the product’s stability is short).

2. Staff members use safety materials and equipment while preparing hazardous medications.

3. Staff members ensure accuracy when preparing medications.

4. Staff members avoid contamination when preparing medications and use the following techniques:
   - Clean or sterile techniques
   - Prepare products in a clean, uncluttered, and separate area
   - Use a laminar airflow hood or other class 100 environment when preparing any intravenous admixture, any sterile product made from nonsterile ingredients, or any sterile product that will not be used within one day
   - Physically check the medication’s integrity

TIP: Create a policy to handle hazardous medication accidents. Make sure only those authorized to contain the spill are in the area.

Regulate late-night access
The pharmacy opens at 7 a.m. and closes at midnight during the week, 10 p.m. on the weekends. Nursing supervisors have access to the pharmacy after it closes. If they must mix medications, pharmacists conduct a review the following morning.

A pharmacy manager is on call 24 hours a day if someone has a question about mixing a medication, Merchant says.

The emergency room is one department that may need to mix medications after hours, Merchant says. For example, a patient may be admitted with seizures. Supervisors can mix intravenous phenytoin, an easy-to-prepare medication that can be brought to the floor quickly to help stabilize the patient, she says.

Pharmacy staff members mix any medications that might be needed during the night before the pharmacy closes. Staff members then deliver the medications to the floor where they are needed.

TIP: Designate after-hours pharmacy access only to authorized staff members, such as nursing supervisors, and review any after-hours access as soon as the pharmacy opens. Keep a pharmacist on call if an emergency occurs or a supervisor has questions about certain medications.
Some organizations still aren’t sure how to interpret the Health Insurance Portability and Accountability Act of 1996 (HIPAA). For example, some organizations thought staff training and education ended immediately after HIPAA took effect April 14. Other facilities can be overzealous in their attempts to comply and miss the intent of law.

Finding a middle ground that involves continuous staff training and properly documenting compliance efforts is the key to meeting HIPAA requirements, says Kate Borten, CISSP, president of The Marblehead Group in Marblehead, MA.

Why do we go to extremes?
A recent discussion on a HIPAA listserv indicates that many organizations overanalyze certain aspects of the law. One member wanted to know what happens if a patient is unconscious and staff cannot get patient consent for treatment or to bill for care provided, says Borten.

“‘HIPAA 101’ tells us we don’t need patient agreement or consent to bill for services,” says Borten. “Maybe some state laws require patient consent for billing, but that is different than HIPAA requirements. Responding to a medical emergency trumps privacy in a case like this.”

Pharmacies, whether in a hospital or elsewhere, have some special challenges. In response to criticism of its initial proposed regulation, the Centers for Medicare & Medicaid Services’ final HIPAA privacy rule allows pharmacists to dispense prescriptions to a family member or friend. Initially, it would have required patients to pick up their own prescriptions, posing significant hardship to significantly ill patients.

HIPAA attempts to strike a balance between patient care and privacy. In the past, it was too easy for third parties to obtain patient information from pharmacists who were trying to be helpful. Pharmacies are now required to verify that the person picking up a prescription is authorized to do so.

HIPAA doesn’t address every aspect of patient safety, however. For example, one common practice that still raises eyebrows is the request by pharmacies that customers sign a receipt on a clipboard that shows the names of other customers.

While HIPAA does not ban this practice, a more private alternative should be sought. When pharmacies find an alternative method, they will raise the bar for the rest of the industry, says Borten.

Spend more time documenting
Just because April 14 has come and gone, that doesn’t mean you are off the hook for HIPAA compliance, says Borten. Facilities need to establish new processes to show how well they monitor information privacy and security, and that means you have to write down how you monitor those things.

“Lawyers say, ‘If it isn’t documented, it didn’t happen,’” says Borten.

For example, facilities must track when they release protected health information for certain purposes, and they must be able to show patients a list of those disclosures if patients request it. Most organizations provide information all the time via phone calls, faxes, and paper or electronic forms, says Borten.

“Disclosing information as it relates to treatment or payment is okay, but you have to track certain other disclosures, and I suspect many organizations do not do an adequate job of tracking those,” says Borten.

“If a patient wants to see a report of who you disclosed information to, and you haven’t documented it properly, it might look like there haven’t been any disclosures. But that may not be true.”

To guarantee you keep track of HIPAA-
specified disclosures, create detailed procedures and policies and monitor how often staff comply. Consistently enforce those procedures and educate staff that protecting patient information is everyone’s responsibility, says Borten.

“If you have staff who are responsible for getting the bills out or staff responsible for patient care, they might argue that those parts of their job are more important,” says Borten.

“But they also have to view privacy and security as important. It should become the habit of each individual in the organization.”

Keep educating staff
HIPAA education didn’t end on April 14, and it doesn’t apply only to staff. You have to make sure any volunteers or students understand that your organization takes privacy and security seriously, says Borten.

Make sure everyone on your work force knows to report any privacy or security problems and they know to go to the privacy or security officer with any questions.

For example, does your front office staff know what to do if patients ask for a copy of the statement they signed that acknowledges they received a copy of the privacy notice?

Or if your pharmacy staff feel they haven’t received sufficient training about privacy and security, they need to take the initiative and seek out more education, says Borten.

“If someone is not sure about how to do something as it relates to HIPAA, make sure they ask and get the information right,” says Borten.

“Patients have filed complaints with the Office for Civil Rights, saying that they tried to exercise their rights as outlined in the privacy notice and organizations have either refused or weren’t able to provide the information.”

CMS balks at funding specialty residencies

Now that the Centers for Medicare & Medicaid Services (CMS) has announced its decision to continue funding pharmacy residency training in hospitals, it’s important to ensure that your training is comprehensive.

CMS announced its decision August 1 in the Federal Register after hospitals and national organizations pressured the agency to reconsider its proposal to eliminate funding for first-year pharmacy residencies. CMS had considered the move as part of its Hospital Inpatient Prospective Payment System for fiscal year 2004.

Organizations such as the American Society of Health-System Pharmacists (ASHP) and the American Pharmacists Association (APhA) had urged CMS to continue to fund the residencies. As a result, CMS says it will continue its current reimbursement schedule for first-year residencies in the new fiscal year, which began October 1.

However, CMS continues to balk at providing pass-through funding for second-year specialty residencies, and says it will reinstate the funding only if it finds that such residencies are the “industry norm” for hospitals.

According to CMS, most hospitals hire pharmacists who have completed a pharmacy practice residency to work directly in patient care, but that less than half of them actually require pharmacists to undergo additional training in a specialty residency before working in such niche areas as oncolo-
gy or geriatric pharmacy.

“These residencies are extremely valuable programs and contribute significantly to better-trained pharmacists and healthier patients, says [Henri R. Manasse Jr., PhD, ScD, chief executive officer and executive vice president for ASHP.](http://www.accreditinfo.com)

“The profession prevailed in the first big battle, but there’s a second one that we still have,” adds [Susan Winckler, RPh, JD, staff counsel for the APhA, which accredits 17 different specialty residency programs.](http://www.accreditinfo.com)

Pharmacy organizations such as ASHP and APhA will continue lobbying CMS to delay its decision until CMS determines whether this reasoning is correct. With specialty training now in jeopardy, it’s more important than ever to provide residents with comprehensive training. After all, they’re a crucial member of your patient safety team and can be a life-saving checkpoint in your medication management process.

Consider this: A recent study by researchers in the United Kingdom found that near misses caught by a pharmacist are six times more frequent than dispensing errors that reach the patient ([Drug Safety, Vol. 26, No. 11](http://www.accreditinfo.com)).

### Three tips for training future pharmacists

How can you ensure that pharmacy residents get the most out of their year of intense training?

Consider the following tips from your colleagues:

1. **Evaluate your overall structure.** How does your organization show its commitment to residency training at the hospital and department levels?

   Do residents go through a well-organized orientation that helps them navigate their way through each rotation? Do health care professionals have time to spend with residents?

   “[The resident wants] the responsibility of performing tasks but they also want coaching and mentoring. That’s the real key to success,” says [Daniel Ashby, MS, FASHP](http://www.accreditinfo.com), director of pharmacy for Johns Hopkins Hospital in Baltimore and president of the American Society of Health-system Pharmacists.

2. **Provide continuous feedback.** Do residents begin each rotation with clearly written goals? Are there processes in place throughout your organization to support those goals?

   “There must be consistent evaluation and follow-up on goals,” says [Alana Arnold, PharmD](http://www.accreditinfo.com), who supervises all first-year and specialty residency programs at Children’s Hospital in Boston.

   In between rotations, says Arnold, each resident’s past and present preceptor meets to discuss which goals the resident has met and which goals he or she should continue working on.

   The resident’s most recent preceptor then meets with the resident to discuss the resident’s strengths and weaknesses.

3. **Diversify their experience.** In addition to their clinical rotations, residents at Children’s Hospital must gain hands-on experience by working in compounding.

   “We make sure that they also do packaging so that their whole experience is well-balanced,” Arnold says.
Prescription drug plan update

Conference committee differs on reform bill provisions

Congressional conference committee members continue to disagree over key issues in the Medicare reform bill, reducing hope that the entire bill will pass, says Bill Sarraille, a partner with the Washington, DC–based law firm of Sidley, Austin, Brown & Wood LLP.

Republican and Democratic representatives continue to wrangle over prescription drug benefits and drug reimportation—whether to allow drugs back into the United States so seniors may take advantage of Canadian price controls, Sarraille says.

“The battle lines are being drawn,” Sarraille says. “Increasingly, the chatter is that the complete bill may not be salvageable.”

In the prescription drug benefit, the issue of dual eligibles—people covered by both Medicare and Medicaid—has two sides: whether states or the federal government should be responsible for paying portions of the coverage costs for low-income seniors. Debate focuses on relieving states of some of their existing burden, Sarraille says.

The House dual-eligible provision would cost more than $40 billion over 10 years. Senate negotiators seek a lower price tag.

With increased budget expenditures and a record federal deficit, 30 conservative House Republicans signed a letter saying their ability to compromise on a number of critical issues was “limited.”

Some legislators have considered removing the benefit provision from the bill altogether, attempting to pass it separately.