

(Original Signature of Member)

106TH CONGRESS
2D SESSION

H. R. _____

IN THE HOUSE OF REPRESENTATIVES

Mr. BLILEY (for himself, Mr. DINGELL, Mr. BILIRAKIS, Mr. BROWN of Ohio, Mr. WHITFIELD, Mrs. CAPPS, Ms. DEGETTE, Mr. DEUTSCH, Mr. GREEN of Texas, Mr. PALLONE, Mr. RUSH, Mr. SAWYER, Mr. STRICKLAND, [insert names of additional cosponsors from attached list]) introduced the following bill; which was referred to the Committee on

A BILL

To amend titles XVIII, XIX, and XXI of the Social Security Act to make additional corrections and refinements in the Medicare, Medicaid, and State children's health insurance programs, as revised by the Balanced Budget Act of 1997.

1 *Be it enacted by the Senate and House of Representatives*
2 *of the United States of America in Congress assembled,*



1 **SECTION 1. SHORT TITLE; AMENDMENTS TO SOCIAL SE-**
 2 **CURITY ACT; REFERENCES TO OTHER ACTS;**
 3 **TABLE OF CONTENTS.**

4 (a) **SHORT TITLE.**—This Act may be cited as the “Bene-
 5 ficiary Improvement and Protection Act of 2000”.

6 (b) **AMENDMENTS TO SOCIAL SECURITY ACT.**—Except as
 7 otherwise specifically provided, whenever in this Act an amend-
 8 ment is expressed in terms of an amendment to or repeal of
 9 a section or other provision, the reference shall be considered
 10 to be made to that section or other provision of the Social Se-
 11 curity Act.

12 (c) **REFERENCES TO OTHER ACTS.**—In this Act:

13 (1) **BALANCED BUDGET ACT OF 1997.**—The term
 14 “BBA” means the Balanced Budget Act of 1997 (Public
 15 Law 105-33).

16 (2) **MEDICARE, MEDICAID, AND SCHIP BALANCED**
 17 **BUDGET REFINEMENT ACT OF 1999.**—The term “BBRA”
 18 means the Medicare, Medicaid, and SCHIP Balanced
 19 Budget Refinement Act of 1999, as enacted into law by
 20 section 1000(a)(6) of Public Law 106-113 (Appendix F).

21 (d) **TABLE OF CONTENTS.**—The table of contents of this
 22 Act is as follows:

Sec. 1. Short title; amendments to Social Security Act; references to other Acts; table of contents.

TITLE I—BENEFICIARY IMPROVEMENTS

- Sec. 101. Improving availability of QMB/SLMB application forms.
- Sec. 102. Study on limitation on State payment for medicare cost-sharing affecting access to services for qualified medicare beneficiaries.
- Sec. 103. Election of periodic colonoscopy.
- Sec. 104. Waiver of 24-month waiting period for medicare coverage of individuals disabled with amyotrophic lateral sclerosis (ALS).
- Sec. 105. Elimination of time limitation on medicare benefits for immunosuppressive drugs.
- Sec. 106. Preservation of coverage of drugs and biologicals under part B of the medicare program.
- Sec. 107. Demonstration of medicare coverage of medical nutrition therapy services.

TITLE II—OTHER MEDICARE PART B PROVISIONS

Subtitle A—Access to Technology

- Sec. 201. Annual reports on national coverage determinations.



- Sec. 202. National limitation amount equal to 100 percent of national median for new clinical laboratory test technologies; fee schedule for new clinical laboratory tests.
- Sec. 203. Clarifying process and standards for determining eligibility of devices for pass-through payments under hospital outpatient PPS.
- Sec. 204. Access to new technologies applied to screening mammography to enhance breast cancer detection.

Subtitle B—Provisions Relating to Physicians Services

- Sec. 211. GAO study of gastrointestinal endoscopic services furnished in physicians offices and hospital outpatient department services.
- Sec. 212. Treatment of certain physician pathology services.
- Sec. 213. Physician group practice demonstration.
- Sec. 214. Designation of separate category for interventional pain management physicians.
- Sec. 215. Evaluation of enrollment procedures for medical groups that retain independent contractor physicians.

Subtitle C—Other Services

- Sec. 221. 3-year moratorium on SNF part B consolidated billing requirements.
- Sec. 222. Ambulatory surgical centers.
- Sec. 223. 1-year extension of moratorium on therapy caps.
- Sec. 224. Revision of medicare reimbursement for telehealth services.
- Sec. 225. Payment for ambulance services.
- Sec. 226. Contrast enhanced diagnostic procedures under hospital prospective payment system.
- Sec. 227. 10-Year phased-in increase from 55 percent to 80 percent in the proportion of hospital bad debt recognized.
- Sec. 228. State accreditation of diabetes self-management training programs.
- Sec. 229. Update in renal dialysis composite rate.

TITLE III—MEDICARE PART A AND B PROVISIONS

- Sec. 301. Home health services.
- Sec. 302. Advisory opinions.
- Sec. 303. Hospital geographic reclassification for labor costs for other PPS systems.
- Sec. 304. Reclassification of a metropolitan statistical area for purposes of reimbursement under the medicare program.
- Sec. 305. Making the medicare dependent, small rural hospital program permanent.
- Sec. 306. Option to base eligibility on discharges during any of the 3 most recent audited cost reporting periods.
- Sec. 307. Identification and reduction of medical errors by peer review organizations.
- Sec. 308. GAO report on impact of the emergency medical treatment and active labor act (EMTALA) on hospital emergency departments.

TITLE IV—MEDICARE+CHOICE PROGRAM STABILIZATION AND IMPROVEMENTS

Subtitle A—Payment Reforms

- Sec. 401. Increasing minimum payment amount.
- Sec. 402. 3 percent minimum percentage update in 2001.
- Sec. 403. 10-year phase in of risk adjustment based on data from all settings.
- Sec. 404. Transition to revised Medicare+Choice payment rates.



Subtitle B—Administrative Reforms

- Sec. 411. Effectiveness of elections and changes of elections.
 Sec. 412. Medicare+Choice program compatibility with employer or union group health plans.
 Sec. 413. Uniform premium and benefits.

TITLE V—MEDICAID

- Sec. 501. DSH payments.
 Sec. 502. New prospective payment system for Federally-qualified health centers and rural health clinics.
 Sec. 503. Optional coverage of legal immigrants under the medicaid program.
 Sec. 504. Additional entities qualified to determine medicaid presumptive eligibility for low-income children.
 Sec. 505. Improving welfare-to-work transition.
 Sec. 506. Medicaid county-organized health systems.
 Sec. 507. Medicaid recognition for services of physician assistants.

TITLE VI—STATE CHILDREN'S HEALTH INSURANCE PROGRAM

- Sec. 601. Special rule for availability and redistribution of unused fiscal year 1998 and 1999 SCHIP allotments.
 Sec. 602. Optional coverage of certain legal immigrants under SCHIP.

TITLE VII—EXTENSION OF SPECIAL DIABETES GRANT PROGRAMS

- Sec. 701. Extension of juvenile and Indian diabetes grant programs.

1 **TITLE I—BENEFICIARY**
 2 **IMPROVEMENTS**

3 **SEC. 101. IMPROVING AVAILABILITY OF QMB/SLMB AP-**
 4 **PLICATION FORMS.**

5 (a) THROUGH LOCAL SOCIAL SECURITY OFFICES.—

6 (1) IN GENERAL.—Section 1804 (42 U.S.C. 1395b-2)
 7 is amended by adding at the end the following new sub-
 8 section:

9 “(d) AVAILABILITY OF APPLICATION FORMS FOR MED-
 10 ICAL ASSISTANCE FOR MEDICARE COST-SHARING.—The Sec-
 11 retary shall make available to the Administrator of the Social
 12 Security Administration appropriate forms for applying for
 13 medical assistance for medicare cost-sharing under a State plan
 14 under title XIX. Such Administrator, through local offices of
 15 the Social Security Administration shall—

16 “(1) notify applicants and beneficiaries who present at
 17 a local office orally of the availability of such forms and
 18 make such forms available to such individuals upon re-
 19 quest; and





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Subject: Medicine & Health Daily, September 26, 2000

MEDICINE & HEALTH DAILY
TUESDAY, SEPTEMBER 26, 2000

TOP STORIES:

COMMERCE GIVES UNANIMOUS APPROVAL TO MEDICARE, MEDICAID CHANGES
HASTERT LETTER SAYS CLINTON HAS BLOCKED COMPROMISE, LISTS OBJECTIVES
HOUSE UNANIMOUSLY PASSES STERNS VA HEALTH BILL
NASI PANEL SAYS MEDICARE WILL NEED ADDITIONAL REVENUES

NOTE TO READERS: Please see the bottom of today's issue for your password to the Medicine & Health Archives. Included are back issues of the weekly news section, Perspectives, and Marketplace, searchable by key word and by date.

HOUSE COMMERCE COMMITTEE OKAYS BBA REVISION PACKAGE INCLUDING \$6 BILLION FOR M+C PLANS...

The rare bloom of bipartisanship was glimpsed for the briefest of moments this afternoon at the House Commerce Committee, culminating in unanimous voice vote approval of a \$21 billion package of revisions of the 1997 Balanced Budget Act. A number of its provisions may fall to the wayside after the House Ways and Means Committee conducts its BBA revisions markup -- possibly Thursday -- and House leaders try to meld the two packages. But for this afternoon, at least, GOP and Democratic staffers beamed -- and even exchanged a few bipartisan hugs -- at pulling off a markup many observers thought wouldn't occur. The committee's unanimous approval of H.R. 5291, "The Beneficiary Improvement and Protection Act of 2000," gives Commerce a better shot at putting its stamp on Medicare changes in a process where Ways and Means usually rules.

Under the five-year deal, Medicare HMOs get \$4.8 billion in direct increases and another \$1.2 billion that would occur as result of increases in the fee-for-service side of the program. Home health agencies would get changes worth \$1 billion, and skilled nursing facilities revisions worth \$1 billion. Hospitals benefit from some \$6 billion in revisions, with Medicare Part-A only revisions still to come in Ways & Means action. Commerce voted for almost \$1 billion in drug coverage improvements, including \$300 million for improved coverage of self-administered injectables and \$600 million for immunosuppressant coverage.

21 Billion

HMOs =	6	6
HH	1	
SNF	1	
HOSPITALS	6	acc. PSM
INJECTABLES	0.3	}
IMMUNO	0.6	
Bones	1	

Staffers pegged the value of changes benefiting beneficiaries at about \$1 billion. Among those changes: low-income seniors would no longer have to go to welfare offices to apply for Qualified Medicare Beneficiary (QMB) or Specified Low Income Medicare Beneficiary (SLMB) benefits. Beginning in 2004, Social Security offices could provide application forms and help in filling them out. In addition, HHS, states, and beneficiary groups would have to work together to develop a simplified application for QMB/SLMB programs, which assist low-income beneficiaries in paying out-of-pocket costs not covered by Medicare.

Medicare HMO provisions would raise the minimum payment rate to \$475 per member per month in rural areas, and to \$575 in metro areas with more than 250,000 people. The two percent "hold harmless" increase in payments each year would be increased to three percent, at a five-year cost of some \$400 million. Risk adjustment would be phased in over 10 years starting in 2004 based on data from all health care settings. Plans that withdrew from M+C or scaled back their service areas would be able to reenter the program. Plans would have to resubmit their "Adjusted Community Rate" applications in areas where capitation rates increased as a result of the legislation.

Plans had wanted to be able to resubmit ACRs in all areas - not just those where rates rose -- to avoid beneficiary complaints that benefits in one part of a service area were less generous than in another. The marked up bill also provides that if a Medicare+Choice enrollee switches from one plan to another the change is effective the same month it is made. Another M+C provision gives employers and labor groups more flexibility to offer benefits through the program. And HHS would be given discretion to allow variations in premiums and benefits across counties.

Commerce voted to postpone reductions in state caps on disproportionate share hospital payment, freezing them at FY 2000 levels for the next two years, and beginning to index state-specific allotments to inflation starting in FY 2001. "Low-DSH" states would be able to rebase their DSH allotments to one percent of their total Medicaid program expenditures and then increase for inflation from the new base. In addition, if the TennCare program is terminated in Tennessee, that state would be treated like all other states with respect to DSH allotments.

Commerce also voted to implement over a 10-year period a provision that increases from 55 percent to 80 percent the proportion of beneficiary indigent care costs covered by Medicare after due diligence by the hospital to recover the amount from the patient. Another provision benefiting hospitals lets them apply for reclassification of geographic wage levels in connection with their skilled nursing facilities, home health services, and inpatient long-term care hospital services. Commerce also approved a provision that gives permanent status to the "Medicare Dependent Hospitals" program.

Commerce also unanimously approved two other bills today. H.R. 1798, introduced by Rep. Jim Greenwood (R-PA), aims to increase the percentage of the NIH budget for clinical research. Only one percent of the NIH budget now goes for that purpose. The bill aims to increase that figure to two or three percent. A key objective is to attract young physicians to clinical

research. The second bill, H.R. 762, was introduced by Rep. Carrie Meek (D-FL). It aims to expand NIH research on lupus, and to increase treatment services for the disease, which disproportionately afflicts African-American women.

The Committee also approved a provision that it estimates allows states that have not spent their fiscal 1998 State Children Health Insurance Program allotments to keep 60 percent of their unspent funds. They'd be given an added year to spend those funds. Under current law, the 41 states that have not used up their FY 1998 money are required to turn it over to the 9 states that have at the end of fiscal 2000. Specifically, Commerce voted today that funds will be distributed to each state under this formula: the total amount spent in FY 1998, 1999, and 2000 minus the FY 1998 allotment.

..BUT WAR BETWEEN THE STATES ERUPTS OVER "UPL" MEDICAID "SCAMS"

No Commerce Committee meeting would be complete without rancor, and today's markup did not disappoint on that score despite the bipartisan action on BBA changes. Representatives from New York, Louisiana, and Illinois offered and then withdrew amendments to stop HCFA from issuing a rule that would prevent states from manipulating Medicare upper payment limit amounts to inflate how much their Medicaid programs spend as a way of getting higher federal Medicaid matching payments. Reps. John Dingell (D-MI) and Henry Waxman (D-CA) said the HCFA rule should be allowed to be issued to head off "scams" that threaten the fiscal integrity of Medicaid. But states taking in millions from the UPL tactic warned that many poor people would lose health care if HCFA goes ahead and said abuses could be curbed with amendments to ensure that UPL-derived funds are spent only on Medicaid-eligibles for Medicaid services. The amendments were withdrawn as part of a Committee agreement to limit how many amendments were voted on today. But the UPL issue will be one of the more bitterly contested issues in coming weeks and months.

Commerce also voted to approve a number of other Medicare changes in addition to those in a draft version of the bill reported by M&H Daily yesterday. Those additional provisions will be summarized in a Medicine & Health Flash to be transmitted later this evening.

HASTERT BLASTS CLINTON OBSTRUCTIONISM, VOICES HOPE FOR AGREEMENTS ON Rx DRUGS, BBA GIVEBACKS

Speaker of the House Denny Hastert (R-IL) has written to President Clinton saying the President has made a bipartisan compromise on a Medicare prescription drug benefit difficult by opposing constructive bipartisan and GOP proposals. Nevertheless, Hastert suggests that the Administration and Republicans can reach agreements on five items, including \$40 billion over five years for a Medicare Rx drug program and Medicare modernization, \$21 billion over five years in BBA givebacks for relief for Medicare providers, immediate Rx drug help for needy seniors, a Medicare lockbox, and Rx drug re-importation.

"First, you rejected the recommendations of the Bipartisan Commission to

Strengthen Medicare," Hastert tells the President in his letter. "Second, House Democrats walked out when the House passed a bill that would have reduced the cost of prescription drugs by 25 percent by offering a voluntary insurance plan within the current Medicare program. Finally, you rejected an offer by Senate Republicans to immediately help the neediest of our seniors with their 'Helping Hand' proposal." Helping Hand refers to Sen. Finance Committee Chair William Roth's (R-DE) proposed grants to states to help provide prescription drugs to needy seniors while a full-scale Medicare Rx drug program gets up and running.

In some of the areas covered in the letter, there would seem to be substantial substantive agreement. In the letter, the Speaker calls for "a Medicare lockbox to make sure the dollars in the Medicare Part A Trust Fund are not used for other purposes." The President and Vice President Gore have also proposed Medicare lockboxes; in Medicare at the Crossroads: the Gore-Lieberman Plan, released yesterday, the Democratic ticket promises to "place Medicare in an iron-clad, off-budget lockbox that would prevent politicians from using Medicare as a piggy bank for unnecessary tax cuts or spending increases." While there have been arguments from each side that the other side's lockbox is not securely locked, the differences appear mainly on the margins and everyone is essentially agreed that the Medicare-generated surplus will be used only for Medicare or for paying down the debt.

Another area where agreement could be possible is drug re-importation. According to the letter, Republicans "would also like to enact legislation that would allow seniors to buy lower-priced drugs in countries like Canada." "Both the House and the Senate have passed versions of this legislation and we are willing to work with you to find an acceptable version that preserves the safety of our drug supply," Hastert says. President Clinton yesterday wrote to Hastert and Sen. Majority Leader Trent Lott (R-MS) in support of Sen. James Jeffords' (R-VT) "Medicine Equity and Drug Safety Act of 2000," currently part of the Senate-passed Agriculture Department appropriations bill, which would allow the re-importation into this country of FDA-approved drugs and set up safeguards to protect drug safety.

Hastert's letter also addresses BBA givebacks, an area of significant agreement on dollar amounts but featuring underlying disagreements. "We propose that an additional \$21 billion be spent over the next five years to provide relief to Medicare providers, especially those that can ensure that Medicare plans that currently provide Rx drug coverage to seniors continue to do so and expand their coverage to others," Hastert's letter says. While \$21 billion is the BBA giveback number that the Administration has put forth, there are differences on how to allocate that amount among the Administration plan and Congressional plans, and among the plans coming out of different committees in Congress. Today, the House Commerce Committee marked up and passed its \$21 billion BBA giveback package. (See separate story)

The Speaker says Republicans are ready to work with Clinton "as soon as possible on a proposal to provide immediate assistance to the neediest seniors. Since your proposal, the House passed plan, and the Senate's 'Helping Hand' proposal all address this population, we do not think it

would be difficult to find common ground." Despite Hastert's expressed confidence, this is one of the most hotly contested areas this fall. The White House has expressed vociferous opposition to using state programs to provide Rx drug assistance to low-income Medicare beneficiaries, saying that existing state Rx assistance programs have low participation rates and that 50 state programs would take longer to set up than one federal program. Recent reports that 40 states have not spent all of their money under the State Children's Health Insurance Program provide some ammunition for the Administration in its arguments against using state programs, as do objections to the concept from both Republican and Democratic governors who fear being left on the hook for Medicare Rx drug costs despite GOP assurances otherwise.

Finally, Hastert says Republicans "would also like to lock away up to \$40 billion in resources over the next five years to provide a prescription drug benefit for all seniors and to modernize the Medicare program." This is another hotly contested area, as the Administration has proposed spending more money and providing Rx coverage directly through Medicare using pharmacy benefit managers. Bush and other Republicans would provide drug benefits through competing private plans with government backstops.

HOUSE UNANIMOUSLY PASSES STEARNS BILL INCREASING COMPENSATION TO VA PROVIDERS

On Sept. 21, the House unanimously passed the Department of Veterans Affairs Health Care Personnel Act of 2000, sponsored by Rep. Cliff Stearns (R-FL). The bill, H.R. 5109, would grant nurses at the Veterans' Affairs Department (VA) the same annual pay increases received by other federal employees and would provide them with a greater role in decision making at VA. Stearns' legislation would also revise and increase the rates of special pay for VA dentists and would include pharmacists among the provider occupations exempt from a statutory cap on special salary rates.

Additionally, H.R. 5109 directs VA to establish a pilot program in four regions where 70 percent or more of the veterans live at least two hours driving time from the nearest VA hospital. The program would allow these veterans to seek care in non-VA hospitals, with the VA coordinating care to ensure that the veterans do not incur additional out-of-pocket costs and that they receive any specialized care required. The program would expand on a small Florida study program that Stearns called a "smashing success with a 98-percent patient satisfaction rate." Stearns said the program saved between 15 percent and 28 percent of the cost taxpayers would have paid had these patients traveled to distant VA hospitals.

Stearns' bill also says that, during a veteran's initial clinical examination, VA doctors must inquire about the veteran's military history and any service-related exposures.

Negotiations are now in progress to resolve differences between H.R. 5109 and the Senate version of the bill, S. 1810, said a Veterans' Health Subcommittee source, who expressed the hope that the negotiations could yield a consensus bill within the next week. The source said the Administration had expressed concern regarding the bill's provisions

increasing compensation for dentists and establishing the pilot program for treating veterans at non-VA hospitals, but he was hopeful that the "overwhelming value" of the bill's other provisions would outweigh any White House concerns that remained relevant to the final bill.

NASI REPORT CITES NEED FOR ADDITIONAL TAXPAYER REVENUES FOR MEDICARE

Medicare will need substantial new revenues if the program is to maintain benefit levels in the decades ahead, says a report from a diverse panel convened by the National Academy of Social Insurance (NASI), the fourth in a series of NASI reports on Medicare. Even more resources will be needed if Medicare expansions like prescription drug coverage are adopted. The report says that making Medicare more efficient and requiring greater beneficiary contributions can help but will not eliminate the need for additional funds. And, without endorsing any specific proposal, the report sets forth several different options for raising those additional funds, a task the report calls doable while saying it will require hard choices.

The report emphasizes that using the federal budget surplus is not a substitute for added revenues. It explains that the Medicare trust fund, which would not need the cash infusion right away, would invest the surplus in special Treasury securities. "When Medicare begins to redeem its securities because Medicare expenditures each year begin to exceed annual receipts into the trust fund, the burden of meeting those obligations will fall on citizens at that time. At that point, in order to meet the Medicare obligations, the government will either have to raise general revenue taxes, reduce spending on other services, or redeem Medicare's securities by issuing new debt to the public -- that is, to state, local, and foreign governments, individuals, or businesses and institutions outside of government."

The report acknowledges, "If Medicare's surpluses have been used to reduce the public debt earlier, then it will be less of a problem to increase the public debt at a later point in time; in that sense, reducing current debt does help with financing Medicare's future burdens." But the report goes on to point out that "when people buy Treasury bills or bonds (and even though they treat them as assets), this means that other current spending will be lower. Regardless of how the obligations to Medicare are financed, the burdens will be felt at that time."

Two members of the NASI panel discussed the report at a reporters' breakfast this morning: panel chair Marilyn Moon, Senior Fellow at the Urban Institute, and Sheila Burke, long-time chief of staff to former Senate Majority Leader Bob Dole and currently with the Smithsonian Institution. They were joined by NASI's Michael Gluck, who co-authored the report. With the caveat that they had not analyzed the two proposals, Moon and Burke both hazarded that even combining the savings contained in the Medicare plans advanced by Presidential candidates Al Gore and George W. Bush probably would not solve the funding problems identified in the report.

Using 1998 baseline data (due to the lag time in doing the necessary analysis), the report says that Medicare will need 111 percent more in

taxpayer revenues, as a percentage of GDP, in 2030 than it needed in 1998 to finance the same benefits. Even with the efficiencies assumed by the Breaux-Thomas premium support plan voted on by the 1999 National Bipartisan Commission on the Future of Medicare, Medicare would need 86 percent more taxpayer revenues in 2030 to maintain benefit levels.

The report says that acting this year to increase the combined payroll tax that currently finances Medicare Part A from 2.9 percent to 4.84 percent would fill the revenue gap the report identifies and allow Medicare to maintain today's benefit level in 2030. So would adding an 8.43 percent surcharge on income taxes already raised or establishing a 2.02 percent tax on all goods and services purchased except housing costs, financial services, and some labor. Taxing employee health insurance subsidies received from employers as ordinary income and including them in payroll calculations would also provide the needed revenue, according to the report. Doubling all federal excise taxes, including gas taxes, would raise 54 percent of the needed revenue, and doubling only federal alcohol and tobacco taxes would raise 12 percent.

The report notes that the 2000 Medicare projections are considerably more optimistic than 1998 projections. "In 1998, the Medicare Trustees projected that Medicare spending would reach 5.85 percent of GDP by 2030, up from its 1998 level of 2.56 percent. Using updated information in 2000, the Trustees projected that Medicare spending would only reach 4.36 percent of GDP in 2030...This 25 percent reduction within a mere two years reflects how much an improved economy, cuts in reimbursement rates (through the Balanced Budget Act of 1997), efforts to curb waste, fraud, and abuse, and slowing overall health care spending can improve the outlook. It also shows the uncertainty of such estimates over time."

"The fact that Medicare's financial outlook can improve so dramatically so fast in one direction means that at some point in the coming decades, it could worsen just as quickly," the report says, citing one of the reasons why its analysis based on the more pessimistic 1998 baseline and its discussion of options for providing additional revenue remain relevant. The report also notes that, "even with the improvement, the current system will still be in need of new revenues (by 2025 in the case of the Hospital Insurance Part A Trust Fund). Medicare's share of GDP is still projected to rise 87 percent between 2000 and 2030 from 2.33 percent to 4.36 percent of GDP. This occurs because the program will go from covering one in every eight Americans to one in every four and health care costs are projected to rise."

The report warns against complacency. "Although recent optimistic projections may leave policy makers disinclined to adopt changes that will involve any pain, Medicare will eventually still need new revenues. Starting early to raise those revenues (or enact cuts) will make tax increases faced by families in any given year smaller than if we wait until the significant revenue needs are close at hand. The panel believes it is important to begin this process as soon as possible."

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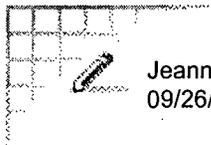
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Medicare Reform: Promise given back to



Jeanne Lambrew
09/26/2000 09:33:53 PM

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cc: See the distribution list at the bottom of this message
Subject: Highlights of Commerce BBA Mark Up

Rationale for Mark-Up. Having not successfully had a mark up on health all year, and fearing that they would be frozen out of negotiations without one (as they were last year), a bipartisan mark was produced and passed today. It spent the a large proportion of the Republican Leadership's \$21 billion over 5 years (the same as our Mid-session review) -- despite the fact that Commerce has only partial jurisdiction over Medicaid. This means that this is a high-water mark if the Republicans try to constrain the entire package to our dollar amounts. Dingell did point out that if the Republicans are indeed using the President's \$40 billion allocation, they should add on top of that another \$30 for the coverage pieces, since we did not pay for legal immigrants, etc., out of this pot.

Highlights: Medicare Part A service (hospitals, most nursing homes, hospice) which comprise about 60 percent of Medicare spending are in the jurisdiction of the Ways and Means Committee.

The Commerce Committee reported a bill that included Medicare give-back proposals and other Medicare benefit expansions in addition to several Medicaid proposals. CBO has not completed their final scoring of the bill, but their preliminary cost estimates indicate that the bill would increase mandatory outlays by \$13.9 billion over 5 years and \$37.5 billion over 10 ten years. We believe that in a number of areas CBO's cost estimates may be understated. The chart below summarizes CBO's scoring.

	Five-Year Total	Ten-Year Total
Medicare Provisions	\$9.6	\$27.0
Medicaid Provisions	\$4.3	\$10.5
Total	\$13.9*	\$37.5*

(*Note these numbers may change as CBO finalizes its cost estimates.)

Highlights:

- **Managed care:** Received about \$4.8 billion over five years and \$13.5 billion over 10 years in direct payment increases to Medicare managed care plans plus indirect increases of \$1.2 billion over five years and \$4.6 billion over 10 years for a total of \$6 billion over 5 / \$18.1 billion over 10 years.
- **Home health:** One-year delay on home health 15 percent cut: \$1.3 billion over 5 / \$2.3 billion over 10 years
- **Therapy cap and consolidated billing delays:** (small cost)
- **Removing time limits on coverage of immunosuppressive drugs:** \$0.6 billion over 5 / \$1.6 billion over 10 years
- **Miscellaneous Medicare beneficiary improvements:** Election of periodic colonoscopy; waiver of

24-month waiting period for people with disabilities with Lou Gerhig's disease; simplifying QMB applications

- **Medicaid DSH increases:** Increasing state allotments: \$3.3 billion over 5 years; \$8.3 billion over 10 years
- **Medicaid coverage of legal immigrant children and pregnant women in Medicaid and CHIP:** Has a two-year waiting period but we could likely remove this in conference. \$0.5 billion over 5 / \$1.5 billion over 10 years
- **Childrens' outreach policies (in PB):** This includes presumptive eligibility, transitional Medicaid extension
- **Extension of juvenile diabetes provision:** Extends it for 5 years (like our MSR) and increases total from \$60 to \$100, split between Type I and IHS. JDF is still seeking 2001 funding increases but this is an important next step
- **CHIP allotment reallocation change:** Basically, let the 40 states that have not spent their 1998 allotments keep about most of it and reallocates the remaining amount to the 10 states that have spent all of their 1998 allotments. Note: we are trying to stay out of this formula fight but think that this is probably the right type of solution.

The bill did not include two priorities in our package: Ricky Ray and the nursing home quality initiative. We will work on getting those in the Senate.

The House Ways and Means Committee may mark-up their give-back bill as early as Thursday which will include many of the Medicare Part A give-backs that are currently in-play (e.g., inpatient hospital update, IME payment increases, etc.). Only considering the likely hospital and skilled nursing facility (SNF) provisions, the W&M bill could increase Medicare payments by as much as \$11 billion over five years and \$28 billion over 10 years. However, the costs of the reported bill could be much higher, especially if the W&M bill includes additional managed care provisions and home health payment increases.

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National Association of
Community Health Centers, Inc.®

November 19, 1999

The Honorable William Jefferson Clinton
President of the United States of America
The White House
1600 Pennsylvania Avenue, NW
Washington, DC 20500

Dear Mr. President:

On behalf of America's community health centers, I am writing to express my deep gratitude for your efforts and those of your staff, to protect the health center safety net from the full impact of the 1997 Balanced Budget Act (BBA) and to ensure adequate Medicaid payments to health centers. Because of your support, health centers will avoid the BBA's most devastating cuts and have been given reprieve to continue advocating for a long-term solution to the phase-out of cost based reimbursement begun by the BBA.

As you know, health centers have historically relied on the Medicaid program paying its fair share of the cost of care furnished to Medicaid beneficiaries in order to allow them to maximize the care they provide to uninsured patients. Without a legislative solution to ensure sufficient Medicaid funding, health centers would be forced to cross-subsidize Medicaid underpayments with Federal grant dollars intended to care for the uninsured, thereby eliminating key health care access points for some of the most vulnerable patients in the country.

We know that you fought to support our efforts to enact a prospective payment system for health centers in the Medicaid program in an effort to protect the vital services provided to uninsured Americans. Although the final legislation does not include that new payment system, the compromise agreement on Medicaid payments to health centers that is included constitutes a significant improvement over current law. We are especially grateful for the efforts of Chris Jennings and other Administration staff members in helping to forge this compromise.

While it is not all that health centers has fought for, the compromise will delay the potential elimination of care for people in low-income rural and urban communities across the country. In addition, the Congressional study included in the agreement provides the first real opportunity to present Congress with information on the devastating impact the phase-out is having on communities that are already facing service shortages. We look forward to working with you and Congress to provide a permanent solution for our safety net providers and the people they serve.

Thank you again for your efforts. As always, please feel free to contact me if I can be of any assistance to you in the future.

Sincerely,

Tom Van Coverden
President and CEO



American Association of
HEALTH PLANS

Press Release

FOR IMMEDIATE RELEASE
November 19, 1999

Contact: Susan Pisano
(202) 778-3245

Statement of Karen Ignagni On Balanced Budget Refinement Act of 1999

“The bipartisan Balanced Budget Refinement Act of 1999 is an important milestone on the path to modernizing Medicare and closing the fairness gap for millions of beneficiaries. We applaud Members of Congress from both parties for recognizing that Medicare must be stabilized and that beneficiaries should have expanded health plan choices.

As the 2000 election cycle begins in earnest, it is important to heed the lesson of 1999: seniors and disabled beneficiaries have sent a clear signal that they value health plans and want lawmakers to preserve the affordable coverage and comprehensive benefits that only Medicare+Choice health plans can provide.

The Balanced Budget Refinement Act is good news for beneficiaries. With that in mind, Congress and the Administration should build on this bipartisan foundation and resolve to enact long-term reforms in 2000 to ensure that the program will be available for both current and future beneficiaries.”

###

Karen Ignagni is President & Chief Executive Officer of the American Association of Health Plans (AAHP).

AAHP is the national trade association representing more than 1,000 managed care plans, including health maintenance organizations (HMOs), preferred provider organizations (PPOs), and other similar health plans providing coverage to more than 140 million Americans.

THE AMERICAN PSYCHOANALYTIC ASSOCIATION

CENTRAL OFFICES
309 EAST 49TH STREET
NEW YORK, NEW YORK 10017
(212) 752-0450

November 19, 1999

The Honorable William Jefferson Clinton
President of the United States
1600 Pennsylvania Avenue, NW
Washington, DC 20500

Re: Reform Amendments to the Balanced Budget Act of 1997

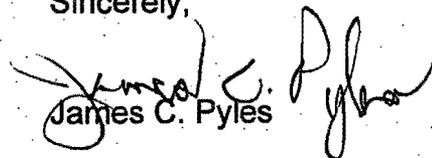
Dear Mr. President:

On behalf of the American Psychoanalytic Association, I would like to thank you for your role in achieving bipartisan agreement on the amendments to the Balanced Budget Act of 1997. We are particularly grateful for the provision that directs the General Accounting Office to conduct a study and report to Congress on the effect of the OASIS data collection requirement on the privacy interests of Medicare beneficiaries receiving services in their homes. [Section 301(b)]

As you are aware, the public cares deeply about the privacy protection of medical information and especially mental health information. That concern is particularly great when the right to privacy in one's own home is jeopardized. We greatly appreciate your recognition of this issue and your willingness to address it.

As studies and surveys have found repeatedly, the protection of medical privacy is an essential element of quality health care. We look forward to working with you to protect this fundamental right as well as access to effective mental health services.

Sincerely,


James C. Pyles

BALANCED BUDGET REFINEMENT ACT OF 1999
Questions and Answers -- Draft 11/19/1999 3:41 PM

BBRA Support

Q: *Your support for the Balanced Budget Refinement Act of 1999 seems to be in conflict with earlier statements about the consequences of the BBA. Why is that?*

A: The Balanced Budget Refinement Act (BBRA) modifies payment reductions resulting from the Balanced Budget Act of 1997. As I said before the Senate Finance Committee on July 22, although the Administration continues to believe the BBA had a positive effect on the Medicare Trust Fund, the Administration shared congressional concerns that some BBA provisions may have had unintended consequences for beneficiaries. For example, we have consistently raised concerns about the potential effect of BBA on beneficiaries' access to high-quality health care, including therapy services, hospital and skilled nursing facility care.

The Balanced Budget Refinement Act complements the administrative actions we have already announced by: placing a moratorium on the therapy caps that have proven harmful to beneficiaries; increasing payments for very sick patients in nursing homes this year; restoring funding to teaching hospitals; and easing the transition to the new prospective payment system for hospital outpatient departments; among others.

Unfortunately, this legislation also includes provisions that are not justifiable, such as a \$4.8 billion payment increase to managed care plans that are already overpaid according to most experts and a wasteful increase in oxygen reimbursement. This is troubling because any excess payments from the Medicare trust fund puts the program at greater risk, and we certainly would have preferred a smaller package, without such increases, fully paid for within a balanced budget.

However, this bill represents negotiations and compromises with Congress. Our goal was to ensure that Medicare beneficiaries have access to quality health care and to help providers deal with the transition to the BBA provisions. I think we all agree the BBA made necessary and long-overdue changes in the way Medicare paid health care providers, and in coverage for important prevention services. I think we all still agree that if we are to strengthen and modernize Medicare for the future, we must come together early next year to enact comprehensive Medicare reform.

THERAPY CAPS

Q: *Are you satisfied with the solution regarding limitations on therapy caps?*

A: We think this was a prudent way to address this problem in the short term. As you know, we have always had concerns about the limits to outpatient rehabilitation therapy when they were proposed by Congress during the 1997 BBA negotiations. Congress agreed, and worked with us to assess the situation, providing the temporary revisions necessary to ensure that all beneficiaries have access to needed care.

The BBA limited yearly payments for physical/speech therapy and occupational therapy to \$1,500 per beneficiary. The Inspector General confirmed that this was too low, causing a large number of therapy users to have charges exceed the caps. It was simply not acceptable to have beneficiaries pay for these services out of pocket.

The BBRA places a two-year moratorium on the two payment caps, and revised a BBA-mandated study to make sure that we develop an alternative, more rational system for therapy services payment. It also continued our efforts to step up medical review to prevent fraud. These are important steps, and one reason why the Administration will sign this bill.

[BACKGROUND: The therapy caps were never proposed by the Administration.]

SKILLED NURSING FACILITIES

Q: *The BBRA includes increases for SNFs although HHS has claimed that there was not an access problem. Why is that?*

A: In fact, we recognized early on that we and the industry did not have the data to fully address the costs of very sick patients, such as the costs of their drugs. HCFA has research underway to allow us to refine the PPS administratively, to better reflect the needs of high-cost patients. This research will be completed in December and we will use the results to refine the system in October 2000.

All along, we have been talking with Congress about the need for a legislative solution to this problem that can provide relief before we are able to implement our planned refinements administratively.

Now, through the legislative process, we have been able to find a quick, short-term solution that complements the regulatory changes to which we are planning to make next year. We need to work together to find a long-term approach that continues to provide the necessary care.

[BACKGROUND: The bill increased the base for payment rates for 15 resource utilization groups (RUGs) by twenty percent – 12 are for medically complex cases. The bill also increased the base for payment rates for 3 rehabilitation RUGs, which we did not think was necessary.

The Inspector General reported in October that in the wake of the implementation of that prospective payment system, it is taking more time to place patients who were in need of extensive services, particularly patients with end-stage renal disease.

HHS supported this PPS system during the original BBA negotiations.]

TEACHING HOSPITALS

Q: What does the BBRA do for teaching hospitals?

A: The BBRA addresses the payment issues that teaching hospitals have been facing through several measures.

First, the BBRA provides additional funding to smooth the transition for hospitals to the outpatient department prospective payment system (PPS) and clarifies congressional intent that the new system is not supposed to impose an additional reduction of 5.7 percent on top of the removal of formula-driven overpayment.

Second, the BBRA increases indirect medical education payments (IME). This provides critical assistance to teaching hospitals adjusting to the changes in the health care system.

Third, the BBRA takes steps toward reforming direct medical education payments. This bill begins to reduce the geographic disparity in payments in direct medical education. It raises the minimum payment for hospitals to 70 percent of the national, geographically adjusted average payment and limits growth in payments for hospitals with costs above 140 percent of the geographically adjusted average payment.

Finally, the BBRA increases disproportionate share hospital (DSH) payments. Under the BBRA, DSH payments would be reduced at lower rates over a longer period of time than that set out by the BBA. This restoration helps these hospitals care for the uninsured.

[Background: Regarding the BBRA's provision to smooth the transition to the new outpatient department PPS, we had proposed a budget neutral transition using our administrative authority.]

Q: *Do you support these measures? Isn't your support for the increased funding for teaching hospitals just a political move to help the First Lady in her campaign for the Senate seat in New York?*

A: Not at all. We have repeatedly supported targeted measures that are designed to relieve the pressure on teaching hospitals caused by the BBA. These institutions are vitally important to the American health delivery system. All across the country, academic teaching hospitals take care of a lot of poor people and are an integral part of medical education. We have always taken the reports of financial pressures from these institutions very seriously.

We have supported, and continue to support, targeted efforts tailored to address the problems that academic teaching hospitals are feeling- but not a blind infusion of money. These BBRA provisions focus on the importance of graduate medical education, the reduction of geographic disparities in health care delivery and the provision of health care services to the poor and underserved- and are the type of targeted, focused steps to help teaching hospitals that the Administration has supported and pushed for.

Q: *But haven't you said that teaching hospitals' financial woes are not Medicare's problem?*

A: It is true that we cannot allow academic teaching hospitals to cost-shift their private sector discounts to Medicare. However, we still want to pay teaching hospitals accurately for their Medicare-related services and support our efforts to ease the transition for teaching hospitals into the outpatient prospective payment system.

MEDICARE HMO FUNDING

Q: *Why are you supporting a bill that provides for increased money for managed care organizations when you have repeatedly cited that they are overpaid?*

A: The Administration does not support the provisions that provide an extra \$4.8 billion to managed care plans that are already overpaid, according to several reports including those released by the HHS Inspector General and the General Accounting Office.

However, because of our desire to work with Congress to relieve the unintended effects of the BBA on patients' health care and congressional unwillingness to back down from funneling more funds to already overpaid managed care organizations, in the spirit of compromise, in our negotiations with Congress we acquiesced to these provisions.

[In the past we have been strongly opposed to increasing payments for Medicare managed care organizations. Studies by the Inspector General, the General Accounting Office and other experts have consistently reported that Medicare's payment to managed care organizations in the Medicare+Choice program have been too high. In addition, plan withdrawals from the Medicare+Choice program are not entirely related to low Medicare payments. Reports show that some of the plan withdrawals are attributable to the plans' inability to compete in certain areas and insufficient provider networks.]

Q: *But won't these excess payments put the Medicare Trust Fund at greater risk? How can you accept that as part of your compromise?*

A: What we accepted was preserving access to quality health care for all beneficiaries. But there are indeed provisions of the BBRA that we do not support precisely because they are unnecessary and may affect the Medicare Trust Fund. We certainly would have preferred a smaller package, fully paid for within a balanced budget.

Moreover, we will continue to monitor the implementation of the BBA and the refinements included in the BBRA so that we may stay apprised of the effects on beneficiary access to high-quality health care.

The Administration has been vigilant in its efforts to extend the life of the trust fund through aggressive management of the Medicare system and HCFA's implementation of structural reforms set up through the BBA. In fact, Medicare spending overall is declining in part because of our successful efforts to fight waste, fraud and abuse. Excess payments to managed care organizations will also decrease due to the Administration's efforts to implement a health-related risk adjustment mechanism. The Administration will continue its commitment to substantially extend the exhaustion date of the Medicare Trust Fund.

TRUST FUND COSTS OF ADMINISTRATIVE ACTIONS

Q: *How much do the administrative actions cost?*

A: Under the current budget rules, administrative actions aren't scored, so we have no cost estimates for these proposals.

Q: *What are the administrative costs of implementing the BBRA?*

A: With the passage of BBRA, the Administration is still estimating the additional costs of implementing BBRA.

TRUST FUND

Q: *If you really care about the Medicare Trust Fund, why are you supporting legislation that will cost \$16 billion and exhaust the trust fund even faster?*

A: What we accepted was preserving access to quality health care for all beneficiaries. But there are indeed provisions of the BBRA that we do not support precisely because they are unnecessary and may affect the Medicare Trust Fund. We certainly would have preferred a smaller package, fully paid for within a balanced budget.

Moreover, we will continue to monitor the implementation of the BBA and the refinements included in the BBRA so that we may stay apprised of the effects on beneficiary access to high-quality health care.

The Administration has been vigilant in its efforts to extend the life of the trust fund through aggressive management of the Medicare system and HCFA's implementation of structural reforms set up through the BBA. In fact, Medicare spending overall is declining in part because of our successful efforts to fight waste, fraud and abuse. The Administration will continue its commitment to substantially extend the exhaustion date of the Medicare Trust Fund.

OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

Q: *You're giving the hospital industry a huge break by eliminating a 5.7 percent cut required by the Balanced Budget Act. But you say there's no cost. Isn't this just using smoke and mirrors to hide a big giveaway?*

A: Not at all. This provision clarified Congressional intent from the Balanced Budget Act, and we acted only after several conversations with members of Congress on the issue.

The outpatient prospective payment system provision in the Balanced Budget Act was intended to rationalize outpatient payment policy. The law was not intended to impose an additional reduction in aggregate payments to hospital outpatient departments. No such reduction was contemplated when the budget law was negotiated, and we believe that a reduction would be unwise.

However, a technical drafting change produced confusion over the outpatient payment formula. The Administration worked with Congress to draft language that clarifies the law and helps us carry out the intent of Congress. Under the Budget Enforcement Act, legislative action is "scored" only when it changes current law. Findings or clarifications by Congress such as this one do not change the law and do not result in scoring.

[BACKGROUND: OMB Director Jack Lew advised Congress in an Oct. 18 letter that we are not aware of any cases since enactment of the Budget Enforcement Act in 1990 where findings or clarifications by Congress were scored. We supported the OPD PPS, but agree that there was a technical drafting change that produced confusion and did not intend to have the reduction.

The Administration supported the creation of an outpatient prospective payment system, but favored a more aggressive schedule to reduce the excessive co-payments that beneficiaries now pay]

OXYGEN PAYMENT INCREASE

Q: Why are you raising payments for oxygen supplies, when all the studies by the IG and the GAO show that Medicare already pays too much for oxygen supplies?

A: This Act addresses many of the problems raised by the Administration and Congress, but unfortunately also includes a few provisions that are not justifiable, such as the slight increase in oxygen payments. The BBA reductions for oxygen were supported by numerous GAO and IG studies and have not affected beneficiary's access to oxygen. We remain concerned about such unnecessary increases that could impact the Medicare Trust Fund.

However, because of our desire to work with Congress to relieve the unintended effects of the BBA on patients' health care, in the spirit of compromise during our negotiations, we acquiesced to some provisions so that we could preserve high quality care for beneficiaries.

[Background: HCFA supported the 30 percent reduction in oxygen payments in the original BBA, and the President had proposed slightly larger cuts.]

HOME HEALTH AGENCIES

Q: You've said in the past that the people who qualify for home health services are getting them, so why are you giving extra money to home health agencies?

A: A recent study by the Inspector General study shows that a big part of the decline in home health claims under the Balanced Budget Act reflects our successful efforts to reduce improper payments for unnecessary or inappropriate claims.

Delaying the scheduled 15% reduction is a prudent move together with the requirement that directs an HHS study on the need and implication of a 15%

reduction. However, it now makes sense to delay the additional 15 percent payment cuts scheduled for next year when we begin to pay home health agencies based on each patient's expected need. This will allow a smoother transition to the prospective payment system, while allowing us to gather more evidence to ensure that we are paying agencies appropriately for quality care. This will help us make sure that even the frailest beneficiaries continue to receive many services in their homes as covered under Medicare law.

Q: A huge number of home health agencies have closed since the BBA went into effect, and those that are left say that the \$1.3 billion in relief isn't enough to save them. Why didn't you include more money for home health?

A: Medicare's home health benefit is essential for millions of elderly and disabled Americans, and we must assure access to care for those who qualify for its services. A recent study by the Inspector General study shows that a big part of the decline in home health claims under the Balanced Budget Act reflects our successful efforts to reduce improper payments for unnecessary or inappropriate claims. Most of the evidence to date suggests that beneficiaries who qualify for services continue to have access to care.

In addition, we've already taken a number of administrative actions to help home health agencies adapt to BBA-related changes, such as changing the surety bond requirements and allowing agencies three years -- including one year without interest -- to repay overpayments related to the interim payment system. We will continue to take appropriate steps to ensure continued access to quality care for these vulnerable patients.

[Background: HCFA supported the creation of the home health prospective payment system now scheduled to go into effect on October 1, 2000.]

BALANCED BUDGET REFINEMENT ACT OF 1999: HIGHLIGHTS

November 18, 1999

The Medicare, Medicaid and SCHIP Balanced Budget Refinement Act (BBRA) of 1999 addresses flawed policy and excessive payment reductions resulting from the Balanced Budget Act (BBA) of 1997. The President, Vice President and Secretary Shalala are pleased that Medicare beneficiaries' access to high-quality health care is improved through this bipartisan legislation. All parties to the agreement, in particular Mr. Thomas, Mr. Bliley, Mr. Dingell, Mr. Rangel, Mr. Stark, Senator Roth and Senator Moynihan, played critical roles in achieving this outcome.

This BBRA addresses many of the problems raised by the Administration and Congress, by, for example, placing a moratorium on the therapy caps that have proven harmful to beneficiaries; increasing payments for very sick patients in nursing homes this year; restoring funding to teaching hospitals; and easing the transition to the new prospective payment system for hospital outpatients, among others. Unfortunately, it includes provisions that are not justifiable, such as a \$4 billion payment increase to managed care plans that are already overpaid according to most experts. This is troubling because any excess payments from the Medicare trust fund put the program at greater risk. This legislative package costs about \$1.2 billion in 2000 and \$16 billion over 5 years.¹ The major provisions (not all provisions) are described below, along with their 5-year costs.

HOSPITALS (\$6.8 billion)

- **Modifies outpatient department policies.** The BBA created a new prospective payment system (PPS) for hospital outpatient care that pays set amounts for services that are similar clinically and in their use of resources. This bill adjusts the PPS. It:
 - **Smooths the transition to the PPS.** During the first 3 and a half years of the PPS, this bill creates payment floors to minimize the disruption of the new system. Small rural hospitals would be held harmless for 4 years while cancer hospitals are permanently held harmless from the PPS. In addition, there will be a budget-neutral 3-year pass-through for certain drugs, devices and biologicals and outlier policy for high-cost cases. The bill also extends the current hospital outpatient capital policy through the implementation of PPS.
 - **Clarification of budget-neutral implementation of PPS.** This bill clarifies Congress's intent that the new system is not supposed to impose an additional reduction of 5.7 percent on top of the removal of formula-driven overpayment. (Note: OMB would not score this clarification)
- **Increases Indirect Medical Education Payments.** Under the BBA, teaching hospitals' indirect medical education (IME) payment add-on was reduced to 6.0 percent in 2000, and 5.5 percent in 2001 and subsequent years. This proposal would raise the add-on to 6.5 percent in FY 2000, 6.25 percent in 2001, and 5.5 percent in 2002 and thereafter. This provides critical assistance to teaching hospitals adjusting to the changes in the health care system.

¹ All estimates from CBO preliminary score, 11/18/99. The total cost also includes changes in premium revenue.

- **Takes Steps Towards Reforming Direct Medical Education.** This bill begins to reduce the geographic disparity in payments for direct medical education. It raises the minimum payment for hospitals to 70 percent of the national, geographically adjusted average payment and limits growth in payments for hospitals with costs above 140 percent of the geographically adjusted average payment. For these hospitals, payments per resident will be frozen for FY 2001 and 2002 and increased at a rate of inflation (consumer price index) minus 2 percentage points for FY 2003 through 2005.
- **Increases disproportionate share hospital (DSH) payments.** The BBA reduced DSH payments by 3 percent in 2000, 4 percent in 2001, and 5 percent in 2002. This proposal increases the payment rates set in the BBA. Under this bill, DSH would be reduced by 3 percent in 2001 and 4 percent in 2002. This restoration helps these hospitals care for the uninsured.
- **Increases payments for PPS-exempt hospitals.** The BBA authorized the creation of a PPS system for inpatient rehabilitation hospitals. This bill makes adjustments to this PPS and requires the development of PPS systems for long-term care and psychiatric hospitals. It also includes a wage adjustment of the percentile cap for existing PPS-exempt hospitals and enhanced payments for long-term care and psychiatric hospitals.
- **Improves rural hospital programs.** This bill modifies and improves a series of Medicare policies that support rural health care providers. They complement the special protection for rural hospitals in the outpatient PPS system.
 - Allows certain hospitals to reclassify to rural for purposes of designation as a Critical Access Hospital (CAH), Sole Community Hospital or Rural Referral Center. Updates certain standards applied for geographic reclassification.
 - Extends Medicare dependent hospital (MDH) program for five years; improves the CAH program.
 - Provides exceptions to residency caps for rural graduate medical education.
 - Rebases the targets for Sole Community Hospitals and provides for the full market basket increase in 2001.
- **Administrative actions.** This complements the Administration's actions to delay the expansion of the hospital transfer policy; stop recoupment of DSH payments based on unclear guidance; delay implementation of the volume control system and refine the ambulatory payment classification system under the outpatient PPS; change to the wage threshold to allow rural hospitals to reclassify for payment purposes; and others.

SKILLED NURSING FACILITIES & THERAPY SERVICES (\$2.7 billion)

- **Provides immediate increases in payment for high-cost cases.** The BBA created a new prospective payment system (PPS) for skilled nursing facilities that was implemented on July 1, 1998. Under this system, payments are based on service needs of patients adjusted for area wages. Effective April through October 1, 2000, 20 percent will be added to 12 resource utilization groups (RUGs) for medically complex cases and 3 rehabilitation RUGs. The bill also creates special payments to facilities that treat a high proportion of AIDS patients for 2000-2001 and excludes certain services (certain ambulance services, prostheses, chemotherapy) from consolidated billing and the PPS system.
- **Increases payment rates.** This bill increases payments across-the-board by 4 percent for 2001 and 2002. It also gives nursing homes the option to elect to be paid at the full Federal rate for SNF PPS.
- **Imposes two-year moratorium on payment caps.** The BBA limited yearly payments for physical / speech therapy and occupational therapy to \$1,500 each per beneficiary. This limit is too low, causing a large number of therapy users to have payments exceed the caps and have to pay for services out-of-pocket. This bill puts a two-year moratorium on the caps, steps up medical review to prevent fraud, and revises a BBA-mandated study to develop an alternative, more rational system for therapy services payment.
- **Administrative actions.** Apart from this bill, the Administration will increase payment for high acuity patients and exclude certain types of services furnished in hospital outpatient departments from SNF PPS.

HOME HEALTH (\$1.3 billion)

- **Delays 15 percent to one year after the implementation of the home health prospective payment system (PPS).** In addition to creating a new PPS for home health, the BBA also required a 15 percent reduction in payment limits. This bill delays implementation of the 15 percent reduction until after the first year of implementation of PPS.
- **Provides immediate adjustments.** The bill raises the per beneficiary limit by 2 percent for agencies subject to the per beneficiary limit with limits below the national average in 2000; pays \$10 per beneficiary in 2000 to agencies to help cover the cost associated with OASIS data collection and reporting requirements; eases and clarifies the surety bond provision; and excludes durable medical equipment from home health consolidated billing.

- **Administrative actions.** This bill complements the Administration's actions to delay tracking and pro-rating payments; provide for extended interim payment system repayment schedules; postpone and change surety bond requirements; among others.

BENEFICIARY IMPROVEMENTS (\$0.3 billion)

- **Limits beneficiary hospital outpatient coinsurance.** The BBA included a provision to reduce the Medicare beneficiary coinsurance for hospital outpatient department services from its current approximately 50 percent of costs to 20 percent over a number of years. This policy would provide an additional protection by limiting the amount of coinsurance that a beneficiary pays for outpatient care to the Part A deductible (\$776 in 2000).
- **Increases coverage of immunosuppressive drugs.** Currently, Medicare pays for the prescription drugs that help prevent rejection of transplants for 36 months. This proposal would, for the next 5 years, extend coverage of these drugs for another 8 months for beneficiaries whose coverage would otherwise expire.

MANAGED CARE (\$4.8 billion)

- **Alters the plan for risk adjustment for managed care plans.** The BBA requires that payments to managed care plans be risk adjusted, to prevent adverse selection and to encourage plans to enroll sicker beneficiaries. Rather than implement this immediately, the Administration developed a 5-year phase-in plan which is supported by virtually all independent experts. This proposal alters the phase-in by reducing the amount of risk adjustment scheduled for 2001 and 2002.
- **Increases rates.** Although the General Accounting Office and other independent experts believe that managed care plans continue to be overpaid – even after the BBA – this proposal raises the annual rate increase for 2002 from the fee-for-service growth rate minus 0.5 to the fee-for-service growth rate minus 0.3. It also provides an entry bonus for plans entering counties not previously served and for plans that had previously announced that they were withdrawing from counties.
- **Changes provider participation rules and quality standards.** The bill includes a number of provisions to accommodate health plans, including: giving plans more time to submit adjusted community rates; providing greater flexibility in benefits and reducing the user fees paid for the Medicare education campaign; reducing quality standards for preferred provider organizations; and expanding deeming provisions.
- **Changes demonstrations.** This bill delays the competitive pricing demonstration project and extends the social health maintenance organization demonstration and several others.

- **Interaction with fee-for-service policies.** Medicare+Choice rates are linked to growth in fee-for-service spending. Since the policies in the bill increase fee-for-service spending, they increase managed care payments.
- **Administrative actions.** The Administration has and will continue to take administrative actions to improve beneficiary protections and access to information, ease provider participation rules and extend the frail elderly demonstration.

OTHER PROVIDERS (\$0.8 billion)

- **Fixes the fluctuation in physician payments (sustainable growth rate).** This change stabilizes physician payments and is budget-neutral over 5 years.
- **Increases payments for Pap smears.** Sets the minimum payment rate at \$14.60 beginning in 2000.
- **Increases payments for renal dialysis.** Medicare's payments for dialysis have not increased since 1991. Consistent with a recommendation from the Medicare Payment Advisory Commission, this bill increases the composite payment rate by 1.2 percent in 2000 and another 1.2 percent in 2001.
- **Increases updates for hospice, durable medical equipment, and oxygen.** Payment rate increases to hospices would be temporarily increased by 0.5 for 2001 and 0.75 for 2002 and DME and oxygen suppliers by 0.3 for 2001 and 0.6 for 2002.
- **Delays authority to adopt competitive purchasing practice.** The bill delays the Secretary's inherent reasonableness authority until a GAO report is issued and she issues a final rule.
- **Provides hospital / area-specific adjustments.** The bill includes several changes to local demonstration, hospital designations, etc.

MEDICAID & CHILDREN'S HEALTH INSURANCE PROGRAM (\$0.8 billion)

- **Extends the phase-out of cost-based reimbursement for community health centers.** The BBA phased out the Medicaid requirement to pay federally-qualified health centers and rural health clinics based on cost. The 2000 phase-out – where payments are based on 95 percent of costs – would be extended for 2001 and 2002 under this bill. In 2003, payments are based on 90 percent and in 2004 on 85 percent of costs. A study would determine how these clinics should be paid in subsequent years.

- **Extends the availability of the \$500 million fund for children's health outreach.** The welfare reform law put aside a \$500 million fund for states to use for the costs of simplifying their eligibility systems and conducting outreach. To date, only about 10 percent of this fund has been spent, and for nearly 30 states, the funding sunsets this year. This bill eliminates the sunset and extends the availability of this fund until it is expended.
- **Changes Medicaid disproportionate share hospital (DSH) payments and rules.** The BBA included a number of significant changes in the Medicaid DSH program, changing states' allotments. The base year data used to set the DSH allotments in the BBA were flawed for some states. This bill adjusts the allotments for DC, Minnesota, New Mexico and Wyoming. It also makes the DSH transition rule permanent and does not allow states to use enhanced Federal matching payments under the State Children's Health Insurance Program (SCHIP) for DSH.
- **Stabilizes SCHIP allocation formula; adjusts allotment for territories.** Under the BBA, states receive an allotment of the total Federal funding based on their proportion of low-income uninsured children. This formula would result in large, annual fluctuations in state allotments. This bill alters the formula, and puts floors and ceilings on the allotment changes to make funding for states more predictable. It also increases the available funding for territories.
- **Improves data collection and evaluation of SCHIP.** One of the centerpieces of the BBA was the creation of this new program to provide health insurance to children in families with incomes too high for Medicaid but too low to afford private insurance. However, the BBA did not provide funding for monitoring and evaluating the implementation and outcomes of SCHIP. This bill adds funding for data collection and evaluation of this program.

BALANCED BUDGET REFINEMENT ACT OF 1999: HIGHLIGHTS
November 18, 1999

OVERALL

- **Cost:** 2000: \$1.2 billion. 2001: \$5.8 billion. 5 yrs: \$16.0 billion. 10 yrs: \$27.0 billion
- **Trust fund effect:** Not yet known, but House Ways and Means was about 1 year
- **Premium effect:** About \$1 in 2001, the largest year. No effect in 2000
Note: CBO 1997 estimates of 2000: \$55.30. Actual 2000: \$45.50

HOSPITALS (\$6.8 billion)

- **Outpatient departments (\$5.0 billion)**
 - Corridors, hold harmless for rurals, cancer, budget-neutral pass-through for certain drugs, devices and biologicals and outlier policy (\$1.4 billion)
 - Extends capital reduction policy for 6 months until PPS in 9/00 (-\$.3 billion)
 - Clarification of budget-neutral PPS (5.7%), (\$3.9 billion. Note: no OMB score)
- **Increases Indirect Medical Education Payments.** 6.5 percent in FY 2000, 6.25 percent in 2001, and 5.5 percent in 2002 and thereafter. (\$0.6 billion)
- **Reforming Direct Medical Education.** Raises the minimum payment to 70 percent of the national, geographically adjusted average. Limits growth for those above 140 percent of the geographically adjusted average payment (freeze for FY01-02, CPI - 2 for FY03-05. (\$0)
- **Increases disproportionate share hospital (DSH) payments.** Reduced by 3 percent in 2001 and 4 percent in 2002. (\$0.1 billion)
- **Increases payments for PPS-exempt hospitals.** Adjusts rehab PPS; requires new PPS systems for LTC, psych hospitals. Wage adjustment of percentile cap for existing PPS-exempt hospitals; higher payments for LTC, psych hospitals. (\$0.3 billion)
- **Improves rural hospital programs.** (\$0.8 billion)
 - Allows certain hospitals to reclassify to rural for purposes of designation as a Critical Access Hospital (CAH), SCH, RRC. Updates standards for geographic reclassification.
 - Extends MDH program for five years; improves the CAH program.
 - Provides exceptions to residency caps for rural graduate medical education.
 - Rebases SCH, provides for the full market basket increase in 2001.
- **Administrative actions.** Delay the expansion of the hospital transfer policy; stop recoupment of DSH payments based on unclear guidance; delay implementation of the volume control system and refine the ambulatory payment classification system; change to the wage threshold to allow rural hospitals to reclassify for payment purposes; and others.

SKILLED NURSING FACILITIES & THERAPY SERVICES (\$2.7 billion)

- **Add 20 percent to 15 RUGs (3 rehab) for 4 to 10/00.** Also creates special payments to facilities that treat a high proportion of AIDS patients for 2000-2001. Excludes certain ambulance services, prostheses, chemotherapy from consolidated billing (\$1.4 billion)
- **Adds 4 percent for 01-02; option for full Federal rate.** (Federal rate: \$0.7 billion)
- **Imposes two-year moratorium on therapy caps.** (\$0.6 billion)
- **Administrative actions.** Increase payment for high acuity patients beginning 10/00. Exclude certain types of services furnished in hospital outpatient departments from SNF PPS.

HOME HEALTH (\$1.3 billion)

- **Delays 15 percent to one year after PPS.** (\$1.3 billion)
- **Raises per bene limit by 2 percent; pays \$10 per beneficiary in 2000 for OASIS; eases and clarifies the surety bond provision; excludes DME from consolidated billing.** (negligible)
- **Administrative actions.** Delay tracking and pro-rating payments; provide for extended IPS repayment schedules; postpone and change surety bond requirements; among others.

BENEFICIARY IMPROVEMENTS (\$0.3 billion)

- **Limits OPD outpatient coinsurance to the Part A deductible (\$776 in 2000).** (\$0.2 billion)
- **Increases coverage of immunosuppressive drugs** from 36 months to 8 months for beneficiaries whose coverage would otherwise expire for 5 years. (\$0.15 billion)

MANAGED CARE (\$4.8 billion)

- **Risk adjustment:** Original: 90/10; 70/30; 45/55; 20/80; 100 in 2004.
Proposed: 90/10; 90/10; 80/20; silent (\$1.3 billion)
- **Increase rate by FFS – 0.3 percent in 2002 (rather than 0.5).** Also provides an entry bonus for plans entering unserved counties & plans previously announced withdrawal. (\$0.3 billion)
- **Changes provider participation rules and quality standards** Gives plans more time to submit adjusted community rates; providing greater flexibility in benefits and reducing the user fees paid for the Medicare education campaign; reducing quality standards for preferred provider organizations; and expanding deeming provisions.
- **Changes demonstrations.** Delays competitive pricing demonstration project and extends the social health maintenance organization demonstration and several others. (\$0.3 billion)
- **Interaction with fee-for-service policies.** (\$2.9 billion)
- **Administrative actions.** The Administration has and will continue to take administrative actions to improve beneficiary protections and access to information, ease provider participation rules and extend the frail elderly demonstration.

OTHER PROVIDERS (\$0.8 billion)

- **Fixes the fluctuation in physician payments (sustainable growth rate).** (budget neutral)
- **Pap smears:** Minimum payment rate at \$14.60 beginning in 2000. (\$0.1 billion)
- **Increases payments for renal dialysis.** Increases by 1.2% in 00 & 01. (\$0.3 billion)
- **Hospice:** 0.5 for '01, 0.75 for '02, **DME & oxygen:** 0.3 for '01, 0.6 for '02. (\$0.1 billion)
- **Delays authority inherent reasonableness** until a GAO report. (negligible cost)
- **Provides hospital / area-specific adjustments.** (\$0.3 billion)

MEDICAID & CHILDREN'S HEALTH INSURANCE PROGRAM (\$0.8 billion)

- **FQHCS:** Extends 95 percent of costs for 2001 and 2002 (\$0.1 billion)
- **\$500 million fund for outreach.** Available until expended. (\$0.2 billion)
- **Changes Medicaid disproportionate share hospital (DSH) payments and rules.** The BBA included a number of significant changes in the Medicaid DSH program, changing states' allotments. The base year data used to set the DSH allotments in the BBA were flawed for some states. This bill adjusts the allotments for DC, Minnesota, New Mexico and Wyoming. It also makes the DSH transition rule permanent and does not allow states to use enhanced Federal matching payments under the State Children's Health Insurance Program (SCHIP) for DSH. (\$0.2 billion)
- **Stabilizes SCHIP allocation formula; adjusts allotment for territories.** Under the BBA, states receive an allotment of the total Federal funding based on their proportion of low-income uninsured children. This formula would result in large, annual fluctuations in state allotments. This bill alters the formula, and puts floors and ceilings on the allotment changes to make funding for states more predictable. It also increases the available funding for territories. (\$0.1 billion)
- **Improves data collection and evaluation of SCHIP.** One of the centerpieces of the BBA was the creation of this new program to provide health insurance to children in families with incomes too high for Medicaid but too low to afford private insurance. However, the BBA did not provide funding for monitoring and evaluating the implementation and outcomes of SCHIP. This bill adds funding for data collection and evaluation of this program. (\$0.1 million)

BALANCED BUDGET REFINEMENT ACT -- Preliminary CBO Scoring 11/15/99; 5:38pm

(Only provisions that cost/save \$0.1 b shown; by fiscal year, in billions of dollars)

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2000-2004	2000-2009
HOSPITALS												
Teaching Hospitals												
IME: 6.5 in '00, 6.25 in '01; 5.5 in 02 et seq.	0.2	0.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.6	0.6
Natl GME transition	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Hosp: DSH-3% in FY 01, 4% in FY 02	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1
<i>Subtotal</i>	0.2	0.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.7	0.7
Hospital Outpatient Departments (OPD)												
floors	0.1	0.4	0.7	0.6	0.3	0.0	0.0	0.0	0.0	0.0	2.0	2.1
Temporary outlier; extend capital reduction	-0.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	-0.3	-0.3
Clarification that PPS is aggregate budget neutral**	0.2	0.8	0.8	0.8	1.0	1.1	1.1	1.2	1.3	1.4	3.6	9.8
<i>Subtotal</i>	0.0	1.2	1.5	1.4	1.3	1.1	1.1	1.2	1.3	1.4	5.3	11.6
PPS-Exempt Hospitals												
Hosp: LTC & Psych Bonus 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
Wage-adjust 75th pctile cap for TEFRA hosps	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.3	0.8
PPS for psych, long-term care 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
<i>Subtotal</i>	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.3	0.8
Rural Provisions												
Crit Access Hosps: 96 hour avg LOS	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.4
Crit Access Hosps: Conversion of closed 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
Crit Access Hosps: Investor-owned	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1
Swing beds in hosps w/ 51-100 beds	0.0	0.0	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1
Phase in 1996 Cost Base for SCH Now Paid Federal Rate	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.3
SCH: 2001 full MB	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.3
5-Year extension of Medicare-dependent hospital pgm	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.2
GME: Increase # of residents in rural programs	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.2
<i>Subtotal</i>	0.0	0.0	0.1	0.0	0.0	0.0	0.1	0.1	0.1	0.2	0.8	1.7
HOSPITALS: Subtotal	0.2	1.7	1.7	1.5	1.4	1.2	1.3	1.4	1.5	1.7	7.1	14.8
SKILLED NURSING FACILITIES / THERAPY SERVICES												
Increase 15 RUG by 20% 4-10/00; rates by 4% in '01-02	0.2	0.4	0.6	0.1	0.0	0.0	0.0	0.0	0.0	0.0	1.4	1.4
Higher of cur law & 100% federal rate	0.1	0.4	0.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.7	0.7
Separate billing of certain services, AIDS facilities, etc.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Therapy: 2-year moratorium on caps	0.2	0.3	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.6	0.6
<i>Subtotal</i>	0.5	1.1	0.9	0.1	0.0	0.0	0.0	0.0	0.0	0.0	2.7	2.7
HOME HEALTH												
Delay 15% reduction to one year after PPS	0.0	1.0	0.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.3	1.3
Surety bonds	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1
Pay \$10 per bene in FY 2000 for OASIS	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
<i>Subtotal</i>	0.0	1.0	0.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.3	1.4
BENEFICIARY IMPROVEMENTS												
Pgm pays copays above Part A deductible	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.3
Immunosuppressive drugs	0.0	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.2
<i>Subtotal</i>	0.0	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.3	0.5
MANAGED CARE												
Risk adjustment 90/10, 90/10, 80/20, 70/30	0.0	0.2	0.3	0.5	0.3	0.0	0.0	0.0	0.0	0.0	1.3	1.3
Rate increase: update at ffs - 0.3 in 2002	0.0	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.8
Boost Pmts for plans serving counties	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1
Extend Community Nursing Demonstration Org demo	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1
S/HMOs, extend 18 mths after report	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1
M+C: Competitive bidding demo demo	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1
Medicare+Choice Interaction	0.0	1.0	0.8	0.3	0.1	0.2	0.2	0.2	0.2	0.2	2.1	3.0
<i>Subtotal</i>	0.0	1.2	1.1	0.9	0.5	0.3	0.3	0.3	0.3	0.4	4.0	5.5
OTHER PROVIDERS												
MD: SGR technical fix; -0.2% budget neutrality adj	0.0	0.3	0.1	-0.1	-0.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Moratorium on Inherent Reasonableness	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Pap smears (increase payment)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.3
Dialysis Update	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.3	0.8
DME & Oxygen rate increase	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Hospice Update	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1
Reclassify of specific hospitals *	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.5
Muni Health Services Demo: 2 year extension	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1
<i>Subtotal</i>	0.0	0.4	0.2	0.0	-0.2	0.1	0.1	0.1	0.1	0.1	0.8	1.8
PART B PREMIUM EFFECT												
TOTAL, MEDICARE	1.1	5.7	4.2	2.9	1.9	1.8	1.9	2.0	2.2	2.3	15.6	25.8
MEDICAID, STATE CHILDREN'S HEALTH INSURANCE PROGRAM												
Medicaid Interaction with Part B Premium	0.0	0.1	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.2
Medicaid DSH: modify allotments for MN, WY, NM, DC	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.3
Medicaid: lift sunset & limits transition funds	0.1	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.2
Medicaid: effect of FQHC/RHC	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1
S-CHIP: allotments for Puerto Rico & territories	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.3
S-CHIP: modify allocation formula	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
S-CHIP: improved data collection & evaluations of S-CHIP	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1
TOTAL, MEDICAID, CHIP	0.1	0.2	0.1	0.1	0.1	0.1	0.0	0.1	0.1	0.1	0.8	1.3
TOTAL, DIRECT SPENDING	1.2	5.9	4.3	3.0	2.0	1.9	1.9	2.1	2.3	2.4	16.4	27.1

* NW MS Regional Med Ctr deemed a RRC; reclassify certain counties in NY & NC; LTC hospital deemed a new provider; reclassify county in Indiana; adjust wage index in Hattiesburg MS; reclassify certain counties in OH; adjust wage indexes in PA; reclassify a county in VT; SNF fix in Baldwin or Mobile Co. AL, 00
 ** OMB would not score this legislative clarification of language

Medicare Monthly Part B Premiums
(CBO Baseline and Projections)

			CBO: 1997		CBO: 1999		Post-BBRA	
Actual								
2004			\$82.20	11%	\$70.70	10%	\$71.60	10%
2003			\$74.20	11%	\$64.10	11%	\$65.20	10%
2002			\$67.00	10%	\$58.00	8%	\$59.30	7%
2001			\$60.70	10%	\$53.90	9%	\$55.20	12%
2000	\$45.50	0%	\$55.30	9%	\$49.50	9%	\$49.50	9%
1999	\$45.50	4%	\$50.60	11%	\$45.50	4%		
1998	\$43.80	0%	\$45.70	4%				
1997	\$43.80	3%						
1996	\$42.50	-8%						
1995	\$46.10	12%						
1994	\$41.10	12%						
1993	\$36.60	22%						
1992	\$29.90	0%						
1991	\$29.90	5%						
1990	\$28.60	-10%						
1989	\$31.90	29%						
1988	\$24.80	39%						
1987	\$17.90	15%						
1986	\$15.50	0%						
1985	\$15.50	6%						
1984	\$14.60	20%						
1983	\$12.20	0%						
1982	\$12.20	11%						
1981	\$11.00	15%						
1980	\$9.60							

WORK INCENTIVES IMPROVEMENT ACT OF 1999

November 18, 1999

Today, the House of Representatives will vote on the Work Incentives Improvement Act of 1999. The President challenged Congress to pass this bill in his State of the Union address, and fully funded it in his 2000 budget. It gives people who want to work a chance to do so by removing the out-dated rules that end Medicaid and Medicare coverage when people with disabilities return to work. It modernizes the employment services system for people with disabilities. And, it affirms the basic principle manifested in the Americans with Disabilities Act: that all Americans should have the same opportunity to be productive citizens.

IMPROVES HEALTH CARE OPTIONS FOR PEOPLE WITH DISABILITIES BY:

- **Removing limits on the Medicaid buy-in option for workers with disabilities.** This act creates two new options for states that build on a Medicaid buy-in, created by President Clinton in the Balanced Budget Act of 1997. First, it lets states remove the income limit of 250 percent of poverty (about \$21,000), allowing them to set higher income, unearned income, and resource limits. This important change allows people to buy into Medicaid when their jobs pay more than low wages but may not have access to private health insurance. Second, it creates the option to allow people with disabilities to retain Medicaid coverage even though their medical condition has improved as a result of medical coverage. This act also provides \$150 million over 5 years in health care infrastructure grants to states to support people with disabilities who return to work.
- **Creating a new Medicaid buy-in demonstration to help people who are not yet too disabled to work.** This act provides \$250 million to states for a demonstration to assess the effectiveness of providing Medicaid coverage to people whose condition has not yet deteriorated enough to prevent work but who need health care to prevent that level of deterioration. For example, a person with muscular dystrophy, Parkinson's Disease, or diabetes may be able to function and continue to work with appropriate health care, but such health care may only be available once their conditions have become severe enough to qualify them for SSI or SSDI and thus Medicaid or Medicare. This demonstration would provide new information on the cost effectiveness of early health care intervention in keeping people with disabilities from becoming too disabled to work.
- **Extending Medicare coverage for people with disabilities who return to work.** This act extends Medicare Part A premium coverage for people on Social Security disability insurance who return to work for another four and a half years. This means the difference between a monthly premium of nearly \$350 (which is about the cost of purchasing Part A and B coverage) and \$45.50. Although Medicare does not currently provide prescription drugs which are essential to people with disabilities, this assistance will be available nationwide, even in states that do not take the Medicaid options.

ENHANCES THE EMPLOYMENT SERVICES SYSTEM BY:

- **Creating a "Ticket to Work Program."** This new system will enable SSI or SSDI beneficiaries to obtain vocational rehabilitation and employment services from their choice of participating public or private providers. If the beneficiary goes to work and achieves substantial earnings, providers would be paid a portion of the benefits saved.

Medicare Part B Premiums
(CBO Baseline and Projections)

	2000	2001	2002	2003	2004
Post-BBA, 1997	55.30	60.70	67.00	74.20	82.20
Post-BBA Giveback 1999	49.50	55.20	59.30	65.20	71.60
Pre-BBA Giveback 1999	49.50	53.90	58.00	64.10	70.70
		+1.30			

Note: Actual premium for 2000 is \$45.50, lower than what CBO projected in January

1996 1997

1998 1997 2000 2001
42.80 45.50 45.50 Actual

1996 1997 1998 1999 2000 2001

THE WHITE HOUSE
WASHINGTON

November 18, 1999

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

Dear Mr. Chairman:

Yesterday, in preparation for the release of your package, we worked on a draft document summarizing major provisions of the Balanced Budget Refinement Act (BBRA). It included placeholder language that was not finalized and cleared by me.

In response to an urgent request for background information, the draft BBRA summary document was sent to Congressional staff without my authorization. This document was not given by any Administration official to any media, consumer or provider representatives – nor will it be.

I am personally extremely embarrassed about this situation and hope that you will accept my apologies for this mistake. As you know, we have worked together constructively through the process of developing the Balanced Budget Refinement Act. You have been straightforward in your dealings with the Administration and we have done everything possible to reciprocate. I want to once again thank you for your leadership in developing and drafting this legislation.

Sincerely,

A handwritten signature in black ink, appearing to read "Chris Jennings", with a long horizontal flourish extending to the right.

Chris Jennings
Deputy Assistant to the President
For Health Policy



Established in 1978

November 18, 1999

The Honorable William Jefferson Clinton
The White House
1600 Pennsylvania Avenue, NW
Washington DC 20500

Dear President Clinton:

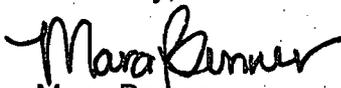
On behalf of the Home Health Services & Staffing Association (HHSSA) that represents over 1,500 home health providers caring for thousands of home health patients, thank you for your efforts this year to restore access for the sickest Medicare beneficiaries to the home health benefit. The legislation, as agreed to by you and the Congress, is a major step towards ensuring care for all eligible patients suffering from a diagnosis such as diabetes, Alzheimer's disease, and multiple sclerosis.

We look forward to working with you next year to ensure quality care and proper implementation of the new prospective payment system for Medicare home health services. As the home health industry undergoes the transition to an entirely new reimbursement system, we are committed to working with you to ensure access for all Medicare beneficiaries.

As the country debates the importance of long term care and caring for the aging population, HHSSA will continue to ensure that home health services remains a viable, cost-effective, and popular choice for all senior citizens. The association greatly appreciates your willingness to work with us on this pledge.

Thank you, again, for taking the steps necessary this year to restore access to care for Medicare beneficiaries.

Sincerely,


Mara Benner
Executive Director



ASSOCIATION OF
AMERICAN
MEDICAL COLLEGES

2450 N STREET, NW, WASHINGTON, DC 20037-1127
PHONE 202-828-0400 FAX 202-828-1123
HTTP://WWW.AAMC.ORG

Jordan J. Cohen, M.D., President

November 17, 1999

The President
The White House
Washington, DC 20500

Dear Mr. President:

On behalf of the nation's teaching hospitals and medical schools, I write to express the sincere gratitude of the Association of American Medical Colleges (AAMC) for your support of our institutions as we have all worked to secure important financial relief from the unintended consequences of the Balanced Budget Act of 1997 (BBA).

Your administration has been instrumental in securing the enactment of legislation to protect Medicare indirect medical education payments to teaching hospitals. Our members are deeply appreciative of the time and effort devoted to this important policy matter. Numerous discussions have taken place over the last several months between many of our teaching hospital chief executive officers and John Podesta, Steve Richetti, Jack Lew, Secretary Shalala, Chris Jennings, Dan Mendelson, Barbara Woolley and others in your administration. We are grateful for the constructive dialogue that was evident in these meetings.

We are well aware of the numerous occasions on which you have spoken publicly in particular support of teaching hospitals and the multiple missions of medical schools and teaching hospitals. Your articulate public statements have been an inspiration to all of us as we have pursued relief from the BBA.

Taken together, the BBA relief legislative package and administrative actions will help to ensure that the unique services provided by teaching hospitals and medical schools—the education of highly skilled doctors, the conduct of life-enhancing clinical research and the delivery of quality patient care—will continue.

Sincerely,

Jordan J. Cohen, M.D.



AAMC Statement on BBA Relief Legislation
Statement From
Jordan J. Cohen, M.D.,
President, Association of American Medical Colleges
November 16, 1999

The Association of American Medical Colleges (AAMC) appreciates the collaborative effort on the part of Congress and the Clinton Administration to secure a measure of relief for all healthcare providers--including U.S. teaching hospitals--from the debilitating Medicare cuts authorized by the Balanced Budget Act of 1997 (BBA).

The legislative remedies are a clear acknowledgement by federal lawmakers that teaching hospitals and faculty do indeed provide unique services worthy of special support. The true beneficiaries of this legislation are the patients who will continue to benefit from the primary products of teaching hospitals--the education of highly skilled doctors, the conduct of life-enhancing clinical research, and the delivery of quality patient care.

We are particularly pleased that the concerns raised by the teaching hospital community regarding steep cuts to the indirect medical education (IME) payments are addressed in the BBA relief legislation. In addition, the legislation agreed to by the House and Senate addresses the problematic changes being made to outpatient payments and eases the cuts in disproportionate share payments (DSH).

While the AAMC is gratified that U.S. teaching hospitals will receive some relief from the BBA cuts, the Association recognizes that Medicare is one of only a number of payers placing financial pressure on teaching hospitals. We hope that the collective goodwill experienced during this current BBA debate will carry over into future discussions to create a stable stream of revenue that eases these pressures and supports the education, research, and patient care missions of teaching hospitals, medical schools, and faculty.

Contact:- John Parker
202-828-0975
jeparker@aamc.org

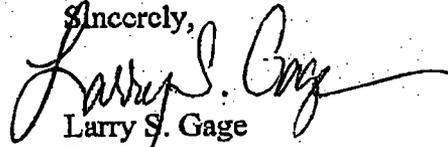
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The Association of American Medical Colleges represents the 125 accredited U.S. medical schools; the 16 accredited Canadian medical schools; some 400 major teaching hospitals, including 74 Veterans Administration medical centers; 91 academic and professional societies representing nearly 88,000 faculty members; and the nation's 67,000 medical students and 102,000 residents.

Additional information about the AAMC and U.S. medical schools and teaching hospitals is available at www.aamc.org/newsroom.

Mr. President, NAPH thanks you again for your leadership. We look forward to working with you next year as you and your Administration continue to address the health care needs of low income and uninsured Americans.

Sincerely,



Larry S. Gage
President

THE WHITE HOUSE

WASHINGTON

November 15, 1999

The Honorable Dennis Hastert
Speaker of the House of Representatives
H-232 Capitol Building
Washington, DC 20515

Dear Mr. Speaker:

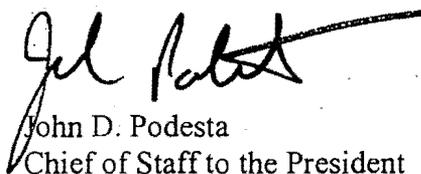
We are pleased that we have been able to work out a strong, bipartisan agreement on the Balanced Budget Refinement Act of 1999. All parties to the agreement, in particular Mr. Thomas, Mr. Bliley, Mr. Dingell, Mr. Rangel, Mr. Stark, Mrs. Johnson, Mr. McCrery, Senator Roth, Senator Moynihan and Senator Nickles, played critical roles in achieving this outcome. We know that this was as high a priority for you as it has been for the President and we appreciate your leadership.

As you know, a technical drafting change in the BBA has resulted in some confusion over the outpatient payment formula that could result in a reduction in payments. Aside from correcting a payment formula flaw, the hospital outpatient PPS was not designed to impose an additional reduction in aggregate payments. We continue to believe that such a reduction would be unwise. During our deliberations on the Balanced Budget Refinement Act, we agreed to resolve any confusion through a Congressional intent clarification provision. Earlier today, language to this effect was worked out between the White House and Mr. Thomas.

As Office of Management and Budget (OMB) Director Lew indicated in his letter to Mr. Thomas on October 18, findings or clarifications by Congress do not change the law and do not result in scoring. Therefore, the attached clarifying language on the hospital outpatient department policy would not be scored by OMB. With this in mind, we would not characterize such legislation as having an adverse effect in any way on the Social Security surplus.

Achieving a bipartisan consensus on addressing the unintended consequences of the BBA is an important accomplishment. The President hopes that we can build on this achievement and pass legislation to strengthen and modernize Medicare.

Sincerely,



John D. Podesta
Chief of Staff to the President

Enclosure

1 **SEC. 201. CONGRESSIONAL POLICIES REGARDING IMPLE-**
2 **MENTATION OF CERTAIN PROVISIONS.**

3 (a) INTENTION REGARDING BASE AMOUNTS IN AP-
4 PLYING THE HOSPITAL OUTPATIENT PROSPECTIVE PAY-
5 MENT SYSTEM.—With respect to determining the amount
6 of copayments described in paragraph (3)(A)(ii) of section
7 1833(t) of the Social Security Act, as added by section
8 4523(a) of Balanced Budget Act of 1997, Congress finds
9 that such amount should be determined without regard
10 to such section, in a budget neutral manner with respect
11 to aggregate payments to hospitals, and that the
12 Secretary of Health and Human Services has the authority
13 to determine such amount without regard to such section.



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

THE DIRECTOR

November 5, 1999

The Honorable Richard A. Gephardt
Democratic Leader
United States House of Representatives
Washington, D.C. 20515

Dear Mr. Leader:

This letter responds to your request on our views of the Balanced Budget Act adjustment bills that are currently being considered in Congress. As you know, the President is committed to moderating policies in the Balanced Budget Act of 1997 that are flawed or have unintended consequences for Medicare beneficiaries and providers. The Administration has taken numerous administrative actions to this end and believes that the Congress should not conclude its first session until necessary legislative changes are made.

Most of the Administration's specific policy suggestions and concerns with the House and Senate bills have been discussed at the staff level, and we will continue that collaboration. I want to take this opportunity to restate our commitment to broader Medicare reform and concern about the potential effect of the adjustment bills on the budget and Medicare trust fund.

The problems caused by the 1997 Balanced Budget Act that we have mutually identified are serious and require immediate action. However, even greater challenges are presented by the demographic and health changes of the 21st century. The doubling of the Medicare population in the next 30 years and advances in medicine will strain Medicare's ability to provide basic health services to seniors and people with disabilities. This is why the President developed a plan to strengthen and modernize Medicare, including adding a long-overdue, voluntary prescription drug benefit. This plan remains one of the Administration's top priorities and we hope to work with you to ensure its passage in 2000.

In the absence of broader reforms, the Administration continues to believe that legislation to correct problems with the Balanced Budget Act policies should be paid for and not undermine the solvency of the Medicare trust fund. The President's Medicare reform plan included a set of proposals to modernize traditional Medicare and reduce costs which would help in this regard. Other offsets, which could include appropriate tax offsets, could also be used. Regardless of the approach, I strongly encourage you to protect the progress we have made in extending the life of the Medicare trust fund and not reverse the gains which we have worked so hard together to achieve.

Medicare Reform:
Provider Give-Back Plan

There are several provisions of the bills that we have identified in staff discussions that could be modified or eliminated. I want to reiterate our concern about a further slow-down of the implementation of the managed care risk adjustment system. The BBA required that payments to managed care plans be risk adjusted. To ease the transition to this system, we proposed a 5-year, gradual phase-in of the risk adjustment system. This phase-in forgoes approximately \$4.5 billion in payment reductions that would have occurred if risk adjustment were fully implemented immediately. The Medicare Payment Advisory Commission and other experts support our planned phase-in. These experts also believe that Medicare continues to overpay managed care plan. In light of this, we think that increased payments to managed care plans through this mandated slow-down of risk adjustment are unwarranted at this time.

The Administration would also support the inclusion of language to clarify the intent of Congress for determining aggregate payments to hospitals under OPD PPS. A technical drafting error in the BBA language authorizing the PPS system has produced some confusion over the aggregate payment formula for this system. The enactment of clarifying language on the subject would be most useful in eliminating the confusion caused by this drafting error.

BBA was an historic and major, bipartisan achievement. Because of its magnitude, it is not surprising that there are a number of modifications that we mutually agree are necessary to address its unintended and negative consequences. The Administration looks forward to working with you on these modifications to ensure that Medicare continues to provide high-quality, accessible health care.

Sincerely,



Jacob J. Lew
Director