

Withdrawal/Redaction Sheet

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. briefing paper	Options for Responding to Last Week's Decision by Many HMO's to Pull Out of Medicare (2 pages)	nd	P5

COLLECTION:

Clinton Presidential Records
 Domestic Policy Council
 Chris Jennings (Subject File)
 OA/Box Number: 23757

FOLDER TITLE:

HMO Withdrawal

gf26

RESTRICTION CODES

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

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

C. Closed in accordance with restrictions contained in donor's deed of gift.

PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).

RR. Document will be reviewed upon request.

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

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



Bob Rozen <rmrozen@washingtoncounsel.com>
05/22/2000 09:17:15 AM

Record Type: Record

To: Devorah R. Adler/OPD/EOP

cc:

Subject: FW: RN letter to Hill on HR 1304 -Reply

Please make sure Chris sees this letter with respect to H.R. 1304.

American Academy of Nurse Practitioners
American College of Nurse Midwives
American College of Nurse Practitioners
American Nurses Association
Association of Women's Health, Obstetric and Neonatal Nurses
National Association of Hispanic Nurses
National Association of Nurse Practitioners in Women's Health
National Black Nurses Association

May 19, 2000

Dear Representative:

As the House of Representatives prepares for floor consideration of H.R. 1304, the Quality Health-Care Coalition Act of 1999, we are writing to make sure you are aware that associations representing the nursing profession, and especially advanced practice nurses, remain strongly opposed to this legislation. We are concerned that this legislation will raise the cost of health care and give physicians the legal means to limit the services provided by advanced practice nurses.

We want to be clear that the Nadler amendment adopted by the Judiciary Committee, which purports to prohibit physicians from reaching agreements to limit the coverage or reimbursement of services provided by non-physician providers, would be ineffective in protecting advanced practice nurses from continuing efforts by physicians to limit their role in the health care delivery system. Although we appreciate the attempt to protect our interests, we do not believe the amendment will preserve for advanced practice nurses the vital protection currently provided by the antitrust laws.

While the amendment suggests that advanced practice nurses may

retain some antitrust protection against the most blatant exclusionary practices, it does not ensure them protection against the more subtle practices that, in fact, pose the greatest risk. Thus, the proposed amendment would not prevent physicians from collectively negotiating with health plans for contractual terms that have the effect of placing non-physician providers at a great competitive disadvantage. Consider, for example, contract terms

that require that a physician be present for certain procedures, even though nurse providers can furnish the procedures independently under state and federal law;

that impose "quality" standards that forbid or discourage referrals to advanced practice nurses;

that mandate certain educational or experience requirements that typically can be met by most physicians, but by only few or no non-physician providers; or

that establish reimbursement rates that are so low for non-physician providers that it is not viable for any of them to participate with health plans as independent providers.

Under existing antitrust laws, physicians can advocate for such terms, even if they disadvantage non-physician providers or are not in the interest of consumers. But the antitrust laws do not allow physicians to engage in collective negotiation and other joint conduct that would allow them to force their views on health plans. H.R. 1304, even with the Nadler amendment, permits such coercion.

Moreover, we do not believe that any amendment can be drafted to assure non-physician providers such as advanced practice nurses that H.R. 1304 does not take from them vital antitrust protection. That is because, by its own terms, H.R. 1304 will give physicians the ability to force health plans to accept the terms that the physicians collectively negotiate, and these terms can be couched in an infinite number of ways in which non-physician providers can be unfairly disadvantaged. Provisos like the Nadler amendment simply will encourage physicians who wish to compete unfairly with non-physician providers to be more resourceful and subtle in their negotiation efforts. The ultimate result -- with or without the Nadler amendment -- will be the same under H.R. 1304. Between physicians and non-physician providers, the playing field will be tilted far in favor of physicians, who will have the unfettered bargaining clout to insist on contractual provisions that place non-physician providers at an unfair disadvantage.

For these reasons, we remain strongly opposed to H.R. 1304. We appreciate your consideration of our views on this important issue for the nursing profession.

American Academy of Nurse Practitioners
American College of Nurse Midwives

American College of Nurse Practitioners
American Nurses Association
Association of Women's Health, Obstetric and Neonatal Nurses
National Association of Hispanic Nurses
National Association of Nurse Practitioners in Women's Health
National Black Nurses Association

Doctor Anti-Trust (Campbell bill) File

~~Chris~~



Bob Rozen <rmrozen@washingtuncounsel.com>
05/18/2000 11:45:41 AM

Record Type: Record

To: Devorah R. Adler/OPD/EOP

cc:

Subject: Antitrust legislation

Chris: The House leadership is expected to make a decision tomorrow on the exact timing of when H.R. 1304 would be brought up for consideration. We were told last night it would likely come before PNTR which indicates probable floor action on Tuesday. While the leadership had indicated last week that amendments would be in order, that is looking less likely now. Not that it matters; the bill is likely to pass with well over 300 votes in support. This is the case even though it would be highly destructive of our health care system if enacted into law. There is no support for the bill in the Senate. Many offices have been contacted but no one has stepped forward to cosponsor. Nevertheless, we are very worried that a big vote in the House will give the bill momentum and something will happen in the Senate. This has been quite frustrating because most of the offices we speak to in the House agree that this is bad policy but they want to be on the side of the docs and take a slap at managed care. This is a lot more about money, however, than it is about broad political attractiveness. The American public is not demanding an antitrust exemption for doctors so they can make more money.

According to Justice and the FTC: if doctors get an antitrust exemption (something that no other group of independent business have), they will use their bargaining power to set higher prices and engage in boycotts against health plans to force other conditions to their liking. Note well, physicians can already band together to negotiate with health plans for the purpose of patient care. What they are looking for is the ability to get together to increase their incomes. This will raise the cost of health insurance, and increase the number of uninsured. This is not something that we are claiming alone, it is in the FTC and DOJ testimony. The FTC also says that the legislation would evidently even permit chain pharmacies such as CVS and Rite Aid to get together for the purpose of setting higher prices on prescription drugs. At a time when one of the most important public policy issues in health care is the rising cost of prescription drugs, giving pharmacies greater power to raise drug prices seems crazy.

Currently, health plans do not permit physicians within their networks to balance bill patients. In fact, in return for being able to bill the health plan directly, typically physicians are not even permitted to balance bill patients outside plan networks. With the new bargaining power given physicians under this legislation, prohibitions on balance billing could go away. So could any effort by health plans to require physicians to maintain a process for monitoring medical errors.

Today, the FTC and DOJ have a very active offices assigned to deal with violations of the antitrust rules by physicians, parmacists, and other health care professionals. At least once a month, major consent decrees are announced where a group of health care professionals have illegally banded together to boycott plans and successfully extort far higher reimbursements. According to Joel Klein: "Our investigators reveal that when health care professionals jointly negotiate with health insurers, without regard to antitrust laws, they typically seek to significantly increase their fees, sometimes by as much as 20-40% ." I have attached some FTC summaries of recent cases. Please take a moment to read a couple of these summaries to see what kinds of practices physicians engage in today, when it is illegal. Imagine what will occur if these anticompetitive practices were to be made legal under H.R. 1304.

Please work to come out with a strong, principled SAP against this bad legislation. If anyone needs any background information, we can provide it. Our website is: <http://www.healthantitrust.org/>

I WOULD STILL LIKE TO SPEAK WITH YOU.

<<FTC cases settleed in 2000.doc>>



- FTC cases settleed in 2000.doc

For Release: April 13, 2000

Austin, TX Surgeon Groups Agree to Settle FTC Charges of Price-Fixing and Concerted Refusals to Deal with Health Plans

An independent practice association ("IPA") containing most of the general surgeons in the Austin, Texas area, and six competing general surgery practice groups that include nearly all of the IPA members, have agreed to settle Federal Trade Commission charges that they conspired to restrain competition among general surgeons in the Austin area. According to the FTC, Texas Surgeons, P.A. ("Texas Surgeons IPA") served as a vehicle for the six competing general surgery practice groups to collectively refuse to deal with two health plans, thereby forcing the plans to accept the IPA's demands to raise surgical rates. As a result, the plans, patients, and employers (including the State of Texas Employees Retirement System and other self-insured employers that utilized the plans' physician networks) were forced to bear more than \$1,000,000 in increased costs for surgical services in 1998 and 1999. The proposed settlement is designed to prevent recurrence of the illegal concerted actions alleged in the complaint, while allowing the respondents to engage in legitimate joint conduct.

The conduct that gave rise to the proposed consent agreement occurred prior to enactment of a 1999 Texas statute that permits the State Attorney General to approve, under certain conditions, joint negotiations between health plans and groups of competing physicians. Because the statute places various limitations on collective negotiation of fees, it is unclear whether conduct of the type described in the complaint could meet the conditions for approval set forth in that statute. The proposed FTC order permits future conduct by the respondents that is approved and supervised by the State of Texas, insofar as that conduct is protected from liability under the federal antitrust laws pursuant to the "state action" doctrine. The state action doctrine shields private conduct that is both: (1) in accordance with a clearly articulated and affirmatively expressed state policy to supplant competition; and (2) actively supervised by the state itself.

The FTC's complaint charges that the Texas Surgeons IPA orchestrated agreements among its physician members to coerce health plans to raise surgical rates to levels demanded by the IPA. The six general surgery practice groups actively participated in the unlawful conduct, the complaint alleges, through their collective control of the Texas Surgeons IPA board of directors, and through their direct participation in collective rate negotiations. The Texas Surgeons IPA, the complaint states, did not engage in any activity that might justify collective agreements on the prices members would accept for their services.

According to the FTC's complaint, in April 1997, Blue Cross Blue Shield of Texas ("Blue Cross") implemented its previously-announced proposal to change its reimbursement system from one based on historical charges to one similar to the system used by the federal government in its Medicare program. The effect of this change was to increase rates paid to primary care physicians, and to reduce rates to all physician specialists (including general surgeons). Soon thereafter, the respondents, through the Texas

Surgeons IPA, began collectively negotiating to obtain higher rates.

Despite multiple attempts by Blue Cross to negotiate individually with the six respondent general surgery practice groups, those groups insisted on negotiating only through the Texas Surgeons IPA, the complaint charges. In September 1997, the Texas Surgeons IPA sent Blue Cross a package of identically worded contract termination notices for each general surgeon member of the Texas Surgeons IPA, with a cover letter stating that the termination notices were due to Blue Cross's "unacceptable" rate reductions. In December 1997, the Texas Surgeons IPA members, dissatisfied with Blue Cross's rate offers, collectively effected their resignations from Blue Cross, and jointly announced that action in a prominent advertisement in Austin's major daily newspaper.

In early 1998, after Blue Cross experienced difficulty in securing the services of a general surgeon for an emergency room patient, Blue Cross concluded that it needed to reach a rate agreement with the respondents as soon as possible to avoid inadequate general surgery coverage for Blue Cross subscribers in the Austin area. Soon thereafter, the respondents collectively negotiated a rate agreement with Blue Cross, increasing Blue Cross surgery rates nearly 30% above the April 1997 levels, according to the FTC.

The complaint also charges that in early November 1997, United HealthCare of Texas ("United") received a written notice from the Texas Surgeons IPA that all of its members would be terminating their contracts with United effective January 1, 1998, due to proposed fee reductions for 1998 that United announced in October 1997. United's proposed fee reductions went into effect on January 1, 1998 for surgical procedures not usually performed by general surgeons, but, due to respondents' unlawful concerted action, the comparable proposed fee reductions for general surgeries never went into effect. After the Texas Surgeons IPA rejected United's request to negotiate with the six respondent general surgery practice groups on an individual basis, and after United explored the possibility of creating a panel of general surgeons that did not include general surgeons from the six respondent general surgery practice groups, it concluded that it had no realistic alternative other than to begin collective fee negotiations with the Texas Surgeons IPA.

The complaint alleges that, in November 1997, the Texas Surgeons IPA required United to sign a waiver of its right to bring a private antitrust action against the Texas Surgeons IPA or its members stemming from respondents' collective fee negotiations with United. The complaint charges that the respondents then demanded and received an agreement from United to increase general surgery fees for United's various plans between 12% to 40% above the fees that United announced in October 1997.

The proposed settlement would prohibit the respondents from entering into or facilitating any agreement: (1) to negotiate on behalf of any physicians with any health plan; (2) to deal, refuse to deal, or threaten to refuse to deal with any health plan; (3) regarding any term on which any physicians deal, or are willing to deal, with any health plan; or (4) to restrict the ability, or facilitate the refusal, of any physician to deal with any health plan on an individual basis or through any other arrangement.

In addition, the settlement would prohibit the respondents from exchanging, or facilitating the exchange of information among Austin area physicians concerning: (1) negotiations with any health plan regarding reimbursement terms; or (2) any physician's actual or contemplated intentions or decisions with respect to any terms, dealings, or refusals to deal with any health plan. The proposed settlement permits each respondent general surgery practice group to participate in arrangements for the provision of physician services that are limited to physicians from the same practice group and allows the respondents to engage in conduct (including collectively determining reimbursement rates with health plans) that is reasonably necessary to operate any "risk-sharing" or "clinically-integrated" joint arrangement (as those terms are defined in the order).

The Commission vote to accept the proposed settlement and place it on the public record for comment was 5-0. An announcement regarding the proposed consent agreement will be published in the Federal Register shortly. The agreement will be subject to public comment until May 15, after which the Commission will decide whether to make it final. Comments should be addressed to the FTC, Office of the Secretary, 600 Pennsylvania Avenue, N.W., Washington, D.C. 20580.

NOTE: A consent agreement is for settlement purposes only and does not constitute an admission of a law violation. When the Commission issues a consent order on a final basis, it carries the force of law with respect to future actions. Each violation of such an order may result in a civil penalty of \$11,000 per day.

Copies of the complaint and proposed settlement, and an analysis of the agreement to aid in public comment are available from the FTC's web site at <http://www.ftc.gov> and also from the FTC's Consumer Response Center, Room 130, 600 Pennsylvania Avenue, N.W., Washington, D.C. 20580; toll-free: 877-FTC-HELP (877-382-4357); TDD for the hearing impaired 202-326-2502. To find out the latest news as it is announced, call the FTC NewsPhone recording at 202-326-2710.

For Release: March 21, 2000

Puerto Rico Dental Association Agrees to Settle FTC Charges of Price Fixing, Boycotting Providers, and Restraining Truthful Advertising by Members

The Colegio de Cirujanos Dentistas de Puerto Rico ("Colegio"), an association of approximately 1800 dentists licensed to practice dentistry in Puerto Rico, has agreed to settle Federal Trade Commission charges that it restrained competition among dentists in Puerto Rico by fixing the terms under which individual dentists would deal with health insurers and other payers of health care services, orchestrating or threatening boycotts of payers by its members to obtain higher reimbursement, and preventing or discouraging truthful, nondeceptive advertising by members. The proposed settlement of the charges would prohibit the Colegio from continuing the illegal conduct alleged in the complaint.

The FTC's complaint alleges that the Colegio, with a membership that includes almost all dentists practicing in Puerto Rico, acted as the collective bargaining agent for its members. Through its Committee on Prepaid Dental Services, and in other ways, the Colegio engaged in negotiations with numerous payers about fees and other terms its members would accept from these payers. According to the proposed complaint, the Colegio promulgated an ethical rule that bars dentists from contracting with any health insurance plan ("plan") that is not endorsed or approved by the Colegio. The complaint also alleges that the Colegio refused to approve plans unless they reimbursed dentists on a fee-for-service basis; were open to participation by all dentists; and were "responsive" to raising fees at the Colegio's request.

The complaint alleges that the Colegio set the prices and other terms under which its member dentists would deal with plans for many years, both before and after Puerto Rico's adoption of the "Reform," a program to provide medical, pharmaceutical, and dental services to the indigent established pursuant to the Puerto Rico Health Insurance Administration Act. For example, outside of the Reform, from 1992 through 1994, the Colegio successfully negotiated on behalf of its members to obtain fee increases from the two largest payers for dental coverage in Puerto Rico, Triple S and La Cruz Azul. Subsequently, under the Reform, the Colegio successfully limited payers from discounting the fees of dentists, blocked payers from implementing new health care delivery systems, and achieved some increases in fees paid to dentists.

The complaint also alleges that the Colegio has acted to prevent certain forms of truthful, nondeceptive advertising. Its Code of Ethics bans advertising that is not "professionally acceptable," use of most illustrations, advertisements deemed not in good taste, and all personal solicitations. The complaint further alleges that the Colegio applied its Code of Ethics to ban advertising by dentists who truthfully advertised their willingness to accept Reform patients from neighboring areas where dentists were conducting a boycott of the Reform.

According to the FTC, the Colegio has not integrated the practices of its members in any

economically significant way, nor has it created any efficiencies that might justify the acts alleged in the complaint. The complaint charges that conduct by the Colegio has restrained competition among dentists and injured consumers in a number of ways, such as:

- fixing or increasing the prices for dental services;
- fixing the terms and conditions upon which dentists would deal with payers (thereby raising the price to consumers of insurance coverage);
- raising prices paid by, and delaying the offer of dental services under, the Reform; and
- depriving consumers of truthful information about dental services.

Under the proposed settlement, the Colegio would be prohibited from:

- negotiating on behalf of any dentists with any payer or provider;
- refusing to deal, boycotting, or threatening to boycott any payer or provider;
- determining any terms, conditions, or requirements upon which dentists will deal with any provider, including terms of reimbursement, and whether the plan is open to participation by all Colegio members; and
- restricting or interfering with truthful advertising or solicitation concerning dental services.

Further, the Colegio would be prohibited from communicating to any payer or provider any term, condition, or requirement on which Colegio members are willing or unwilling to deal with a payer or provider, and from communicating with any member concerning the desirability or appropriateness of any term or condition of a payer relating to dental services, or whether the plan is open to participation by all Colegio members. The Colegio cannot facilitate in any manner, or transfer the exchange of, information concerning dentists' intentions to contract with any payer, or under what terms.

The proposed order does not prohibit the Colegio from engaging in activities encompassed in safety zones recognized by the DOJ/FTC *Statements of Enforcement Policy in Health Care*, or from communicating with payers about other matters, unless the communication is part of an agreement or course of conduct specifically prohibited by the order.

In addition, the proposed order would not restrict the right of the Colegio to provide government bodies with information and opinions in an effort to influence legislation or regulatory action. A proviso states explicitly that the order does not prohibit the Colegio from petitioning any federal, state, or Commonwealth government executive agency or legislative body concerning legislation, rules, or procedures, or from participating in any federal, state, or Commonwealth administrative or judicial proceeding, in so far as such

activity is protected under doctrine recognized by the United States Supreme Court.

The proposed settlement would also prohibit the Colegio from restricting truthful advertising of dental services or solicitation of patients. The Colegio, however, can formulate, adopt, disseminate, and enforce reasonable ethical guidelines governing the conduct of its members with respect to representations that respondent reasonably believes would be false or deceptive within the meaning of Section 5 of the Federal Trade Commission Act.

The proposed settlement also contains a number of record keeping and reporting requirements to assist the Commission in monitoring compliance with the proposed order.

The Commission vote to place the proposed settlement on the public record for comment was 5-0. An announcement regarding the proposed consent agreement will be published in the Federal Register shortly. The agreement will be subject to public comment for 60 days, after which the Commission will decide whether to make it final. Comments should be addressed to the FTC, Office of the Secretary, 600 Pennsylvania Avenue, N.W., Washington, D.C. 20580.

NOTE: A consent agreement is for settlement purposes only and does not constitute an admission of a law violation. When the Commission issues a consent order on a final basis, it carries the force of law with respect to future actions. Each violation of such an order may result in a civil penalty of \$11,000.

Copies of the complaint, proposed settlement and an analysis of the agreement to aid in public comment are available from the FTC's web site at <http://www.ftc.gov> and also from the FTC's Consumer Response Center, Room 130, 600 Pennsylvania Avenue, N.W., Washington, D.C. 20580; toll-free: 877-FTC-HELP (877-382-4357); TDD for the hearing impaired 202-326-2502. To find out the latest news as it is announced, call the FTC NewsPhone recording at 202-326-2710.

For Release: March 7, 2000

Wisconsin Chiropractic Association and Its Director Agree to Settle FTC Charges of Price-Fixing;

Related Settlement with Two La Crosse Chiropractors Resolving Allegations of Price-fixing and Organizing Boycott of Local Managed Care Plan

The Wisconsin Chiropractic Association (WCA) and its executive director, Russell A. Leonard, have agreed to settle Federal Trade Commission allegations that they orchestrated a conspiracy among WCA members to increase prices for chiropractic services and to boycott third-party payers to obtain higher reimbursement rates. The result, the FTC said, was higher prices for consumers of chiropractic services. The proposed settlement would prohibit the WCA and Leonard from fixing prices for any chiropractic goods or services, or the terms of third-party payer contracts.

Additionally, Michael T. Berkley, D.C., and Mark A. Cassellius, D.C., have agreed to settle Federal Trade Commission allegations that they conspired to fix prices for chiropractic services and to boycott the Gundersen Lutheran Health Plan (Gundersen) to obtain higher reimbursement for chiropractic services in and around La Crosse, Wisconsin. The proposed settlement of these charges would prohibit Drs. Berkley and Cassellius from fixing prices for any chiropractic goods or services, and from orchestrating concerted refusals to deal.

Wisconsin Chiropractic Association

The Wisconsin Chiropractic Association, based in Madison, is an association of more than 900 Wisconsin chiropractors, representing about 90 percent of the chiropractors licensed in the state. Professional services performed by chiropractors include manual therapy of the spinal and extra-spinal regions to improve joint and neurophysiological function.

In January 1997, the federal government and many private insurance companies began using new billing codes for chiropractic manipulations. According to the FTC's complaint, the WCA and Leonard used the implementation of the new codes as a vehicle for orchestrating a collective price increase by Wisconsin chiropractors. The WCA and Leonard organized and conducted seminars on the new codes throughout the State of Wisconsin, at which, among other things, Leonard advised chiropractors to raise their prices to specific levels, and assured members that if they all raised their rates, third-party payers would not reject or reduce these higher charges for the new codes. Leonard also surveyed member pricing in certain localities, and reported back to members that chiropractors in these areas had succeeded in raising reimbursement levels, the FTC stated.

The complaint further charges that the WCA, again acting principally through its executive director, engaged in other acts and practices in furtherance of its goal of increasing compensation for chiropractors in the state. In particular, the WCA: circulated

fee surveys to facilitate coordinated pricing by its members; urged chiropractors to negotiate higher fees with the plans and advised members to discuss contract offers with one another to improve their bargaining position with third-party payers; and encouraged and assisted in boycotts of two managed care plans to obtain higher reimbursement rates for chiropractic services.

The proposed settlement would prohibit the WCA from fixing prices or encouraging others to fix prices for chiropractic services, and from creating or endorsing any fee schedule for health care services. It also would bar the WCA from: organizing or engaging in any agreement to negotiate on behalf of any chiropractor or group of chiropractors; or to boycott any payer or provider. In addition, the settlement would prohibit the WCA from: advising chiropractors to refuse or accept any term of any participation agreement; soliciting or communicating any chiropractor's intentions concerning any participation agreement; or organizing or participating in any meeting or discussion that they expect or reasonably should expect will facilitate communications concerning any chiropractor's intentions pertaining to any participation agreement.

Because of the WCA's misuse of fee surveys alleged in the FTC complaint, the proposed settlement also would prohibit the WCA from initiating, conducting, or distributing any fee surveys for any health care goods or services prior to December 31, 2001. In addition, for five years thereafter, the WCA may conduct or distribute any fee survey only if (1) it conforms to the requirements of the safe harbor provisions regarding fee surveys contained in the *Statements of Antitrust Enforcement Policy in Health Care* issued by the FTC and Department of Justice; and (2) respondents do not have access to the raw data.

The settlement with Leonard is similar to that with the WCA. It contains a proviso which allows Leonard to engage in certain acts otherwise prohibited by the order, providing he is acting as an agent, employee or representative exclusively for a single provider or payer.

Drs. Berkley and Cassellius

In the second case announced today, the FTC alleges that shortly after attending the WCA's seminars, Drs. Berkley and Cassellius organized two meetings of La Crosse area chiropractors to discuss Gundersen's failure to utilize the new CMT codes and its reimbursement rates. At these meetings, the complaint alleges, the chiropractors discussed prices, agreed that Gundersen should increase its reimbursement rate, and agreed to terminate their participation in the Gundersen plan if it did not address their concerns. According to the complaint, Dr. Berkley, acting on behalf of the La Crosse area chiropractors, notified Gundersen of the meetings and told Gundersen that if it did not increase its reimbursement rates to at least 85 percent of average billed charges, Gundersen would be unable to obtain agreements with the chiropractors. In June 1997, fearing the loss of a significant number of its chiropractic providers, Gundersen acceded to the chiropractors' demands and increased its reimbursement rates by 20 percent.

The proposed consent agreement to settle these allegations would prohibit Drs. Berkley

and Cassellius from fixing prices for any chiropractic goods or services. In addition, they would be prohibited from: (1) engaging in collective negotiations on behalf of any chiropractors; (2) orchestrating concerted refusals to deal; and (3) fixing prices, or any other terms, on which chiropractors deal. Further, the proposed settlement would prohibit Drs. Berkley and Cassellius from encouraging, advising or pressuring any person to engage in any action that would be prohibited if the person were subject to the order. The proposed settlement does include a proviso allowing Drs. Berkley and Cassellius to engage in conduct (including collectively determining reimbursement and other terms of contracts with payers) that is reasonably necessary to operate (a) any "qualified risk-sharing joint arrangement," or (b) any "qualified clinically integrated joint arrangement."

All of the proposed settlements include a number of recordkeeping and reporting requirements designed to assist the FTC with monitoring compliance with the order.

The Commission votes to place the proposed consent agreements on the public record for comment were 5-0. An announcement regarding the proposed consent agreements will be published in the Federal Register shortly. The agreements will be subject to public comment for 30 days, until April 6, after which the Commission will decide whether to make them final. Comments should be addressed to the FTC, Office of the Secretary, 600 Pennsylvania Avenue, N.W., Washington, D.C. 20580.

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Copies of the complaints, proposed agreements and orders, and an analysis of each agreement to assist in public comment are available from the FTC's web site at <http://www.ftc.gov> and also from the FTC's Consumer Response Center, Room 130, 600 Pennsylvania Avenue, N.W., Washington, D.C. 20580; 877-FTC-HELP (877-382-4357); TDD for the hearing impaired 202-326-2502. To find out the latest news as it is announced, call the FTC NewsPhone recording at 202-326-2710.

Withdrawal/Redaction Marker

Clinton Library

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001. briefing paper	Options for Responding to Last Week's Decision by Many HMO's to Pull Out of Medicare (2 pages)	nd	P5

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

COLLECTION:

Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Subject File)
OA/Box Number: 23757

FOLDER TITLE:

HMO Withdrawal

gf26

RESTRICTION CODES

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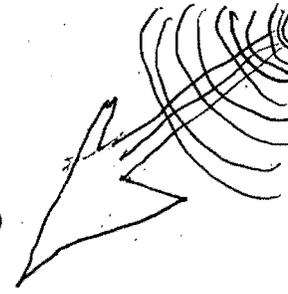
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- b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
- b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

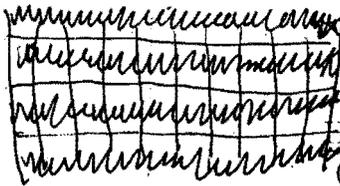


offer made per person cost
- from

May 19, 2000
(House)



SCOPE



Class Actions

H.R. 1304 - Quality Health-Care Coalition Act
(Rep. Campbell (R) CA and 219 cosponsors)

Attending to ensure doc...
in - cost a...
what then or...
greater market...
consolidation...
of health...
plans.

The Administration strongly opposes enactment of H.R. 1304, which would immunize independent-contractor doctors and other health care professionals in private practice from antitrust prohibitions. The bill would change, for the health care industry, the competitive system applicable to the rest of the American economy. It would uniquely authorize health care professionals who are not employed by health insurance plans, and thus not exempt from antitrust scrutiny under existing law, to negotiate collectively with any health plan over fees and collectively to refuse to deal with any plan that did not accede to their demands. The bill would allow these health professionals to raise their fees to health insurers without fear of antitrust liability and without regard to competitive market forces fostered by the antitrust laws.

H.R. 1304 would hurt consumers and taxpayers by raising the costs of both private health insurance and governmental programs with no assurance that quality of care would be improved. There is no justification to accord special status to health care professionals under the antitrust laws, differentiating them from other professionals and independent contractors, such as architects, engineers, or lawyers. It would be both unwise and harmful to consumers to grant them a special exemption.

The better approach is to empower consumers by encouraging price competition, opening the flow of accurate, meaningful information to consumers, and ensuring effective antitrust enforcement both with regard to buyers (health insurance plans) and sellers (health care professionals) of provider services. Competitive issues are best dealt with in a manner that promotes competition, not retards it, as H.R. 1304 would do if enacted.

Pay-As-You-Go Scoring

H.R. 1304 would affect direct spending and receipts; therefore, it is subject to the pay-as-you-go (paygo) requirement of the Omnibus Budget Reconciliation Act of 1990. According to the Congressional Budget Office (CBO), H.R. 1304 would reduce Federal receipts by \$145 million in FY 2001 and a total of \$10.9 billion during FYs 2001-2010. In addition, CBO estimates that H.R. 1304 would increase direct spending for the Federal Employees Health Benefits Program, Medicaid, and the State Children's Health Insurance Program by \$165 million in FY 2001 and a total of \$11.3 billion during FYs 2001-2010. OMB's scoring of H.R. 1304 is under

→ 1304
→ Let them
be in
to
Let them
to let
Consumer
redemption

development.

* * * * *

(Do Not Distribute Outside Executive Office of the President)

This Statement of Administration Policy was developed by the Legislative Reference Division (Pellicci) in consultation with Associate Director _____, the DPC (), WHLA (), WHGC (), HD (). EIML (), and BASD (). The Departments of Justice (per), Health and Human Services (per), the Treasury (per), and Labor (per), and the Federal Trade Commission (per), the Office of Personnel Management (per), and the National Labor Relations Board (per).

OMB/LA Clearance: _____

Background

The position is identical to that taken by the Justice Department in testimony before the House Judiciary Committee on June 22, 1999. It is also consistent with Justice Department letters transmitted to Congress on August 22, 1996, October 10, 1995 (in a joint letter with the FTC), and April 14, 1994.

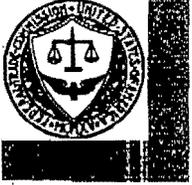
Summary of H.R. 1304

[TO BE SUPPLIED]

Pay-As-You-Go Scoring

[SEE ABOVE]

LEGISLATIVE REFERENCE DIVISION DRAFT
05/17/00 - 5:00 P.M.



Federal Trade Commission

Facsimile Transmittal Sheet

To:	Chris Jennings Fax number: 456-5557	Total number of pages sent (including this cover sheet): 6
From:	David Thomas Congressional Relations Federal Trade Commission Washington, D.C. 20580 Telephone: (202) 326-2195 Facsimile: (202) 326-3585	Sending Organization Code: 0309 Date: 5/16/2000 Time:
Subject:	HR 1304 - The Campbell Bill	
Note:	CHRIS - The Campbell Doctor's Antitrust Bill (HR 1304) is likely to be on the House floor next week. As you may know, the FTC has serious concerns about this bill & has testified on the matter. Please feel free to call me with any questions at 326-2468. Thanks, David	

- Republicans getting healthy w/ docs
 - Dems concerned: AFSCME mkt Drug controls - AFL-CIO
 but AFSCME on the profits. Some says it is bad policy that allow

AMA Assertion: *The bill would not allow price fixing by health care professionals.* *for controls.*
not a say later

FACT: The bill clearly allows price fixing. It would allow doctors and others to agree with their *primary* competitors on the prices they will accept from health plans. This is price fixing. The bill also permits competing providers to back up their price fixing with collective refusals to deal -- that is, they can agree that they will all refuse to contract with any health plan that does not agree to pay the fees demanded. This could leave patients having to pay out of pocket for needed medical services.

The AMA says "price fixing will still be illegal" because the bill would not allow health care professionals to set prices "outside of contract negotiations." That is like saying the bill does not allow price fixing because it does not immunize price fixing in all settings.

The AMA also suggests that price fixing would not be immunized because "fees would be determined through these negotiations between health care professionals and health plans -- not by agreement among the health care professionals." That is the equivalent of suggesting that if all car dealers agreed to sell a Ford Taurus at a set price, they have not fixed prices because the consumer must still agree to pay the price.

AMA Assertion: *The FTC and DOJ would supervise negotiations under HR 1304.*

FACT: This claim is false. The bill provides for no regulatory oversight. The AMA later explains that the bill does not decrease the authority of the antitrust agencies over "activities that are not allowed under HR 1304."

AMA Assertion: *FTC and DOJ opposition to HR 1304 is based on academic theory, not the real world.*

FACT: The agencies' opposition is based on their experience investigating and prosecuting cases in which health care providers have engaged in collective negotiations to raise the fees paid by health plans -- precisely the type of conduct that HR 1304 would immunize.

AMA Assertion: *HR 1304 would promote competition by correcting the imbalance that currently exists in the marketplace between health care professionals and health plans.*

FACT: The bill would permit doctor monopolies. These monopolies could negotiate with health plans -- even those that the AMA would concede are not "dominant" purchasers. This does not "level the playing field," it tilts it entirely in favor of physician cartels.

AMA Assertion: *The argument that HR 1304 will drive up the cost of health care is a smokescreen thrown up by the insurance industry.*

FACT: The federal antitrust agencies, economists, employer groups, the Consumer Federation of America, and the American Bar Association's Antitrust Section have all expressed their belief that the bill threatens to substantially increase health care costs.

AMA Assertion: Current antitrust enforcement policies are inadequate because the agencies have broad discretion to declare negotiating arrangements insufficient to pass antitrust muster.

FACT: Antitrust law allows doctors to collectively negotiate with health plans in various circumstances in which consumers are likely to benefit. The agencies have issued health care policy statements and numerous advisory opinions that emphasize physicians' ability under the antitrust laws to organize networks and other joint arrangements to deal collectively with health plans.

I. An Antitrust Exemption Is Not an Appropriate Response to Health Plans' Superior Bargaining Power Relative to Individual Physicians.

- **Provider preferences are not necessarily the same as consumers'.** Physician preferences are not an effective surrogate for consumer desires. Providers typically envision a single standard for quality health care, while consumer preferences vary (e.g., different notions of "quality"; different cost/quality trade offs -- some would rather pay more for a wider choice of providers, others would not; some consumers want nurse midwives, others don't). Organized groups of providers have used their collective power to impose on the market their view of what consumers should want, such as banning the dissemination of information through advertising; excluding non-physician health care providers; and suppressing alternatives to traditional fee for service medical practice.
- **Physicians and Other Providers Can Collectively Provide Information and Views to Payers and Others, Short of Collective Negotiation or Boycott.** The antitrust laws do not prevent providers from collectively expressing the view -- to payers, regulators, and the public -- that a health plan's policies or decisions are arbitrary or medically unsound, and presenting medical or scientific data to support their views.
- **Doctors can, and many do, take steps to increase both their efficiency and their bargaining power, by establishing larger practice groups or setting up joint ventures.** The relative bargaining power of plans and providers varies tremendously among markets.
- **Market Responses Have Already Occurred In Connection With Some of the Concerns That Have Been Raised About Managed Care.** Managed care products have changed in response to consumer demand. Many plans have expanded their panels, expanded direct access to specialists, or offered products that permit patients to use non-network providers, and many are also taking steps to implement external review systems.
- **When consumers can choose between managed care and indemnity plans, they predominantly choose managed care. Market pressure on physicians to participate in particular plans that flows from consumers' decisions to enroll in such plans should not be overridden through an exemption.** Even where employees are not offered a choice, employers emphasize the importance of employee preferences in the design of health plans, because businesses offer health insurance in order to attract and retain employees.
- **The McCarran-Ferguson Act does not shield collusion by providers on their terms of dealing with health care providers.** The Supreme Court has held that participation contracts between an insurer and health care providers are not "the business of insurance" and thus do not fall within the exemption.
- **The enforcement agencies review health plan mergers, and are prepared to take action in appropriate cases.**

II. Legislative Action to Address Concerns about Health Plans Should Focus on Making the Market Work Better and Targeted Regulation to Curb Abuses

- **The recommendation of the broad-based presidential commission (composed of representatives of providers, consumers, employers, labor, and health plans) that studied changes in the health care system, and the need for measures to protect consumers and promote quality, did not include antitrust immunity for health care providers. The Commission recommended adoption of a consumer bill of rights, and endorsed various steps to make the market work better, such as mechanisms to increase consumer information and enhance consumer choice. For example, it recommended health plans disclose information regarding: limits on coverage; drug formularies; how procedures and drugs are deemed experimental; dispute resolution procedures; disenrollment rates; clinical quality and service performance measures; providers' financial incentives; and requirements to access specialty care.**
- **Where consumers lack adequate information, then government responses should focus on addressing those information gaps.**
- **Concerns about particular contract terms or practices, such as "gag clauses" or arbitrary denials of care, can be dealt with through targeted legislation.**

III. Limiting the Bill to Negotiation of Quality Terms Would Not Significantly Limit its Scope

- **Virtually any issue or concern can be couched in quality terms. Doctors's historical opposition to HMOs was based on the premise that price competition among doctors would lead to a deterioration of medical care. Physicians could easily use a quality pretext to cover demands designed to exclude alternative suppliers of health care services or place them at a competitive disadvantage**
- **Efforts to increase fee levels can be couched in quality terms. Physicians often assert that low fees have led, or will lead, to a deterioration of medical care or access to services.**
- **Utilization review activities affect both quality and cost. Total costs depend on both price and volume and mix of services.**

IV. Permitting Collective Negotiation on "Quality" Issues Would Not Necessarily Improve the Quality of Care Received by Patients

- **Eliminating utilization management would not improve quality. The literature on quality of care shows pervasive problems with underuse of treatments that have been shown to be effective; use of procedures that are not necessary or are inappropriate; poor**

provision of services leading to avoidable complications; and major variations in medical practice among different geographic areas. Efforts to move toward "evidence based" medicine and standards to assure that proven interventions are used consistently and that services are not provided unnecessarily or inappropriately require some oversight of decisions made by individual doctors.

- **All medical care decisions involve some weighing of the costs and benefits of care.** Such tradeoffs should be made by informed consumers in consultation with their treating physicians, not imposed on the market by provider groups.
- **Higher costs tend to result in reduced access to insurance, and thus, reduced access to care.**

Medicare HMO
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September 22, 1999

Medicare H.M.O.'s to End Free Drugs, Report Says

By ROBERT PEAR

WASHINGTON — The Clinton Administration said on Tuesday that health maintenance organizations would no longer provide free drug coverage to any Medicare recipients next year, and White House officials expressed alarm about the trend toward fewer benefits and higher prices.

In the past, many H.M.O.'s attracted elderly and disabled patients by offering prescription drugs at no charge. But in a new report, to be issued on Wednesday, the White House says that all Medicare H.M.O.'s offering drug coverage will charge co-payments for the medicines next year.

As a result, it says, more than 1.2 million Medicare beneficiaries who now have access to free drugs will have to make co-payments, and many more will have to pay higher premiums for such coverage.

Co-payments for brand-name drugs will rise an average of 21 percent, while co-payments for the generic versions of such drugs will rise 8 percent, the White House said. Co-payments now typically range from \$5 to \$20 a prescription.

Vice President Al Gore plans to highlight the trend in a speech here on Wednesday to the American Medical Association, saying it shows that Congress should approve Clinton's proposal to guarantee coverage of prescription drugs in both Medicare H.M.O.'s and the original fee-for-service Medicare program.

"Families that depend on Medicare cannot depend on their

Interactive Guide
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(July 13, 1999)

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Medicare cannot depend on their H.M.O.'s to deliver the affordable critical benefits that enticed them to choose an H.M.O. in the first place," Gore says in remarks prepared for the conference.

Excerpts from the speech and the report were obtained on Tuesday by The New York Times.

About 6.3 million of the 39 million Medicare beneficiaries are in health maintenance organizations. But, the White House says, recent trends have undermined confidence in these health plans, as many H.M.O.'s have decided to pull out of Medicare or reduce the areas they serve.

Health insurers say the Government should increase payments to them, or they will drop even more of the drug benefits they now provide voluntarily.

Susan M. Pisano, a spokeswoman for the American Association of Health Plans, which represents H.M.O.'s, said: "President Clinton is proposing new prescription drug benefits on the one hand while promoting policies that erode existing benefits on the other. The first order of business should be to make sure no beneficiaries lose the benefits they currently have."

The White House report suggests that elderly people cannot depend on H.M.O.'s for generous benefits. "More managed-care plans are charging Medicare beneficiaries higher co-payments for prescription drugs," it says. "In 2000, no Medicare beneficiaries will have access to a prescription drug benefit without any co-payments. In 1999, however, over 1.2 million Medicare beneficiaries had access to a prescription drug benefit where there are no co-payments."

For nearly a year, Medicare officials contended that the cutbacks by H.M.O.'s were just routine business decisions. Lawmakers from both parties, deluged with complaints from constituents, say the officials misjudged the severity of the problem and its political implications.

About 100 people enrolled in Medicare H.M.O.'s are expected to hold a rally on Wednesday at the Capitol, where they will plead with Congress to pump money into the program so they can keep their benefits.

The White House report documents what Gore describes as troubling trends:

¶H.M.O.'s have reduced coverage for prescription drugs used by Medicare beneficiaries. This year 21 percent of Medicare plans limit drug coverage to \$500 or less. But next year 32 percent of Medicare H.M.O.'s will have such limits.

[Breaks Logjam \(June 30, 1999\)](#)
[Democrats Stall Senate to Force Debate on Health Care \(June 24, 1999\)](#)

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¶The number of beneficiaries who have access only to the most expensive H.M.O.'s -- those with annual premiums of \$960 or more -- will quadruple, to 207,000 next year, from 50,000 this year.

¶Some states, like Iowa and Delaware, will see "a substantial decrease in the number of beneficiaries" who have access to drug coverage through Medicare H.M.O.'s.

In other states, drug coverage will still be available, but at much higher premiums.

The Medicare program generally does not pay for drugs outside the hospital. Medicare H.M.O.'s are not required to offer drug benefits, and the Government does not pay them for such benefits, even though patients have come to expect them.

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DRAFT

Medicare ~~Choice~~ pull-out plan
Choice HMO

Only

Medicare+Choice in 2000: Plan Participation Summary

All information is as of July 8, 1999. Except where noted, "enrollees" refers to Medicare+Choice enrollees. Except where noted, the term "non-renewal" includes both actual non-renewal of entire contracts as well as service are reductions.

Year 2000 Benefits and Premiums Based on preliminary review and analysis of ACR data.

- Beginning in January 2000, we expect that fewer Medicare eligibles will have access to a managed care health plan. Approximately 70% of the current Medicare eligibles (or 27 of 39 million) now have access to a managed care health plan. Beginning in January 2000, we expect that fewer than 67% (or 26 million) of Medicare eligibles will have access to a managed care plan.
- Fewer Medicare eligibles will have access to a managed care plan with no monthly premiums. In 2000, fewer Medicare eligibles will have access to a \$0 (zero) premium plan than in 1999. In 1999, approximately 65% of those Medicare eligibles with access to a managed care plan could join a plan without paying monthly premiums. Based on preliminary estimates, we expect that only 36% of persons living where managed care plans are available may join a \$0 premium plan.
- Overall, we expect that managed care enrollees will pay more to join a managed care plan in 2000, compared to what they paid in 1999. In 1999, approximately 15% of the total managed care plans (or benefit packages) had premiums in excess of \$30 a month. In 2000, we expect that over 50% of the managed care plans in 2000 will have premiums of more than \$30.

Based on preliminary estimates, it appears that the total amount of out-of-pocket costs that M+C enrollees pay for services will increase significantly in 2000, compared to 1999. On average, enrollees will pay approximately \$75.00 per month in premiums and copayments in 2000, more than twice the approximately \$35.00 per month they are currently paying.

- The majority of Medicare eligibles with access to a managed care plan continue to receive prescription drug coverage as part of their basic services. In 1999 and in 2000, approximately 25 million Medicare eligibles (or over 90% of the total with access to a managed care plan) will have access to a basic managed care plan which includes prescription drug coverage. In addition, another 1%-2% will have the option to pay additional premiums for prescription drug coverage.

Internal only

Non-renewal Summary

General

- About 95% of current Medicare+Choice enrollees will be able to continue with their current plan.
- There were 56 service area reductions affecting 152,482 enrollees. These plans will continue serving other parts of their current service areas. There were 41 non-renewals affecting 168,628 enrollees.

In total, 97 contracts non-renewed or reduced their service areas, affecting 321,110 enrollees (5.1% of the 6.2 million Medicare+Choice enrollees) who live in 327 counties in 33 states.

- In 1998, there were 54 service area reductions affecting 191,851 enrollees. There were 45 non-renewing contracts affecting 214,687 enrollees. In total, 405,538 enrollees (about 6.5 percent of enrollment at the time in 1998) were affected, in 407 counties in 29 states and the District of Columbia.

Abandoned Counties

- 79,186 (1.3 percent of all enrollees) of the 321,110 affected enrollees will have no other M+C plan available. These enrollees live in 110 counties in 21 states.
- In 1998, 51,276 enrollees (less than 1 percent of enrollment at the time in 1998) were left with no other plan. They lived in 79 counties. Four of these counties (Kent and Sussex in Delaware, Monroe in Florida and Muskingum in Ohio) now have an M+C plan available.

Benefits and Premiums for Nonrenewing Plans

- Approximately 79% (73 of 92) of M+C organizations who reduced their service areas or withdrew their managed care contract offered a \$0 (zero) premium plan.
- Approximately 60% (or 58 of 92) of M+C organizations who reduced their service areas or withdrew their managed care contract offered a prescription drug benefit.

Payments in Affected Areas

- Two-thirds of affected enrollees -- more than 200,000 enrollees -- live in areas where the payment rate was between \$450 to less than \$550.
- Some areas were disproportionately affected. The most disproportionately affected areas were where the payment rate was between \$450 to less than \$500 and with growth rates between 5 percent to less than 7.5 percent --- about 13.8 percent of all enrollees were affected in such areas compared to 5.1 percent of enrollees nationwide.

DRAFT

In this category (\$450 to less than \$500), growth rates did not matter. For example, in area with growth rates of 10 percent or higher, 11.1 percent of enrollees were affected compared to 5.1 percent of enrollees nationwide. Overall, in this category, 12 percent of enrollees were affected.

- Beneficiaries in counties with payments from the floor to \$500 make up 24.2 percent of beneficiaries enrolled in M+C but represent 50.1 percent of withdrawals.
- Beneficiaries in counties with payments from the floor to \$550 make up 50.8 percent of M+C enrollees but represent 77.7 percent of withdrawals.
- The national median payment rate, weighted by beneficiaries is \$499.04 for 2000. The national median payment rate, weighted by enrollees is \$548.59 for 2000. The national mean payment rate, weighted by beneficiaries is \$513.62 for 2000. The national mean payment rate, weighted by enrollees is \$560.20.
- On the other hand, some areas were not as hard hit.
 - 1.3 percent of enrollees in areas with payment rates of \$600 or more were affected.
 - 2.3 percent of enrollees in areas with 2 percent growth rates were affected.

Choices

- About 75.3 percent of affected enrollees will have one or more M+C plan available.
- 58.2 percent of affected enrollees will have two or more M+C plans available.

Geographic Distribution

- Enrollees in 33 states were affected by non-renewals.
- Some of the hardest hit states include:
 - The following states have the most enrollees affected (number of enrollees in parentheses): New York (39,000); Louisiana (34,000); Texas (32,000); Florida (29,000); and Arizona (27,000).
 - In terms of enrollees affected as a percentage of all Medicare+Choice enrollees in the state, the following states were most affected: New Hampshire (83% -- 13,000 enrollees affected); South Carolina (69% -- 1,100 enrollees affected); Nebraska (45% -- 5,400 enrollees affected); Iowa (44% -- 1,400 enrollees affected); and Louisiana (43% -- 16,700 enrollees affected).

- In terms of affected enrollees as percentage of all beneficiaries in the state, the following states were most affected: New Hampshire (8% -- 13,000 enrollees affected); Louisiana (6% -- 34,000 enrollees affected); Nevada (4% -- 9,600 enrollees affected); Arizona (4% -- 27,000 enrollees affected); and Colorado (3% -- 15,000 enrollees affected).

Other Plan Types

- 18,702 enrollees in cost plans and 7,058 enrollees in demonstration plans were affected by non-renewals.
- In 1998, about 53,000 enrollees were affected by non-renewals by other plan types.

Other Payors

- FEHB expects to lose 36 plans (about 13 percent) out of the current 280. This will affect about 36,000 contract holders (i.e., employees and retirees but not including dependent) out of about 3.8 million contract holders. Thus about 1 percent of contract holders will be affected.



GEORGETOWN UNIVERSITY

Office of the President
Assistant for Federal Relations

October 18, 1999

Mr. Christopher Jennings
Deputy Assistant to the President for Health Policy
OEOB, Room 216
Washington, DC 20500

Tel: 202-456-5560
Fax: 202-456-5557

Dear Mr. Jennings:

We met with you in January of 1998 concerning the Medicare Demonstration Program authorized under PL 105-33 at Georgetown University Medical Center. Working with the Division of Demonstration Programs of the Healthcare Financing Administration in Baltimore, Maryland, we submitted our formal application April 27th, 1999, the cover letter of which is attached.

Prior to that time and currently, we have been using \$6 million appropriated in the District of Columbia appropriations law for both FY98 and FY99 to advance the program. The language in the FY99 law is as follows: "For payment to the District of Columbia Financial Responsibility and Management Assistance Authority, \$3,000,000 for the continued funding of a Medicare Coordinated Care Demonstration Project in the District of Columbia as specified in section 4016(b)(2)(C) of the Balanced Budget Act of 1997."

We are well along in the development of critical pathways for patient management and are expending considerable time and effort to devise a computer information system essential for the Demonstration Program.

This Spring, we asked Senator Specter and Senator Roth to provide special assistance for the startup of our Medicare Demonstration program, in particular for waivers of certain regulations which currently hinder Federal funding for essential aspects of the program.

The Senate Appropriations Subcommittee on Labor, Health and Human Services, and Education has included language in its Report to accompany S. 1650 that responds largely to our request. (See the attached.). In as much as the original legislation allows the Secretary to grant waivers, the new language will, we hope, encourage the granting of funding for case management services, flexible benefits and information infrastructure.

Washington DC 20057

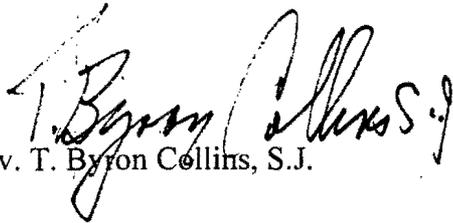
Tel: (202) 687-3455 FAX: (202) 687-1656

georgew@gunet.georgetown.edu

Since the Appropriations Bill for Labor, HHS and Education may well become part of an Omnibus Appropriations Bill, we ask that you advocate the inclusion of the Senate language in the President's program.

We are prayerfully grateful for your assistance.

Sincerely,



Rev. T. Byron Collins, S.J.



Rev. William L. George, S.J.

Final Appropriations Bill Language FY2000 DRAFT (revised):

Labor, Health and Human Services, & Education Appropriations:

Sec. _____

The Health Care Finance Administration shall provide funding for the Medicare demonstration program established by PL 105-33 Sect. 4016 (b) (2) (C) to cover the one-time costs for information infrastructure and recurring costs of case management services, flexible benefits and program management.

HCFA Demonstration

Background:

Senate Subcommittee on Labor, Health and Human Services, and Education and Related Agencies Appropriations has included language in its Report 106-166 [To accompany S. 1650] encouraging the agency to fund innovative components of the project.

Senate Report language for Report 106-166 [To accompany S.1650]:

p. 202: "The Committee is aware of efforts at Georgetown University Medical Center to improve medical care of Medicare eligible patients by designing a computer system to track actual costs of treatment for under-served Medicare patients in the Washington metropolitan area and comparing these costs with the DRG-established program costs. This demonstration would provide the Medicare system with a model for closer tracking of health care costs needed to improve coverage, and ultimately, improve medical care."

p. 203: "The Committee is aware that the Medicare Demonstration program in the nation's capital is authorized in the Balanced Budget Act of 1997. The objective of the Demonstration, as specified in the legislation, is to improve the quality of care for the sickest, neediest Medicare patients in the national capital region at no increase costs [sic] to Medicare. Federal funding would ensure the success of the demonstration by covering the three components of the demonstration project: case management services, flexible benefits and information infrastructure."



GEORGETOWN UNIVERSITY

Office of the President
Assistant for Federal Relations

October 22, 1999

Ms. Catherine Jansto
Associate Director, Division of Demonstration Programs
Healthcare Financing Administration
Division of Demonstration Programs
7500 Security Blvd., CS-15-06
Baltimore, Maryland 21244-1850

Tel: 410-786-7762
Fax: 410-786-1048

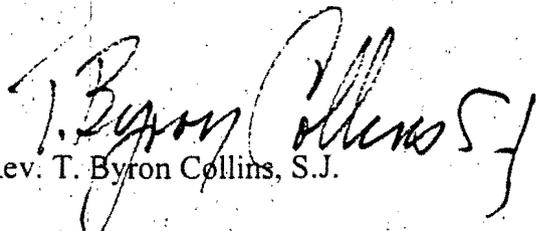
Dear Ms. Jansto,

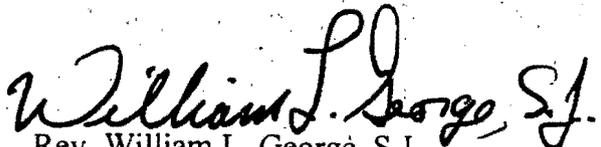
Enclosed is a letter from our Executive Vice President for Health Sciences dated September 22, 1999. In this letter, Dr. Sam Wiesel appoints Dr. James C. Welsh as the Principal Investigator of the Georgetown University Medicare Demonstration Program.

If you have any questions concerning the Medicare Demonstration Program, please contact Dr. Welsh by phone (202) 687-1035 or by fax (202) 687-6048.

Dr. Welsh will in due course be in touch with your office.

Sincerely,


Rev. T. Byron Collins, S.J.


Rev. William L. George, S.J.

Welsh/Heddon

Washington DC 20057

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“Coordinated Medicare for the
Chronically Ill”
A Medicare Demonstration Project



Georgetown University Medical Center
October 1999

Estimated 1999 FFS Costs

\$ 1,540.83 PMPM

- Hypertension
- Diabetes
- Congestive Heart Failure
- Ischemic Heart Disease
- Stroke
- Peripheral Vascular Disease
- Liver Disease
- Cancer
- Respiratory Disease

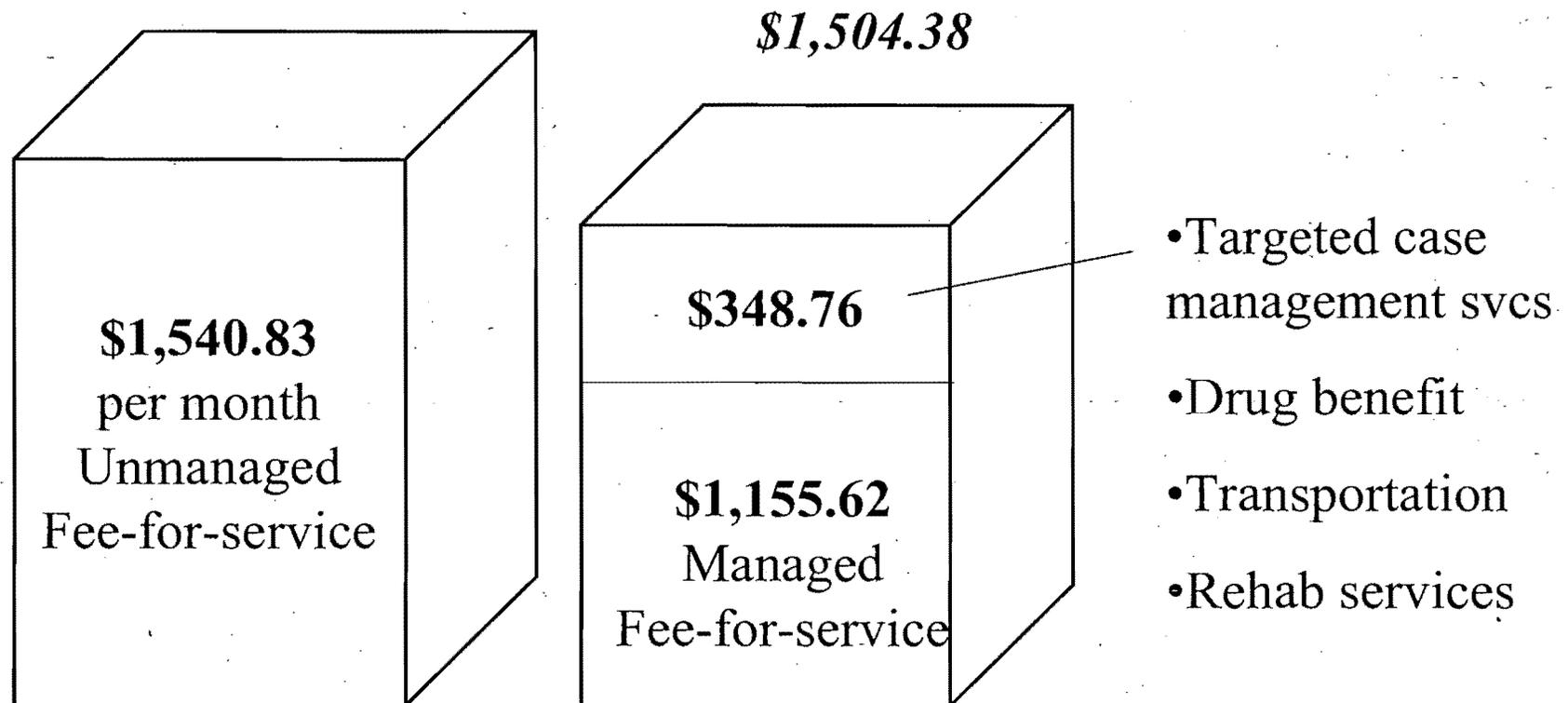
Refer to Exhibits 1 & 2

Estimated FFS Costs per Enrollee

1997 FFS Cost per Enrollee (Based on 5% sample of HCFA claims for targeted disease groups)	\$ 1,054.08
Adjusted for GUMC (Blended 1997 AAPCC rate (80% DC: 20% PG)/ 1997 National Average AAPCC)	↓ \$ 1,331.06
Adjusted for Health Care Inflation (1997-99)	↓ \$ 1,540.83
	per month

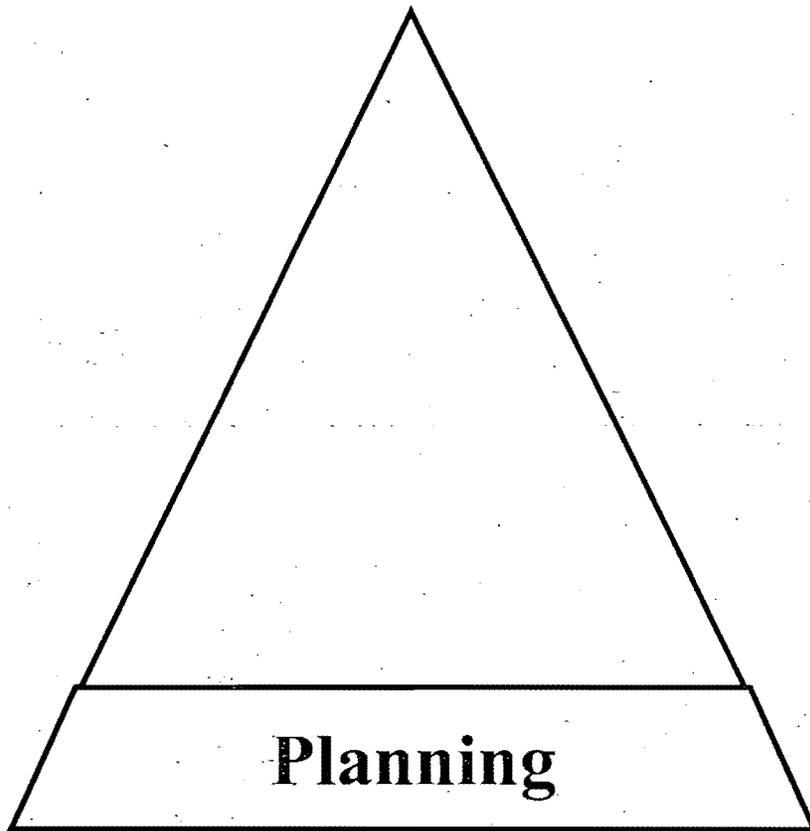
Refer to Exhibit 1

Why a Coordinated Fee-for-Service Model?



Refer to Exhibit 2

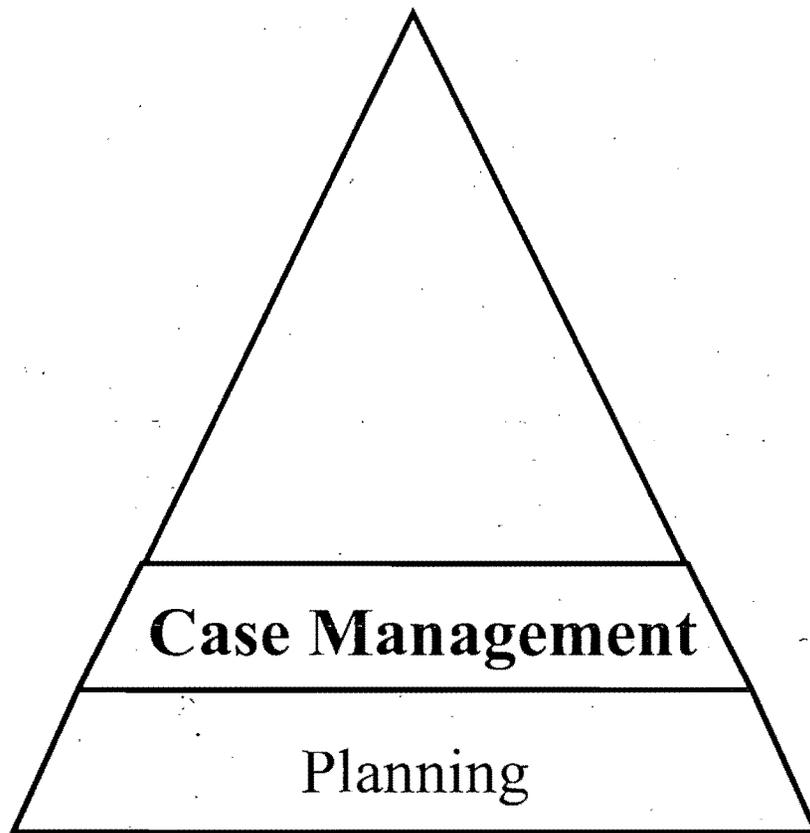
Planning



Initial DC appropriated funds to plan the Demonstration Project and provide assistance to first year operating costs:

- Needs Assessment
- Market Assessment
- IS research
- Pathways research
- Program Design

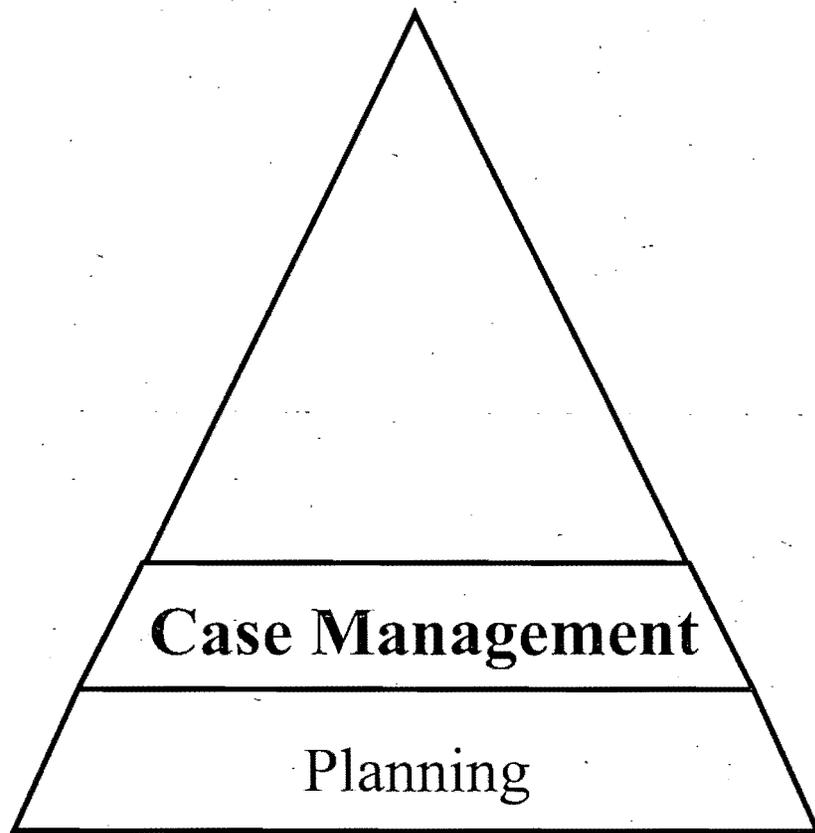
Case Management Services



- Foundation of the program
- Care coordination
- Navigate enrollees through the program
- “Case Manager-Enrollee” relationship provides for program continuity
- Provide early intervention
- Bridge inpatient-outpatient care

Refer to Exhibit 3

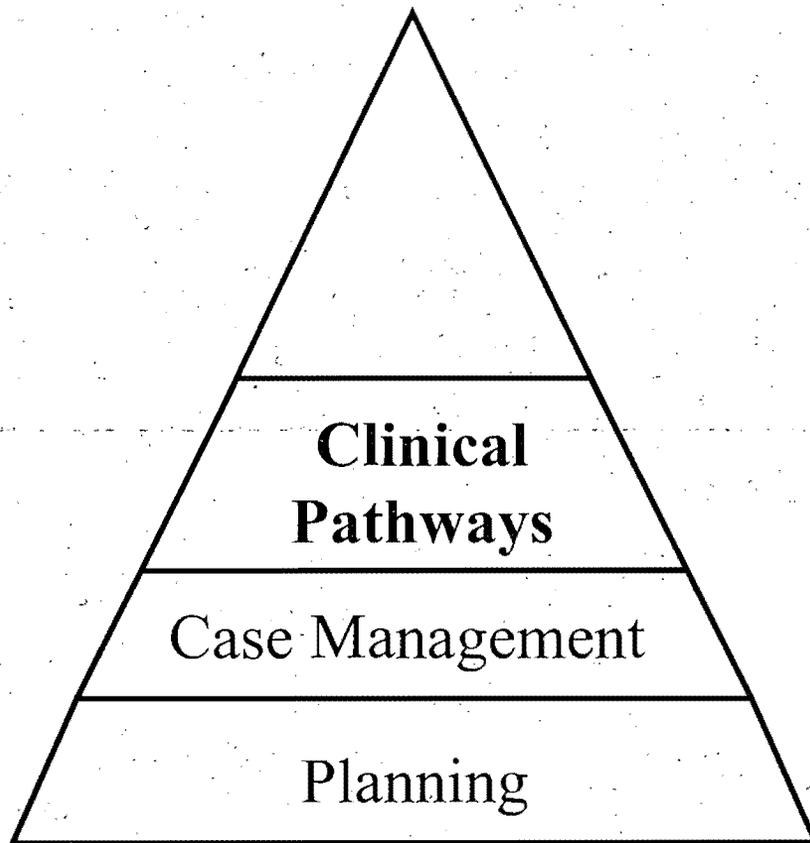
Case Management Services



- Not currently covered by Medicare program
- Case manager to enrollee ratio of 1:50
- Modeled on PACE program ratio
- Estimated PMPM is \$161.76

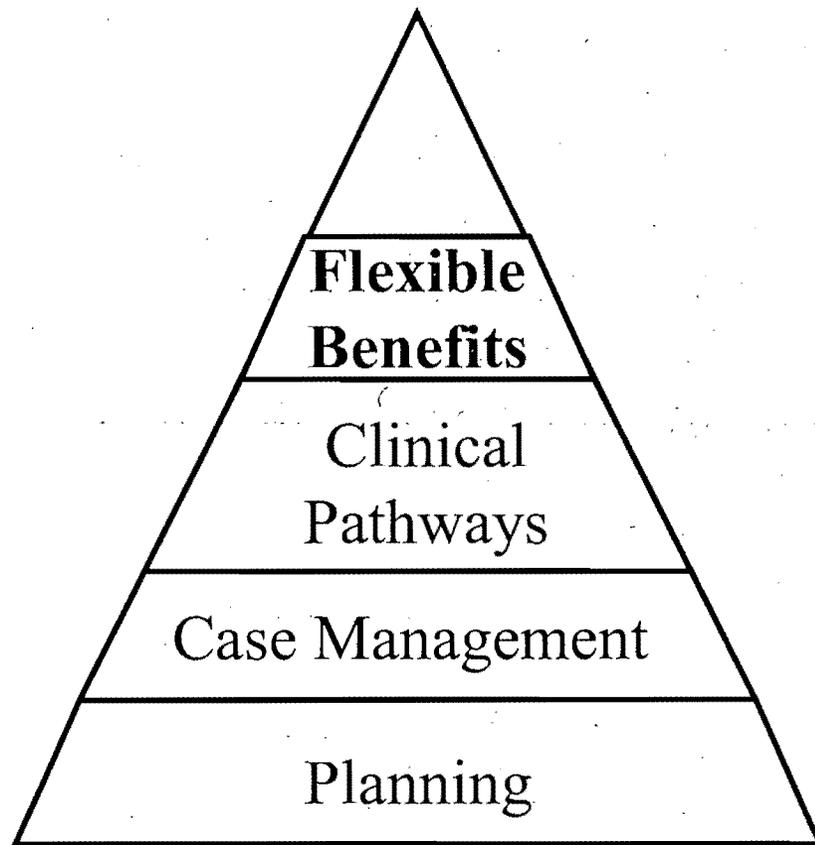
Refer to Exhibit 3

Clinical Pathways



- Provide coordinated treatment plans to 11 groups of the most chronically-ill patients
- Pathways were based on a study of HCFA claims demonstrating highest cost and resource demands on Medicare program
- Pathways encompass inpatient and outpatient care

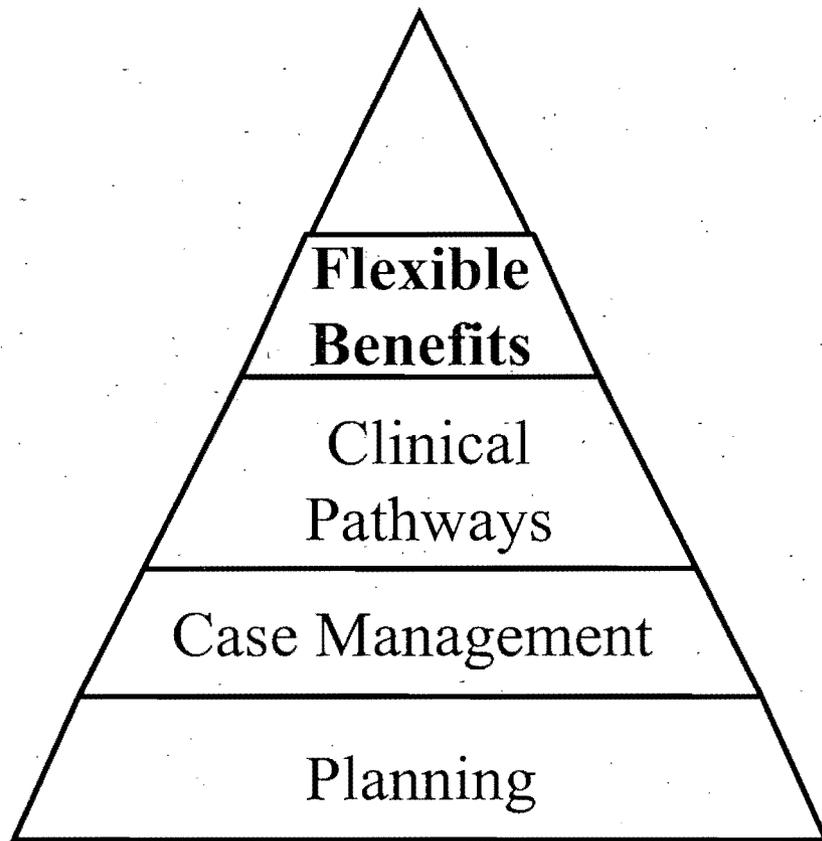
Flexible Benefits



Goal is to provide more effective care by reducing barriers inherent in FFS structure.

- Access to providers
- Access to treatment
- Access to coordinated restorative care

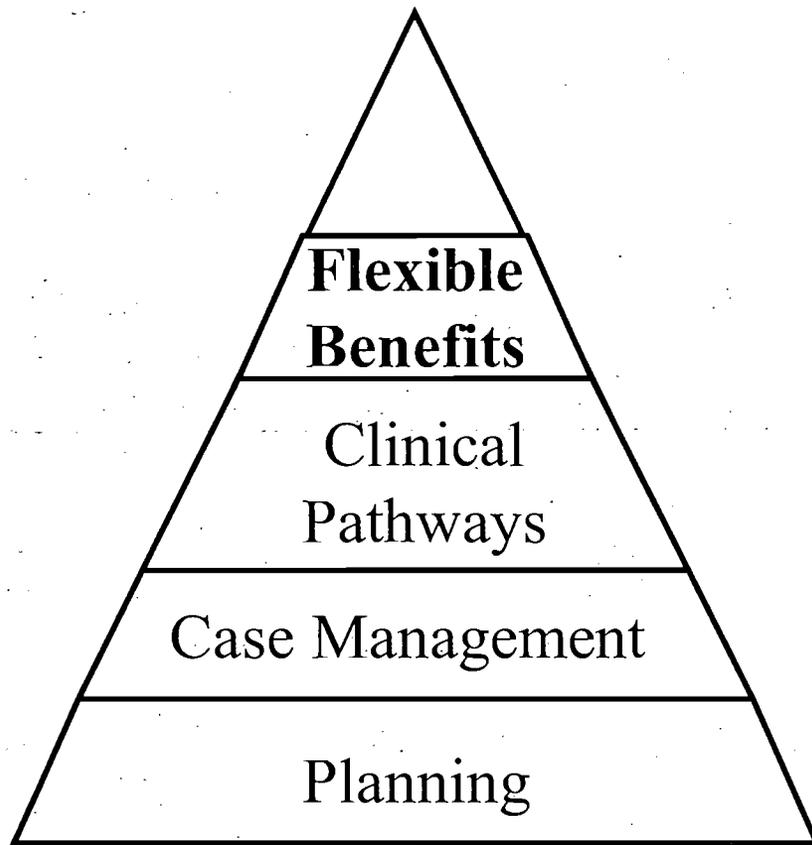
Flexible Benefits



Includes federal funding for:

- Co-insurance (Parts A and B deductibles and copayments)
- Prescription drugs (pathway specific)
- Rehab services (pathway specific)
- Transportation services

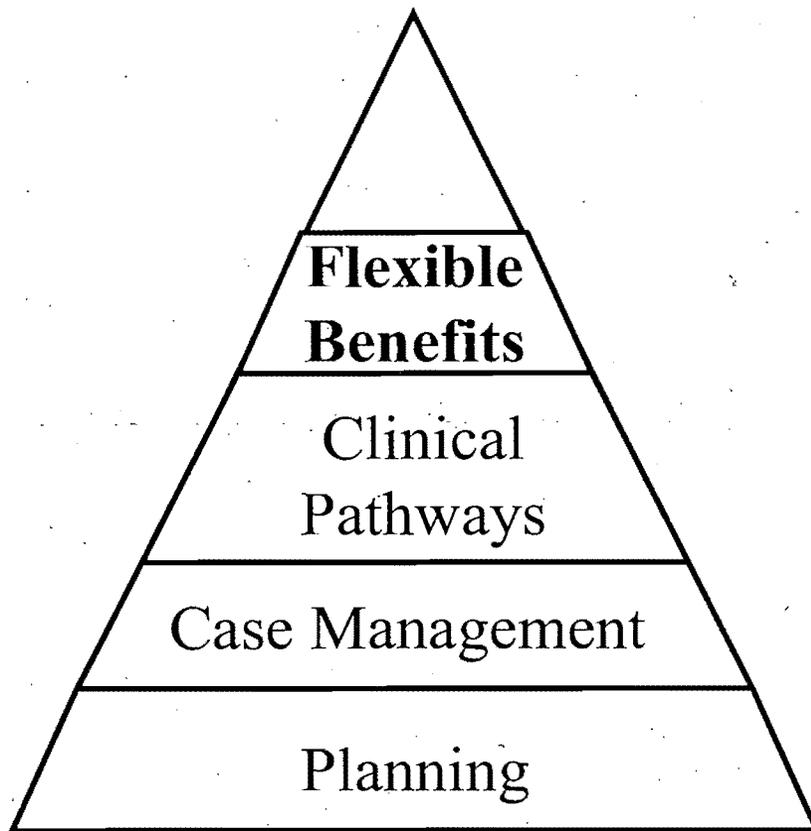
Co-insurance Federal-funded



- Reduces financial barriers to access by covering 20% patient copayment
- Clinical pathways will focus on minimizing inpatient care, but funds will also assist with Part A deductibles
- Estimated cost of \$135.13 PMPM

Refer to Exhibit 4A

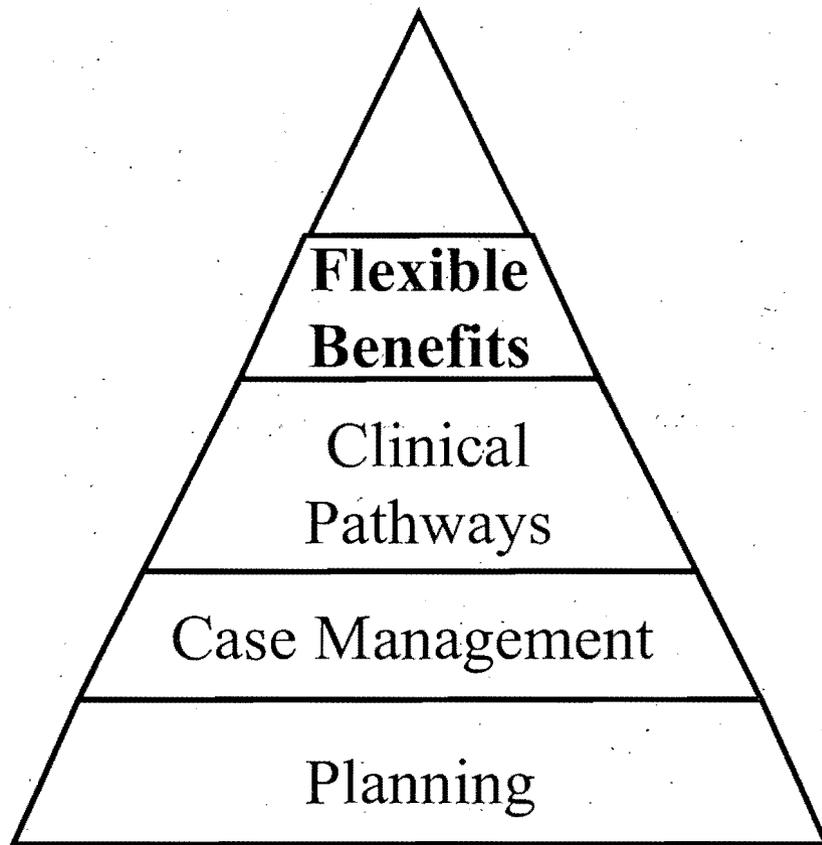
Prescription Drug Benefits



- Concept is similar to annual benefit provided by Medicare risk providers
- Often reason for choosing a Medicare risk product
- \$1,500 annual enrollee cap
- Drug benefit is specific to each pathway
- Links the disease management process to cost-effective use of prescription drugs
- Estimated cost of \$140.93 PMPM

Refer to Exhibit 4B

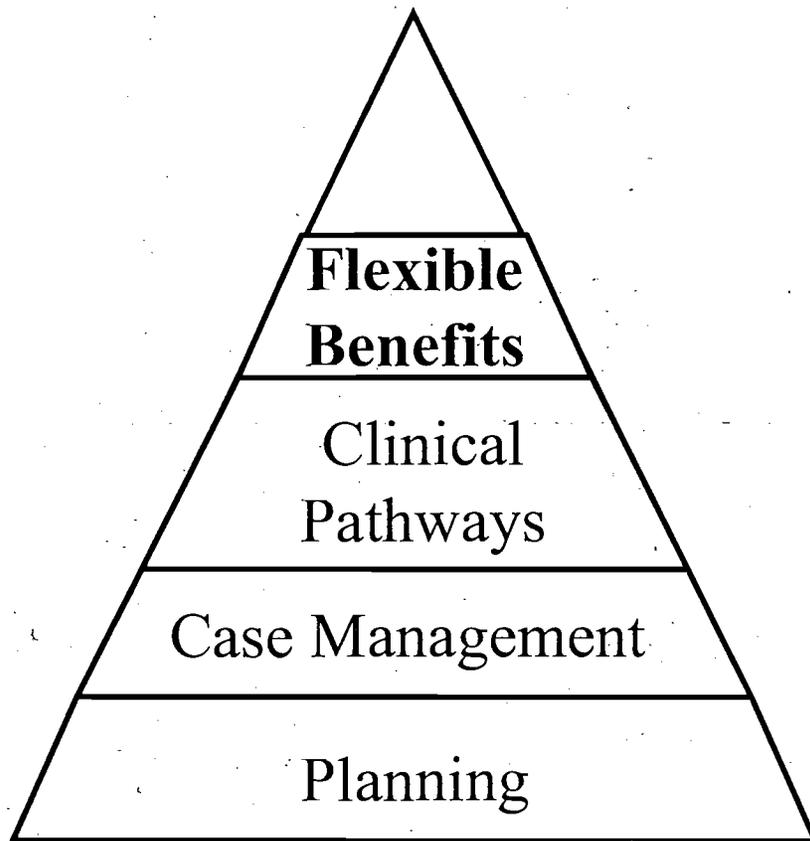
Rehabilitation Services



- Provides for physical, occupational and speech therapy services
- Pathway-specific with limits defined by clinical pathways rather than by reimbursement limits
- Includes medical devices
- Estimated cost of \$40.41 PMPM

Refer to Exhibit 4C

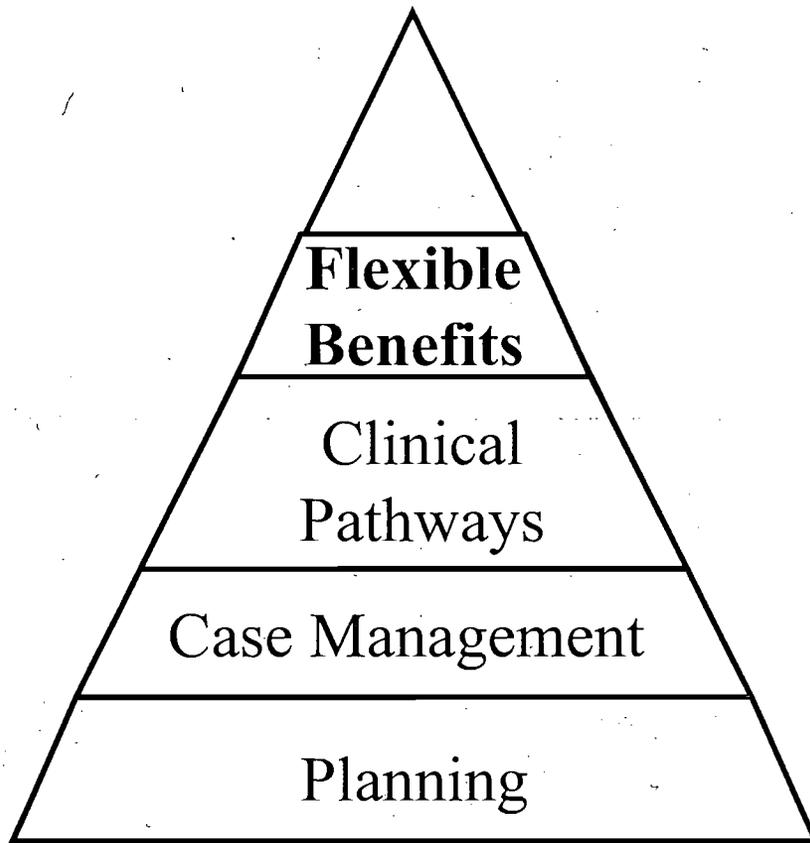
Transportation



- Provides transportation service to physician appointments at community sites or to the hospital
- Facilitates removal of barriers to access
- Estimated cost of \$5.66 PMPM

Refer to Exhibit 4D

Summary of Flexible Benefit Costs



Co-Insurance	\$ 135.13
Pharmacy	\$ 140.93
Rehab Services	\$ 40.41
Transportation	<u>\$ 5.66</u>

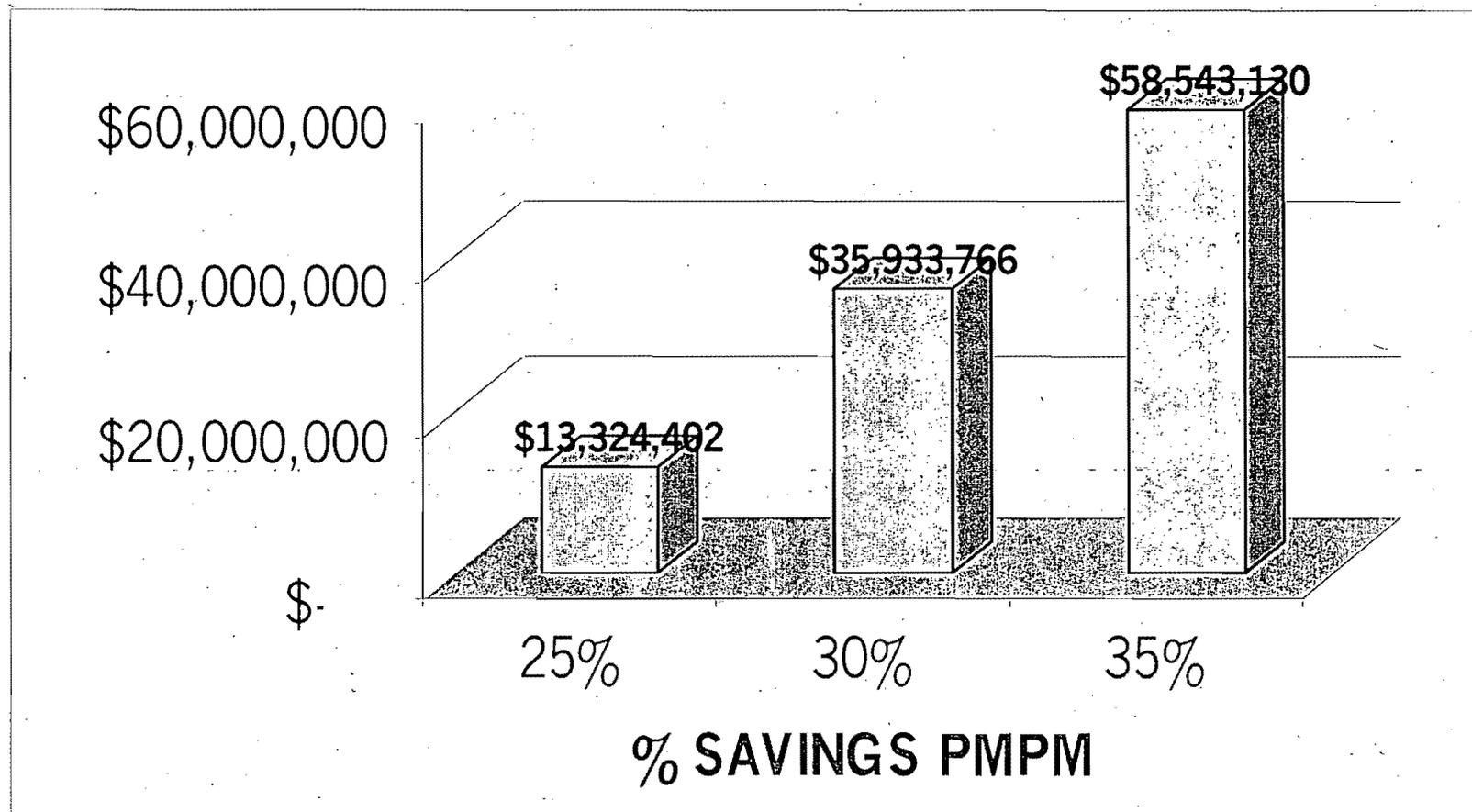
Total PMPM for
Flexible Benefits **\$ 322.13**

Estimated Project Costs per Enrollee

Project expects savings of 25% from implementation of intensive case-managed coordinated care model	\$ 1,540.83 ↓ \$ 1,155.62
Add: Case Management Services PMPM	161.76
Add: Flexible Benefits PMPM	<u>322.13</u>
Total Project PMPM Cost per Enrollee	\$ 1,639.51
Less: Co-Insurance and Deductibles	<u>(135.13)</u>
Net Project PMPM Cost per Enrollee	\$ 1,504.38
At 25% Savings, Project vs. FFS Cost per Enrollee	\$ 36.45

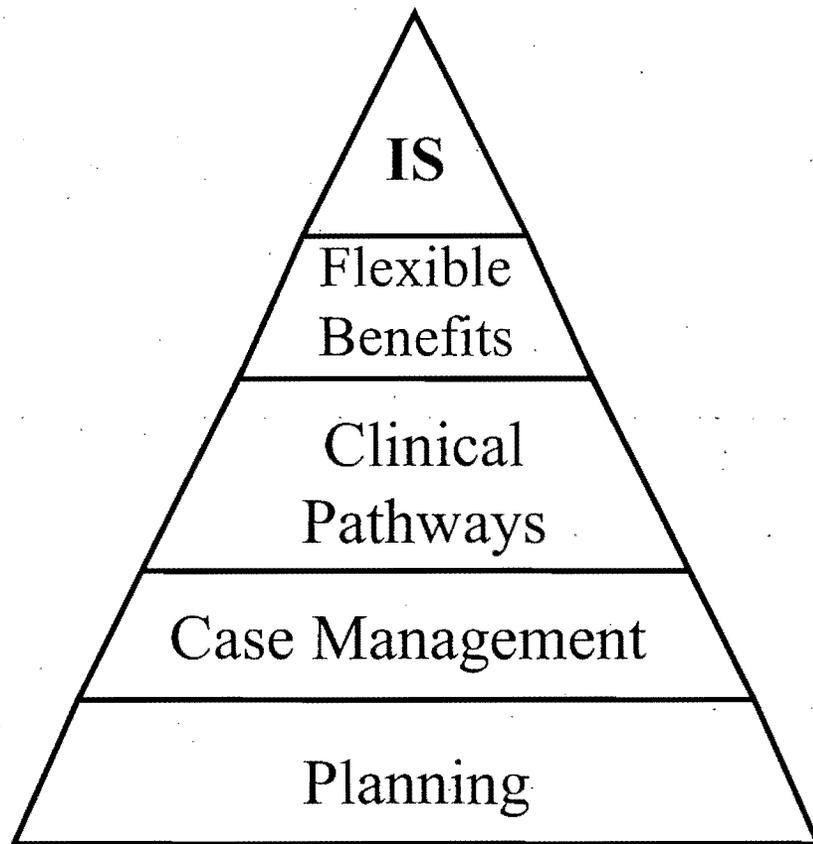
Refer to Exhibit 7

Cumulative Medicare Program Savings



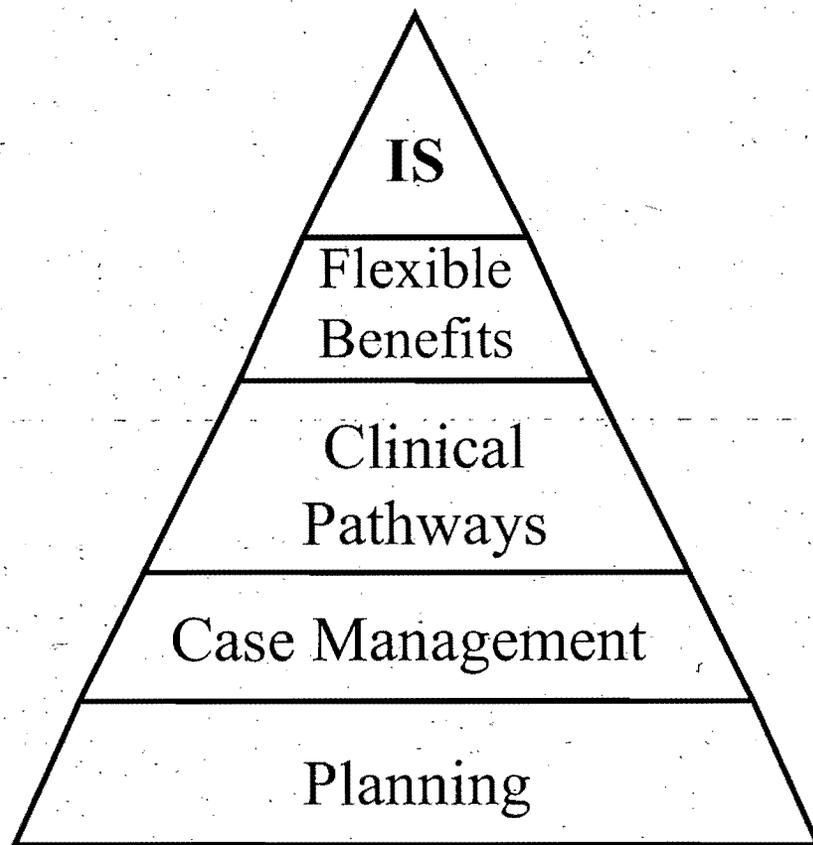
Refer to Exhibit 7

Information Systems Infrastructure



- Will be designed to quantify relationship between enrollee costs and Medicare program costs
- Will link providers, nurse case managers and enrollees
- Estimated cost of \$2.4-\$4.0 million
- Develop, customize, implement and maintain
- Separate from Demonstration Project operating costs

Information Systems Infrastructure

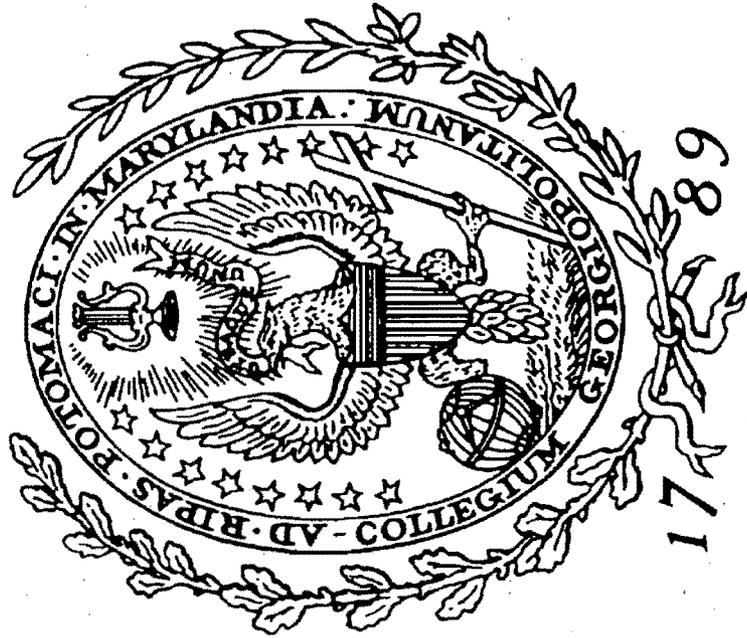


- Compiling a functional needs assessment
- **Purchase of selected vendor software**
- **Purchase of hardware and network components**
- Implementation support
- **Development costs**
- Training costs
- Related travel costs

Program Management

Includes:

- Administrative and Support Staff
- Benefits Administration
- Network Development
- Research & Financial Analysis Staff
- Program Indirect Costs



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- Exhibit 2 Summary of PMPM Waiver Requests
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- Exhibit 4B Flexible Benefits – Pharmacy Costs PMPM
- Exhibit 4C Flexible Benefits – Rehabilitation Services Costs PMPM
- Exhibit 4D Flexible Benefits – Transportation Services Costs PMPM
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- Exhibit 6 Annual Costs of the Demonstration Project
- Exhibit 7 Demonstration Project/FFS Cost Comparison with Projected Savings

EXHIBIT 1 - Estimated PMPM Costs of a Demonstration Project Enrollee under FFS

Disease State	Total Persons (A)	Adjusted Total (B)	Avg Cost per Patient	Avg Months of Eligibility	Est. Member Months (C)	Est. PMPM Cost (D)
Hypertension	419,375	229,398	\$ 7,476	11.39	2,612,845	656.37
Diabetes	193,923	106,076	\$ 9,623	11.39	1,208,204	844.86
Congestive Heart Failure	111,621	61,057	\$ 18,092	11.39	695,436	1,588.41
Ischemic Heart Ds	210,614	115,206	\$ 12,403	11.39	1,312,195	1,088.94
Stroke	95,298	52,128	\$ 15,585	11.39	593,738	1,368.31
Peripheral Vascular Ds	122,972	67,266	\$ 15,219	11.39	766,156	1,336.17
Hepatic Ds	12,956	7,087	\$ 21,854	11.39	80,720	1,918.70
Cancer	71,914	39,337	\$ 11,127	11.39	448,048	976.91
Respiratory Ds	195,060	106,698	\$ 16,099	11.39	1,215,288	1,413.43
Total	1,433,733	784,252	\$ 12,006	11.39	8,932,630	1,054.08
1997 National Avg AAPCC	\$ 465.36					
1997 Blended AAPCC Rate (E)	\$ 587.64					
Adjusted 1997 FFS Medicare Cost per Enrollee (F)	\$ 1,054.08					
Cost Factor GUMC-USA (G)	1.26					
Adjusted 1997 FFS Medicare Cost per GUMC Enrollee (H)	\$ 1,331.06					
Trend Factor, 1996-99	1.16					
Estimated 1999 FFS Medicare Cost per GUMC Demonstration Project Enrollee	<u>\$ 1,540.83</u>					

Assumptions:

- (A) = Number of eligible persons in the 5% national sample of HCFA claims remains same as original proposal.
- (B) = Total possible pathway candidates in the sample less 45.3% co-morbidity rate.
- (C) = Estimated member months are the adjusted total volume of potential enrollees multiplied by 11.39 months.
- (D) = Average PMPM cost is a weighted average. PMPM costs by disease state were multiplied by unduplicated eligible enrollee volumes.
- (E) = 1997 Blended Per Capita Cost from the HCFA Medicare website based on AAPCC data for 80% DC:20% PG County.
- (F) = Adjusted 1997 FFS Cost per Enrollee is based on national average costs and does not reflect cost at GUMC or the the demonstration project's target market service area.
- (G) = Cost factor is calculated as blended AAPCC rate for demonstration project region divided by national average rate.
- (H) = Adjusted 1997 FFS Cost per GUMC Enrollee reflects target market service area impact on enrollee costs.

**EXHIBIT 2 - Summary of PMPM Waiver Requests
(with comparison of Project versus FFS Enrollee PMPM Costs)**

SUMMARY OF PMPM WAIVER REQUESTS

CASE MANAGEMENT PORTION

Case Management Services \$ 161.76

FLEXIBLE BENEFITS PORTION

Patient Co-Insurance Deductibles & Copayments \$ 135.13

Pharmacy Services \$ 140.93

Physical Medicine & Rehabilitation \$ 40.41

Transportation Services \$ 5.66

\$ 322.13

ESTIMATED PMPM BASE COST PER ENROLLEE ESTIMATE (A) \$ 1,155.62

ADD: CASE MANAGEMENT PMPM WAIVERS \$ 161.76

ADD: FLEXIBLE BENEFITS PMPM \$ 322.13

TOTAL PROJECT PMPM COST PER ENROLLEE \$ 1,639.51

TOTAL PROJECT PMPM COST PER ENROLLEE (less Co-Ins and deductibles) \$ 1,504.38

Projected differential from unmanaged costs \$ 36.45

(A) = Estimated to be 75% of unmanaged FFS costs

EXHIBIT 3 - Case Management Costs PMPM

CASE MANAGEMENT SERVICES

	YR 1	YR 2	YR 3	YR 4	YR 5
Annual Enrollment Volumes (A,B)	1,500	3,000	4,500	6,000	7,500
Enrollees per Case Manager (C)	50	50	50	50	50
Case Management FTEs	30	60	90	120	150

Salaries (D,E)	Base Salary	YR 1	YR 2	YR 3	YR 4	YR 5
Clinical Manager	65,000	65,000	66,950	68,959	71,027	73,158
Case Management Staff	45,000	1,350,000	2,767,500	4,255,065	5,815,348	7,451,092
Office Assistant	28,000	65,000	66,950	68,959	71,027	73,158
Total Case Management Program Salaries		1,480,000	2,901,400	4,392,982	5,957,402	7,597,408

Benefits at 26%	384,800	754,364	1,142,175	1,548,925	1,975,326
Rent (F)	83,232	162,939	248,889	341,455	441,027
Travel (G)	63,375	126,750	190,125	253,500	316,875
Office supplies (H)	18,000	38,160	60,674	85,753	113,623
Minor capital (I)	1,700	-	1,700	-	-
Purchased services (J)	15,500	16,120	16,765	17,435	18,133
Utilities (K)	26,250	51,985	79,239	108,079	138,585
Training and seminars (L)	11,200	22,351	34,161	46,659	59,877
Indirect costs (M)	833,623	1,629,628	2,466,684	3,343,683	4,264,341

Total Case Management Program Costs	2,917,680	5,703,697	8,633,395	11,702,892	14,925,195
Total Case Management Costs per Enrollee	1,945	1,901	1,919	1,950	1,990
PMPM Case Management Costs	162.09	158.44	159.88	162.54	165.84

Five Year Average of PMPM Costs for Case Management Services \$ 161.76

Assumptions:

- (A) = Annual enrollment volumes from original proposal.
- (B) = All enrollees will be case managed.
- (C) = Benchmarked from On-Lok Senior Services, a PACE program, San Francisco, CA.
- (D) = Salaries include a 3% COLA per annum.
- (E) = Salaries include a 3% COLA per annum, base salary escalation for new hires at 2% per annum.

Base Salary	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5
	45,000	45,900	46,818	47,754	48,709

(F) = Rent at \$34 per sq ft, 2 case managers per 144 sq ft office, annual escalation of 6%. Includes clinical manager and support staff.

Sq ft costs	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5
\$	34.00	35.36	36.77	38.25	39.78

(G) = Travel at 0.325 per mile, no annual escalation included. Estimated at 25 miles per day per case manager excluding weekends.

Tot Hrs/FTE	2080	2080	2080	2080	2080
Tot Days/FTE	260	260	260	260	260
Total FTEs	30	60	90	120	150
Total Days	7,800	15,600	23,400	31,200	39,000
x 25 mi/day	x 25				
Total Miles	195,000	390,000	585,000	780,000	975,000
x .325 per mi	x 0.325				
\$	63,375	126,750	190,125	253,500	316,875

(H) = Office supplies at \$12 per enrollee and includes charts, paper and miscellaneous office supplies, escalated 3% per year.

Cost per Pt	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5
\$	12.00	12.72	13.48	14.29	15.15
\$	18,000	38,160	60,674	85,753	113,623

(I) = Minor capital includes 1 fax machine at \$500 with an additional fax machine in year 3, and two printers at \$600 each with an additional two printers in year 3.

(J) = Purchased services include copier rental at \$3500 per year and cleaning service at \$1000 per month, escalated 4% per year.

(K) = Utilities include telephone service at \$600 per FTE per year and electricity at 0.24/sq ft per month, escalated 3% per year.

	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5
Cost per FTE	\$ 600.00	\$ 618.00	\$ 636.54	\$ 655.64	\$ 675.31
No. FTEs	32.0	62.0	92.0	122.0	152.0
Telephone	\$ 19,200	\$ 38,316	\$ 58,562	\$ 79,988	\$ 102,646
Electricity	\$ 7,050	\$ 13,669	\$ 20,678	\$ 28,091	\$ 35,938
Total Utilities	\$ 26,250	\$ 51,985	\$ 79,239	\$ 108,079	\$ 138,585

(L) = Training and seminars at \$350 per FTE per year, escalated 3% per year

Cost per FTE	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5
\$	350.00	360.50	371.32	382.45	393.93

(M) = Other indirect costs at 40% of direct costs.

EXHIBIT 4A - Co-Insurance (Deductible and Copayment) Costs PMPM

CO-INSURANCE WAIVERS

		YR 1	YR 2	YR 3	YR 4	YR 5
Annual Enrollment Volumes		1,500	3,000	4,500	6,000	7,500
Less: 40% with secondary coverage		(600)	(1,200)	(1,800)	(2,400)	(3,000)
Applicable Volumes		900	1,800	2,700	3,600	4,500
Medicare Part A						
Deductibles						
Projected Volume of Admissions (A)	1.36	1,224	2,448	3,672	4,896	6,120
Patient Deductibles for Hospital Care	\$ 764	935,136	1,870,272	2,805,408	3,740,544	4,675,680
Medicare Part B						
Deductibles (D)	\$ 100	90,000	180,000	270,000	360,000	450,000
Annualized Copay less Deductible (E)	\$ 1,472.56	1,325,304	2,730,126	4,218,045	5,792,782	7,458,207
Total Co-insurance payments (Parts A & B)		2,350,440	4,780,398	7,293,453	9,893,326	12,583,887
Divide by Total Enrollees						
Annual Co-Insurance Cost per Enrollee	\$	1,566.96	\$ 1,593.47	\$ 1,620.77	\$ 1,648.89	\$ 1,677.85
PMPM Co-Insurance per Enrollee	\$	130.58	\$ 132.79	\$ 135.06	\$ 137.41	\$ 139.82
Average PMPM Co-Insurance	\$	135.13				

Assumptions:

- (A) = Estimated volume of admissions is 1.36 admissions per enrollee.
- (B) = Assumes each hospitalization occurs in separate benefit periods.
- (C) = Assumes no annual rate of inflation in Part A costs.
- (D) = Medicare Part B deductibles at \$100 per year. Assumes no annual rate of inflation in Part B costs.
- (E) = Copayments at 20% of Medicare allowable.

1997 AAPCC Part B Aged Rate - DC	\$ 200.20
1997 AAPCC Part B Aged Rate - PG	\$ 218.89
Blended Part B Aged Rate (80%DC:20%PG)	\$ 203.94

Blended Parts A & B Aged Rates	\$ 587.64
% of Total Blended Rate is Part B	34.7%

Estimated Cost per GUMC Enrollee	\$ 1,510.62
Part B Cost at 34.7%	\$ 524.19

Part B Cost divided by 80% to Estimate Medicare Allowable Cost	\$ 655.23
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Patient Part B Copay at 20% of Allowable	\$ 131.05
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Multiply by 11.39 average enrollment period	\$ 1,572.56
Less \$100 annual deductible	(\$100.00)

Annual Part B Patient Copay at 20% of Allowable	<u>\$ 1,472.56</u> * Five year projection above includes a 3% annual COLA.
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EXHIBIT 4B - Pharmacy Costs PMPM

PHARMACY SERVICES

	YR 1	YR 2	YR 3	YR 4	YR 5
Annual Drug Allocation per Enrollee	\$ 1,500.00	\$ 1,500.00	\$ 1,500.00	\$ 1,500.00	\$ 1,500.00
PMPM Drug Allocation	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00	\$ 125.00
Add: 6% Annual Escalation	\$ 125.00	\$ 132.50	\$ 140.45	\$ 148.88	\$ 157.81
Five Year Average of PMPM Costs for Pharmacy Services	\$ 140.93				

EXHIBIT 4C - Rehabilitation Services Costs PMPM

PHYSICAL MEDICINE & REHABILITATION SERVICES

	% Inpt.	Estimated Annual Volume	Estimated Applicable Percent	Estimated Applicable Volume	Avg PT Hours	PT Rate	80% of Charges	20% of Charges	Avg ST Hours	ST Rate	80% of Charges	20% of Charges	Avg OT Hours	OT Rate	80% of Charges	20% of Charges
HTN	1	15	25	4	10	248.00	\$ 7,440	\$ 1,860	0	220.00	\$ -	\$ -	10	248.00	\$ 7,440	\$ 1,860
DM	3	45	33	15	25	248.00	\$ 73,656	\$ 18,414	0	220.00	\$ -	\$ -	8	248.00	\$ 23,570	\$ 5,892
CHF	47	705	25	176	20	248.00	\$ 699,360	\$ 174,840	0	220.00	\$ -	\$ -	8	248.00	\$ 279,744	\$ 69,936
IHD	15	225	100	225	20	248.00	\$ 892,800	\$ 223,200	0	220.00	\$ -	\$ -	8	248.00	\$ 357,120	\$ 89,280
CVA	11	165	90	149	36	248.00	\$ 1,060,646	\$ 265,162	20	220.00	\$ 522,720	\$ 130,680	20	248.00	\$ 589,248	\$ 147,312
PVD	9	135	33	45	10	248.00	\$ 88,387	\$ 22,097	0	220.00	\$ -	\$ -	10	248.00	\$ 88,387	\$ 22,097
CA	9	135	25	34	20	248.00	\$ 133,920	\$ 33,480	0	220.00	\$ -	\$ -	8	248.00	\$ 53,568	\$ 13,392
COPD	4	60	33	20	20	248.00	\$ 78,566	\$ 19,642	10	220.00	\$ 34,848	\$ 8,712	8	248.00	\$ 31,427	\$ 7,857
LIVER	1	15	25	4	20	248.00	\$ 14,880	\$ 3,720	0	220.00	\$ -	\$ -	8	248	\$ 5,952	\$ 1,488
	100	1500		670			\$ 3,049,656	\$ 762,414			\$ 557,568	\$ 139,392			\$ 1,436,456	\$ 359,114

Physical Therapy Services (6)	3,049,656
Speech Therapy Services (7)	557,568
Occupational Therapy Services (8)	1,436,456
Medical Devices (9)	50,437
Total Rehab Services - Medicare portion	5,094,116
x GUMC Rehab Cost-to-Charge Ratio	x 0.396646
Total Cost of Rehab Services at GUMC	2,020,561
Less: 40% with secondary coverage	(808,224)
Total Medicare Only	1,212,337
Less: 40% without demonstrated financial need	(484,935)
Total Applicable Medicare Demo Enrollee Costs	727,402
Divide by Total Enrollees	/ 1500
Annualized Rehab Services Cost per Enrollee	484.93
PMPM Rehab Services Cost (All services)	\$ 40.41

Total Enrollees per Year	1500
Less: 40% with secondary coverage	(600)
Total Medicare Only Enrollees	900
Less: 40% w/o demonstrated financial need	(360)
Total Applicable Medicare Demo Enrollees	540

Assumptions:

1. Used Georgetown inpatient discharge data - since hospital discharges drive need for outpatient rehabilitative care.
2. Used Lewin Group market analysis on available market share as stated in original proposal.
3. All pathways operational in projection as illustrated in original proposal.
4. Based on estimations of applicable volumes made by GUMC Department of Physical Medicine & Rehabilitation, it appears that 45% of inpatient discharges will require rehabilitative services (PT, OT and/or ST).
5. Waiver estimates exempt from \$1,500 dual annual caps on PT/ST and OT services.
6. Based on 80% of charges submitted for Medicare reimbursement based on GUMC cost. Outpatient services are paid on a fee schedule and are subject to capped limits, however to estimate GUMC costs, the GUMC cost-to-charge ratio for rehab services was applied to gross charges.
7. Same as assumption #6 for speech therapy services.
8. Same as assumption #6 for occupational therapy services.
9. Medical devices from analysis projected at 1% of total rehab costs. 80% submitted for Medicare reimbursement at cost.

EXHIBIT 4D - Transportation Services Costs PMPM

TRANSPORTATION SERVICES

	YR 1	YR 2	YR 3	YR 4	YR 5
Annual Enrollment Volumes	1,500	3,000	4,500	6,000	7,500
Annual Transportation Needs at 1 trip/month	18,000	36,000	54,000	72,000	90,000
Geographic Distribution					
80% District: 20% Prince Georges County					
District of Columbia					
	Est Freq				
Projected Annual Enrollees (A)	14,400	28,800	43,200	57,600	72,000
Trips to a Community Site	75%				
Avg Cost per Trip to Site (B)	\$ 6.16	\$ 6.35	\$ 6.54	\$ 6.73	\$ 6.94
Total Avg Cost per Trip to Site (C)	\$ 7.09	\$ 7.30	\$ 7.52	\$ 7.74	\$ 7.98
Total Estimated Costs to Site(s)	\$ 76,538	\$ 157,669	\$ 243,598	\$ 334,542	\$ 430,722
Trips to GUMC	25%				
Avg Cost per Trip to GUMC (D)	\$ 9.25	\$ 9.53	\$ 9.81	\$ 10.11	\$ 10.41
Total Avg Cost per Trip to GUMC (E)	\$ 10.64	\$ 10.96	\$ 11.29	\$ 11.62	\$ 11.97
Total Estimated Costs to GUMC	\$ 38,295	\$ 78,888	\$ 121,881	\$ 167,384	\$ 215,507
Total Estimated Transportation DC (F)	\$ 114,833	\$ 236,556	\$ 365,480	\$ 501,926	\$ 646,229
Prince Georges County					
	Est Freq				
Projected Annual Enrollees (A)	3,600	7,200	10,800	14,400	18,000
Trips to a Community Site	75%				
Avg Cost per Trip to Site (G)	\$ 9.00	\$ 9.27	\$ 9.55	\$ 9.83	\$ 10.13
Total Avg Cost per Trip to Site (H)	\$ 10.35	\$ 10.66	\$ 10.98	\$ 11.31	\$ 11.65
Total Estimated Costs to Site(s)	\$ 27,945	\$ 57,567	\$ 88,941	\$ 122,145	\$ 157,262
Trips to GUMC	25%				
Avg Cost per Trip to GUMC (I)	\$ 16.50	\$ 17.00	\$ 17.50	\$ 18.03	\$ 18.57
Total Avg Cost per Trip to GUMC (J)	\$ 18.98	\$ 19.54	\$ 20.13	\$ 20.73	\$ 21.36
Total Estimated Costs to GUMC	\$ 17,078	\$ 35,180	\$ 54,353	\$ 74,644	\$ 96,104
Total Estimated Transportation MD (K)	\$ 45,023	\$ 92,746	\$ 143,293	\$ 196,789	\$ 253,366
Grand Total Estimated Transportation	\$ 159,856	\$ 329,303	\$ 508,773	\$ 698,715	\$ 899,595
Total Estimated Costs at 60% Utilization	\$ 95,913	\$ 197,582	\$ 305,264	\$ 419,229	\$ 539,757
Annual Transportation Costs per Enrollee	\$ 63.94	\$ 65.86	\$ 67.84	\$ 69.87	\$ 71.97
PMPM Transportation Costs per Enrollee	\$ 5.33	\$ 5.49	\$ 5.65	\$ 5.82	\$ 6.00
Five Year Average of PMPM Costs for Transportation Services	\$ 5.66				

Assumptions:

- (A) = 80% of projected enrollees from Washington DC.
- (B) = Average cost per trip to a community-based site is the average cost of travel within four DC zones in SE DC.
- (C) = Total average cost per trip includes a 15% gratuity.
- (D) = Average cost per trip to GUMC is calculated based on an average of 4 zones from SE DC to GUMC.
- (E) = Same as Assumption C.
- (F) = Total costs include a 3% annual inflation rate.
- (G) = MD rate is \$2.25 per first 1/2 mile, then 0.75 per mile thereafter. Estimated distance to site is 10 miles.
- (H) = Total average cost per trip includes a 15% gratuity.
- (I) = Estimated distance to GUMC is 20 miles.
- (J) = Same as Assumption H.
- (K) = Total costs include a 3% annual inflation rate.
- (L) = Assumes 60% of enrollees will qualify for transportation services based on financial need.

EXHIBIT 5 - Estimation of Administrative Overhead

Administrative Overhead	Annual (A)	Year 1	Year 2	Year 3	Year 4	Year 5
Salaries						
Principal Investigator	\$ 110,000	\$ 110,000	\$ 113,300	\$ 116,699	\$ 120,200	\$ 123,806
Program Administrator	\$ 89,000	\$ 89,000	\$ 91,670	\$ 94,420	\$ 97,253	\$ 100,170
Medical Director (B)	\$ 125,000	\$ 75,000	\$ 103,000	\$ 106,090	\$ 109,273	\$ 112,551
Physician Advisors (C)	\$ 50,000	\$ 75,000	\$ 77,250	\$ 79,568	\$ 81,955	\$ 84,413
Executive Assistant	\$ 35,000	\$ 35,000	\$ 36,050	\$ 37,132	\$ 38,245	\$ 39,393
Communications Manager	\$ 50,000	\$ 50,000	\$ 51,500	\$ 53,045	\$ 54,636	\$ 56,275
Financial Analysts (D)	\$ 45,000	\$ 45,000	\$ 46,350	\$ 47,741	\$ 49,173	\$ 50,648
Outreach Workers (E)	\$ 32,000	\$ 32,000	\$ 65,380	\$ 101,012	\$ 138,725	\$ 178,607
Consultants	\$ 50,000	\$ 50,000	\$ 50,000	\$ 50,000	\$ 50,000	\$ 50,000
Research/Data Analyst	\$ 45,000	\$ 45,000	\$ 46,350	\$ 47,741	\$ 49,173	\$ 50,648
Subtotal Salaries		\$ 606,000	\$ 680,850	\$ 778,446	\$ 834,982	\$ 894,252
Total Overhead FTEs		6.75	7.00	8.00	8.00	8.00
Benefits at 26%	\$ 144,560	\$ 164,021	\$ 189,396	\$ 204,095	\$ 219,506	\$ 235,773
Rent (F)	\$ 33,048	\$ 36,328	\$ 44,009	\$ 46,650	\$ 49,449	\$ 52,357
Travel (G)	\$ 6,094	\$ 6,500	\$ 6,500	\$ 6,500	\$ 6,500	\$ 6,500
Office supplies (H)	\$ 2,025	\$ 2,163	\$ 2,546	\$ 2,623	\$ 2,701	\$ 2,780
Minor capital (I)	\$ 2,200	\$ -	\$ -	\$ 3,300	\$ -	\$ -
Purchased services (J)	\$ 7,000	\$ 7,210	\$ 7,426	\$ 7,649	\$ 7,879	\$ 8,113
Flexible benefits management (K)	\$ 364,650	\$ 1,037,850	\$ 1,711,050	\$ 2,384,250	\$ 3,057,450	\$ 3,730,650
Utilities (L)	\$ 6,849	\$ 7,316	\$ 8,612	\$ 8,870	\$ 9,137	\$ 9,404
Miscellaneous direct expense	\$ 164,140	\$ 271,913	\$ 384,718	\$ 489,849	\$ 594,562	\$ 699,675
Other indirect costs (M)	\$ 347,507	\$ 575,679	\$ 814,503	\$ 1,037,080	\$ 1,258,773	\$ 1,480,947
Total Administrative Overhead		\$ 1,684,073	\$ 2,789,831	\$ 3,947,207	\$ 5,025,847	\$ 6,100,208

Notes:

- (A) - Includes 3% annual COLA.
- (B) - Phased-in in Year 1, 50% first 6 months, 100% thereafter.
- (C) - Physician Advisors at \$10,000 per year - five physician team + a permanent physician advisor at \$25,000 per year.
- (D) - Financial Analysts, 1 in years 1-2; 2 in years 3-5 at \$45,000 per year.
- (E) - Outreach workers beginning with 1 FTE in year 1 and an additional FTE each year thereafter.
- (F) - Rent at \$34 per sq ft x 144 sq ft office, annual escalation of 6%. Offices for Principal Investigator, Program Administrator, Medical Director, Assistant, Communications Manager and Analysts.

	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5
Rent per FTE	\$ 4,896	\$ 5,190	\$ 5,501	\$ 5,831	\$ 6,181

- (G) - Travel at 0.325 per mile, no annual escalation included at 20 miles per FTE per day (Principal Investigator, Program Administrator, Medical Director, Communications Manager).

Travel per FTE	\$ 1,625
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- (H) - Office supplies at \$300 per FTE, escalated 3% per year.

	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5
Office supplies per FTE	\$ 300.00	\$ 309.00	\$ 318.27	\$ 327.82	\$ 337.65

- (I) - Minor capital includes 2 fax machines at \$500, with an additional fax machine in year 4. Also includes 2 printers at \$600 with an additional printer in year 4.

- (J) - Purchased services include rental of two copiers at \$3500 each per year, escalated 3% per year.

- (K) - Flexible benefits management of pharmacy services, rehab services and transportation waivers at 20%.

	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5
Pharmacy services	\$ 274,814	\$ 782,162	\$ 1,289,510	\$ 1,796,858	\$ 2,304,206
Rehab services	\$ 78,800	\$ 224,276	\$ 369,752	\$ 515,228	\$ 660,704
Transportation services	\$ 11,037	\$ 31,413	\$ 51,789	\$ 72,165	\$ 92,541
	\$ 364,650	\$ 1,037,850	\$ 1,711,050	\$ 2,384,250	\$ 3,057,450

- (L) - Utilities at \$600 per FTE for telephone service and 0.24 per sq ft per month for electricity, escalated 3% per year.

	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5
No. FTEs	6.75	7.00	8.00	8.00	8.00
No. Sq Ft	972	1008	1152	1152	1152
Telephone	\$ 4,050	\$ 4,326	\$ 5,092	\$ 5,245	\$ 5,402
Electricity	\$ 2,799	\$ 2,990	\$ 3,520	\$ 3,625	\$ 3,734
Total Utilities	\$ 6,849	\$ 7,316	\$ 8,612	\$ 8,870	\$ 9,137

- (M) - Indirect costs at 26% of direct administrative costs.

EXHIBIT 6 - Estimated Annual and Cumulative Costs of the Demonstration Project

	Year 1 Month 1	2	3	4	5	6	7	8	9	10	11	12	End of Year 1 Total	End of Year 2 Total	End of Year 3 Total	End of Year 4 Total	End of Year 5 Total		
VOLUME																			
Monthly Enrollment	125	125	125	125	125	125	125	125	125	125	125	125	<i>Annual Enrollment</i>	1,500	1,500	1,500	1,500	1,500	
Cumulative Enrollment	125	250	375	500	625	750	875	1,000	1,125	1,250	1,375	1,500	<i>Cumulative Enrollment</i>	1,500	3,000	4,500	6,000	7,500	
Member Months	125	250	375	500	625	750	875	1,000	1,125	1,250	1,375	1,500	<i>Member Months</i>	9,750	27,750	45,750	63,750	81,750	
EXPENSE																			
Case Management PMPM	\$ 161.76	20,220	40,440	60,660	80,880	101,100	121,320	141,540	161,760	181,980	202,200	222,420	242,640	<i>Case Management</i>	\$ 1,577,160	\$ 4,488,840	\$ 7,400,520	\$ 10,312,200	\$ 13,223,880
Flexible Benefits																			
Pharmacy Waivers	\$ 140.93	17,616	35,233	52,849	70,465	88,081	105,698	123,314	140,930	158,546	176,163	193,779	211,395	<i>Pharmacy</i>	\$ 1,374,068	\$ 3,910,808	\$ 6,447,548	\$ 8,984,288	\$ 11,521,028
Rehab Services Waivers	\$ 40.41	5,051	10,103	15,154	20,205	25,256	30,308	35,359	40,410	45,461	50,513	55,564	60,615	<i>Rehab Services</i>	\$ 393,998	\$ 1,121,378	\$ 1,848,758	\$ 2,576,138	\$ 3,303,518
Transportation Waivers	\$ 5.66	708	1,415	2,123	2,830	3,538	4,245	4,953	5,660	6,368	7,075	7,783	8,490	<i>Transportation</i>	\$ 55,185	\$ 157,065	\$ 258,945	\$ 360,825	\$ 462,705
Flexible Benefits PMPM	\$ 187.00	23,375	46,750	70,125	93,500	116,875	140,250	163,625	187,000	210,375	233,750	257,125	280,500		\$ 1,823,250	\$ 8,812,845	\$ 14,529,285	\$ 11,921,250	\$ 15,287,250
Total Direct Services Expense		43,595	87,190	130,785	174,380	217,975	261,570	305,165	348,760	392,355	435,950	479,545	523,140	Total Direct Services Expense	\$ 3,400,410	\$ 13,301,685	\$ 21,929,805	\$ 22,233,450	\$ 28,511,130
Cumulative Direct Expense		43,595	130,785	261,570	435,950	653,925	915,495	1,220,660	1,569,420	1,961,775	2,397,725	2,877,270	3,400,410		\$ 3,400,410	\$ 16,702,095	\$ 38,631,900	\$ 60,865,350	\$ 89,376,480
Add: Co-Insurance Waivers	\$ 135.13	16,891	33,783	50,674	67,565	84,456	101,348	118,239	135,130	152,021	168,913	185,804	202,695	<i>Co-Insurance</i>	\$ 1,317,518	\$ 3,749,858	\$ 6,182,198	\$ 8,614,538	\$ 11,046,878
Add: Network Development*														<i>Network Development</i>	\$ 500,000	\$ 375,000	\$ 675,000	\$ 900,000	\$ 1,125,000
* Provider-Enrollee Ratio 1:1000																			
Add: Program Admin Expense	\$ 140,339	\$ 140,339	\$ 140,339	\$ 140,339	\$ 140,339	\$ 140,339	\$ 140,339	\$ 140,339	\$ 140,339	\$ 140,339	\$ 140,339	\$ 140,339	\$ 140,339	<i>Program Admin Expense</i>	\$ 1,684,073	\$ 2,789,831	\$ 3,947,207	\$ 5,025,847	\$ 6,100,208
Total Program Expense (excl. IS)	\$ 200,826	\$ 261,312	\$ 321,798	\$ 382,284	\$ 442,771	\$ 503,257	\$ 563,743	\$ 624,229	\$ 684,716	\$ 745,202	\$ 805,688	\$ 866,174	Total Program Expense (excl. IS)	\$ 6,902,000	\$ 20,216,374	\$ 32,734,210	\$ 36,773,834	\$ 46,783,215	
Cumulative Program Expense (excl. IS)	\$ 200,826	462,138	783,936	1,166,220	1,608,991	2,112,248	2,675,991	3,300,220	3,984,936	4,730,138	5,535,826	6,402,000		\$ 6,902,000	\$ 27,118,374	\$ 59,852,584	\$ 96,626,418	\$ 143,409,633	
Add: Information Systems	4,000,000														\$ 4,000,000				
Add: Maintenance at 15% of cost over remaining four years of life.														\$ 600,000	\$ 600,000	\$ 600,000	\$ 600,000	\$ 600,000	
Total Expense (incl. IS)	4,200,826	261,312	321,798	382,284	442,771	503,257	563,743	624,229	684,716	745,202	805,688	866,174	Total Services Expense	\$ 10,902,000	\$ 20,816,374	\$ 33,334,210	\$ 37,373,834	\$ 47,383,215	
Cumulative Total Expense	4,200,826	4,462,138	4,783,936	5,166,220	5,608,991	6,112,248	6,675,991	7,300,220	7,984,936	8,730,138	9,535,826	10,402,000		\$ 10,402,000	\$ 31,218,374	\$ 64,552,584	\$ 101,926,418	\$ 149,309,633	

EXHIBIT 7 - PMPM Cost Comparison and Savings Projections

COSTS PMPM

Case Management Services	\$	161.76
Flexible Benefits		
Co-Insurance Deductibles & Copayments	\$	135.13
Pharmacy Services	\$	140.93
Physical Medicine & Rehabilitation	\$	40.41
Transportation Services	\$	5.66
Subtotal Flexible Benefits	\$	322.13
Subtotal Demonstration Project PMPM Costs	\$	483.89
Add: Estimated PMPM Base Cost per Enrollee (A)	\$	1,155.62
Total Cost PMPM per Project Enrollee	\$	1,639.51

SAVINGS PMPM

Total Cost PMPM per Project Enrollee less Co-Insurance	\$	1,504.38
Compare to: 1999 FFS Cost per Project Enrollee	\$	1,540.83
Projected PMPM Differential from Unmanaged Costs	\$	36.45

IF THE PROJECT DEMONSTRATES COORDINATED PATIENT CARE PROVIDING SAVINGS BELOW THE PROJECTED COST OF:

	PMPM (B)	Less: FFS PMPM	NET SAVINGS PMPM
25%	\$ 1,504.38	-\$1,540.83	\$ 36.45
30%	\$ 1,404.09	-\$1,540.83	\$ 136.74
35%	\$ 1,303.80	-\$1,540.83	\$ 237.03

TOTAL ANNUALIZED SAVINGS (NET SAVINGS PMPM x ANNUAL MEMBER MONTHS)

	Year 1	Year 2	Year 3	Year 4	Year 5	Cumulative
Projected Member Months	9,750	27,750	45,750	63,750	81,750	
At 25% PMPM Savings	\$ 355,387	\$ 1,011,487	\$ 1,667,587	\$ 2,323,687	\$ 2,979,787	\$ 8,337,937
At 30% PMPM Savings	\$ 1,333,235	\$ 3,794,591	\$ 6,255,947	\$ 8,717,303	\$ 11,178,659	\$ 31,279,733
At 35% PMPM Savings	\$ 2,311,082	\$ 6,577,694	\$ 10,844,306	\$ 15,110,918	\$ 19,377,530	\$ 54,221,528
Items Exempt from Savings Calculations:						
1. Administrative overhead	\$ 1,684,073	\$ 2,789,831	\$ 3,947,207	\$ 5,025,847	\$ 6,100,208	
2. Info systems infrastructure						
Initial capitalization	\$ 4,000,000					
Maintenance (C)		\$ 600,000	\$ 600,000	\$ 600,000	\$ 600,000	
Total Exempt Items	\$ 5,684,073	\$ 3,389,831	\$ 4,547,207	\$ 5,625,847	\$ 6,700,208	\$ 25,947,166

Notes:

(A) = Estimated at 80% of unmanaged FFS cost.

(B) = Project PMPM less percent savings through demonstrated coordination of care.

(C) = Maintenance at 15% of total cost of information system over the life of the system (shown over remaining four years).