

I. PROVISIONS THAT SHOULD BE EXCLUDED FROM COMMITTEE BILLS

Tier 1: Concerns

	2001	5-Year	10-Year	Support	Comments
Delay Implementation of HCFA's Proposed Schedule for Managed Care Risk Adjustment	n/a	n/a	n/a	All bills	Not justifiable
Remove Budget Neutrality Requirement for Managed Care Plans	n/a	n/a	n/a	All bills	Not justifiable
VA Medicare Subvention	n/a	n/a	n/a	W&M	Not consistent with Administration proposal.
Coverage and Appeals Process	n/a	n/a	n/a	W&M	Cost concerns; PBR conflict
New Technology DRGs for Inpatient Hospital PSS.	n/a	n/a	n/a	W&M	Cost concerns; Administrative burden
Medicare+Choice: Allow plans to vary premiums across counties within service areas	n/a	n/a	n/a	Cmrce	Inconsistent with current policy or providing uniform benefits to beneficiaries in the same service area
Coverage of Nutritional Therapy for Beneficiaries with Diabetes or Renal Disease	n/a	n/a	n/a	All bills	Language vague concerning eligibility and frequency.
Prohibit Regulations on Self-Injectible Part B Drugs	n/a	n/a	n/a	W&M Finance	Conflicts with current process
Medicare Drug Reimbursement (AWP)	n/a	n/a	n/a	W&M	Program Integrity Concerns
Outpatient PPS Provider Based Criteria.	n/a	n/a	n/a	Finance	Program integrity concern
HCPCS Coding Modifications	n/a	n/a	n/a	W&M	Administrative Burden
Medicaid 1115 Waiver Expedited Review Process	n/a	n/a	n/a	Finance	Timeline too restrictive. Six-month timeline optimal.
Subtotal:	\$n/a	\$n/a	\$n/a		

II. PRIORITIES THAT SHOULD BE INCLUDED IN COMMITTEE BILLS

Tier 1 Priorities

	2001	5-Year	10-Year
Nursing Home Grants	\$0.2	\$1.0	\$1.0
Medicaid DSH: Extra funding; 175 percent cap	n/a	\$1.0	n/a
Ricky Ray	\$0.6	\$0.6	\$0.6
Extend Part A Coverage for Disabled Individuals	\$0.0	\$0.0	\$0.1
Waive Copays/Deductibles for Preventive Benefits	\$0.0	\$2.1*	\$6.6*
Family Opportunity Act	\$0.2	\$3.9	\$11.3
MICASSA Grant	\$0.05	\$0.05	\$0.05
Home Health: Two-years of 15% delay	\$0.0	\$2.5**	\$2.5**
Subtotal:	\$1.1	\$11.2	\$22.15

Tier 2 Priorities:

	2001	5-Year	10-Year
Restoration of SSI benefits for Disabled Immigrants (Medicaid Costs Only; does not include SSA costs)	\$0.0	\$1.3	\$8.8
Expand Medicaid Eligibility to 300% of SSI	\$0.0	\$0.4	\$1.3
Medicaid Breast and Cervical Cancer Treatment	\$0.0	\$0.3	\$1.0
Medicaid and SCHIP Eligibility Alignment	\$0.1	\$0.2	\$0.5
Medicaid and SCHIP Age Expansion	\$0.1	\$0.9	\$2.1
Require Medicaid Coverage of Smoking Cessation Drugs	\$0.0	\$0.1	\$0.2
Homeless Initiative (State Grants & Demonstrations)	\$0.0	\$0.0	\$0.0
Medicare+Choice DSH Carveout	\$0.0	\$0.0	\$0.0
Subtotal:	\$0.2	\$3.2	\$13.9

* Cost estimates do not include managed care impact.

** Total cost provided (before managed care impact); MSR proposed only one-year delay which CBO scores at about \$1.0 billion over five-years.

III. PRIORITIES THAT ARE CURRENTLY INCLUDED IN COMMITTEE BILLS

Mid-Session Review Proposals:

	2001	5-Year	10-Year	Support	Comments
PPS Hospitals: MB Update in FY01 & '02	\$0.6*	\$3.3*	\$9.1*	Finance	Finance also included MB-1 for '03
IME: Maintain 6.5% in 2001 and 2002	\$0.1*	\$0.1*	\$0.1*	W&M, Finance	W&M had 6.25% in 2002
Reduce Medicare DSH reduction in FY 2001	\$0.1*	\$0.2*	\$0.2*	W&M, Finance	Do not include MSR repeal in '01 but lower reductions
SNF: MB Update in FY 2001	\$0.0*	\$0.5*	\$1.4*	W&M, Finance	Finance includes full MB for FY 2001 and 2002.
Delay therapy caps for an additional year	\$0.0*	\$1.3*	\$1.3*	W&M, Finance	
Home Health: Delay 15% reduction one year	\$0.0*	\$1.1*	\$1.1*	W&M, Finance	
Home Health: MB Update in FY 2001	\$0.0*	\$0.5*	\$1.6*	W&M, Finance	
ESRD: Increase composite rate by 1.2 percentage points in 2001	\$0.0*	\$0.5*	\$1.4*	All bills	
Puerto Rico Hospitals: 75/25 Blend	0.0*	\$0.1*	\$0.3*	W&M, Finance	
Medigap Improvements	n/a	n/a	n/a	Finance	
Disease Management Demonstration	n/a	n/a	n/a	W&M	Current drafted to include an unworkable requirement to provide drugs.
Diabetes Extension (Commerce scoring above MSR)	\$0.0	\$0.1	\$0.2	Cmrce, Finance	Cmrce \$50M each year IHS and NIH. Finance provided \$100M each year IHS and NIH.
Medicaid DSH Increases	\$0.3	\$2.2	\$8.1	Cmrce, Finance	Cmrce indexed 2000 to CPI; Finance did MSR one-year fix
Permanent Coverage of Immunosuppressive Drugs	\$0.1	\$0.8	\$3.0	Cmrce, W&M, Finance	Bills exceed FY 2001 Budget proposal
Permanently Extend QI-1 Program	\$0.0	\$0.2*	\$0.9*	Finance	
Medicaid for Legal Inmigrant Children and Pregnant Women	\$0.1	\$0.5	\$1.6	Cmrce	Still includes 2-year ban on benefits.
Transitional Medicaid Extension	\$0.0	\$0.5	\$0.5	Cmrce	One-year extension only
Expand Presumptive Eligibility Sites for Medicaid Children	N/A	\$0.5	N/A	Cmrce	Finance has an unrelated proposal that Admin wouldn't oppose.
Subtotal:	\$1.3	\$12.4	\$30.9		

* Cost estimates do not include managed care impact.

Other Proposals:

	2001	5-Year	10-Year	Support	Comments
Conrad Rural Hospital Policies	n/a	n/a	n/a	W&M, Finance	
Hospice Full MB Update in FY 2001-2002	\$0.1*	\$0.7*	\$1.6*	Finance	
Accelerate Buy-Down of Hospital Outpatient Copayments	n/a	n/a	n/a	All three	
Telemedicine	\$0.0*	\$0.3*	\$2.7*	All three	HCFA and OMB staff recommend Administration endorse Thomas proposal.
Medicare Coverage of Screening Colonoscopy for Average Risk Individuals	n/a	n/a	n/a	All bills	
Medicare Coverage of Pap Smears	n/a	n/a	n/a	W&M, Finance	We prefer proposal to waive deductibles and cost-sharing. U.S. Preventive Services Task Force does not support.
Medicare Coverage of Glaucoma Screening	n/a	n/a	n/a	W&M	We prefer proposal to waive deductibles and cost-sharing. U.S. Preventive Services Task Force does not support.
SCHIP/Medicaid technical BA fix	\$0.0	\$0.0	\$0.0	Finance	Finance included at HCFA's request.
Subtotal:	\$n/a	\$n/a	\$n/a		

* Cost estimates do not include managed care interaction.

$\underline{545}$
 WSM \$29.2
 C \$18.2
 F \$28.1

$\underline{1070}$
 \$935
 \$55.2
 \$72.2

WS → OW \$30
 &

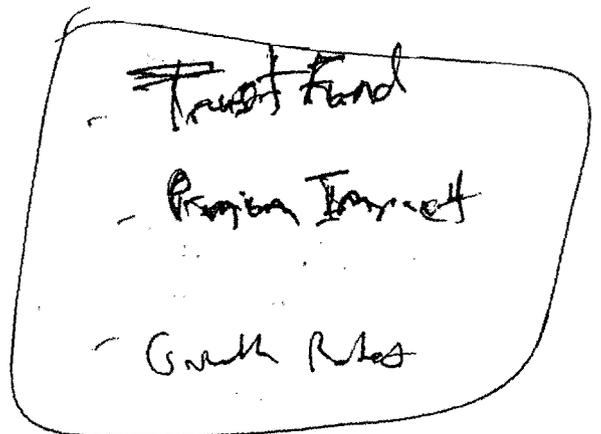
OW \$100

Breeding →

Prouder →
 → back on

AARP → on in program

managed care

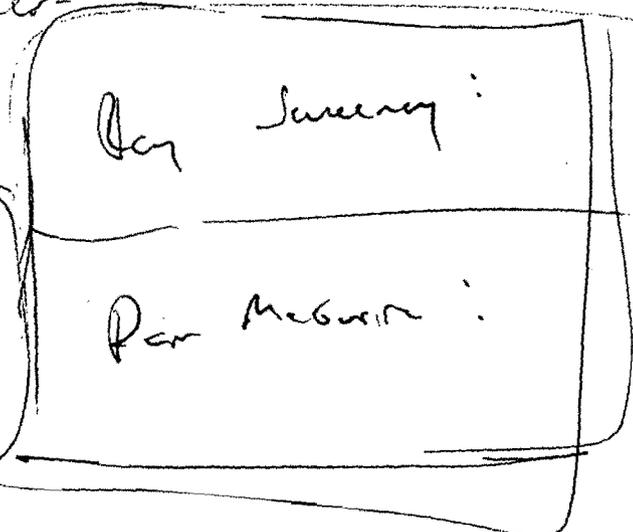


↓
 CAP or total
 member of policy

Managed care

Get into UPL

5.2 → met
 Meeting w/
 HHS, SGA,
 P&P, APUs,
 CJA Alliance



NGA

All states

Managed

Care Overpayments

State directors / Tech level / UPL

TIMELINE OF ADMINISTRATION'S FORMAL POSITION ON MEDICARE / MEDICAID IMPROVEMENTS

- February 7, 2000 President introduces budget that includes:
- Funding for a meaningful Medicare drug benefit – the most needed benefit improvement
 - \$110 billion over 10 years for health coverage including:
 - Medicaid / CHIP options for legal immigrants
 - New enrollment options for uninsured children
 - Extension of Medicaid for people leaving welfare for work
- June 29, 2000 President's Midsession Review added \$40 billion for Medicare / Medicaid improvements in addition to beneficiary improvements in budget
- July 26, 2000 President announces support for the Family Opportunity Act for children with disabilities which has 78 Senate cosponsors as part of the 10th anniversary of the Americans with Disabilities Act
- September 16, 2000 President unveils proposal to improve quality in nursing homes; introduced and support by, among others, Senators Grassley and Breaux
- September 26, 2000 House Commerce Committee introduces and supports unanimously a bipartisan Medicare / Medicaid proposal including:
- Medicaid / CHIP options for legal immigrants
 - New enrollment options for uninsured children
 - Extension of Medicaid for people leaving welfare for work
 - New enrollment options for low-income Medicare beneficiaries
 - Waive Medicare waiting period for people with Lou Gehrig's disease
- October 5, 2000 Senate Finance Committee releases – but does not mark up – Medicare / Medicaid bill that includes:
- Additional hospital assistance including 2nd year of hospital inpatient market basket; 2nd year of 6.5 percent of indirect medical education; Puerto Rico hospital formula fix
 - Additional rural provider assistance including help for home health
- October 6, 2000 Congressional Budget Office releases preliminary cost estimates of the House Commerce, House Ways and Means, and Senate Finance bills
- October 10, 2000 President sends letter expressing serious concerns about Committee bills and explicitly cites unjustifiable HMO payment increases without accountability AND omissions of:
- Medicaid / CHIP options for legal immigrants
 - Fully funding of the Ricky Ray Relief Fund
 - Medicaid buy-in for children with disabilities (Family Opportunity Act)
 - Grants to people with disabilities in the community
 - Improving nursing home quality
 - Eliminating Medicare preventive services cost sharing
 - Targeting dollars to vulnerable hospitals and home health agencies

Week of October 15 Reports that Republican Leadership plan dropped key priorities

October 17, 2000 Budget Director Lew and Secretary Shalala issue senior advisors' veto recommendation on draft Republican Medicare / Medicaid bill has excessive, unaccountable HMO payment increases, inadequate beneficiary protections (that explicitly cross-reference the beneficiary concerns outlined in October 10th letter) and fails to address necessary assistance for providers including:

- Medicaid payment for disproportionate share hospitals
- Hospital payments increases (same as Finance Committee bill)
- Teaching hospital payment increases (same as Finance Committee bill)
- Home health payments (delay 15 percent cut for another year)
- Nursing home quality grants
- Hospice payments (2nd year of full inflation update)
- Managed care: Willing to support floor payment increase if tied to accountability provisions

October 20, 2000 Bipartisan, bicameral meeting in which Administration lays out explicit concerns and desired improvements that were detailed in letters of October 10 and October 17

October 26, 2000 President issues veto threat on larger bill that includes the Medicare / Medicaid legislation specifically states that it "continues to fail to attach accountability provisions to excessive payment increases to health maintenance organizations (HMOs) while rejecting critical investments in beneficiaries and vulnerable health care providers. Specifically, you insist on an unjustifiable spending increase for HMOs at the same time as you exclude bipartisan policies such as health insurance options for children with disabilities, legal immigrant pregnant women and children, and enrolling uninsured children in schools, as well as needed payment increases to hospitals, academic health centers, home health agencies, and other vulnerable providers. Congress should not go home without responding to the urgent health needs of our seniors, people with disabilities, and children and the health care providers who serve them."

October 26, 2000 House votes on bill; Republicans do not get enough votes to override President's veto

October 30, 2000 House Democrats introduce a Medicare / Medicaid bill that includes bipartisan priorities; Republicans reject it

Laurie M.

Aliza Rubin (212) 448-2870

FYI - ~~the~~ This illustrates why Robert Pear's ~~article~~
article asserting that we just yesterday
raised the bar on the BBRA negotiations
is fallacious.

CS

November 3, 2000

The Honorable Trent Lott
United States Senate
SR-487 Russell Senate Office Building
Washington, DC 20510

Dear Majority Leader Lott:

The undersigned 84 organizations that represent millions of healthcare consumers and providers write to express our strong concern about your rejection of inexpensive bipartisan policies that would provide health coverage to uninsured children, children with disabilities, people leaving welfare for work, and low-income seniors. In your Medicare/Medicaid plan, H.R. 5543 (which was included as part of the conference report for H.R. 2614), you have omitted long-overdue coverage expansions that have strong bipartisan support. These coverage expansions would permit families to buy Medicaid coverage for their children with disabilities; enroll uninsured but eligible children at schools; extend Medicaid coverage for those moving from welfare to work; furnish health coverage to legal immigrant pregnant women and children; and improve enrollment of low-income Medicare beneficiaries in cost-sharing assistance programs.

This is not about money. It is a question of priorities. H.R. 5543 includes significant Medicaid savings as a result of codification of the Medicaid upper payment limit regulation (\$21 billion over 5 years, \$77 billion over 10 years). It is only fair that a small percentage of these Medicaid savings be reinvested in the Medicaid program. Moreover, as Congress apparently rejects the managed care protections promised to consumers in the Patients Bill of Rights, H.R. 5543 increases payments to health maintenance organizations (HMOs) by \$34 billion over 10 years (43 percent of total spending) -- even though only 16 percent of Medicare beneficiaries are in managed care.

Our organizations believe that H.R. 5543 represents skewed priorities that do not reflect the interests of the American people. These coverage expansions are not "snippets from the cutting room floor" as was described on the floor of the House of Representatives but rather essential investments in health care that have been approved by a bipartisan vote in the House Commerce Committee or have overwhelming bipartisan support. We urge you to work with Congress and the Administration in a bipartisan manner to enact Medicare/Medicaid refinements legislation that includes these coverage proposals that provide necessary health care coverage to vulnerable populations:

- Family Opportunity Act: Parents of children with disabilities are leaving their jobs, foregoing promotions and raises, and even giving up custody to the state in order to maintain Medicaid eligibility for their children. Establishing a state option to allow families to purchase Medicaid coverage for their children with disabilities builds on the success of last year's Ticket to Work and Work Incentives Improvement Act by ensuring that families do not have to choose between work and health care for their children. The Family Opportunity Act has the bipartisan support of 78 Senators and 140 Members of the House.

- Legal Immigrants: Even though lawfully present immigrant families work hard and pay taxes, states do not have the ability to provide federal Medicaid and S-CHIP coverage to immigrant children and pregnant women because of their date of entry. This policy means that children develop preventable health complications and that pregnant women are denied essential prenatal care. Giving states this option is good for all Americans because it enhances public health and enables families to obtain care for their children before a minor complaint escalates into an expensive and tragic emergency. This proposal has strong bipartisan support, and a modified version was approved by the House Commerce Committee.
- Presumptive Eligibility: Many children who are eligible for Medicaid and S-CHIP remain uninsured because of enrollment barriers. Allowing states an expanded option to “presumptively” enroll children in Medicaid at schools, child care centers, homeless shelters and other sites makes it easier for working families to sign up for Medicaid and S-CHIP. This provision was included in the bipartisan House Commerce Committee refinement package.
- Welfare to Work: Families taking jobs and leaving welfare are eligible for transitional health coverage through Medicaid. However, the important program is scheduled to expire in a year. The provision would extend the program for an additional year as well as simplify reporting requirements that have previously discouraged enrollment and placed a burden on states. This provision was included in the bipartisan House Commerce Committee refinement package.
- Low-Income Elderly: About 55 percent of low-income Medicare beneficiaries currently eligible for assistance with Medicare premiums, deductibles, and cost-sharing do not receive it. Beneficiaries often do not enroll because of long, complex applications that must be completed in welfare offices. The provision would permit enrollment at Social Security Offices and establish a uniform, simple, and short application for participating in such cost assistance programs. This provision was included in the bipartisan House Commerce Committee refinement package.

We hope that Congress and the Administration can work together in a bipartisan manner to enact Medicare/Medicaid refinement legislation that includes these important bipartisan initiatives that would provide essential health care coverage to vulnerable families and take critical steps towards reaching our shared national goal of providing health care to uninsured Americans.

Sincerely,

Ambulatory Pediatric Association
 American Academy of Child and Adolescent Psychiatry
 American Academy of Pediatrics
 American Association on Mental Retardation
 American College of Nurse-Midwives
 American College of Osteopathic Pediatricians
 American Counseling Association
 American Medical Student Association
 American Network of Community Options and Resources
 American Nurses Association
 American Occupational Therapy Association

American Pediatric Society
American Psychiatric Association
American Public Health Association
Asian Pacific American Legal Center, California
Association for Gerontology and Human Development in
Historically Black Colleges and Universities
Association of Maternal and Child Health Programs
Association of Medical School Pediatric Department Chairs
Association of PeriOperative Registered Nurses
Bazelon Center for Mental Health Law
Brain Injury Association, Inc.
Center for Hispanic Policy and Advocacy, Rhode Island
Center for Medicare Advocacy, Inc.
Center for Public Policy Priorities, Texas
Center for the Study of Latino Health
Children's Defense Fund
Coalition for Humane Immigrant Rights of Los Angeles
Committee for Hispanic Children and Families
Consortium for Citizens with Disabilities Health Taskforce
Council for Exceptional Children
Council for the Spanish Speaking, California
Disability Rights Education and Defense Fund
Easter Seals
Episcopal Church, Office of Government Relations
Epilepsy Foundation
Families USA
Federation for Children with Special Needs
Friends Committee on National Legislation
Frosina Information Network, Massachusetts
Health Consumer Alliance, California
Illinois Coalition for Immigrant and Refugee Rights
Justice for All
Latino Council on Alcohol and Tobacco
Lutheran Services in America
Massachusetts Immigrant and Refugee Coalition
Massachusetts Law Reform Institute
Mennonite Central Committee U.S.; Washington Office
National Academy of Elder Law Attorneys
National Alliance for the Mentally Ill
National Asian Pacific American Legal Consortium
National Association of Pediatric Nurse Associates and Practitioners
National Association of Psychiatric Treatment Centers for Children
National Association of Retired and Senior Volunteer Program Directors
National Association of School Nurses
National Association of Senior Companion Project Directors
National Caucus and Center on Black Aged Inc.
National Council for Community Behavioral Healthcare
National Council of La Raza
National Council of Senior Citizens
National Council on the Aging
National Education Association

National Health Law Program
National Hispanic Council on Aging
National Hispanic Medical Association
National Immigration Forum
National Immigration Law Center
National Latino Children's Health Institute
National Mental Health Association
National Parent Network on Disability
National Partnership for Women & Families
National Senior Citizen Law Center
National Therapeutic Recreation Society
New York Greater Upstate Law Project, Inc.
New York Immigration Coalition
Project Inform
Service Employees International Union
Society for Adolescent Medicine
Society for Pediatric Research
The Arc of the United States
The San Francisco AIDS Foundation
United Cerebral Palsy Associations
Unitarian Universalist Association
Unitarian Universalist Service Committee
United Church of Christ, Office of Church in Society

cc: President William J. Clinton
The Honorable Tom Daschle
The Honorable Richard Gephardt

- ~~Capt~~ Anderson

776-9577

690-8428

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release

November 2, 2000

REMARKS BY THE PRESIDENT
ON THE BUDGET

The Rose Garden

10:45 A.M. EST

THE PRESIDENT: Good morning. Thank you. Let me begin with a word about developments in the Middle East. Last night, the parties announced that they had reached an understanding on how to end the violence based on the agreement we reached at Sharm el-Sheikh.

I hope the parties can move forward to put an end to this violence that has caused so much pain on both sides. We know it won't be easy. This morning we were reminded once again in Jerusalem that there are those who seek to destroy the peace through acts of terror. This cannot be permitted to prevail. It is now time for those who believe in peace to stand together to stop this violence and to work against the terrorists.

I wanted all of you to be here today because you've worked so hard on our priorities here at home. The Republican leadership of the 106th Congress has proven itself unable to finish its work before facing the voters. Congressional Republicans are leaving behind a legacy of unfinished business on health care, education, economic progress, and social justice. Regrettably, this is a Congress that may well be remembered for broken promises, lost opportunities and misplaced priorities.

In contrast, our administration, with congressional Democrats, put forward an achievable agenda for America and its families -- a real patients' bill of rights, expanding health coverage to millions of uninsured Americans, a raise in the minimum wage, tax cuts for education and retirement, improving our public schools, protecting our environment, strengthening Medicare with a voluntary prescription drug coverage for all seniors, and a balanced budget that pays off the debt by 2012.

We had a simple strategy to accomplish these goals -- heeding the

wisdom of the American people, reaching out to win bipartisan majorities in Congress, and calling for a vote. That's putting progress over partisanship. Results should have been a strong record of legislative achievement. But time and again, rather than listening to the voices of the American people and responding to the bipartisan calls within the Congress, the Republican leadership has bowed to the demands of special interests.

On every single issue we have worked in good faith to craft compromises that were good for the American people. And when Democrats

and

Republicans have worked together we have actually made real progress. We won new investments for our inner cities, rural communities and Native American communities, and 79,000 new housing vouchers for families

climbing

their way out of poverty. We increased our investment in a clean environment and doubled our funds for land conservation. We enacted the largest one-year increase ever requested for Veterans Affairs and the largest increase in the history of the National Science Foundation. And we met our historic commitment to debt relief for developing countries.

Just last Sunday we reached bipartisan agreement on an education budget that would have been a tremendous achievement for our children. But under orders from their special interest, the Republican leadership cancelled the compromise we had reached with the Republican congressional negotiators. So unless we keep fighting, there will be no funds for school construction, no more progress toward cutting class size by hiring 100,000 new qualified teachers, no new investment in teacher quality, no new funding to strengthen accountability, turn around failing schools, double the number of children served in after-school programs. That is wrong. So we must keep working to make it right.

We built a bipartisan coalition to strengthen Medicare and Medicaid by expanding coverage for children with disabilities, Americans moving from welfare to work, and pregnant women and children who are legal immigrants. But the Republican leadership rejected these proposals in favor of a massive give-away to HMOs -- tens of billions of dollars without taking adequate care of these vulnerable populations, or adequately compensating the teaching in rural hospitals, home health agencies, and other providers who serve our people. Before this year is out, we must resolve this matter, finally and fairly.

The leadership says they didn't have time to complete the budget. But they wasted no time in blocking fair treatment for Latino immigrants, in blocking common-sense gun safety legislation, in trying to stop new worker safety rules, in filing the spending bills -- filling the spending

bills they did pass with political election year pork.

One thing should be clear: the lack of progress in this Congress was not a failure of bipartisanship. On raising the minimum wage, a real patients' bill of rights, hate crimes legislation, campaign finance reform, school construction, new markets legislation for the areas still not touched by our prosperity -- on every single one of these issues we had bipartisan majorities, Republicans and Democrats, ready to pass them. But the Republican leadership and their special interest allies, unfortunately, still had the power to kill them.

It is unfortunate that their leadership failed to deliver on so much that was within our grasp. But the fight is not over. The American people expect us to finish the job they sent us here to do, and when the Republican leadership comes back after the election, I hope we are ready to work together -- and they are ready to work together -- to meet that challenge. I am ready. We've done a lot of good, but there's too much left undone; too much that a majority of both parties support.

So thanks for your efforts. Let's go out and let the American people have their say, and we'll come back and go to work after the election. Thank you very much. (Applause.)

END 10:52 A.M. EST

NEWS

FROM THE COMMITTEE ON WAYS AND MEANS SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
October 31, 2000

Contact: Greg Crist or Arne Buresh
(202) 225-8933

Congressional Medicare Plan Will Lower Costs & Add New Benefits, President's Plan Won't

*White House Medicare Plan Silent on New Benefits, Offers Less Help to
Rural Areas, and Won't Lower Seniors' Out-of-Pocket Costs*

WASHINGTON— Ways and Means Health Subcommittee Chairman Bill Thomas (R-CA) today released Congressional Budget Office (CBO) scoring of the House-passed Medicare refinement plan and compared the data with the Clinton Administration's request. The attached chart reveals that the Congressional plan creates new and expands existing Medicare benefits while reducing seniors' out-of-pocket costs and enacting a new Medicare Patient Bill of Rights. The President's proposal included no new benefits, cost reductions or patient protections.

"While the President talks about priorities for Medicare, his plan shortchanges beneficiaries with no new benefits and no new patient protections. Seniors on fixed incomes want more bang for their Medicare buck, not more empty promises. It's not too late to sign this plan, strengthen Medicare and give beneficiaries the help they need," said Chairman Thomas.

Chairman Thomas also released the following numbers showing which Medicare recipients would be affected the most by a presidential veto:

- ▶ As many as 1.5 million residents in nursing homes would be evicted if their skilled nursing facilities were forced to close.
- ▶ 3.8 million seniors disabled at home could lose access to vital home health care.
- ▶ As many as 6.2 million seniors enrolled in Medicare+Choice plans would be left without coverage, including access to prescription drugs. A 1999 Kaiser Foundation study reported that Medicare beneficiaries who were disenrolled from M+C plans were more likely to face higher out-of-pocket costs, fewer benefits and higher premiums. Further, the study found that beneficiaries with the greatest problems after a M+C plan left the area were disabled, racial or ethnic minority seniors, and the poor and near-poor.
- ▶ 136,000 Medicare beneficiaries could lose the intensive rehabilitation therapy they need from skilled nursing facilities.
- ▶ As many as 98,000 future doctors could be denied training at teaching hospitals.

-more-

**BUDGETARY IMPACT OF THE HOUSE-PASSED MEDICARE BENEFICIARY
IMPROVEMENT AND PROTECTION ACT OF 2000**

Program Refinements	5 Year Costs	% of Package
Direct Benefits for Seniors & Disabled	\$6.7	21.3%
Hospitals (Inpatient, Outpatient, DSH)	\$11.0	34.9%
Home Health & Hospice (15% stay, market basket update)	\$1.8	5.7%
Nursing Homes (Market basket, Therapy Copys)	\$1.6	5.1%
Dialysis & Durable Medical Equipment	\$0.9	2.9%
Additional Medicare Services (Drugs and biologicals, etc)	\$1.4	4.4%
Medicare + Choice	\$6.3	20%
Part B Premium & M+C Interaction	\$1.8	5.7%
TOTAL FUNDING (Numbers may not add due to rounding)	\$31.5	100%

The President's proposal includes no new benefits, cost reductions or patient protections.

Summary	Congressional Plan 5 Year Costs	President's Plan 5 Year Costs
Direct Benefits to Seniors and Disabled (Lower co-pays, new lab tests, new and expanded preventive benefits)	\$5.7	\$0.0
Total Medicare Funding	\$31.5	\$21
FY 2003-2007 Medicare Budget Cuts	\$0.0	-\$30

Preliminary Estimate of H.R. 5543, the Benefits Improvement and Protection Act of 2000

as published at <http://www.house.gov/rules/tax5.pdf>

in billions of dollars, by fiscal year

10/26/2000 05:38 PM

FFS Policies

ESRD/Dialysis/EPO or Eligibility Expansion Policies (don't affect M+C rates)

422	Dialysis update	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.2	0.4
-----	-----------------	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----

HH Policies (special Part B Premium calculation)

501	HH: delay 15 percent reduction	0.0	0.6	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.7	0.7
502	HH: update	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.8	1.5
503	HH: PIP extension	0.1	-0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
504	HH: telemedicine	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
505	Study: cost of nonroutine medical supplies	no direct spending											0.0	0.0
506	HH: treatment of branch offices	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
507	HH: modify definition of homebound	0.0	0.0	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.3	0.3	0.3	1.4

FFS Policies (standard Part B Premium calculation)

101	Biennial pap smears and pelvic exams	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.3	0.8
102	Screening for glaucoma	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.3	0.9
103	Screening colonoscopy	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.2
104	Screening mammography	0.0	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.5	1.5
105	Nutrition therapy for renal and diabetic patients	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.3	0.7
111	HOPD: beneficiary copayments	0.2	0.3	0.3	0.4	0.6	0.9	0.9	0.8	0.7	0.6	0.6	1.8	5.7
112	Coverage of drugs and biologicals	0.1	0.1	0.2	0.3	0.4	0.5	0.6	0.7	0.9	1.0	1.0	1.1	4.8
113	Immunosuppressive drugs	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.6	1.5
114	Billing limits on prescription drugs	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.2
121	Demor: disease management /a	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
122	Cancer prevention and treatment demo	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
123	Study: thyroid screening	no direct spending											0.0	0.0
124	Study: consumer coalitions	no direct spending											0.0	0.0
125	Study: effect of payment at Medicaid rates for QMBs	no direct spending											0.0	0.0
126	Study: wolver of 24-month waiting period	no direct spending											0.0	0.0
127	Study: preventive interventions	no direct spending											0.0	0.0
128	Study: cardiac/pulmonary rehabilitation therapy	no direct spending											0.0	0.0
201	CAH: no cost-sharing for clinical lab services	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1
202	CAH: physicians paid under all-inclusive rate	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1
203	CAH: exempt swing beds from SNF PPS	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.3

Preliminary Estimate of H.R. 5543, the Benefits Improvement and Protection Act of 2000

as published at <http://www.house.gov/rules/tax5.pdf>

in billions of dollars, by fiscal year

10/26/2000

03:39 PM

204	CAH: ER physicians	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.2
205	CAH: ambulance	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1
206	Study: CAH with distinct-part units	no direct spending										0.0	0.0
211	Rural DSH	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.9	2.0
212	SRMDH based on 2 of 3 recent cost reports	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.3
213	SCH: base year option	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1
214	Study: cost and volume of rural psych units	no direct spending										0.0	0.0
221	Rural ambulance	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.3
222	Physician assistant services	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.3
223	Telhealth services	0.0	0.0	0.0	0.0	0.1	0.1	0.2	0.3	0.3	0.4	0.1	1.5
224	Rural health clinics	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1
225	Study: low-volume rural providers	no direct spending											
301	Hospital: inpatient PPS update	0.6	0.9	0.6	0.7	0.9	1.1	1.1	1.1	1.2	1.2	3.7	9.5
302	Hospital: IME adjustment	0.1	0.4	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.6	0.6
303	Hospital: DSH adjustment	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1
304	Hospital: reclassification and wage index changes	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
305	Rehabilitation hospitals	0.0	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.2
306	Psychiatric hospitals	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
307	Long-term care hospitals	0.2	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.3	0.3
311	SNF: update	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.4	1.1
312	SNF: increase in nursing component of federal rate	0.2	0.6	0.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0	1.0
313	SNF: limit consolidated billing to Part A covered stays	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
314	SNF: re-distribute increase in federal rate for rehab RUGs	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
316	SNF: geographic reclassification	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
321	Hospital: update	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.2	0.4
322	Hospital: physician codification	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
323	Study: hospice benefit	no direct spending										0.0	0.0
331	Part A late-enrollment penalty	below										0.0	0.0
332(a)	SNF: posting of information on nursing facility staffing	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
401	HOPD: update	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.3	0.3	0.8	2.0
402	HOPD: pass-through payments	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
403	HOPD: transitional corridors for certain hospitals	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1
404	HOPD: provider-based status	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.3
405	HOPD: children's hospitals	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
406	Temperature-monitored cryoblation	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Preliminary Estimate of H.R. 5543, the Benefits Improvement and Protection Act of 2000

as published at <http://www.house.gov/rules/tax5.pdf>

in billions of dollars, by fiscal year

10/26/2000 05:38 PM

411	Studies: physician services	no direct spending										0.0	0.0
412	Physician group practice demonstration	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
413	Study: groups retaining independent contractor MDs	no direct spending										0.0	0.0
421	Therapy: one-year delay of caps	0.0	0.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.2
422	Dialysis update	above										0.0	0.0
423	Ambulance payments	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.2
424	Ambulatory surgical centers: delay PPS	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
425	DME: update	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.3	0.7
428	Prosthetics and orthotics: update	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1
427	Prosthetics and orthotics: custom orthotics	0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.0
428	Prosthetics: replacements	0.0	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.5
429	Drugs and biologicals (payment freeze)	0.0	0.0	0.0	0.0	0.0	0.0	-0.0	0.0	0.0	0.0	0.0	0.0
430	Contrast-enhanced diagnostic procedures	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
431	Community mental health centers	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1
432	Payment to Indian providers	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1
433	Study: surgical first assisting of certified RN first assistants	no direct spending										0.0	0.0
434	Study: certain nonphysician professional services	no direct spending										0.0	0.0
435	Study: certain other nonphysician professional services	no direct spending										0.0	0.0
436	Study: emergency and medical transportation services	no direct spending										0.0	0.0
437	Study: Medicare payments	no direct spending										0.0	0.0
438	Study: outpatient pain management	no direct spending										0.0	0.0
501	HH: delay 15 percent reduction	above										0.0	0.0
502	HH: update	above										0.0	0.0
503	HH: PIP extension	above										0.0	0.0
504	HH: telemedicine	above										0.0	0.0
505	Study: cost of nonroutine medical supplies	above										2.2	2.2
506	HH: treatment of branch offices	above										0.0	0.0
507	HH: modify definition of homebound	above										0.0	0.0
511	GME: floor	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.3	0.8
512	Nursing/Allied Health education	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
521	Appeals process	0.0	0.0	0.1	0.1	0.2	0.2	0.3	0.3	0.4	0.4	0.4	2.0
522	Coverage process	included in section 521										0.0	0.0
531	New clinical lab tests and durable medical equipment	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1
532	HCPCS: level III codes	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
533	Hospital: adjustment inpatient PPS for new technology	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Preliminary Estimate of H.R. 5543, the Benefits Improvement and Protection Act of 2000

as published at <http://www.house.gov/rules/tax5.pdf>
 in billions of dollars, by fiscal year

10/26/2000 05:38 PM

541	Payment for bad debt	0.2	0.2	0.2	0.2	0.3	0.3	0.3	0.3	0.3	0.3	1.2	2.8
542	Pathology payments	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
543	Advisory opinion authority	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
544	MedPAC reports	no direct spending										0.0	0.0
545	Patient assessment instruments	no direct spending										0.0	0.0
546	Study: impact of EMTALA	no direct spending										0.0	0.0
831	SHMO: 1-year extension	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
832	CNO: conditions for extension	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
833	Municipal health services demos: extension	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
834	Cost Contracts: service area extension	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
901	PACE: extension	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
902	PACE: permit operating arrangements	Included in section 901										0.0	0.0
903	PACE: waiver authority	Included in section 901										0.0	0.0
	Subtotal, FFS Polices	2.7	5.0	3.6	3.7	4.4	5.3	5.6	5.9	6.2	6.6	19.3	49.0
	Subtotal, FFS for M+C Interaction	2.6	4.9	3.6	3.7	4.3	5.2	5.6	5.8	6.2	6.5	19.1	48.5
	M+C Policies and Interactions												
601	Minimum payment amount	0.9	1.0	1.2	1.5	1.8	1.5	2.2	2.5	2.8	3.2	6.2	18.4
602	Minimum percentage increase	above										0.0	0.0
603	10-year phase-in of risk adjustment	above										0.0	0.0
604	Deadline for offering/withdrawing plans	above										0.0	0.0
605	Payment rates for ESRO patients	above										0.0	0.0
606	Permit premium rebates to beneficiaries	above										0.0	0.0
607	Risk adjustment for congestive heart failure	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1
608	New entry bonus	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
609	Report: adjust payment rates for DoDVA spending	no direct spending										0.0	0.0
611	Payment for new benefits	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
612	Implementation of new regulatory requirements	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
613	Approval of marketing material	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
614	Duplicative regulation	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
615	Uniform coverage policy	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
616	Health disparities	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
617	Employer or union health plans	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
618	Medigap enrollment for certain beneficiaries	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Preliminary Estimate of H.R. 5543, the Benefits Improvement and Protection Act of 2000

as published at <http://www.house.gov/rules/tax5.pdf>

in billions of dollars, by fiscal year

10/26/2000 05:38 PM

619	Effective date of elections	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
620	Enrollment in other plans of M+C beneficiaries with ESRD	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
621	Choice of SNF for M+C enrollees	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
622	Accountability	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
631	SHMO: 1-year extension	above									0.0	0.0	
632	CNO: conditions for extension	above									0.0	0.0	
633	Municipal health services demos: extension	above									0.0	0.0	
634	Cost Contracts: service area extension	above									0.0	0.0	
	M+C interaction	0.0	1.3	1.1	1.2	1.4	1.8	2.0	2.2	2.6	2.9	4.6	16.0
	Gross Outlays, Current Enrollees, traditional benefits	3.6	7.2	5.9	6.4	7.5	8.3	9.8	10.6	11.6	12.7	30.6	83.6
	Subtotal, Gross Mandatory Outlays	3.6	7.2	5.9	6.4	7.5	8.3	9.8	10.6	11.6	12.7	30.6	83.6
	Premiums, Current Enrollees, traditional benefits	0.0	-0.5	-0.7	-0.8	-1.0	-1.1	-1.3	-1.4	-1.6	-1.7	-3.0	-10.2
331	Part A late-enrollment penalty	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Subtotal, Premiums	0.0	-0.5	-0.7	-0.8	-1.0	-1.1	-1.3	-1.4	-1.6	-1.7	-3.0	-10.2
	Total, Net Medicare Outlays	3.6	6.7	5.2	5.6	6.5	7.2	8.5	9.1	10.1	11.0	27.5	73.4
	Medicaid/SCHIP/Other Provisions and Interactions:												
	Changes in cost sharing	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.1	0.1	0.4
	New Medicare coverage of Medicaid-covered services	-0.0	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2	-0.3	-1.0
222(a)	SNF: pooling of information on nursing facility stay	no budgetary effect										0.0	0.0
541	Payment for bad debt	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.5	-1.2
701	DSH payments	0.3	0.7	0.8	1.0	1.1	0.4	0.4	0.4	0.4	0.4	3.9	6.1
702	New payment system for FQHCs and RHCs	0.0	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.3	1.0
703	Streamlined approval of section 1115 waivers	no budgetary effect										0.0	0.0
704	Medicaid county-operated health systems	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1
705	Require HHS to issue final regulation on UPLs	-0.5	-2.4	-4.6	-8.4	-7.6	-8.8	-9.8	-11.0	-12.3	-13.3	-21.5	-78.7
708	Alaska FMAP	0.0	0.0	0.0	0.0	0.0	-0.0	-0.0	-0.0	-0.0	-0.0	0.2	0.2
	Medicaid interactions with SCHIP provisions	0.0	0.0	0.0	0.0	0.0	0.0	-0.0	-0.0	-0.0	-0.0	0.0	-0.0
801	Special rules for 1998 and 1999 SCHIP allotments	0.0	0.0	0.0	0.0	0.0	-0.1	0.0	0.0	0.1	0.0	0.0	0.1

Preliminary Estimate of H.R. 5543, the Benefits Improvement and Protection Act of 2000

as published at <http://www.house.gov/rules/tax5.pdf>
 in billions of dollars, by fiscal year

10/26/2000 05:39 PM

802 Authority to pay certain SCHIP costs from Title XXI funds	no budgetary effect											0.0	0.0
901 PACE: extension	above											0.0	0.0
902 PACE: permit operating arrangements	above											0.0	0.0
903 PACE: waiver authority	above											0.0	0.0
911 Additional QMB/SLMB outreach efforts	no budgetary effect											0.0	0.0
921 Authorize additional Maternal and Child Health grants	no direct spending											0.0	0.0
931 Additional funding for diabetes programs		0.0	0.1	0.1	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.5	0.5
932 Ricky Ray		0.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.5	0.5
Medicaid Payment of Part B Premiums		0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.3	0.9
Subtotal, Medicaid/SCHIP/Other		0.3	-1.6	-3.6	-3.3	-6.4	-8.4	-9.3	-10.4	-11.8	-12.7	-16.6	-69.2

Net mandatory outlays	3.9	5.1	1.5	0.3	0.1	-1.2	-0.9	-1.3	-1.7	-1.8	10.9	4.2
------------------------------	------------	------------	------------	------------	------------	-------------	-------------	-------------	-------------	-------------	-------------	------------

Memorandum: Part B Premium (dollars per month)

Current Law	50.00	53.20	58.80	64.20	69.70	74.70	79.40	84.20	89.70	95.10
Proposed Law	50.00	54.40	60.10	66.00	71.80	77.10	82.10	87.10	92.80	98.40

a/ Assumes payments for Rx's would not be included in negotiated fee and disease management organizations would therefore decline to participate.



NATIONAL ASSOCIATION FOR HOME CARE

228 Seventh Street, SE, Washington, DC 20003 • 202/547-7424 • 202/547-3540 fax

October 19, 2000

Mary Suther
Chairman of the Board
Val J. Halamandaris
President

Honorable Frank E. Moss
Senior Counsel

Stanley M. Brand
General Counsel

Honorable William Thomas
Chairman
Subcommittee on Health
Committee on Ways and Means
U. S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

Many thanks for once again providing leadership to help blunt some of the unintended consequences of the Balanced Budget Act of 1997 (BBA). Your efforts, as always, are greatly appreciated.

Balancing concerns about fiscal responsibility with the interests of Medicare beneficiaries and the providers that serve them is a very difficult job. We are grateful that you have offered to delay the scheduled 15 percent cut for an additional year, to provide a full market-basket inflation update for fiscal year 2001, and to extend periodic interim payments for two months. These provisions will be of great help to home health agencies and the patients they serve. However, with all due respect, as the benefit most hard-hit by the BBA, home health providers and the patients they serve are in need of additional support in order to further stabilize the program and enhance access to needed care.

As you know, under the BBA, home health outlays dropped 54 percent in a two-year period and the total number of beneficiaries served dropped by nearly 1 million. The BBA has exacted \$70 billion from the home health program, more than four times the \$16 billion savings target set by the Congress. The number of home health agencies has dropped by about one-third, and the budgets of those agencies remaining have dropped by close to 40 percent.

We urge your further consideration of several proposals that are designed to help shore up the ailing home health program – specifically, requiring payment for non-routine medical supplies on a fee schedule rather than as part of the prospective payment base payments (this proposal would be budget-neutral); increasing allowable expenditures for high cost, outlier patients; and additional payments for care provided to rural patients. Senator William Roth has seen fit to include these provisions in a bipartisan legislative package he has proposed, and we would encourage you to work with your colleagues to address these areas as you finalize the BBA refinements package.

Your assistance in this regard will be greatly appreciated – not only by the home health agencies, doctors, nurses, and home health aides that provide these important services, but also by the millions of vulnerable Medicare beneficiaries that rely on us for their care and protection.

Many thanks for your thoughtful consideration of our requests.

Sincerely,

Val J. Halamandaris
President

cc: Hon. Trent Lott
Hon. Dennis Hastert

02/18/2000 22:55

XXXXXXXXXX

0X



FACSIMILE TRANSMISSION

555 West 57th Street / New York, N.Y. 10019 / (212) 246-7100 / FAX (212) 262-6350
 Kenneth E. Raske, President

Date: *Oct. 19, 00*
 Time:

TO: *Chris Jennings*
FAX # 202-456-5557

FROM: **Kenneth E. Raske**
 President

Phone: 212-246-7100
 E-mail: raske@gnyha.org

We are transmitting *2* pages including this cover sheet. If you have not received all of the pages, PLEASE CALL OUR OFFICE AS SOON AS POSSIBLE.

MESSAGE: *Per my e-mail to you yesterday - see the attached.*

K

Main Number (212) 246-7100
 Fax Number (212) 262-6350

Hard Copy will will not be sent by mail.

October 19, 2000

Letters to the Editor
The New York Times
229 West 43rd Street
New York, New York 10036-3959

To the Editor:

Re "Medicare Bill That Favors H.M.O.'s Faces a Veto" (Oct.18): The Balanced Budget Act of 1997 (BBA) enacted unprecedented and damaging funding cutbacks to hospitals and other health care providers throughout the country. These federal cutbacks are doing serious—and possibly irreparable—damage to our country's health care providers. Now it appears that Congressional leaders are putting forward a BBA relief package that provides disproportionate funding to the HMOs at the expense of desperately needed relief for hospitals and other health care providers. We, who collectively represent more than 1,800 hospitals and other health care providers, applaud the Clinton Administration's call for meaningful bipartisan action to restore urgently needed funds to health care providers. We have consistently supported bipartisan legislation in the Congress, sponsored by a majority in both Houses, which reflects the urgency of desperately needed Medicare funding restorations. Bipartisan leadership and action is needed before Congress adjourns.

Sincerely,

Gary S. Carter, President
New Jersey Hospital Association
P.O. Box One, 760 Alexander Road, CN-1
Princeton, NJ 08543-0001
(609) 275-4000

C. Duane Dauner, President
California Healthcare Association
1201 K. Street, Suite 800
Sacramento, CA 95814-1100
(916) 443-7401

Ronald M. Hollander, President
Massachusetts Hospital Association
Five New England Executive Park
Burlington, MA 01803
(781) 272-8000

Kenneth E. Raske, President
Greater New York Hospital Association
555 West 57th Street, 15th Floor
New York, NY 10019
(212) 246-7100

Daniel Sisto, President
Healthcare Association of New York State
One Empire Drive
Rensselaer, NY 12144
(518) 431-7600

Terry Townsend, President
Texas Hospital Association
6225 U.S. Highway 290 E., P.O. Box 15587
Austin, TX 78761-5587
(512) 465-1000



EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

THE DIRECTOR

October 17, 2000

The Honorable Trent Lott
Majority Leader
United States Senate
Washington, D.C. 20510

Dear Mr. Leader:

We are writing to express our serious concerns about persistent reports that your Medicare provider payment restoration bill inappropriately allocates resources towards health maintenance organizations (HMOs) and away from beneficiary and health care provider needs. Not only are large managed care payment increases unjustifiable, but you appear to be raising payments without any accountability provisions that would ensure that services and plan participation are maintained. Should these untargeted, excessive and unaccountable HMO payment increases crowd out critical beneficiary and health care provider policies, we would recommend that the President veto your legislation.

In recent days, it has become clear your preliminary Balanced Budget Act refinements bill dedicates well over one-third of its spending to Medicare HMO payment increases. This is despite the facts that only 16 percent of Medicare beneficiaries are enrolled in HMOs and no independent study validates that they are underpaid. This excessive allocation for HMOs stands in sharp contrast to your net dedication of less than 10 percent of total spending to needed benefit improvements – far below one-third of total spending as has been reported in the media. Similarly, hospitals, home health agencies, hospices, and other providers have a stronger case for relief yet adequate payment increases do not appear to be in your bill, raising further questions about your priorities.

Inadequate Beneficiary Provisions

After attempts by the Administration and Congressional Democrats to secure long-overdue benefit improvements in Medicare and Medicaid, we are troubled by reports that virtually all of these provisions have been significantly scaled back or dropped entirely. Such Medicare provisions include the reduction of hospital outpatient coinsurance; elimination of coinsurance for existing preventive benefits; improving enrollment of low-income beneficiaries in cost sharing assistance programs; an expanded homebound definition for home health services for Medicare beneficiaries; and the creation of a meaningful beneficiary appeals process. The bill appears to omit almost all of the Administration's Medicaid priorities, denying health insurance options for legal immigrant pregnant women and children; denying funding for states to encourage community care for people with disabilities; denying working families the option of

buying their disabled children into Medicaid; and denying parents of uninsured children the option of more easily enrolling them in Medicaid and the State Children's Health Insurance Program. The President referenced these priorities and others in his letter to you on October 10, 2000.

Fails to Provide Necessary Assistance for Providers

Your legislation also appears to fall short on assisting Medicare and Medicaid providers that have stronger justification for payment increases than do Medicare HMOs. Some of the important priorities that you overlook include:

- Payments for hospitals serving low-income and uninsured patients. Despite strong bipartisan support, your bill apparently includes less than \$1 billion over 10 years for states and hospitals. The Administration believes that \$10 billion over 10 years should be dedicated to Medicaid DSH to assist hospitals serving low-income and uninsured patients by raising both the state allotments and the hospital-specific DSH limits to 175 percent of net uncompensated care. This will also help states and hospitals adjust to the new Medicaid upper payment limit rule.
- Hospital payment increases. The Balanced Budget Act reduced hospital updates below the projected inflation increase for 2001 and 2002. The Administration supports restoring the full inflation update amount for both years and not reducing the update factor for subsequent years below minus 0.5 percentage points. The Administration is also concerned about reports that, despite the bipartisan support for its proposal to increase payments for hospitals in Puerto Rico, this provision has been dropped in your bill.
- Teaching hospital payments. The Administration supports maintaining the hospital indirect medical education payment adjustment at 6.5 percent for 2001 and 2002 – and is concerned about reports that the full 6.5 percent adjustment for 2002 is not included in the Republican proposal. Teaching hospitals have been extraordinarily successful at producing physicians and researchers and caring for underserved populations, and should not be forced to cut back on these important activities due to inadequate payments.
- Home health care payments. The Balanced Budget Act reduced payments to home health agencies, contributing to a nearly 50 percent decline in Medicare home health spending between 1996 and 1999. The Administration supports delaying the 15 percent reduction in home health spending for an additional two years to assess the adequacy of the new prospective payment system.
- Nursing home quality grants. Similar to your approach to Medicare HMOs, your increased payments to nursing homes are not accompanied by increased accountability to improve patient safety and quality of care. The Administration supports the bipartisan proposal to increase staffing ratios through financial incentives and disincentives in the context of a \$1 billion, five-year grant program to improve staff recruitment, retention, and reporting.

- Hospice payments. Despite their importance in caring for seniors at the end of life, hospices' Medicare payments have failed to keep pace with their costs. The Administration supports at minimum repealing the payment reductions through 2002.
- Managed care payments. Since Medicare HMO rates are linked to traditional Medicare, increases in other providers' payments automatically yield higher payment rates for HMOs. In addition, the Administration plans on phasing in risk adjusted payments gradually over a multi-year period. We also are willing to support responsible "floor" payment increases to managed care plans in counties with low payment rates. However, any additional payment increases should be linked to specific accountability provisions that require plans to agree to both remain in the communities they are serving and maintain benefits for at least three years.

The President strongly believes that these beneficiary and provider investments can be accommodated if you reduce your unjustified HMO payment increases. Targeting managed care payment increases to low-reimbursement counties and exacting a service commitment from plans in return for higher payments will strengthen the investment and lower the proportion of dollars spent on managed care. In addition, we believe that most of the provider payment increases should be time-limited, lasting for two years. With these changes, it should be possible to dedicate at least one-third of the bill's spending to beneficiary improvements in a fiscally responsible manner.

We all know that meaningful health reform must be done on a bipartisan basis. We successfully worked together on the original Balanced Budget Act as well as the refinement bill passed last year. While we are deeply disappointed that the Congress has failed to act on a bipartisan Medicare prescription drug benefit, we remain hopeful that we can enact the Vice President's bipartisan proposal to move the Medicare Trust Fund off budget, assuring that its surplus is used only for Medicare and debt reduction. If your provider restoration bill continues to include untargeted, excessive and unaccountable HMO payment increases without meaningful investments in beneficiary and health care provider policies, we will recommend that the President veto it. We urge you to make a commitment to dedicate one-third of the spending to beneficiaries; to provide meaningful assistance to other vulnerable health care providers; and to hold Medicare HMOs accountable to remain in their communities and maintain benefits for at least three years. Such a plan will better serve Medicare beneficiaries, their health care providers, and the taxpayers who support the program.

Sincerely,



Jacob J. Lew

Director

Office of Management and Budget



Donna Shalala

Secretary

Department of Health and Human Services

cc: The Honorable Thomas A. Daschle
The Honorable Richard A. Gephardt

Identical Letter Sent to The Honorable J. Dennis Hastert

AGENDA: MEDICARE GIVEBACK BILLS
October 16, 2000

I. BUDGET AND MIDSESSION REVIEW

	<u>5 Years</u>	<u>10 Years</u>
Budget Policies on Medicare / Medicaid:	\$14 billion	\$35 billion
Midsession Review:	\$21 billion	\$40 billion
TOTAL:	\$35 billion	\$75 billion

II. REPUBLICAN PRELIMINARY PROPOSAL

Managed Care	\$11.4 billion (37%)	\$45.5 billion (48%)
Hospitals	\$8.1 billion (26%)	\$17.5 billion (19%)
Rural Providers	\$2.0 billion (6%)	\$4.6 billion (5%)
Home Health	\$1.3 billion (4%)	\$2.3 billion (2%)
Nursing Homes	\$1.6 billion (5%)	\$2.8 billion (3%)
Beneficiaries	\$2.3 billion (7%)	\$4.7 billion (5%)
Other	\$4.2 billion (14%)	\$16.8 billion (18%)
TOTAL:	\$30.9 billion	\$94.2 billion

III. ADMINISTRATION AND DEMOCRATIC PRIORITIES THAT ARE EXCLUDED

Hospitals:

Medicaid DSH	\$5 billion	\$10 billion
2 nd yr market basket	\$0.3 billion	\$1 billion
2 nd yr teaching hospitals	\$0.2 billion	\$0.2 billion
Puerto Rico hospitals	\$0.1 billion	\$0.3 billion
Subtotal:	\$5.6 billion	\$11.5 billion

Home Health: 2nd yr delay of 15% cut \$1.8 billion \$1.8 billion

Nursing Homes: Quality grants \$1 billion \$1 billion

Hospice: 2nd yr market basket \$0.6 billion \$0.7 billion

Beneficiaries: See attached

IV. OTHER MEDICARE ISSUES

Medicare Lock Box

Prescription Drugs

**ADMINISTRATION AND DEMOCRATIC BENEFICIARY PRIORITIES
EXCLUDED FROM REPUBLICAN BILL**

	2001	5 Yrs	10 Yrs
MEDICARE			
Hospital Outpatient Services: Hospital outpatient copayment, buydown (full Ways & Means provision)	\$0.0	\$1.0	\$2.4
Preventive Services: Waive deductibles and copays	\$0.0	\$1.0	\$3.3
Adult Day Care: Permit adult day care under home health	\$0.0	\$0.2	\$0.7
ALS: Waive 24 month waiting period for Medicare eligibility for persons with Lou Gehrig's Disease (ALS)	\$0.0	\$0.3	\$0.7
Low-Income Medicare Beneficiaries: Improving enrollment of QMBs through applying at Social Security offices	\$0.0	\$0.9	\$5.4
Low-Income Medicare Beneficiaries: Permanent extension premium assistance for those between 120 and 135% poverty	\$0.0	\$0.1	\$0.2
SUBTOTAL	\$0.0	\$3.5	\$12.7
DISABILITY			
Kennedy-Jeffords: Permanent extension of Medicare to disabled workers	\$0.0	\$0.1	\$0.3
Disabled Children: Family Opportunity Act: Medicaid buy-in for disabled children	\$0.0	\$2.1	\$7.3
Long Term Care: MiCASSA long term care systems grants	\$0.05	\$0.05	\$0.05
Long Term Care: Medicaid disability 300% of SSI option for community care	\$0.0	\$0.4	\$1.3
SUBTOTAL	\$0.05	\$2.65	\$8.95
MEDICAID AND S-CHIP			
Legal Immigrants: Medicaid and S-CHIP for legal immigrants	\$0.0	\$0.6	\$1.6
Children's Enrollment: Eligibility simplification	\$0.0	\$1.6	\$4.0
Children's Enrollment: Presumptive eligibility for Medicaid	\$0.1	\$0.5	\$1.1
Welfare to Work: Permanently extend, simplify transitional Medicaid	\$0.0	\$1.6	\$4.8
Homeless Children's Outreach: Homeless children grant program	\$0.01	\$0.01	\$0.01
Smoking Cessation: Mandatory Medicaid coverage of these drugs	\$0.0	\$0.07	\$0.15
SUBTOTAL	\$0.11	\$4.38	\$11.66
OTHER			
HIV/HEMOPHILIA: Full funding of Ricky Ray Relief Fund	\$0.57	\$0.57	\$0.57
TOTAL	\$0.73	\$11.1	\$33.88

* Not including Medicare interactions for M+C. For additional policies, the cost is the incremental cost of the provision above the provision understood to be included in the Republican package.

THE WHITE HOUSE
WASHINGTON

October 10, 2000

Dear Mr. Leader:

I am writing to express my serious concerns that the Congressional Republican Leadership is preparing to pass unjustifiably large Medicare health maintenance organization (HMO) payment increases while preventing passage of a strong Patients' Bill of Rights. Managed care reform in the 106th Congress should focus on patient protections, not on excessive payments to managed care plans. Moreover, these reimbursement increases are effectively diverting resources from critically important health care priorities.

This past weekend marked the 1-year anniversary of the overwhelmingly bipartisan passage of the Norwood-Dingell Patients' Bill of Rights. Despite the bipartisan majority supporting this bill in the Senate, parliamentary and political tactics have blocked an up-or-down vote on this long-overdue legislation.

At least as disconcerting is that Congress is proposing to dedicate \$25 to \$53 billion in increased payments to managed care -- without a sound policy basis. The Congress is currently contemplating dedicating 40 to 55 percent of their total investment in provider payments and beneficiary services to increase managed care payments -- over twice the amount they plan to spend on hospitals and over five times the amount that they plan to spend on beneficiaries. The Congress is proposing this investment despite studies showing that Medicare managed care plans are overpaid by nearly \$1,000 per enrollee and that their payment rates have grown faster under the Balanced Budget Act than the payment rates for traditional Medicare.

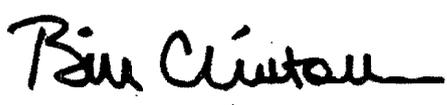
It is important to note that increased payments provide no guarantee that Medicare HMOs will stop dropping benefits or abandoning seniors' communities altogether. It is clear that increasing payments to managed care plans did not work this year -- we invested an additional \$1.4 billion in Medicare+Choice, yet watched nearly 1 million seniors and people with disabilities lose access to plans. Without explicit accountability provisions, it will not work next year either.

The unwarranted managed care payment increases would deprive funding for initiatives that would have real effects on peoples' lives, such as: restoring State options to insure vulnerable legal immigrants; fully funding the Ricky Ray Relief Fund; providing health insurance to children with disabilities; funding grants to integrate people with disabilities into the community; improving nursing home quality; eliminating Medicare preventive services cost sharing; targeting dollars to vulnerable hospitals; assuring adequate payments to teaching hospitals and home health agencies; and funding other critical health priorities. These high-priority initiatives are outlined in additional detail in the attached document.

These initiatives represent our highest health priorities. In contrast, Congress is increasing reimbursement to managed care plans at a time when Medicare managed care plans are about to receive billions of dollars in increased Medicare payments, which are linked to increases in fee-for-service payments to hospitals, nursing homes, and other providers.

It is long past time that we work together in a bipartisan fashion to respond to the Nation's highest health care priorities. It is irresponsible to provide excessively high reimbursement rates for HMOs without ensuring that they are accountable through the Patients' Bill of Rights and through commitments to provide stable and reliable services to Medicare beneficiaries. I urge you to produce more balanced legislation that puts Medicare beneficiaries and the Nation's taxpayers first.

Sincerely,



The Honorable Trent Lott
Majority Leader
United States Senate
Washington, D.C. 20510

HEALTH CARE PRIORITIES LEFT UNDERFUNDED DUE TO MASSIVE OVERPAYMENTS TO MANAGED CARE PLANS

Restoring the State options to insure vulnerable legal immigrants. Despite the fact that legal immigrants pay taxes and have typically waited years to come to the U.S., welfare reform prohibited States from extending Medicaid or State Children's Health Insurance Program coverage to legal immigrant children and pregnant women for their first five years in this country. This contributed to the sharp decline in Medicaid and subsequently S-CHIP participation by legal immigrant children (from 37 percent in 1995 to 29 percent in 1999). Restoring this State option would insure 144,000 children and 33,000 pregnant women per year at a 10-year cost of \$1.6 billion, and has broad, bipartisan support including that of Governor Jeb Bush.

Fully funding the Ricky Ray Relief Fund. The bipartisan Ricky Ray Hemophilia Relief Fund was enacted to provide one-time \$100,000 relief payments to up to 7,500 persons with hemophilia (or their survivors) who contracted HIV while receiving blood clotting factor between 1982 and 1987. However, due to underfunding, approximately 5,000 people with HIV/AIDS or their families are on a waiting list, hoping to get this relief payment while the person infected is still alive. Ricky Ray himself and hundreds of others have died while waiting for this relief and none of the initiatives in Congress includes a dollar of the needed \$570 million -- which is only about 1 percent of what they dedicated to managed care overpayments.

Health insurance for children with disabilities. Children with special health care needs are three times more likely to be ill and to miss school. Because of their high healthcare costs, parents often cannot afford private insurance and, instead, forego additional income to maintain Medicaid eligibility. Some even place their children in institutions or give up their children so they remain Medicaid-eligible under unfair and outdated rules. The Family Opportunity Act, which has bipartisan support from 78 Senators, would give States the option of letting families with children with disabilities buy into Medicaid. This commonsense policy builds on the bipartisan Work Incentives Improvement Act and is a wise investment.

Grants to integrate people with disabilities into the community. To address the institutional bias in Medicaid toward nursing homes, my Administration has supported \$50 million in System Grants for States, which are part of Senator Harkin's MiCASSA bill, to develop infrastructure that supports community-based care for persons with disabilities. People with disabilities should have real choice in where they want to live, where they receive needed services, in what services they receive, and from whom they are obtained.

Improving nursing home quality. Health and safety are a top concern for both the 1.6 million older Americans and people with disabilities who receive care in nursing homes and their families and friends. Many nursing homes provide high quality care. However, recent reports found that over 50 percent of nursing homes do not maintain the minimum staffing levels necessary to ensure the delivery of quality care. Despite this fact, none of the dollars in the beneficiary and provider restoration initiatives are targeted to increasing the staffing ratios that are linked to increased quality. To rectify this, Republicans have joined Democrats in supporting the Administration's \$1 billion State grant program to increase staffing levels by improving staff recruitment and retention, increasing training, and reward nursing facilities with good records.

Eliminating Medicare preventive services cost sharing. The value of preventive benefits is enormous, contributing to early detection, management and cure of diseases that would otherwise be debilitating and costly. However, too few seniors use these services, in part due to today's copay requirements. In the first 2 years that Medicare covered screening mammography, only 14 percent of eligible women without supplemental insurance received a mammogram. Eliminating cost sharing for current services costs about \$3 billion over 10 years -- but will save innumerable lives and dollars in the future.

Targeting dollars to vulnerable hospitals and home health agencies. Hospitals and home health agencies have experienced financial distress in the last several years, partly from excessive Balanced Budget Act changes and partly from the shift to managed care which, according to recent studies, pays well below Medicare rates. This distress is particularly acute among hospitals serving low-income patients. While the Commerce Committee made a good start in investing over

\$8 billion over 10 years in Medicaid disproportionate share hospital payments, my Administration supports investing more -- \$10 billion over 10 years to increase both the State and hospital-specific limits on these payments. In addition, Medicare spending on home health has significantly declined in recent years and an investment in home health care will likely have a greater impact on improving beneficiary access to care than increase managed care payments.

Other critical health priorities. The provider payment restoration bills should also include other important health policies like: Medicaid and CHIP outreach initiatives; Medicaid coverage of smoking cessation; extended Medicare coverage for workers with disabilities; waiver of the waiting period for Medicare for people with Lou Gehrig's disease; home health coverage for people using adult day care; and adequate funding of providers such as teaching hospitals and hospices. In addition, there has been no attempt by the Republican leadership of the U.S. Senate to even allow Committee consideration of legislation for an affordable, voluntary Medicare prescription drug benefit. This failure to act will result in millions of vulnerable seniors and people with disabilities waiting longer to get the relief that they so desperately need.

DRAFT: PRIORITIES IN MEDICARE / MEDICAID GIVEBACK BILLS:

October 10, 2000

Support:

- * **Medicaid / CHIP option to cover legal immigrant children and pregnant women:** Commerce included provision with 2-year band at a cost of \$1.3 b / 10 yrs. Work to drop 2-year ban (+\$0.2 b / 10 yrs).
- * **Medicaid DSH:** Commerce included \$9.5 b / 10 yrs to raise state DSH allotments. Support lifting hospital-specific cap to 175 percent of uncompensated care costs (about +\$1 b / 10 yrs). Also will work to help states affected by UPL regulation.
- * **Full funding of Ricky Ray Trust Fund:** \$0.57 b / 10 yrs. Not in bills. Fulfills commitment made by Congress and Administration. One-time funding.
- * **Nursing home quality grants:** \$1 b / 10 yrs. Not in bills. Grassley may try to insert in conference. State grants to improve nursing ratios and quality.
- * **MiCASSA Grants:** \$0.05 b / 10 yrs. Not in bills. Supported at anniversary of ADA; highest priority of most disability groups. Promotes de-institutionalization.
- * **Second year of indirect medical education (IME) at 6.5 percent:** Finance includes; total cost of \$0.6 b / 10 yrs. W&M includes 2nd year at 6.25 percent. Extra cost: +\$0.4 b / 10 yrs. Higher priority than hospital update for teaching hospitals.
- **Second year of full PPS market basket:** In Finance along with MB-1 in 2003: \$9.8 b / 10 yrs. Costs less than W&M 1-year full MB (\$10.6 b) because of 2003 reduction.
- **Second year of delay of 15 percent cut in home health:** Not in bills. Additional \$1.8 b / 10 yrs. Would prefer this to MB increase in 2001 which costs \$1.5 b; could supplement with outlier payments (\$0.3 b / 10 yrs)
- **Full update for hospice for 2001-2002:** Finance has lower provision: \$1.4 b / 10 yrs Adds +\$0.2 b / 10 yrs.
- **Expanded definition of homebound for home health services:** Finance allows all beneficiaries using adult day care to continue eligibility for home health services at a cost of \$1.4 b / 10 yrs. Commerce restricted it to Alzheimers' patients.
- **Waiver of 24-month waiting period for ALS:** Commerce: \$0.7 b / 10 yrs. Could explore whether much higher cost if extended to other comparable diseases.
- **Medicare coverage of colonoscopy screening:** All bills: \$0.2 b / 10 yrs
- **Waiving preventive services' cost sharing:** \$3.3 b/10 yrs. Not in bills. Encourages use of current services – may be more beneficial than addition of new benefits.
- **Medicaid presumptive eligibility for children:** Commerce: \$1.1 b / 10 yrs

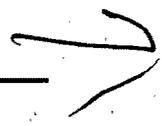
Ar
WPS

- **Extending transitional Medicaid for 1 year:** Commerce: \$0.5 b / 10 yrs. Support permanent extension (additional \$3.8 b / 10 yrs)
- **Telehealth:** Support W&M more limited provision versus Finance & Commerce; not yet proven to be very effective so should go slow.
- **Hospital outpatient coinsurance buydown:** W&M: \$8.4 b / 10 yrs. 45 percent by 2004 and limit to Part A deductible. Prefer W&M to Finance version which is more difficult to administer. [note: reviewing / not sure if I agree]
- **Family Opportunity Act:** Not in bills. Costs \$8 b / 10 yrs. Medicaid buy-in option for children with disabilities. Supported at anniversary of ADA; bipartisan support.
- **Nutritional therapy coverage for beneficiaries with diabetes, cardiovascular, renal disease:** Up to \$2.4 b / 10 yrs. Prefer W&M demonstration. Not yet recommended by experts.
- **QMB enrollment simplification:** Full Commerce package: \$5.4 b / 10 yrs.

Oppose:

- *** Managed care payment increases:** W&M: \$53 b / 10 yrs; Finance: \$30 b / 10 yrs; Commerce: \$25 b / 10 yrs. Overpaid currently. Higher payments will not result in increased retention of plans or better benefits.
- **Benefits, coverage appeals changes:** \$2.7 b / 10 years. Inconsistent with PBOR; creates new administrative burdens.
- **Creating new technology DRGs for inpatient hospital PPS:** W&M. Administrative burden; harms rural hospitals.
- **VA subvention changes:** W&M: \$0.6 b / 10 yrs. Makes demonstration permanent; substitutes for VA funding.
- **Managed care risk adjustment delay:** In House and Senate. Risk adjustment limits discrimination against sicker beneficiaries; HHS has administrative authority to set.
- **Blocking use of updated AWP:** \$0.1 b / 10 years. W&M has more limited provision; need to update periodically to ensure program integrity.
- **Repealing hospital bad debt reduction:** Finance: \$2.7 b / 10 yrs. Proven problem with fraud. If anything, prefer W&M increase in payments (\$1.2 b / 10 yrs).
- **Updates for Orthotics/Prosthetics, PEN, DME, oxygen:** Prefer lower spending of W&M (\$1 b / 10 yrs) to Finance.
- **Higher rate for new mammography technologies:** W&M: \$1.2 b / 10 yrs. Prefer Commerce proposal to pay flat amount (\$0.2 b / 10 yrs)

COVERAGE PROVISION: LEGAL IMMIGRANTS
Medicaid/S-CHIP State Option for Legal Immigrants



Administration FY 2001 Budget Provision

- Provide state option for Medicaid and S-CHIP coverage within 5 year ban to legal immigrant pregnant women, children, and restored SSI-eligibles (SSI restoration for legal immigrants is a separate proposal).
Cost: \$0.0 billion/1, \$1.8 billion/5, \$10.4 billion/10

Congressional Provisions

- Senate Finance: None
- House W&M: None
- House Commerce: Provide state option for Medicaid and S-CHIP coverage for legal immigrant pregnant women and children after 2 years from entry.
Cost: \$0.0 billion/1, \$0.4 billion/5, \$1.4 billion/10

Administration Position: Support Commerce without 2 Year Ban

Cost: \$0.0 billion/1, \$0.6 billion/5, \$1.6 billion/10

Legislative History

- Pre-1996, legal immigrants were entitled to full Medicaid coverage and other public programs. Undocumented aliens were restricted to emergency medical coverage only.
- Welfare reform placed a five-year ban on qualified immigrants (those entering the country legally after August 22, 1996) for receiving Medicaid and S-CHIP coverage. Refugees and asylees are exempt from the ban for seven years. Undocumented aliens remain eligible only for emergency coverage.
- The Administration has included the Medicaid/S-CHIP restoration proposal in the FY 2000 and FY 2001 budgets.

Arguments For:

- Medicaid participation (and subsequently S-CHIP) by legal immigrant children fell from 37 percent in 1995 to 29 percent in 1999. In 1999, 45 percent of immigrant children in low-income families (below 200 percent of poverty) were uninsured. 32 percent of uninsured children were in low-income immigrant families.
- 38 percent of non-citizen children did not see a doctor or nurse in the preceding year. 46 percent of immigrant children and 26 percent of low-income immigrant children had no usual place to get health care.
- Problems with two year ban: A typical immigrant already waits for at least two years before being admitted legally into the United States. For example, for family reunification immigrants, they must wait at least 20 months. For those from Mexico, it is at least six years. The wait may be as high as 21 years. The primary purpose of legal immigration is economic (a higher-paying job) rather than the availability of social services.
- The proposal would insure 144,000 children per year and 32,000 pregnant women per year.

Comments

- Congressional Support: Included in Senate Democratic caucus bill. House Republicans (Diaz-Balart and 7 others) sent letter to Hastert urging inclusion of the provisions in any givebacks legislation on 10/6/00. A bipartisan letter will be sent to Lott, Daschle, Hastert,

Gephardt and the President this week. H.R. 4707, sponsored by Diaz-Balart and Waxman, has 60 co-sponsors. S. 1227, sponsored by Chafee and Graham, has 12 co-sponsors. Included in FamilyCare bills (Senate bill had 3 Republican co-sponsors: Chafee, Collins, and Snowe).

- Other Support: Governor Jeb Bush of Florida has written two letters in support of the restoration (5/11/00, 9/27/00). Governor Davis of California is also writing a letter of support. Letter from hospital groups in support (9/6/00) (AHA, AAMC, CHA, Federation, NACH, NAPH). Letter from several hundred health and children's groups (5/23/00).

Arguments against 2 year provision.

OTHER PROVISION: RICKY RAY
Mandatory Funding of Ricky Ray Trust Fund

Administration Midsession Review Provision

- Provide mandatory funding of \$570 million to Ricky Ray Trust Fund in FY 2001.
Cost: \$0.6 billion/1, \$0.6 billion/5, \$0.6 billion/10

*over
over
Labor HHS
request?*

Congressional Provisions

- Senate Finance: None
- House W&M: None
- House Commerce: None

What is full funding?

Administration Position: Support MSR Proposal

Legislative History

- In November, 1998, the Ricky Ray Hemophilia Trust Fund was authorized for \$750 million to provide one-time \$100,000 relief payments to up to 7,500 persons with hemophilia (or their survivors) who contracted HIV while receiving blood clotting factor between 1982-1987. The fund is scheduled to sunset on November 12, 2003. Any funds not paid at that time are returned to the Treasury.
- In FY 2000, \$75 million was appropriated in Labor/HHS.
- President has asked for \$100 million in Labor/HHS discretionary funding in FY 2001. Should get \$105 million in Labor/HHS.

Arguments For:

- The Ricky Ray Trust Fund was established by Congress with overwhelming bipartisan support and we should fulfill the promise made to affected individuals and their families.
- 7,500 individuals and their families have been awaiting financial relief for as long as 18 years. On July 31, 2000, HRSA began accepting petitions for the Ricky Ray Trust Fund. As of September 30, 2000, HRSA has already received 5,286 applications. Only \$68 million is now available for distributions (payments began August 31, 2000) for a total of 670-680 payments. Payments are made on a first-come first-serve basis (if post-marked on the same day, petitions are ordered based on a lottery system). HRSA has made 491 payments (on 400 petitions) as of September 30, 2000.
- Ricky Ray's own family have not yet received payments (Robert, a brother, is #500; Randy, a brother is #3,600; Ricky Ray's parents, on behalf of Ricky Ray, are #3,200).

*Why if
fund start
in 78?*

*how many
of
numbers?*

Comments

- Congressional Support: Included in Senate Democratic caucus bill. DeWine, McCain and Jeffords and about a dozen Democratic Senators including Graham sent letter to Lott and Daschle on 10/6/00. Waxman, Dingell and Brown sent letter of support to Gephardt on 10/3/00. Original Ricky Ray Trust Fund legislation had 270 co-sponsors in the House (Goss) and 60 co-sponsors in the Senate (DeWine). Legislation passed with unanimous consent in House and Senate.

Full funding still?

Are we lobbying in Senate.

OTHER PROVISION: MiCASSA Grant
Systems Grants to States to Build Up Infrastructure for Community Care

Congressional Provisions

- Senate Finance: None
- House W&M: None
- House Commerce: None

Administration Position:

- Provide mandatory funding of \$50 million in FY 2001 for System Grants to States to develop infrastructure that supports community based care for persons with disabilities. States must work with a consumer task force and may use the grants to support needs assessment, reduce institutional bias, enhance interagency coordination, support public awareness, offset per capita fixed costs to move persons into the community, and cover transitional costs.

Cost: \$0.05 billion/1, \$0.05 billion/5, \$0.05 billion/10

Any state support?

Legislative History

- None

no bills at all? where is the disability community?

Arguments For:

- Persons with disabilities should have real choice in where they want to live, receive needed services, in what services they receive, and from whom they are obtained.
- This is consistent the Supreme Court's Olmstead decision which found that under the ADA states must provide care to persons with disabilities in the most integrated setting appropriate to their needs, rather than only in institutions.
- Focusing on community care rather than institutional care is cost-effective. Care in a nursing home may cost as much as \$55,000 per year.

Comments

- Congressional Support: Included in Senate Democratic caucus bill. Harkin primary supporter (he has sponsored the Medicaid Community Attendant Services and Supports Act of 1999 which has 2 co-sponsors). Number one priority for disability community.

where are they?

Can we define problem better?

COVERAGE PROVISION: CHILDREN WITH DISABILITIES

Family Opportunity Act

Congressional Provisions

- Senate Finance: None
- House W&M: None
- House Commerce: None

Administration Position:

- Support Family Opportunity Act. Provision would permit state option to permit families with children with disabilities to buy into Medicaid if they exceed SSI income (up to 600 percent of poverty) or resource limits. Also, permits 1915(c) waivers for psychiatric level of care, demonstration for children with potentially severe disabilities, and family-to-family information centers on children with special health care needs.

Cost: \$0.2 billion/1, \$3.9 billion/5, \$11.3 billion/10

Legislative History

- None.

*Rev'd at 1 person →
30% of poverty?*
like TH

Arguments For:

- GAO has determined that children with special health care needs are three times more likely to be ill, three times more likely to miss school, and twice as likely to have unmet health care needs. They use more than five times the number of hospital days as other children.
- Parents are foregoing additional income (jobs, promotions, raises) to maintain Medicaid eligibility. They are also placing their children in institutions, or giving up their children to the State because then only the child's income is counted (i.e. zero). According to GAO, in 27 states, custody relinquishment has occurred as a means of ensuring health care coverage for these children. Medicaid's benefit package meets the special health care needs of children with disabilities (personal supports, therapy, EPSDT).
- According to GAO, private insurance is not available or does not provide sufficient benefits for children with special health care needs, especially for lower-income families. Only 55 percent of low-wage employees had access to employer-sponsored health coverage and in the individual market, some carriers deny coverage for conditions such as autism, cerebral palsy, Downs syndrome, and epilepsy. Coverage often limits the number and types of services available, such as therapy and mental health services.
- GAO and States support the buy-in option. → *NBA or cobble?*
explicitly?

Comments

- Congressional Support: S. 2274, sponsored by Grassley and Kennedy, has 77 co-sponsors. H.R. 4825 sponsored by Sessions and Waxman has 125 co-sponsors.
- Other Support: High priority of disability community. Supported by hundreds of disability, children, and health groups.

*↓
where are they?*

**OTHER PROVISION: Nursing Home Quality
Grants to States for Staffing Ratio Improvements**

Congressional Provisions

- Senate Finance: None
- House W&M: None
- House Commerce: None

Administration Position:

- Establishes competitive grant program to States to increase staffing levels by enhancing staff recruitment and retention, increasing training, and reward nursing facilities with good records. 75 percent reserved for states below 2.0 nurse aide staff ratio; 25 percent reserved for states above 2.0 ratio. Impose immediate CMPs through withholding reimbursement; reinvests CMPs in grant program; and requires public information about staffing ratios. Direct HCFA to develop minimum staffing ratios.

Cost: \$0.2 billion/1, \$1.0 billion/5, \$1.0 billion/10

Legislative History

- None

Arguments For:

- GAO determined that more than 25 percent of nursing homes had deficiencies that caused actual harm to residents or placed them at risk of death or serious injury. Many attribute staffing ratios contribute to deficiencies.
- HCFA has determined that the minimum staffing level associated with reducing likelihood of quality of care problems such as pressure sores, weight loss, and unnecessary hospitalizations is about 2.0 hours per resident per day for nurse aides. Optimal care was about 2.9 hours per resident per day.
- Commonwealth Fund believes that increased staffing ratios at meal times would contribute to less dehydration and malnutrition. Determined that 35-85 percent of nursing home residents are malnourished with 30-50 percent substandard in body weight. Malnourished and dehydrated residents have a five fold increase in mortality when admitted to a hospital.
- Providers complain of poor recruitment and retention – 93 percent turnover among nurse aides.
- GAO found that lack of immediate enforcement of CMPs undermines enforcement of federal nursing home safety standards.

Comments

- Congressional Support: Supported by Grassley, Breaux, Gephardt, Waxman, and Stark.

Dwork?

DRAFT: Committee Provisions: October 8, 2000

PROVISION	PROPOSAL	CBO 2001	CBO 5 Year	CBO 10 Year	Support	House W & M	House Commerce	Senate Finance	Conf. Report
HOSPITALS									
PPS Market Basket Update	Full Market Basket in 2001	\$0.6	\$3.8	\$10.6	MSR	X			
	Full Market Basket in 2001, 2002	\$0.6	\$6.2	\$16.4					
	Full Market Basket in 2001 and 2002, MB - 1% in 2003	\$0.6	\$4.0	\$9.8	X			X	
	Full Market Basket in 2001, MB - .55% in 2002, 2003	n/a	n/a	n/a					X
IME	IME Freeze at 6.5% in 2001	\$0.0	\$0.1	\$0.1	MSR				
	IME Freeze at 6.5% in 2001, 2002	\$0.1	\$0.6	\$0.6	X			X	
	IME Freeze at 6.5% in 2001, 6.25% in '02	\$0.0	\$0.2	\$0.2		X			
	IME Freeze at 6.5% in 2001, 6.375% in '02	n/a	n/a	n/a					X
Medicare DSH	Removal of 3% in 2001	\$0.1	\$0.2	\$0.2	MSR				
	Reduction to 2% in 2001, 3% in 2002	\$0.1	\$0.1	\$0.1	X	X		X	
Puerto Rico Hospitals	Permanent adjustment to 75/25	\$0.0	\$0.1	\$0.3	MSR	X		X	
Rehabilitation Hospitals	Increase payments by 2% in 2001 to 100% of pre-BBA payments	\$0.1	\$1.0	\$2.6		X		X	X
Long-Term Care Hospitals	Require HCFA to use DRGs if do not implement alternative PPS by 10/1/02	\$0.0	\$0.0	\$0.0				X	X
	Increase national cap by 2% and 25% increase in others' targets. Not into PPS.	\$0.2	\$0.3	\$0.3		X			
Psychiatric Hospitals	Increases bonus incentive payments to 3% from 2% in 2001.	\$0.0	\$0.0	\$0.0		X			X
Bad Debt	10 year phase in of bad debt reimbursement from 55% to 100%	\$0.1	\$0.8	\$2.7	Oppose		X		
	10 year phase in of bad debt reimbursement from 55% to 70%	n/a	n/a	n/a	Oppose				X
	Increase bad debt reimbursement to 60% over 5 years for QMBs	\$0.0	\$0.4	\$1.2	OK	X			
New Technology DRGs for Hospitals	Revise coverage process for medical drugs, devices; new DRGs for new drugs, devices	\$0.0	\$0.0	\$0.0	Oppose	X			
Needlestick Safety	Apply OSHA standards to public hospitals	n/a	n/a	n/a		X			
Transitional Corridor for OPD PPS	For those hospitals without 1996 cost report	\$0.0	\$0.1	\$0.1		X		X	
Outpatient PPS	Full MB in 2001	\$0.1	\$0.4	\$1.1		X			
Outpatient PPS Vicinity Requirement	Delay implementation until 7/10/01	\$0.0	\$0.0	\$0.0	Oppose			X	

DRAFT: Committee Provisions: October 8, 2000

PROVISION	PROPOSAL	CBO 2001	CBO 5 Year	CBO 10 Year	Support	House W & M	House Commerce	Senate Finance	Conf. Report
Outpatient PPS Pass-Through	Would exclude pass-through drugs based on category rather than individual devices	n/a	n/a	n/a		X	X	X	
	Clarifies that contrast media agents are included in pass-through.	\$0.0	\$0.0	\$0.1			X	X	
Children's Hospitals OPD	Exclude Children's Hospitals from PPS	\$0.0	\$0.0	\$0.0		X			
	Hold harmless from OPD PPS	\$0.0	\$0.0	\$0.0				X	
Geographic Reclassification	Reclassify for labor costs to other departments affiliated with hospital	\$0.0	\$0.2	\$0.6			X		
	Reclassification effective for 3 yrs; permit termination of classification; other changes	\$0.0	\$0.0	\$0.0		X			
GME	Increase floor to 85% of adjusted national average	\$0.1	\$0.4	\$0.9	OK	X			X
	Adjust formula for allied and nursing costs and M+C utilization and other hospitals	n/a	n/a	n/a		X			
	Include costs of clinical psychologists.	\$0.0	\$0.1	\$0.2				X	
	Limits would only include residents in allopathic and osteopathic medicine	\$0.0	\$0.1	\$0.3		X			
RURAL HOSPITALS AND PROVIDERS									
MDH Program	Permanent extension of Medicare Dependent Hospital program	\$0.0	\$0.0	\$0.1			X		
	Changing cost reporting periods for MDHs	\$0.0	\$0.0	\$0.1		X	X	X	
Swing Beds	Permanent exclusion from SNF PPS	\$0.0	\$0.2	\$0.8		X		X	
Lab Reimbursement	Grandfathering independent lab reimbursement outside DRGs	\$0.0	\$0.0	\$0.1	Oppose	X	X	X	
Community Access Hospitals (CAH)	120 percent of fee schedule for outpatient professional services	\$0.0	\$0.1	\$0.1				X	
	All inclusive rate for CAH outpatient services to 110%	\$0.0	\$0.0	\$0.0		X			
	Excluding CAH lab services from fee schedule requirement and no cost-sharing	\$0.0	\$0.1	\$0.1		X		X	
	Consider reasonable costs of ER on-call physicians	\$0.0	\$0.1	\$0.1		X			
	Pay ambulances provided by CAH on reasonable cost basis	\$0.0	\$0.1	\$0.1		X			
	Permit CAHs to operate PPS exempt distinct part rehabilitation, psych units	\$0.0	\$0.2	\$0.4		X		X	

DRAFT: Committee Provisions: October 8, 2000

PROVISION	PROPOSAL	CBO 2001	CBO 5 Year	CBO 10 Year	Support	House W & M	House Commerce	Senate Finance	Conf. Report
Sole Community Hospitals	Rebasing payments for Sole Community Hospitals	\$0.0	\$0.1	\$0.3		X		X	
Rural Medicare DSH	Modification to Medicare DSH for rural hospitals at 15 percent threshold	\$0.2	\$0.9	\$2.1		X		X	
Rural Home Health	10% bonuses for rural HHAs for 2001, '02	\$0.1	\$0.3	\$0.3				X	
Rural Health Clinics	Grandfather ownership by physician assts	\$0.0	\$0.0	\$0.0				X	
	Modify payments by cap exemption	\$0.1	\$0.4	\$0.9		X		X	
Rural Hospital Transition to PPS	Grant program for rural hospitals transitioning to PPS	\$0.0	\$0.0	\$0.0		X			
Rural Ambulances	Increase mileage payments for ambulance trips originating in rural areas that are greater than 17 miles and up to 50 miles	\$0.0	\$0.1	\$0.1		X			
Telemedicine	Demonstration limited to rural HPSA	\$0.0	\$0.0	\$0.0	Prefer limited approach	X			
	Expansion for more sites and all areas	\$0.0	\$0.2	\$2.2			X		
	Expansion (fee schedule plus facility fee, loosen requirements) all areas, transition for new sites	\$0.0	\$0.1	\$1.0					X
	Permit use for home health services	\$0.0	\$0.0	\$0.0			X		
HOME HEALTH									
15 Percent Cut	Delay another year to 2003	\$0.0	\$0.7	\$0.7	MSR	X	X	X	X
	Delay two years to 2004	\$0.0	\$2.5	\$2.5	X				
Market Basket Update	Full update in 2001	\$0.1	\$0.6	\$1.5	MSR; prefer 2 nd yr delay	X		X	
	Full Market Basket in 2001, MB - .55% in 2002, 2003	n/a	n/a	n/a					
Home Health PPS	Delay including medical supplies 18 mos	\$0.0	\$0.0	\$0.0				X	
Periodic Interim Payment	HHA can receive PIPs until 12/1/00	\$0.1	\$0.0	\$0.0		X			
Outlier Payments	Provide additional outlier payments of \$150 million in 2001, 2002	\$0.2	\$0.3	\$0.3				X	
Definition of Homebound	Permitting adult day care visits for Alzheimers or related dementia, and medical services	\$0.0	\$0.2	\$0.7	X		X		
	Permitting adult day care visits, family visits, and religious services	\$0.0	\$0.3	\$1.4	X			X	
Branch Office	Permit services to be provided at branch offices under regulations	\$0.0	\$0.0	\$0.0		X	X	X	

DRAFT: Committee Provisions: October 8, 2000

PROVISION	PROPOSAL	CBO 2001	CBO 5 Year	CBO 10 Year	Support	House W & M	House Commerce	Senate Finance	Conf. Report	
SKILLED NURSING FACILITIES										
Market Basket Update	Full update in 2001	\$0.0	\$0.4	\$1.0	MSR	X				
	Full update + 1% in 2001, 2002	\$0.1	\$1.5	\$4.0					X	
	Full Market Basket in 2001, MB - .55% in 2002, 2003	n/a	n/a	n/a						
Delay of Therapy Caps	Moratorium in 2002	\$0.0	\$0.2	\$0.2	MSR	X	X		X	
	Moratorium until 18 mo after HHS report	\$0.0	\$0.7	\$0.7						X
PPS Federal Rate	Increase nursing component of RUG by 5% in 2001	\$0.1	\$0.3	\$0.3	Prefer Our NH Grant Policy	X			X	
Rehabilitation RUGs	Increase rehab RUGs by 6.7%	\$0.0	\$0.0	\$0.0	Oppose	X				
Consolidated Billing	Limit consolidated billing to Part A residents and therapy for Part A, B stays	\$0.0	\$0.0	\$0.0		X		X		
	3-year delay on Part B consolidated billing	\$0.0	\$0.0	\$0.0			X			
HOSPICE										
Market Basket Update	Full update in 2001, repeal BBRA increase of .5% in 2001, .75% in 2002	\$0.0	\$0.1	\$0.9	X OK	X				
	Full update in 2001, 2002	\$0.1	\$0.7	\$1.6						
	Full update + 1% in '01, '02, repeal BBRA	\$0.0	\$0.4	\$1.1					X	
	Full Market Basket in 2001, MB - .55% in 2002, 2003	n/a	n/a	n/a						
Physician Certification	Clarification so that terminally ill is based on clinical judgment of physician	\$0.0	\$0.0	\$0.0		X				
Demonstration Project	Study adding services to hospice benefit	\$0.0	\$0.2	\$0.2				X		
PHYSICIANS										
Physician Group Demonstration	Provide incentives for fee-for-service group practice to coordinate care	\$0.0	\$0.0	\$0.0			X			
Intervention Pain Management Specialists	Designates as new category of physician specialists	\$0.0	\$0.0	\$0.0			X			
AMBULATORY SURGICAL CENTERS										
Market Basket Update	Full update in '01 when PPS implemented	\$0.0	\$0.0	\$0.0		X				
PPS	Extends phase in to 4 years from 3 years	\$0.0	\$0.0	\$0.0			X	X		
DURABLE MEDICAL EQUIPMENT										
DME/Oxygen/Orthotics/ PEN Updates	Update at CPI in 2001	\$0.1	\$0.5	\$1.1				X		

DRAFT: Committee Provisions: October 8, 2000

PROVISION	PROPOSAL	CBO 2001	CBO 5 Year	CBO 10 Year	Support	House W & M	House Commerce	Senate Finance	Conf. Report
DME Update	Full update in 2001	\$0.0	\$0.1	\$0.1		X			
Orthotics/Prosthetics Market Basket Update	Full update in 2001 and 2002	\$0.0	\$0.1	\$0.2		X			
Orthotics/Prosthetics Replacement	Permit replacement when medically necessary	n/a	n/a	n/a				X	
Orthotics/Prosthetics Customized Supplier	Set certification standards for customized orthotic suppliers	\$0.0	\$0.2	\$0.7		X			
AMBULANCE									
Market Basket Update	Full update in 2001, 2002 + mileage	\$0.0	\$0.2	\$0.5			X		
	CPI adjustment in 2001	\$0.0	\$0.1	\$0.2		X			
	Full update + 1% in '01, full update in '02	\$0.0	\$0.2	\$0.6				X	
Fee Schedule	Elect to bypass fee schedule phase-in	\$0.0	\$0.0	\$0.0				X	
MEDICARE+CHOICE									
Commerce Package	Direct	\$0.8	\$6.2	\$18.4	Oppose large dollar amounts		X		
	Indirect	\$0.0	\$1.4	\$6.5					
	TOTAL	\$0.8	\$7.6	\$24.9					
Senate Finance Package	Direct	\$0.3	\$4.4	\$15.0				X	
	Indirect	\$0.0	\$4.6	\$14.5					
	TOTAL	\$0.3	\$9.0	\$29.5					
W&M Package	Direct	\$0.9	\$8.4	\$35.3		X			
	Indirect	\$0.0	\$4.7	\$17.7					
	TOTAL	\$0.9	\$13.1	\$53.0					
Conference Report	Direct	n/a	n/a	n/a					X
	Indirect	n/a	n/a	n/a					
	TOTAL	n/a	n/a	n/a					
Floor Payment	Increase to \$475 in rural , MSAs \$575	n/a	n/a	n/a			X		
	Increase payment amounts to \$425, \$475 in areas with more than \$250,000 MSA	n/a	n/a	n/a				X	
	Increase to \$450 in all counties	n/a	n/a	n/a		X			
Minimum Update	Increase minimum update in 2001 to 4%	n/a	n/a	n/a		X			
	Increase minimum update in 2001 to 3%	n/a	n/a	n/a			X		
Annual Update	Eliminate reductions in 2001, 2002	n/a	n/a	n/a		X		X	
Budget Neutrality	Eliminate budget neutrality in 2002	n/a	n/a	n/a		X		X	
Plan Bonuses	Increased update of .5% in areas with only one plan (above entry bonus)	n/a	n/a	n/a		X		X	
Negotiated Rate	Permit negotiated rates	n/a	n/a	n/a		X			

DRAFT: Committee Provisions: October 8, 2000

PROVISION	PROPOSAL	CBO 2001	CBO 5 Year	CBO 10 Year	Support	House W & M	House Commerce	Senate Finance	Conf. Report
Risk Adjustments	10 year risk adjustment phase-in Permit full risk adjustment for enrollees with congestive heart failure	\$0.0 \$0.0	\$0.0 \$0.0	\$0.0 \$0.0	Oppose	X	X	X X	
Blended Rate	Elect 50:50 blend in 2001	\$0.0	\$0.0	\$0.0		X		X	
DSH Payments	Carve out DSH payments from M+C	\$0.0	\$0.0	\$0.0	Budget				
Extended Care	Permit beneficiary to choose SNF to receive extended care services	\$0.0	\$0.0	\$0.0		X			
Frail Elderly	Exempt from risk adjustment; require Secretary to establish new payment system	\$0.0	\$0.0	\$0.0				X	
ESRD M+C Rate	Adjust rates for risk	\$0.0	\$0.0	\$0.0		X		X	
ESRD M+C Withdrawal	Permit reenrollment in new plan if plan drops coverage	\$0.0	\$0.0	\$0.0				X	
Premium Reductions	Permit Part B premium reductions as additional benefit under M+C	\$0.0	\$0.0	\$0.0				X	
Transition for Revised Rates	Plans that withdrew may reenter the program upon changes to M+C rates	\$0.0	\$0.0	\$0.0			X		
Elections	Elections are effective month when made	\$0.0	\$0.0	\$0.0			X	X	
Compatibility with Employer, Union Plans	Makes it easier to offer retiree benefits through M+C	\$0.0	\$0.0	\$0.0			X		
Permitting Variation in Premiums	Allow plans to vary premiums across counties within service area	\$0.0	\$0.0	\$0.0	Oppose		X		
Administrative Changes	Permit uniform coverage policy for multistate plan	\$0.0	\$0.0	\$0.0				X	
	Miscellaneous: timely approval of marketing materials, no duplicative regulation, uniform coverage policy	n/a	n/a	n/a		X			
Return to SNF choice	Guarantee SNF choice	n/a	n/a	n/a		X			
Medigap Interaction	Nondiscrimination for those leaving M+C	n/a	n/a	n/a				X	
Education Funds	\$115 million per year (adjusted for inflation) for enrollment education efforts	\$0.1	\$0.5	\$1.0				X	
VA/DOD Cost	Adjust to include costs associated with VA subvention sites	\$0.1	\$0.4	\$1.2	Oppose?			X	
Cost Contractors	Expand service areas, permit new enrollees	\$0.0	\$0.0	\$0.0				X	
Plan Participation	Move election date to November	\$0.0	\$0.0	\$0.0				X	
BENEFICIARY									
Preventive Services	Waive all cost sharing	\$0.0	\$1.0	\$3.3	Budget				

DRAFT: Committee Provisions: October 8, 2000

PROVISION	PROPOSAL	CBO 2001	CBO 5 Year	CBO 10 Year	Support	House W & M	House Commerce	Senate Finance	Conf. Report
Hospital Outpatient Copayments	Accelerate buydown to 60% in 2001, reduce by 5% each year from 2002-2004 until 45% in 2004. Extend Part A deductible limit to all services within day	\$0.2	\$2.8	\$8.4	X	X			
	Cap coinsurance to 50% Part A deductible	\$0.4	\$2.8	\$6.2				X	X
Immunosuppressive Drug Coverage Extension	Increase to 48 months	\$0.0	\$0.3	\$0.3	Budget				
	Eliminate time limits	\$0.1	\$0.6	\$1.5	X	X	X		
	Cover all beneficiaries with covered treatments and ESRD immediately, cover others within 3 years	\$0.1	\$0.6	\$1.9				X	X
Medicare for Workers w/ Disability	Extend Medicare coverage to working disabled permanently	\$0.0	\$0.0	\$0.3	Budget				
Colonoscopy	Election of periodic colonoscopies for average risk beneficiaries	\$0.0	\$0.1	\$0.2	X	X	X	X	
Nutrition Therapy	Coverage for beneficiaries with diabetes or renal disease. No limits.	\$0.0	\$0.3	\$0.6		X			
	Coverage for beneficiaries with diabetes, cardiovascular, or renal disease. Limit to 6 visits with 20% copayments	\$0.1	\$1.0	\$2.4				X	
	Coverage for beneficiaries with diabetes or renal disease. Limit to 6 visits with 20% copayments.	n/a	n/a	n/a					X
	5 year demonstration project	\$0.0	\$0.2	\$0.3	Prefer demo		X		
Pap Smears	Clarifies availability to all women each year for pap smears and pelvic exams	\$0.1	\$0.8	\$1.9		X			
	Increases frequency of pap smears and pelvic exams to 2 years from 3 years	\$0.0	\$0.4	\$1.0				X	
Glaucoma Screening	Create new benefit with no cost sharing	\$0.2	\$1.2	\$2.4		X			X
ALS Coverage	Waive 24 month SSDI waiting period for ALS (Lou Gehrig's disease) patients	\$0.0	\$0.3	\$0.7	X		X		
OTHER MEDICARE									
ESRD Composite Rate	Increase to 2.4% in 2001	\$0.0	\$0.2	\$0.4	MSR	X	X	X	X
Diabetes Training Programs	State accreditation of diabetes self-management programs	\$0.1	\$0.3	\$0.7			X	X	

DRAFT: Committee Provisions: October 8, 2000

PROVISION	PROPOSAL	CBO 2001	CBO 5 Year	CBO 10 Year	Support	House W & M	House Commerce	Senate Finance	Conf. Report
Indian Health Service	Permit freestanding clinics under IHS to receive Part B payments for covered services to Medicare beneficiaries	\$0.0	\$0.0	\$0.0				X	
Mammography	Coverage of new mammography technologies at 150% of rate	\$0.0	\$0.4	\$1.2	Oppose	X			X
	Increase payment for digital mammography by \$15 beginning in 2001	\$0.0	\$0.1	\$0.2	OK		X		
Clinical Lab Tests	Limitation equal to 100 percent of national media for new tests	\$0.0	\$0.0	\$0.1	Support		X	X	
Social HMOs	Extend waivers through 2001	\$0.0	\$0.0	\$0.0		X			
Community Nursing	Extension/modification of CNO demo	\$0.0	\$0.0	\$0.0		X		X	
Municipal Health Services Demonstrations	Extend additional two years to 2004	\$0.0	\$0.0	\$0.0		X			
Medical Errors	Require PROs to target medical errors	\$0.0	\$0.2	\$0.4	OK		X		
Part A Late Enrollment Penalty	No penalty for state employees for late enrollment	n/a	n/a	n/a		X			
Drug, Device Coding	HCPCS Coding Changes	\$0.0	\$0.7	\$3.1	Oppose	X			
Coverage and Appeals Process	New appeals process for coverage, eliminates HCFA review of PRRB decisions, speeds up appeals process, etc	\$0.0	\$0.5	\$2.7	Oppose	X			X
Advisory Opinions	Reauthorize advisory opinion process	\$0.0	\$0.0	\$0.0		X	X	X	
VA Subvention	Expand Medicare coverage of services provided at VA facilities	\$0.0	\$0.2	\$0.6	Oppose				
Disease Management	Demo with 3 organizations to provide care to severely chronically ill beneficiaries	\$0.0	\$0.0	\$0.0	Budget	X			
Part B Drugs AWP Reimbursement	Precludes administrative action until completion of BBRA/GAO study	\$0.0	\$0.0	\$0.0	Oppose: Program integrity	X			
	Precludes HCFA action for one year on outpatient drug reimbursement.	\$0.0	\$0.1	\$0.1					X
	Specifies drugs paid on assignment	\$0.0	\$0.1	\$0.2			X		
Part B Drugs Coverage of Self Administrable	Coverage of drugs and biologicals if not usually self-administrable	\$0.1	\$1.1	\$4.8	OK	X	X		X
	Coverage of self-injected, infusable drugs if not usually self-administrable. Clarifies pre-1997 policy. Not until report released.	\$0.0	\$0.3	\$0.7					X

MEDICAID/S-CHIP

DRAFT: Committee Provisions: October 8, 2000

PROVISION	PROPOSAL	CBO 2001	CBO 5 Year	CBO 10-Year	Support	House W & M	House Commerce	Senate Finance	Conf. Report
Legal Immigrants (Medicaid and S-CHIP)	Extension of state option for legal immigrant pregnant women and children	\$0.0	\$0.6	\$1.6	Budget				
	Extension of SSI for disabled immigrants	\$0.0	\$1.3	\$8.8	Budget				
	State option but only after 2 years of ban	\$0.0	\$0.5	\$1.4	Prefer Budget		X		
Eligibility Simplification	Alignment of CHIP/Medicaid procedures	\$0.0	\$1.6	\$4.0	Budget				
Presumptive Eligibility	Expand eligible entities	\$0.1	\$0.5	\$1.1	Budget		X		
	Permit presumptive eligibility under CHIP	\$0.0	\$0.0	\$0.1				X	
	No longer draw down from CHIP funds for presumptive eligibility	\$0.0	\$0.0	\$0.1	Budget			X	
Transitional Medical Assistance	Lift sunset and simplify TMA	\$0.0	\$1.6	\$4.8	Budget				
	Extend sunset one year and simplify TMA	\$0.0	\$0.5	\$0.5	OK		X		
Medicaid DSH	Freeze at 2000 levels for 2001	\$0.3	\$0.3	\$0.3	(MSR)			X	
	Increase State Caps and Hospital Caps to 175%	\$0.3	\$5.0	\$10.0	X				
	Freeze at 2000 levels in 2001 with CPI adjustments in 2001	\$0.3	\$3.2	\$8.1			X		
	Increase DSH allotment to 1% of Medicaid expenditures if currently less than 1%	\$0.1	\$0.3	\$0.6			X		
	Permit Tennessee to have same allotment if TennCare is revoked or terminated	\$0.1	\$0.3	\$0.6			X		
	Change D.C. Allotment to \$49 million	\$0.0	\$0.1	\$0.2			X		
QMB/SLMB (includes Medicare costs)	Make available QMB/SLMB uniform application forms at SSA offices	\$0.0	\$0.9	\$5.4			X		
QI-1 Program	Permanent extension of QI-1 program	\$0.0	\$0.1	\$0.2	Budget: w/o Cap			X	
FQHCs	Establish PPS in 2001	\$0.0	\$0.4	\$1.1	OK		X	X	
Disabled Children	Family Opportunity Act	\$0.2	\$3.9	\$11.3	X				
Alaska FMAP	Modifies calculation of Alaska's FMAP	\$0.0	\$0.2	\$0.2	Oppose			X	
Homeless Children	FY 2001 coordination grants	\$0.01	\$0.01	\$0.01	Budget				
Smoking Cessation	Medicaid mandatory coverage	\$0.0	\$0.07	\$0.15	Budget				
County Organized Health Systems (CA)	Increase enrollment from 10 to 14 percent	\$0.0	\$0.0	\$0.1	Oppose		X		
Physician Assistants	Recognize as Medicaid providers	\$0.0	\$0.1	\$0.2			X		

DRAFT: Committee Provisions: October 8, 2000

PROVISION	PROPOSAL	CBO 2001	CBO 5 Year	CBO 10 Year	Support	House W & M	House Commerce	Senate Finance	Conf. Report
PACE Program	Extend waiver period to 36 months and states for 4 years, continuation of existing arrangements, and increased flexibility	n/a	n/a	n/a		X			
1115 Waiver Process	Modify renewal process	\$0.0	\$0.0	\$0.0	Oppose			X	
Disability LTC Option	Extend option to 300% of SSI levels	\$0.0	\$0.4	\$1.3	Budget				
Age Expansion	Children 19, 20 under Medicaid and CHIP	\$0.1	\$0.9	\$2.1	Budget				
CHIP Allotments	CHIP reallocation formula	\$0.0	\$0.0	\$0.1			X	X	X
OTHER									
Nursing Home Quality	State grants for improving staffing ratios	\$0.2	\$1.0	\$1.0	X				
Juvenile Diabetes / Indian Health Services	Extend for 5 years at total \$60 m / year	\$0.0	\$0.2	\$0.3	MSR				
	Extend for 5 years at total \$100 m / year	\$0.0	\$0.2	\$0.5	X		X		
	Add \$140 m / year in 2001, 2002	\$0.0	\$0.3	\$0.3	X			X	
Ricky Ray Trust Fund	Mandatory funding in 2001	\$0.6	\$0.6	\$0.6	MSR				
Long Term Care	MiCASSA Systems grants in FY 2001	\$0.05	\$0.05	\$0.05	X				
Title V MCH Program	Increase authorization to \$1.0 b; require links with Medicaid and CHIP	\$0.0	\$0.0	\$0.0				X	

REPUBLICAN LEADERSHIP MEDICARE PLAN REJECTS BIPARTISAN POLICIES THAT REFLECT PEOPLE'S PRIORITIES

REPUBLICAN LEADERSHIP CRAFTED PARTISAN MEDICARE PLAN

- **Republican Leadership – Not Bipartisan -- Proposal.** Rather than conducting a bipartisan, bicameral conference, the Republican Leadership met behind closed doors to develop their Medicare / Medicaid legislation. Not only were Democrats totally excluded but they:
 - Rejected beneficiary priorities included in the bipartisan House Commerce Committee bill
 - Had no Senate Finance Committee process, no input from Senate Democrats.
- **Republican Leadership's Position: Take It or Leave It.** Instead of working in a cooperative, bipartisan process, the Republican Leadership has stated, "This measure is done. All the president has to do it sign it. We don't need another version." [Rep. Bill Thomas, *NYT*, 11/1/00] This is despite the fact that critical bipartisan priorities were dropped from the bill.

INCLUDES UNACCOUNTABLE, UNWARRANTED HMO PAYMENT INCREASES

- **Over One-Third of Allocation to HMOs.** The Leadership plan increases payments to Medicare HMOs by \$11 billion over 5 years and \$34 billion over 10 years – despite the fact that only 16 percent of Medicare beneficiaries are enrolled in HMOs.
- **No Meaningful Guarantee of Increased Access to Plans.** The Republican Leadership relies on a "trickle down" approach of giving large sums of money to HMOs and hoping – not requiring -- that they stay in Medicare in return. Their bill includes no guarantee that plans will not drop out of communities altogether even after receiving a payment increase.

EXCLUDES BIPARTISAN BENEFICIARY AND PROVIDER POLICIES

- **Excludes Bipartisan Family Opportunity Act for Children with Disabilities.** Children with disabilities have special health care needs; they are three times more likely to be ill and use five times the number of hospital days as other children. Because private insurance is often inaccessible or unaffordable for people with disabilities, over 60 percent of the thousands of parents of children with special needs children are turning down jobs, raises, and overtime to keep their income low enough that their children qualify for Medicaid. This bill would establish a new Medicaid buy-in option for children with disabilities in families with income up to 300 percent of poverty (\$42,000 for a family of three). This bill which costs \$2.1 billion over 5 years – less than one-fifth of the managed care investment – has 78 cosponsors in the Senate (S. 2274) and 140 cosponsors in the House (H.R. 4825).
- **Excludes Beneficiary Policies in Bipartisan Commerce Committee Plan.** The Republican Leadership chose to reject most of the beneficiary provisions designed and supported unanimously by House Commerce Committee Republicans and Democrats. These provisions altogether cost only \$2.7 billion over 5 years – one-fourth of what the Republican Leadership plan spends on managed care payment increases. Excluded provisions are:

- **Increasing access to cost-sharing assistance for low-income Medicare beneficiaries.** This bipartisan proposal would help millions of poor and near-poor seniors reduce their Medicare premiums and cost sharing by making it easier to enroll in assistance programs. About 55 percent of Medicare beneficiaries eligible for this assistance do not receive it. These beneficiaries tend to be older women living alone and Hispanic elderly who have difficulty navigating the long and complex applications.
- **Increasing enrollment of uninsured children through schools and other sites.** While the Children's Health Insurance Program contributed to the one million drop in the number of uninsured children last year, 6.3 million children remain uninsured and are potentially eligible for CHIP and Medicaid. This proposal would give states the option to enroll uninsured children in Medicaid in schools, child care referral centers and other sites where these uninsured children are likely to be found. Over half of parents believe that this presumptive eligibility option is the best way to encourage enrollment. Since an estimated 4 million uninsured children are in the school lunch program, allowing schools to help enroll children in health insurance can have a great impact. This proposal has both bipartisan Commerce Committee support and 143 cosponsors (H.R. 827).
- **Restoring Medicaid and CHIP eligibility for children and pregnant women.** Even though legal immigrants pay taxes like other citizens, children and pregnant women who are legal immigrants are not eligible for health insurance through Medicaid or CHIP for 5 years. This inequity created by welfare reform contributed to a 22 percent decline in Medicaid/CHIP coverage of legal immigrant children between 1995 and 1999. Nearly half of immigrant children lack a regular source of health care, often ending up in expensive emergency rooms. Not only does expanding coverage to legal immigrant pregnant women and children have bipartisan Commerce Committee approval, but Governors Jeb Bush, Whitman, Cellucci, Mayor Giuliani, and major health and state associations support it.
- **Extending Medicaid for people moving from welfare to work.** Created in 1988 but expiring by 2002, transitional Medicaid allows people who have increased income due to work to temporarily keep health coverage even though they are no longer Medicaid-eligible. Individuals leaving welfare often are in entry-level jobs that do not offer health insurance to new, low-wage or part-time workers. However, Medicaid helps prevent many of these workers from becoming uninsured. A recent survey found that nearly half of former welfare recipients had Medicaid coverage. This bipartisan Commerce Committee proposal extends this coverage option for another year.
- **Waiving Medicare waiting period for people with Lou Gehrig's Disease (ALS).** About 30,000 people have ALS and 5,000 new cases are diagnosed each year. While this disabling disease qualifies ALS victims for Medicare, they often do not survive the required 24-month waiting period for Medicare. The median survival after diagnosis is 19 months, and the financial costs of this disease may exceed \$200,000 per year in its advanced stages. This proposal, to waive the 24-month waiting period for Medicare coverage, has bipartisan support not only in the House Commerce Committee but also has 283 cosponsors in the House (H.R. 353) and 29 in the Senate (S. 1074).

- **Excludes Bipartisan Provider Payment Policies.** While the Republican Leadership bill provided HMO payment increases without meaningful accountability, it rejected more justifiable provider payment policies such as:
 - **Additional help for hospitals.** The Republican Leadership bill rejects the bipartisan Senate Finance Committee policies to extend the full inpatient hospital market basket update for two years; provide a 6.5 percent indirect medical education (IME) adjustment for two years; and fix Puerto Rico hospitals' payment formula. It also rejected the bipartisan Commerce Committee Medicaid policy to permanently adjust the state disproportionate share hospital (DSH) allotments for inflation.
 - **Additional help for rural providers.** The Republican Leadership bill rejected the bipartisan Senate Finance Committee proposal to provide additional assistance to rural home health agencies and other proposals to further increase Medicare DSH payments for rural hospitals.
 - **Nursing home quality grants.** The Republican Leadership bill rejected the proposal, supported by the Aging Committee leaders Senators Grassley and Breaux, to improve staffing ratios in nursing homes. Inadequate staffing ratios contribute to the more than 25 percent of nursing homes which have had deficiencies that caused actual harm to residents or placed them at risk of death or serious injury. This bipartisan proposal would increase staffing ratios through financial incentives and disincentives in the context of a \$1 billion, five-year grant program to improve staff recruitment, retention, and reporting.

NOT A QUESTION OF MONEY – A QUESTION OF PRIORITIES

- **Republican Leadership Plan Spends Four Dollars on HMOs for Every One Dollar on Beneficiaries.** Having rejected all of the Committees' bipartisan beneficiary proposals, the spending by the Republican Leadership is heavily skewed towards HMOs – even though they get no commitment that these HMOs will stay in their communities as a result of this money.
- **Bipartisan Priorities Are Affordable.** Until last week, the Republican Committees and Leadership stated that they would spend about \$28 billion over 5 years in this Medicare / Medicaid bill. However, because the Leadership included in its bill savings from a modified Administration regulation, its plan now costs \$11 billion. Thus, it could add up to \$17 billion worth of bipartisan priorities and still be below what it just last week said it would spend.

