

COMPARISON OF DISPROPORTIONATE SHARE HOSPITAL (DSH) POLICIES

House Proposal. This option produces \$11.5 billion over five years, assuming 25% offset (excluding interaction with the children's health proposal). This plan has three types of reduction:

- **Small DSH.** States with 1995 DSH spending that is less than or equal to 1% of their total Medicaid spending get no reduction (allotments frozen at 1995 DSH spending level)
- **Low-DSH.** States that are designated as low-DSH, according to the preliminary 1997 DSH allotments, have the following percent reductions taken off of their 1995 DSH spending

<u>1998</u>	<u>1999</u>	<u>2000</u>	<u>2001</u>	<u>2002</u>
1%	2.5%	10%	15%	20%

- **High-DSH.** States that are designated as high-DSH, according to the preliminary 1997 DSH allotments, have the twice the percent reductions taken off of their 1995 DSH spending:

<u>1998</u>	<u>1999</u>	<u>2000</u>	<u>2001</u>	<u>2002</u>
2%	5%	20%	30%	40%

Senate Proposal. This option produces \$12.4 billion over five years, assuming 25% offset and not including savings from retargetting within the allotments. This plan has five types of reductions:

- **Small DSH.** States with 1995 DSH spending that is less than 3% of their total Medicaid spending get no reduction (allotments frozen at 1995 DSH spending level)
- **Low-DSH.** States that are designated as low-DSH, according to the preliminary 1997 DSH allotments, have the following percent reductions taken off of their 1995 DSH spending

<u>1998</u>	<u>1999</u>	<u>2000</u>	<u>2001</u>	<u>2002</u>
0%	2%	5%	10%	15%

- **High-DSH.** States that are designated as high-DSH, according to the preliminary 1997 DSH allotments, have the following percent reductions taken off of their 1995 inpatient spending plus the following percent of their 1995 mental health (MH) DSH spending.

	<u>1998</u>	<u>1999</u>	<u>2000</u>	<u>2001</u>	<u>2002</u>
Reduction:	0%	8%	15%	20%	20%
% of MH DSH	70%	50%	20%	0%	0%

- **Special Rule.** States whose 1995 DSH spending is greater than 12% of their total 1995 spending, but have no mental health DSH spending in 1995, receive the average of their 1995 and 1996 DSH spending for each year between 1998 and 2002 (California and Nevada).
- **Special Rule.** No state can receive a reduction that exceeds 50% of its base year in any given year (Kansas & New Hampshire).

Proposal Like President's. This option produces \$11.8 billion over five years, assuming 25% offset (Green amendment, Commerce Committee). This plan has one type of reduction applied to 2 bases:

- **All states.** All states get an equal percent reduction off their 1995 DSH, up to an upper limit. This "upper limit" is defined as 12% of total 1995 Medicaid spending. In other words, if a state's 1995 DSH exceeds 12% of its total spending in that year, the reduction is taken off of the 12% of the spending, not the full DSH spending. The percentage reductions that would produce savings comparable to the House and Senate Committees' proposals are:

<u>1998</u>	<u>1999</u>	<u>2000</u>	<u>2001</u>	<u>2002</u>
0%	10%	20%	25%	35%

Comparison of Effects of DSH Reductions, 2002

(Dollars in millions, fiscal years)

State	House Commerce Proposal		Senate Finance Proposal		Proposal Like President's	
	% Change In DSH from 1995 DSH	% Change In DSH from 1995 Total	% Change In DSH from 1995 DSH	% Change In DSH from 1995 Total	% Change In DSH from 1995 DSH	% Change In DSH from 1995 Total
National*	-28%	-3%	-24%	-3%	-28%	-3%
Alabama	-40%	-9%	-21%	-4%	-20%	-4%
Alaska	-20%	-1%	-15%	-1%	-35%	-2%
Arizona	-20%	-2%	-15%	-1%	-35%	-3%
Arkansas	0%	0%	0%	0%	-35%	0%
California	-20%	-3%	-18%	-3%	-30%	-4%
Colorado	-40%	-5%	-20%	-2%	-35%	-4%
Connecticut	-40%	-6%	-41%	-7%	-26%	-4%
Delaware	-20%	0%	0%	0%	-35%	-1%
District of Columbia	-20%	-1%	0%	0%	-35%	-1%
Florida	-20%	-1%	-15%	-1%	-35%	-2%
Georgia	-20%	-2%	-15%	-2%	-35%	-4%
Hawaii**	-	-	0%	0%	-	-
Idaho	0%	0%	0%	0%	-35%	0%
Illinois	-20%	-1%	-15%	-1%	-35%	-2%
Indiana	-20%	-3%	-15%	-2%	-27%	-4%
Iowa	-20%	0%	0%	0%	-35%	0%
Kansas	-40%	-4%	-50%	-5%	-35%	-3%
Kentucky	-20%	-2%	-15%	-1%	-35%	-3%
Louisiana	-40%	-12%	-28%	-8%	-14%	-4%
Maine	-40%	-7%	-41%	-7%	-23%	-4%
Maryland	-20%	-1%	-15%	-1%	-35%	-2%
Massachusetts	-20%	-2%	-15%	-2%	-35%	-4%
Michigan	-20%	-2%	-15%	-1%	-35%	-3%
Minnesota	-20%	0%	0%	0%	-35%	0%
Mississippi	-20%	-2%	-15%	-2%	-35%	-4%
Missouri	-40%	-11%	-43%	-11%	-16%	-4%
Montana	0%	0%	0%	0%	-35%	0%
Nebraska	-20%	0%	0%	0%	-35%	0%
Nevada	-40%	-6%	0%	0%	-26%	-4%
New Hampshire	-40%	-15%	-74%	-29%	-11%	-4%
New Jersey	-40%	-10%	-44%	-11%	-17%	-4%
New Mexico	0%	0%	0%	0%	-35%	0%
New York	-20%	-3%	-15%	-2%	-33%	-4%
North Carolina	-20%	-2%	-15%	-2%	-35%	-4%
North Dakota	0%	0%	0%	0%	-35%	0%
Ohio	-20%	-2%	-15%	-2%	-35%	-4%
Oklahoma	-20%	0%	0%	0%	-35%	-1%
Oregon	-20%	0%	0%	0%	-35%	-1%
Pennsylvania	-20%	-3%	-15%	-2%	-32%	-4%
Rhode Island	-20%	-2%	-15%	-2%	-35%	-4%
South Carolina	-40%	-9%	-33%	-7%	-19%	-4%
South Dakota	0%	0%	0%	0%	-35%	0%
Tennessee**	-	-	0%	0%	-	-
Texas	-40%	-7%	-35%	-6%	-24%	-4%
Utah	0%	0%	0%	0%	-35%	0%
Vermont	-20%	-2%	-15%	-1%	-35%	-3%
Virginia	-20%	-1%	-15%	-1%	-35%	-2%
Washington	-20%	-2%	-15%	-2%	-35%	-4%
West Virginia	-20%	-1%	-15%	-1%	-35%	-2%
Wisconsin	0%	0%	0%	0%	-35%	0%
Wyoming**	-	-	0%	0%	-	-

*% Change in DSH from 1995 Total" is the 2002 DSH allotment minus 1995 DSH spending divided into the 1995 Benefits plus DSH spending
House Commerce proposal assumes that high-DSH states (1997 designation) receive twice the percent reduction in DSH as low-DSH states; states <
Senate Finance Committee assumes larger reductions for states with high mental hospital DSH

Proposal like President's assumes that same percent reduction is taken from the lower of DSH or 12% of 1995 total spending.

* Does not include CBO's 25% offset

** Waiver state or state with no DSH



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ZEV YAROSLAVSKY

SUPERVISOR, THIRD DISTRICT
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MEMORANDUM

To: Bruce Vladek, Director, HFCA
Chris Jennings, Special Assistant to the President for Health Policy
Jack Lew, Deputy Director, OMB
Nancy Ann-Min, Deputy Associate Director for Health, OMB

From: Los Angeles County Supervisor Zev Yaroslavsky

Re: Retargeting DSH

Date: December 18, 1996

In the event of Administration considerations to retarget DSH to those institutions that provide indigent care, the attached comparative analysis for the State of California may be enlightening. It compares the total DSH dollars allocated under the State's DSH program (SB 855) to private, university, children's and County hospitals; with the total indigent and bad debt days provided by those institutions. Notice that most of the private DSH facilities either provide little or no indigent care, or else receive thousands of DSH dollars per day for each indigent in-patient day.

Please feel free to call me or our Director of Health Services, Mark Finucane, with any questions. Thanks for your consideration.

ZY:rpt

**LOS ANGELES COUNTY - DEPARTMENT OF HEALTH SERVICES
CALIFORNIA HOSPITAL'S SB 855 INDIGENT AND BAD DEBT RATE PER DAY
FISCAL YEAR 1995-96.**

Hospital Name	Type of Control	Indigent Days (1)	Bad Debt Days (1)	Total Days(1)	DSH Dollars(2)	DSH Per Day
MISSION COMMUNITY HOSPITAL	PRIVATE *	0	8	8	\$1,947,305	\$236,659
LAKESIDE HOSPITAL	PRIVATE *	0	9	9	1,353,210	147,358
COMM. & MISSION HOSPITAL OF HUNTINGTON PARK	PRIVATE (3)	0	181	181	7,236,720	40,072
SAN VICENTE HOSPITAL	PRIVATE	0	2	2	49,648	32,518
QUEEN OF ANGELS-HOLLYWOOD PRESBYTERIAN MEDICAL	PRIVATE * (3)	0	707	707	22,664,641	32,071
VALLEY CHILDREN'S HOSPITAL	CHILDREN'S	125	213	338	8,714,195	25,787
PACIFIC ALLIANCE MEDICAL CENTER	PRIVATE (3)	0	124	124	3,105,206	25,012
SETON MEDICAL CENTER COASTSIDE	PRIVATE	0	1	1	24,882	24,882
CHILDREN'S HOSPITAL - SAN DIEGO	CHILDREN'S	0	281	281	6,290,737	22,421
SEMPERVIRENS PSYCHIATRIC HEALTH FACILITY	COUNTY	0	0	0	18,506	18,506
WHITE MEMORIAL MEDICAL CENTER	PRIVATE * (3)	0	1,513	1,513	27,765,521	18,356
GREATER EL MONTE COMMUNITY HOSPITAL	PRIVATE * (3)	0	227	227	3,661,337	16,107
MONTEREY PARK HOSPITAL	PRIVATE	0	161	161	1,596,130	9,921
SHASTA COUNTY PSYCHIATRIC HEALTH FACILITY	COUNTY	0	0	0	8,874	8,874
CALIFORNIA HOSPITAL MEDICAL CENTER	PRIVATE (3)	88	1,633	1,721	14,862,996	8,637
GARFIELD MEDICAL CENTER	PRIVATE (3)	0	609	609	5,010,610	8,230
SAN BERNARDINO COMMUNITY HOSPITAL	PRIVATE *	0	743	743	5,417,900	7,293
ST. FRANCIS MEDICAL CENTER	PRIVATE * (3)	59	1,239	1,298	9,337,742	7,195
CHILDRENS HOSPITAL LOS ANGELES	CHILDREN'S	864	953	1,827	12,478,322	6,830
CHILDREN'S HOSPITAL MEDICAL CENTER OAKLAND	CHILDREN'S	58	1,488	1,546	9,271,093	5,956
ORTHOPAEDIC HOSPITAL	PRIVATE	0	38	38	202,048	5,345
ALEXIAN BROTHERS HOSPITAL	PRIVATE	40	592	632	3,341,295	5,290
SANTA ANA HOSPITAL MEDICAL CENTER	PRIVATE (3)	272	219	491	2,585,176	5,266
POMONA VALLEY HOSPITAL MEDICAL CENTER	PRIVATE	127	1,063	1,190	5,983,540	5,028
PACIFIC HOSPITAL OF LONG BEACH	PRIVATE	0	238	238	1,111,510	4,675
GEORGE L. MEE MEMORIAL HOSPITAL	PRIVATE (3)	0	75	75	323,285	4,314
ST. ROSE HOSPITAL	PRIVATE	3	728	731	2,788,820	3,813
SUBURBAN MEDICAL CENTER	PRIVATE (3)	0	1,183	1,183	3,852,186	3,256
VALLEY HOSPITAL MEDICAL CENTER	PRIVATE	30	401	431	1,351,155	3,135
CHILDREN'S HOSPITAL OF ORANGE COUNTY	CHILDREN'S	0	1,899	1,899	5,897,470	3,106
SANGER GENERAL HOSPITAL	PRIVATE *	0	205	205	622,045	3,034
SANTA MARTA HOSPITAL	PRIVATE (3)	567	712	1,279	3,871,478	3,027
SAN DIEGO COUNTY MENTAL HEALTH SERVICES LOMA	COUNTY	67	0	67	182,833	2,878
LUCILE SALTER PACKARD CHILDREN'S HOSPITAL AT	CHILDREN'S	0	1,853	1,853	4,492,638	2,424
ST. MARY MEDICAL CENTER	PRIVATE	513	1,360	1,873	4,452,190	2,378
DOCTORS HOSPITAL OF WEST COVINA	PRIVATE (3)	0	47	47	104,924	2,254
CITY OF HOPE NATIONAL MEDICAL CENTER	PRIVATE (3)	117	145	262	565,624	2,161
EAST LA DOCTOR'S HOSPITAL	PRIVATE	0	942	942	2,001,538	2,125
ST. LUKE'S HOSPITAL	PRIVATE (3)	0	1,170	1,170	2,333,720	1,994
ROBERT F. KENNEDY MEDICAL CENTER	PRIVATE (3)	0	1,173	1,173	2,246,224	1,914
CENTRAL VALLEY GENERAL HOSPITAL	PRIVATE	183	177	360	630,375	1,752
BELLFLOWER MEDICAL CENTER	PRIVATE	0	381	381	575,756	1,510
MEMORIAL HOSPITAL OF GARDENA	PRIVATE	0	854	854	1,218,928	1,428
PARADISE VALLEY HOSPITAL	PRIVATE (3)	1,812	1,464	3,276	4,494,501	1,372
VILLA VIEW COMMUNITY HOSPITAL	PRIVATE	873	481	1,354	1,833,216	1,354
SCRIPPS MEMORIAL HOSPITAL - CHULA VISTA	PRIVATE	1,744	1,311	3,055	3,602,554	1,179
DELANO REGIONAL MEDICAL CENTER	PRIVATE	30	1,001	1,031	1,209,856	1,173
LONG BEACH DOCTORS HOSPITAL	PRIVATE	0	141	141	155,244	1,102
ROSS HOSPITAL	PRIVATE	0	80	80	85,096	1,068
AMI GARDEN GROVE HOSPITAL AND MEDICAL CENTER	PRIVATE	1,713	535	2,248	2,364,060	1,052
PACIFICA HOSPITAL OF THE VALLEY	PRIVATE (3)	0	1,536	1,536	1,608,225	1,047
OROVILLE HOSPITAL	PRIVATE	461	510	971	990,560	1,020
UCI MEDICAL CENTER	UC	8,979	2,084	11,063	11,262,036	1,018
VALLEY MEDICAL CENTER OF FRESNO	COUNTY	6,886	3,981	10,867	9,312,204	857
HIGHLAND GENERAL HOSPITAL	COUNTY	15,782	3,111	18,893	16,109,388	853
SAN BERNARDINO COUNTY MEDICAL CENTER	COUNTY	12,983	713	13,696	11,164,626	815
LOS ANGELES COUNTY OLIVE VIEW-UCLA MEDICAL	COUNTY	17,924	519	18,443	14,775,915	801
LINDSAY HOSPITAL MEDICAL CENTER	PRIVATE	89	595	684	533,728	780
JOHN F. KENNEDY MEMORIAL HOSPITAL	PRIVATE * (3)	706	623	1,329	938,880	707
KERN MEDICAL CENTER	COUNTY	11,106	1,037	12,143	8,571,277	706
SANTA CLARA VALLEY MEDICAL CENTER	COUNTY	19,976	2,182	22,158	15,029,529	678
STANISLAUS MEDICAL CENTER	COUNTY	2,419	658	3,077	2,057,611	669
FOUNTAIN VALLEY REGIONAL HOSPITAL	PRIVATE *	1,542	680	2,222	1,435,091	646
COMMUNITY HOSPITAL - SONOMA COUNTY	COUNTY	1,665	241	1,906	1,229,677	645
HUNTINGTON MEMORIAL HOSPITAL	PRIVATE (3)	505	955	1,460	870,912	597

**LOS ANGELES COUNTY - DEPARTMENT OF HEALTH SERVICES
CALIFORNIA HOSPITAL'S SB 855 INDIGENT AND BAD DEBT RATE PER DAY
FISCAL YEAR 1995-96**

Hospital Name	Type of Control	Indigent Days (1)	Bad Debt Days (1)	Total Days(1)	DSH Dollars(2)	DSH Per Day
SAN LUIS OBISPO GENERAL HOSPITAL	COUNTY	550	470	1,020	600,039	588
MERCED COMMUNITY MEDICAL CENTER	COUNTY	1,218	394	1,612	936,363	581
MARTIN LUTHER KING JR. /DREW MEDICAL CENTER	COUNTY	26,923	3,601	30,524	17,217,278	564
SAN JOAQUIN GENERAL HOSPITAL	COUNTY	6,231	205	6,436	3,447,653	536
FIRST HOSPITAL VALLEJO	PRIVATE	0	280	280	146,710	525
BAY HARBOR HOSPITAL	PRIVATE	0	1,317	1,317	690,432	524
MERRITHEW MEMORIAL HOSPITAL	COUNTY	5,958	2,605	8,563	4,336,272	506
SAN MATEO COUNTY GENERAL HOSPITAL	COUNTY	3,462	683	4,145	2,058,012	496
EAST BAY HOSPITAL	PRIVATE *	816	25	841	402,707	479
LOS ANGELES METRO MEDICAL CENTER	PRIVATE	0	794	794	355,980	448
LOS ANGELES COUNTY USC MEDICAL CENTER	COUNTY	113,843	1,395	115,238	47,756,877	414
LOS ANGELES COUNTY/HARBOR-UCLA MEDICAL CENTER	COUNTY	43,782	539	44,321	18,340,396	414
SANTA TERESITA HOSPITAL	PRIVATE	0	1,496	1,496	572,975	383
UNIVERSITY OF CALIFORNIA, DAVIS MEDICAL CENTER	UC	10,375	3,492	13,867	5,158,566	372
SAN FRANCISCO GENERAL HOSPITAL MEDICAL CENTER	COUNTY	31,158	2,152	33,310	12,337,743	370
RANCHO LOS AMIGOS MEDICAL CENTER	COUNTY	31,363	3,800	35,163	12,874,630	366
UCSD MEDICAL CENTER	UC	11,649	1,249	12,898	4,633,834	359
CORONADO HOSPITAL	PRIVATE	68	875	943	308,286	327
VENTURA COUNTY MEDICAL CENTER	COUNTY	1,456	9,570	11,026	3,597,490	326
RIVERSIDE GENERAL HOSPITAL UNIVERSITY MEDICAL	COUNTY	24,892	3,275	28,167	7,839,598	278
MAD RIVER COMMUNITY HOSPITAL	PRIVATE	452	1,210	1,662	457,970	276
NATIVIDAD MEDICAL CENTER	COUNTY	1,776	2,498	4,274	1,147,936	269
BROOKSIDE HOSPITAL	DISTRICT	51	1,403	1,454	378,243	260
CPC ALHAMBRA HOSPITAL	PRIVATE	0	441	441	97,944	222
GOOD SAMARITAN HOSPITAL	PRIVATE *	1,831	162	1,993	439,546	221
PIONEERS MEMORIAL DISTRICT HOSPITAL	DISTRICT	438	661	1,099	222,876	203
MEMORIAL HOSPITAL AT EXETER	PRIVATE	0	285	285	57,352	201
GATEWAYS HOSPITAL AND MENTAL HEALTH CENTER	PRIVATE *	0	268	268	50,960	190
SIERRA KINGS DISTRICT HOSPITAL	DISTRICT	0	145	145	23,266	161
HIGH DESERT HOSPITAL	COUNTY	6,028	1,618	7,646	939,238	123
OJAI VALLEY COMMUNITY HOSPITAL	PRIVATE	22	926	948	107,364	113
TRINITY HOSPITAL	COUNTY	32	364	396	32,999	83
LOMPOC HOSPITAL DISTRICT	DISTRICT	0	1,101	1,101	76,389	69
CPC SIERRA VISTA HOSPITAL	PRIVATE	28	462	491	32,334	66
DOS PALOS MEMORIAL HOSPITAL	PRIVATE	37	648	685	44,814	65
CHOWCHILLA DISTRICT MEMORIAL HOSPITAL	DISTRICT	0	169	169	10,478	62
TUOLUMNE GENERAL HOSPITAL	COUNTY	634	531	1,165	69,095	59
MODOC MEDICAL CENTER	COUNTY	6	483	489	25,156	51
INDIAN VALLEY HOSPITAL DISTRICT	DISTRICT	20	75	95	4,459	47
SENECA HOSPITAL DISTRICT	DISTRICT	35	125	160	7,252	45
HI-DESERT MEDICAL CENTER	DISTRICT	0	1,047	1,047	34,412	33
OAK VALLEY HOSPITAL	DISTRICT	21	1,157	1,178	35,769	30
MAYERS MEMORIAL HOSPITAL	DISTRICT	0	1,065	1,065	28,887	27
JOHN C. FREMONT HOSPITAL	DISTRICT	55	139	194	5,003	26
BLOSS MEMORIAL HOSPITAL	DISTRICT	0	98	98	2,237	23
COALINGA REGIONAL MEDICAL CENTER	DISTRICT	0	2,120	2,120	43,158	20
KINGSBURG MEDICAL CENTER	DISTRICT	0	279	279	5,024	18
SOUTHERN HUMBOLDT COMMUNITY HOSPITAL	DISTRICT	45	211	256	4,128	16
MOUNTAINS COMMUNITY HOSPITAL	DISTRICT	0	364	364	5,523	15
SIERRA VALLEY HOSPITAL DISTRICT	DISTRICT	11	180	171	2,339	14
DEL PUERTO HOSPITAL	DISTRICT	0	346	346	3,389	10
WESTSIDE DISTRICT HOSPITAL	DISTRICT	17	1,510	1,527	13,262	9
SOUTHERN INYO HOSPITAL	DISTRICT	5	423	428	1,387	3
SAN DIEGO COUNTY PSYCH HOSPITAL	COUNTY	2,745	0	2,745	6,570	2
EDGEMONT HOSPITAL	PRIVATE	0	744	744	1,020	1
U.S. FAMILY CARE MEDICAL CENTER	PRIVATE				4,016,320	
TOTAL		438,342	111,445	549,787	\$453,240,459	\$824

NOTES:

* HOSPITALS PAYMENT LIMITED BY OBRA '93

(1) OSHPD FINANCIAL DISCLOSURE REPORT - FY 1993-94

(2) STATE DEPARTMENT OF HEALTH SERVICES - THESE AMOUNT HAVE BEEN REDUCED BY THE HOSPITALS INTERGOVERNMENTAL TRANSFER

(3) MEMBER OF PEACH

Note to John Callahan

Subject: CR Amendments -- California Medicaid DSH

The amendment by Mr. Lewis would extent the transition for hospital-specific DSH cap from January 1, 1995 to July 1, 1998 for the State of California. In addition, it would lower the 200 percent transition to 175 percent for this extended period. CBO estimates that this will have no scoreable impact, but it would just redistribute the funds within the California DSH limit.

HCFA has concerns that this language puts the Administration in an untenable position because this language would help only one State, California. Helping only one State could lead to charges that we are not treating everyone equally. On the other hand, it will also expose us to the risk of other States asking for the same exception. If the Administration supports this proposal we have significant risks either way. If we do it for other States, the cost will increase

HCFA is also concerned that the CBO scoring, while technically correct, does not account for a significant secondary factor. Paying any facility more than its uncompensated cost, either 200 percent or 175 percent, allows the facility to easily "pass back" a portion of the funds to the State. Hence freeing up State funds to be spent on other Medicaid initiatives. This could result in significant increases in Medicaid spending.

Given these concerns HCFA opposes this amendment.

Debbie Chang

cc: Bruce Vlodeck
Judy Moore

**PRESIDENT CLINTON HIGHLIGHTS PROPOSALS TO IMPROVE ACCESS TO
QUALITY HEALTH CARE AT NEW HAMPSHIRE ROUNDTABLE DISCUSSION
February 18, 1999**

Today, President Clinton and Governor Jeanne Shaheen will meet with a panel of New Hampshire residents to discuss the wide range of health care challenges currently facing the nation. The President will emphasize the importance of providing targeted tax credit to defray the costs of long term care services, and will contrast such targeted tax cuts to the Republicans' proposal for an across-the-board tax cut that will squander the budget surplus.

The President will highlight initiatives in his FY 2000 budget that increase access to health care and improve its quality:

- **Addressing growing long-term care needs.** The President's budget includes a historic new initiative to support elderly and disabled Americans with long-term care needs or the family members who care for them. This initiative invests over \$6 billion over five years in long-term care, including a \$1,000 tax credit to compensate for the cost of long-term care services; a new \$625 million National Family Caregiver Program, which will help states provide direct services and support for those caring for elderly family members with long-term care needs; a new proposal to allow states to provide home- and community-based care to people whose income level now qualifies them for nursing-home care under Medicaid; and a national campaign to educate Medicare beneficiaries about long-term care options. The President also will praise New Hampshire's efforts to expand community-based care services for Medicaid enrollees and to provide critical information to elderly and chronically ill adults about their long-term care options.
- **Improving economic opportunities for Americans with disabilities.** More than 70 percent of Americans with disabilities are unemployed, often because they face significant barriers to work, such as the risk of losing health care. The President has proposed a series of bold new initiatives to enable people with disabilities to return to work. This five-year, \$3.2 billion initiative includes full funding for the Jeffords-Kennedy-Roth-Moynihan Work Incentives Improvement Act which will enable many workers with disabilities to buy into Medicaid and Medicare; a \$1,000 tax credit to help offset the cost of the services and supports that people with disabilities may need to get and keep a job; and a new regulation to increase the amount that people with disabilities can earn and still maintain Social Security benefits. New Hampshire currently provides community-based services through Medicaid to individuals with disabilities, and in recognition of the State's innovation in this area, the Vice President recently gave the State a grant to help remove barriers to employment for people with disabilities.
- **Helping small businesses provide health care coverage for their employees.** The President's budget includes a \$44 million investment in targeted tax credits to increase health care coverage by encouraging small businesses to participate in voluntary purchasing coalitions that provide a variety of health care choices at relatively low cost.

This initiative provides a new 10 percent tax credit for small businesses that decide to offer coverage by joining coalitions; encourage private foundations to support coalitions by making their contributions towards these organizations tax-exempt; and offers technical assistance to small business coalitions from the Administrators of the Federal Employees Health Benefit Plan. Governor Shaheen has proposed legislation that creates voluntary small-business purchasing alliances to reduce costs and increase options for small businesses offering health insurance to their employees. She believes that the Administration's proposal will provide needed financing for this effort.

- **Implementing the Children's Health Insurance Program, the largest investment in children's health in a generation.** The Administration is committed to implementing the Children's Health Insurance Program (CHIP) and has developed a national outreach campaign to sign up every child eligible for Medicaid or CHIP coverage. New Hampshire, under Governor Shaheen's leadership, is one of 46 states that already have implemented the CHIP program: the State's program -- Healthy Kids -- provides health insurance to thousands of uninsured New Hampshire children.
- **Protecting patients with a strong, enforceable patients bill of rights.** The President again will call on Congress to pass a strong, federally enforceable patients' bill of rights that includes: guaranteed access to needed specialists; access to emergency room services when and where the need arises; and access to a meaningful external appeals process to resolve disputes with health plans. The President is already doing everything he can to implement these protections by extending them to the 85 million Americans covered by federal health plans. Governor Shaheen has proposed an HMO Accountability Act to provide similar patient protections.

THE PRESIDENT'S HISTORIC LONG-TERM CARE INITIATIVE

February 18, 1999

The President has proposed an historic, seven-part initiative designed to address the broad-based and varied long-term care needs of Americans of all ages. It would not only improve nursing home quality, options for community-based services, and the purchase of long-term care insurance, but would, for the first time, support families who care for their ill relatives. These millions of spouses, children, other relatives and friends are the major providers of long-term care in the U.S. This initiative recognizes this by providing a \$1,000 tax credit for people with long-term care needs or their families to offset the costs of care and a new Family Caregivers Program that offers respite services, information, and other assistance as needed. Altogether, this \$6 billion initiative lays the groundwork for long-term care policy for the twenty-first century.

MILLIONS OF AMERICANS HAVE LONG-TERM CARE NEEDS

- **More and more Americans have a range of long-term care needs.** Over five million Americans have significant limitations due to illness or disability and thus require long-term care. Approximately, two-thirds are older Americans. Also, millions of adults and a growing number of children have long-term care needs because of health condition from birth or a chronic illness developed later in life.
- **The aging of Americans will only increase the need for quality long-term care options.** The number of Americans age 65 years or older will double by 2030 (from 34.3 to 69.4 million), so that one in five Americans will be elderly. The number of people 85 years or older, nearly half of whom need assistance with everyday activities, will grow even faster (from 4.0 to 8.4 million).

MULTI-FACETED INITIATIVE TO SUPPORT FAMILY CAREGIVERS AND ADDRESS GROWING LONG TERM CARE NEEDS. The Clinton Administration's historic long-term care initiative includes:

- **Supporting families with long-term care needs through a \$1,000 tax credit.** This initiative, for the first time, acknowledges and supports millions of Americans with long-term care needs or the family members who care for and house their ill or disabled relatives through a \$1,000 tax credit. This new tax credit supports the diverse needs of families by compensating a wide range of formal or informal long-term care for people of all ages with three or more limitations in activities of daily living (ADLs) or a comparable cognitive impairment. This proposal, which supports rather than supplants family caregiving, would provide needed financial support to about 2 million Americans, including 1.2 million older Americans, over 500,000 non-elderly adults, and approximately 250,000 children. It costs \$5.5 billion over five years and phases out beginning at \$110,000 for couples and \$75,000 for unmarried taxpayers.
- **Creating a new National Family Caregiver Support Program.** Recent studies have found that services like respite care can relieve caregiver stress and delay nursing home entry, and that support for families of Alzheimer's patients can delay institutionalization for up to a year. This new nationwide program would support families who care for elderly relatives with chronic illnesses or disabilities by enabling states to create "one-stop-shops" that provide: quality respite care and other support services; critical information about community-based long-term services that best meet a families' needs; and counseling and support, such as teaching model

approaches for caregivers that are coping with new responsibilities and offering training for complex care needs, such as feeding tubes. This program, which costs \$625 million over five years, would assist approximately 250,000 families nationwide.

- **Expanding Medicaid eligibility for people in home- and community-based care settings.** Historically, Medicaid policy and practice has inadvertently discriminated against people with long-term care needs who want to live in the community by making it much easier to expand coverage to nursing homes than community-based services. To eliminate this “institutional bias,” this proposal would enable states to expand their programs to cover community-based care as well as nursing home residents with income up to 300 percent of the Social Security Income (SSI) limits, without requiring a complicated and frequently time-consuming Federal waiver. This proposal contributes towards this initiative’s goal of giving people with long-term care needs the choice of remaining in their homes and communities. It costs \$110 million over five years.
- **Encouraging partnerships between public housing for the elderly and Medicaid.** This proposal would provide \$100 million in competitive grant funds to qualified elderly housing facilities (Section 202 facilities) to convert to assisted living facilities, so long as those facilities provide Medicaid home and community-based services. As people living these housing facilities age, their need for long-term care services rises, often leaving them with no choice but to move to a nursing home. This proposal would allow such people to “age in place” by funding the conversion of their homes into assisted living facilities. Only sites that agree to bring Medicaid home and community-based services into their converted assisted living facilities would qualify for grants, to ensure that low-income elderly have access to this option.
- **Nursing home quality initiative.** This proposal will provide \$110 million to strengthen Federal oversight of nursing home quality and safety standards by working with States to improve their nursing home inspection systems, crack down on nursing homes that repeatedly violate safety rules, establish a national registry of abusive nursing home workers, and publish nursing home quality ratings on the internet.
- **Having the Federal government serve as a model employer by offering quality private long-term care insurance to Federal employees.** A new proposal would allow the Office of Personnel Management (OPM) to use its market leverage and set a national example by offering non-subsidized, quality private long-term care insurance to all federal employees, retirees, and their families at group rates. This proposal, which costs \$15 million over five years, will provide employers a nationwide model for offering quality long-term care insurance. OPM anticipates that approximately 300,000 Federal employees would participate in this program.
- **Launching a national long-term care education campaign.** Nearly 60 percent of Medicare beneficiaries are unaware that Medicare does not cover most long-term care, and many do not know what long-term care services would best meet their needs. This \$10 million nationwide campaign would provide all 39 million Medicare beneficiaries with critical information about long-term care options including: what long-term care Medicare does and does not cover; how to find out about Medicaid long-term care coverage; what to look for in a quality private long-term care policy; and how to access information about home-and community-based care services that best fit beneficiaries’ needs.

**THE CLINTON ADMINISTRATION'S BOLD NEW INITIATIVE TO IMPROVE
ECONOMIC OPPORTUNITIES FOR AMERICANS WITH DISABILITIES**

February 18, 1999

The President has proposed an historic new initiative that will remove significant barriers to work for people with disabilities. This four-part initiative, which invests over \$3 billion over five years, includes: (1) full funding of the Work Incentives Improvement Act which was recently introduced by Senators Jeffords, Kennedy, Roth and Moynihan; (2) a new \$1,000 tax credit to help with work-related costs for people with disabilities; (3) doubling the funding for assistive technologies; and (4) increasing the amount that people can earn while on disability in order to ease the transition to work. People with disabilities will also benefit from the President's \$6 billion long-term care initiative that complements the health insurance and work incentive proposals. Together, this is the most important effort to improve opportunities for people with disabilities since the Americans with Disabilities Act was passed.

CRITICAL NEED TO REMOVE BARRIERS TO WORK

Since President Clinton and Vice President Gore took office, the American economy has added 17.8 million new jobs. Unemployment is at a 41-year low of 4.3 percent. However, the unemployment rate among working-age adults with disabilities is nearly 75 percent. About 1.6 million working-age adults have a disability that leads to functional limitations and 14 million working-age adults have less severe but still significant disabilities. People with disabilities can bring tremendous energy and talent to the American workforce, yet some outdated, institutional barriers and fewer opportunities often limit their ability to work.

Under current law, people with disabilities often become ineligible for Medicaid, Medicare, or disability insurance if they work. This means that many people with disabilities are put in the untenable position of choosing between health care coverage and work. In addition, the extraordinary advances in technology and communications are often not accessible to or adapted for people with disabilities. Moreover, working itself is usually more expensive for people with disabilities who need personal assistance getting to and from work; special transportation, or technology that is not paid for by their employers.

**INITIATIVE TO IMPROVE ECONOMIC OPPORTUNITIES FOR AMERICANS WITH
DISABILITIES**

- **Funding the Work Incentives Improvement Act in the President's budget.** Health care -- particularly prescription drugs and personal assistance -- is essential for people with disabilities to work. The President included in his FY 2000 budget the Work Incentives Improvement Act. This proposal, which costs \$1.2 billion over 5 years, would:
 - Improve access to health care by:
 - Providing greater incentives and options for states to enable people to return to work to maintain eligibility for Medicaid. This provision: eliminates barriers to the buy-in for people with income above the current limits; allows people who are only able to work because of treatments that are covered to buy into Medicaid; and provides health care grants for states that take these important options;
 - Extending Medicare coverage, for the first time, for people with disabilities who

return to work. While Medicare does not provide as comprehensive a benefit as Medicaid, it assures that all people with disabilities who return to work have access to health care coverage, even if they live in a state that does not take the Medicaid option;

- Creating a new Medicaid buy-in demonstration to help people with a specific physical or mental impairment that, as defined by the state, is reasonably expected to lead to a severe disability without medical assistance. This could help people with muscular dystrophy, Parkinson's Disease, HIV or diabetes who may be able to function and continue to work with appropriate health care, but such health care is currently only available once their conditions have become severe enough to qualify them for SSI or SSDI and thus Medicaid or Medicare.
- Modernize employment-related services by creating a "ticket" that will increase options and access for SSI or SSDI beneficiaries to go to either a public or a private provider for employment-related services. If the beneficiary goes to work and achieves substantial earnings providers would be paid a portion of the benefits saved through either an outcome or "milestone" payment.
- Create a Work Incentive Grant program to provide benefits planning and assistance, facilitate access to information about work incentives, and foster coalitions to better integrate services to people with disabilities working or returning to work.
- **Providing an \$1,000 tax credit for work-related expenses for people with disabilities.** The daily costs of getting to and from work, and being effective at work, can be high if not prohibitive for people with disabilities. Under this proposal, workers with significant disabilities would receive an annual \$1,000 tax credit to help cover the formal and informal costs that are associated with and even prerequisites for employment, such as special transportation and technology needs. Like the Jeffords-Kennedy-Roth-Moynihan Work Incentive Improvement Act, this tax credit, which will help 200,000 to 300,000 Americans, helps assure that people with disabilities have the tools they need to return to work. It also has the advantage of helping people in all states irrespective of whether states take up optional coverage. It costs \$700 million over 5 years.
- **Improving access to assistive technology.** Technology is often not adapted for people with disabilities and even when it exists, people with disabilities may not know about it or may not be able to afford it. This new initiative would accelerate the development and adoption of information and communications technologies, which can improve the quality of life for people with disabilities and enhance their ability to participate in the workplace. This initiative: (1) helps make the Federal government a "model user" of assistive technology; (2) supports new and expanded state loan programs to make assistive technology more affordable for Americans with disabilities; and (3) invests in research and development and technology transfer in areas such as "text to speech" for people who are blind, automatic captioning for people who are deaf, and speech recognition and eye tracking for people who can't use a keyboard. It would cost \$35 million in FY 2000, more than doubling the government's current investment in deploying assistive technology.
- **Increasing the amount that people can earn while on disability to ease the transition to**

work. A new proposed regulation increases the substantial gainful activity (SGA) level from \$500 to 700 per month. Under current rules, people lose eligibility for Social Security Disability Insurance (SSDI) or Supplemental Security Income (SSI) benefits if they can engage in any substantial gainful activity (SGA) that exceeds \$500 per month. Many hesitate to work because they cannot afford to give up critical benefits. Increasing the SGA level would enable the 400,000 beneficiaries who now work to work more, easing their transition to work. This initiative costs \$1.2 billion over five years.

TASK FORCE ON EMPLOYMENT OF ADULTS WITH DISABILITIES. Last March, President Clinton signed the executive order establishing the Presidential Task Force on Employment of Adults with Disabilities. Led by Alexis Herman, Secretary of Labor, and Tony Coelho, this Task Force is charged with coordinating an aggressive national policy to bring adults with disabilities into gainful employment. It produced a set of interim recommendations in December, 1998, summarized below along with the Administration's actions to address them:

RECOMMENDATION

ACTION

- | | |
|--|--------------------------------|
| 1. Work to pass the Work Incentive Improvement Act | President includes in budget |
| 2. Work to pass the Patients' Bill of Rights | High Presidential priority |
| 3. Examine tax options to assist with expenses of work | President includes in budget |
| 4. Foster interdisciplinary consortia for employment services | President includes in budget |
| 5. Accelerate development/adoption of assistive technology | President includes in budget |
| 6. Direct Small Business Administration to start outreach | Vice President announced 12/98 |
| 7. Remove Federal hiring barriers for people w/ mental illness | Mrs. Gore announced 1/99 |
| 8. Develop a model plan for Federal hiring of people w/ disabilities | Vice President announced 12/98 |

PRESIDENT CLINTON'S INITIATIVE ENCOURAGING SMALL BUSINESSES TO OFFER HEALTH INSURANCE

February 18, 1999

This initiative would encourage small businesses to offer health insurance to their workers by developing and/or joining coalitions for purchasing health insurance. Fewer small businesses offer health insurance because of their higher administrative costs and premiums relative to large businesses. As a result, nearly half of uninsured workers are in firms with fewer than 25 employees. This three-part initiative would: (1) provide a tax credit to small businesses who decide to offer coverage by joining coalitions; (2) encourage private foundations to support coalitions by allowing their contributions towards these organizations to be tax exempt; and (3) offer technical assistance to small business coalitions from the Office of Personnel Management, which runs the Federal Employees Health Benefits Program (FEHBP). This initiative would cost about \$44 million over 5 years, and provide thousands of workers and their families the option of affordable health insurance.

INSURANCE AND SMALL BUSINESSES

- **Most of the uninsured work in small businesses.** Workers in small firms are less likely to have access to affordable, job-based health insurance. Although worker in firms with fewer than 25 employees make up about 30 percent of the workforce, they comprise nearly half of the uninsured. Only one-third of firms with fewer than 10 employees and two-thirds of firms with 10 to 24 employees offer coverage, compared to over 95 percent of large firms.
- **Higher premiums and administrative costs.** Small employers state that high premiums and the uncertainty in premium costs are major reasons why they do not offer health insurance. Premiums for the same benefits are higher for small firms than large firms because there are fewer people who can share in the risk of illness and because administrative costs per employee are higher. Insurers' administrative expenses ranged from approximately 5 percent of premiums for the largest employer plans to 30 percent or more of premiums for the smallest employers. As a result of this and other factors, small firms typically offer less generous benefits -- or do not offer coverage at all.

SMALL BUSINESS HEALTH PURCHASING COALITIONS

This initiative would encourage the development of and participation in small business health purchasing coalitions. Coalitions pool employees across firms to gain market power; negotiate with insurers over benefits and premiums; provide comparative information about available health plans; and administer premium payments made by small employers and their participating employees. Despite these advantages, there are few small business health purchasing coalitions today. This in part reflects the lack of up-front funding to develop coalitions (e.g., hiring staff, developing a negotiating strategy, marketing to small businesses). Additionally, coalitions that cannot quickly attract a large enough number of small firms to join them could find themselves without the bargaining power that they need to reduce costs and offer choice.

POLICIES TO ENCOURAGE COALITIONS

- **Tax credit for employers who join coalitions:** A tax credit equal to ten percent of employer contributions to employee health plans, up to \$200 for a single policy and \$500 for a family policy, would be given to qualifying employers. A qualifying small business would have between 3 and 50 employees and purchase coverage through a qualified coalition. To target the credit to employers who would not otherwise offer coverage, eligible employers could not have had an employee health plan during any part of 1997 or 1998. Employers would need to cover seventy percent of those workers who have wages (including deferred wages) in excess of \$10,000 and who are not covered elsewhere by a health plan (typical in the group market). This credit is temporary (up to two years) since the goal is to encourage the one-time action of joining the coalition. The credit would be available for employers taking this option before December 31, 2003.

A qualified coalition is a certified, non-profit organization that negotiates with health insurers to provide health insurance to the employees of its small business members. Its members would include all interested employers with 50 or fewer employees in its area, without regard to the health status or occupation of their employees. It could collect and distribute health insurance premiums but would not be an insurer (bear risk) itself. Its board would include both employer and employee representatives of small businesses, but could not include service providers, health insurers, insurance agents or brokers, and others who might have a conflict of interest. Where feasible, the coalition would offer several health plan choices and at least one open enrollment period per year. These plans would follow state requirements and their premiums could not be rated according to the occupation or existing health status.

- **Financial assistance in creating coalitions.** Currently, funding the start-up expenses of small business health purchasing coalitions would not qualify as a "charitable purpose" Consequently, private foundations are reluctant or, in some cases, prohibited by their own rules from offering grants for this purpose. Under this proposal, any grant or loan made by a private foundation to a qualified small business health purchasing coalition would be treated as a grant (or loan) made for charitable purposes. This special rule would apply only to grants (or loans) made to qualified coalitions for the purpose of funding qualified coalition start-up expenses made during the first two years of their operations. The special foundation rule would apply to grants and loans made prior to December 31, 2003 for start-up expenses incurred prior to December 31, 2005.
- **Technical assistance in creating coalitions.** The Office of Personnel Management (OPM) runs the Federal Employees Health Benefits Program (FEHBP). This program serves as a model for consumer choice of health plans. OPM has considerable experience in working with private plans in coordinating a bidding process, negotiating benefits and premiums, and distributing consumer information. To help small business health purchasing coalitions do the same, it would provided any needed technical assistance to qualified coalitions, sharing its administrative experience.

February 17, 1999

HEALTH CARE ROUNDTABLE WITH NEW HAMPSHIRE RESIDENTS

DATE: February 18, 1999
LOCATION: Dover Municipal Building
TIME: 11:15am - 12:05pm
FROM: Bruce Reed

I. PURPOSE

You will discuss with a group of New Hampshire residents the variety of health care challenges currently facing the nation and highlight the initiatives in your FY 2000 budget that address these challenges. You will highlight the long-term care tax credit and contrast targeted tax credits of this kind to the Republicans' proposal for an indiscriminate, across-the-board tax cut.

II. BACKGROUND

You will highlight initiatives in your FY 2000 budget that increase access to health care and improve its quality:

- **Addressing growing long-term care needs.** Your budget includes a historic new initiative to support elderly and disabled Americans with long-term care needs or the family members who care for them. This initiative invests over \$6 billion over five years in long-term care, including a \$1,000 tax credit to compensate for the cost of long-term care services; a new \$625 million National Family Caregiver Program, which will help states provide direct services and support for those caring for elderly family members with long-term care needs; a new proposal to allow states to provide home- and community-based care to people whose income level now qualifies them for nursing-home care under Medicaid; and a national campaign to educate Medicare beneficiaries about long-term care options. You also will praise New Hampshire's efforts to expand community-based care services for Medicaid enrollees and to provide critical information to elderly and chronically ill adults about their long-term care options.
- **Improving economic opportunities for Americans with disabilities.** More than 70 percent of Americans with disabilities are unemployed, often because they face

significant barriers to work, such as the risk of losing health care. You have proposed a series of bold new initiatives to enable people with disabilities to return to work. This five-year, \$3.2 billion initiative includes full funding for the Jeffords-Kennedy-Roth-Moynihan Work Incentives Improvement Act which will enable many workers with disabilities to buy into Medicaid and Medicare; a \$1,000 tax credit to help offset the cost of the services and supports that people with disabilities may need to get and keep a job; and a new regulation to increase the amount that people with disabilities can earn and still maintain Social Security benefits. New Hampshire currently provides community-based services through Medicaid to individuals with disabilities, and in recognition of the State's innovation in this area, the Vice President recently gave the State a grant to help remove barriers to employment for people with disabilities.

- **Helping small businesses provide health care coverage for their employees.** Your budget includes a \$44 million investment in targeted tax credits to increase health care coverage by encouraging small businesses to participate in voluntary purchasing coalitions that provide a variety of health care choices at relatively low cost. This initiative provides a new 10 percent tax credit for small businesses that decide to offer coverage by joining coalitions; encourage private foundations to support coalitions by making their contributions towards these organizations tax-exempt; and offers technical assistance to small business coalitions from the Administrators of the Federal Employees Health Benefit Plan. Governor Shaheen has proposed legislation that creates voluntary small-business purchasing alliances to reduce costs and increase options for small businesses offering health insurance to their employees. She believes that the Administration's proposal will provide needed financing for this effort.
- **Implementing the Children's Health Insurance Program, the largest investment in children's health in a generation.** Your Administration is committed to implementing the Children's Health Insurance Program (CHIP) and has developed a national outreach campaign to sign up every child eligible for Medicaid or CHIP coverage. New Hampshire, under Governor Shaheen's leadership, is one of 46 states that already have implemented the CHIP program: the State's program -- Healthy Kids -- provides health insurance to thousands of uninsured New Hampshire children.
- **Protecting patients with a strong, enforceable patients bill of rights.** You again will call on Congress to pass a strong, federally enforceable patients' bill of rights that includes: guaranteed access to needed specialists; access to emergency room services when and where the need arises; and access to a meaningful external appeals process to resolve disputes with health plans. You are already doing everything you can to implement these protections by extending them to the 85 million Americans covered by federal health plans. Governor Shaheen has proposed an HMO Accountability Act to provide similar patient protections.

III. PARTICIPANTS

Governor Jeanne Shaheen
Beth Dixon, Concord, NH
David Robar, New London, NH
Karen Goddard, Nashua, NH
Christine Monteiro, Nottingham, NH
Stephen Gorin, Canterbury, NH

IV. PRESS PLAN

Open Press.

V. SEQUENCE OF EVENTS

- You will be announced into the auditorium accompanied by Governor Jeanne Shaheen.
- Gov. Shaheen will make welcoming remarks and introduce you.
- You will make remarks.
- Gov. Shaheen will introduce the roundtable participants and begin the discussion.
- Gov. Shaheen will make concluding remarks.
- You will work a ropeline and depart.

VI. REMARKS

To Be Provided by Speechwriting.

PA DSH FILE

THE WHITE HOUSE

OFFICE OF LEGISLATIVE AFFAIRS
HOUSE LIAISON
-FAX COVER SHEET-

DATE: 12/2

TO: Chris Jennings
DPC

FAX: 05557

FROM:	<input checked="" type="checkbox"/> CHUCK BRAIN	<input type="checkbox"/> BRODERICK JOHNSON
	<input checked="" type="checkbox"/> AL MALDON	<input type="checkbox"/> ELISA MILLSAP
	<input checked="" type="checkbox"/> DARIO GOMEZ	<input type="checkbox"/> JADE RILEY
	<input type="checkbox"/> LISA KOUNTOUPES	

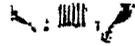
(202)456-6620 (TELEPHONE)
(202)456-2604 (FAX)

SUBJECT: Chris, Chuck wanted to make
sure you had a copy of this

1 OF 16

* PA DSH *

COMMITTEE ON
WAYS AND MEANS
SUBCOMMITTEE
ON HUMAN RESOURCES
RANKING MEMBER
OVERSIGHT
COLEMAN J. CONROY
ADMINISTRATIVE ASSISTANT



2025 RELEASE UNDER E.O. 14176
FAX # 202 225 1822
312-644 1870

Congress of the United States
House of Representatives
Washington, DC 20515-3814

FAX COVER SHEET

TO: Chuck Brain

FROM: Mona Miller

DATE: 11/24

*This is just FYI. We're hoping this might
move HCF A's lawyers. Anything you could
do to move it along would be much appreciated.*

TOTAL NUMBER OF PAGES (INCLUDING COVER): 17

OFFICE FAX NUMBER: (202) 225-1844

OFFICE TELEPHONE NUMBER: (202) 225-2301

PENNSYLVANIA
14TH DISTRICT
COMMITTEE ON
WAYS AND MEANS
SUBCOMMITTEES
HUMAN RESOURCES
RANKING MEMBER
OVERSIGHT
COLEMAN J. DONROY
ADMINISTRATIVE ASSISTANT



2000 FEDERAL BUILDING
1000 LIBERTY AVENUE
PITTSBURGH, PA 15222
(412) 644-2870

Congress of the United States
House of Representatives
Washington, DC 20515-3814

November 23, 1998

The Honorable Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration
200 Independence Avenue, SW
Washington, D.C. 20201

Dear Administrator DeParle:

I am writing to again ask that you reconsider your decision to seek repayment of Medicare Disproportionate Share (DSH) payments made to Pennsylvania hospitals based on General Assistance (GA) days. As you know, this decision is causing considerable hardship for Pennsylvania's safety-net hospitals, which rely heavily on this funding to subsidize care for vulnerable populations and do not have the resources to return past payments.

I understand that your attorneys believe that the law clearly forbids inclusion of these days, notwithstanding the fact that the fiscal intermediary has for the past 12 years required hospitals to include them. However, I have recently learned of a similar case in which HCFA's own provider review board determined that it was appropriate to include charity care days which were part of the Title XIX state plan, whether or not they were federally reimbursable. I am enclosing the case for your review.

As you will see, the situation in Jersey Shore Medical Center vs. Blue Cross of New Jersey closely parallels the one in Pennsylvania. If anything, finding in the provider's favor in this case required a broader interpretation of the law than Pennsylvania is requesting, since the days in this case were part of a separate program, and Pennsylvania's are actually part of its Medical Assistance program.

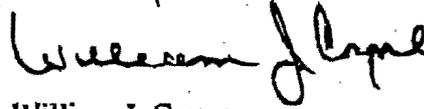
At the very least, this ruling shows that the law does not clearly bar hospitals from including Title XIX days which are not federally funded in their DSH calculations. In fact, I believe that Congress intended for the days to be covered. I have discussed this matter with Congressman Pete Stark, who chaired the Health Subcommittee at the time this law was drafted, and he agrees with my recollection on this point.

Page 2

I hope you will review the case I am sending you and reconsider your decision. I look forward to working with you and your staff to resolve this matter in a way that protects hospitals that provide health care to vulnerable populations.

With all best wishes, I am

Sincerely,



William J. Coyne
Member of Congress

WJC:mm

**PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION
ON-THE-RECORD
99-D4**

**PROVIDER - Jersey Shore Medical Center
Neptune, New Jersey**

**DATE OF HEARING -
August 26, 1998**

Provider No. 31-0073

**Cost Reporting Period Ended -
December 31, 1992**

VL

**INTERMEDIARY -
Blue Cross and Blue Shield Association/
Blue Cross and Blue Shield of New Jersey**

CASE NO. 95-0907

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Intermediary's Contentions	6, 8
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Decision and Order	12

ISSUE:

Was the Intermediary's calculation of the Provider's disproportionate share hospital adjustment proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Jersey Shore Medical Center ("Provider") is a 527 bed acute care hospital located in Neptune, New Jersey. As such, the Provider is reimbursed under Medicare's prospective payment system ("PPS") for inpatient hospital services furnished Medicare beneficiaries.¹

For its cost reporting period ended December 31, 1992, the Provider qualified for a disproportionate share hospital ("DSH") adjustment to its PPS payments pursuant to 42 C.F.R. § 412.106. Blue Cross and Blue Shield of New Jersey ("Intermediary") determined the amount of the Provider's DSH adjustment using only Medicaid paid days in the numerator of the Medicaid proxy portion of the payment formula.²

On August 16, 1994, the Intermediary issued a Notice of Program Reimbursement for the subject cost reporting period, which reflected its DSH determination. On February 9, 1995, the Provider appealed the Intermediary's determination to the Provider Reimbursement Review Board ("Board") pursuant to 42 C.F.R. § 405.1835, 1841, and met the jurisdictional requirements of those regulations.

The Provider, in its appeal to the Board and in its Position Paper, argued in a broad sense that the Medicaid proxy should not be limited to Medicaid paid days but should include all Medicaid eligible days. However, in a letter dated November 13, 1997, the Provider supplemented its Position Paper and identified six specific categories of patient days that should be included in the numerator of the Medicaid proxy.³ The Intermediary reviewed this information and disagreed with the Provider's assertion that: "[s]ll "charity care" days, as that term is used in the New Jersey State plan" should be included in the payment formula. The five categories of patient days that were not disputed are as follows:⁴

- * All days for which a patient was both Medicaid eligible and Medicare Part B eligible.

¹ Intermediary's Position Paper at 1.

² The term "Medicaid proxy" is used to refer to the portion of the DSH payment formula found at 42 C.F.R. § 412.106(b)(4). Intermediary's Position Paper at 3.

³ Provider Letter Dated November 13, 1997 at 16.

⁴ Intermediary's Supplemental Position Paper at 2.

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Other Primary Insurance with Medicaid TPL.

⁵ Note: A variation of these days are actually in dispute. See next paragraph.

⁶ Intermediary's Supplemental Position Paper at 3.

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Accordingly, the Medicaid patient days in controversy in this case are: (1) those days pertaining to patients that have exhausted their Medicare Part A benefits, and (2) those days pertaining to charity care under the New Jersey State plan. The estimated amount of Medicare reimbursement in controversy exceeds \$10,000.

The Provider was represented by Joseph D. Glazer, Esquire, of Reed Smith Shaw & McClay LLP. The Intermediary was represented by Bernard M. Talbert, Esquire, Associate Counsel, Blue Cross and Blue Shield Association.

Patients Who Have Exhausted Medicare Part A Benefits

PROVIDER'S CONTENTIONS:

The Provider contends that patient days related to Medicaid payments for dual-eligible individuals should be included in the numerator of the Medicaid proxy. Specifically, the Provider asserts that in those instances where, during a patient stay, a patient eligible for both Medicare Part A and Medicaid exhausts his or her benefits, Medicare stops paying for the patient's outlier days and Medicaid begins to reimburse the hospital for those costs. The Provider asserts that in these instances the patient is no longer entitled to Medicare benefits and the days related to these costs should therefore be included in the Medicaid proxy.⁷

The Provider asserts that this contention is based upon the articulated principles of the DSH adjustment. The Provider cites 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II) as expressly requiring the inclusion of all days in the Medicaid proxy for which patients were eligible for medical assistance under a State Medicaid plan, which would include the dual-eligible days paid by Medicaid, as follows:

the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX of this chapter [the Medicaid program], but who were not entitled to benefits under part A of this subchapter, and the denominator of which is the total number of the hospital's patient days for such period.

42 U.S.C. § 1395ww(d)(5)(F)(vi)(II).

The Provider also cites, in part, HCFA Ruling 97-2, which changed the Secretary's interpretation of what days should be included in the Medicaid proxy, as follows:

[u]nder the new interpretation, the Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to

⁷ Provider's Supplemental Position Paper at 7.

include all inpatient hospital days of service for patients who were eligible on that day for medical assistance under a State Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for those inpatient hospital services.

HCFA Ruling 97-2.⁴

The Provider notes that according to HCFA Ruling 97-2, the Secretary of Health and Human Services' ("Secretary") agrees that all days for patients eligible for medical assistance under a State Medicaid plan should be included in a hospital's DSH calculation. Moreover, the ruling is applied prospectively to cost reports that are settled after the date it was issued (February 27, 1997) and to cost reports that have been settled prior to the effective date, but for which a hospital has a proper appeal pending on the issue, as does the Provider.

Also regarding the articulated principles of the DSH adjustment, the Provider cites an instructional memorandum issued by the Health Care Financing Administration ("HCFA") on June 12, 1997, which explains how HCFA Ruling 97-2 should be implemented.⁵ The Provider asserts that this memorandum further clarifies the Secretary's interpretation of the days to be included in the Medicaid proxy, as follows:

[c]onsistent with the Courts of Appeals decisions on the issue of Medicaid days, the HCFA Ruling 97-2 was meant to be inclusive, rather than exclusive. This means that, in calculating the number of Medicaid days, fiscal intermediaries should ask themselves, "Was this person a Medicaid (Title XIX) beneficiary on that day of service?" If the answer is "yes," the day counts in the Medicare disproportionate share adjustment calculation. This does not mean that Title XIX had to be responsible for payment for any particular services. It means that the person had to have been determined by a State agency to be eligible for Federally-funded medical assistance for any one of the services covered under the State Medicaid Title XIX plan (even if no Medicaid payment is made for inpatient hospital services or any other covered service). Any examples of days to be counted given in the HCFA Ruling or in HCFA instructions should not be construed as an all-inclusive list.

HCFA Memorandum, FKA-31, June 12, 1997.

Finally, the Provider contends that a letter issued by HCFA on February 29, 1996, also supports the fact that days paid by Medicaid after Medicare Part A benefits are exhausted should be included in the DSH calculation. In that letter, HCFA instructs the Intermediary that in situations where Medicare is the primary payor and Medicaid is the secondary payor, the days related to a

⁴ Provider's Supplemental Position Paper at Exhibit A.

⁵ Provider's Supplemental Position Paper at Exhibit B.

patient's stay should be prorated between the two agencies. As an example, HCFA states that "if a stay of 10 days costs \$10,000 and Medicare paid \$3,000 and Medicaid paid \$7,000, then Medicare would be credited with 3 days and Medicaid would be credited with 7 days." HCFA Letter, FKA-31, February 29, 1996.¹⁰

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the Provider's fundamental argument that Medicaid pays for patient days after Medicare Part A benefits are exhausted is wrong.¹¹ The Intermediary asserts that these days are, in fact, paid by Medicare and must be excluded from the DSH calculation in accordance with 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II), which states, in part,

the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX of this chapter [the Medicaid program], but who were not entitled to benefits under part A of this subchapter, and the denominator of which is the total number of the hospital's patient days for such period.

42 U.S.C. § 1395ww(d)(5)(F)(vi)(II).

The Intermediary asserts that there is a maximum number of days under Medicare Part A which are covered for a Medicare beneficiary. When Part A eligibility is exhausted in the course of a hospital admission, Medicare Part B provides coverage for certain ancillary services. Also, under PPS the Medicare program pays the full diagnostic related group ("DRG") payment for an admission even if technically, the day maximum is reached during the course of the stay. Therefore, Medicare Part A makes payment on behalf of a beneficiary's days because the DRG operating cost payment is not factored down even if covered days are exhausted before discharge.

The Intermediary concludes that in order to be included in the Medicaid proxy, days in which a patient is entitled to Medicaid can not be paid by Medicare Part A, and that condition is not met in this instance.

¹⁰ Provider's Supplemental Position Paper at Exhibit D.

¹¹ Intermediary's Supplemental Position Paper at 4.

Charity Care Program Days Under the New Jersey State Plan

PROVIDER'S CONTRIBUTIONS:

The Provider contends that days related to patients who are eligible for New Jersey's Charity Care program should be included in the DSH calculation since they meet the relevant statutory requirements.¹² Pursuant to 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II), patient days included in the numerator of the Medicaid proxy are defined in terms of whether the patient was "eligible for medical assistance under a State plan approved under subchapter XDK of this chapter."¹³ Respectively, the Provider asserts that the Charity Care program at issue generally provides "medical assistance," or payment for inpatient hospital services, under the New Jersey State Medicaid plan for certain indigent individuals who are not eligible for Medicaid. If a patient meets certain specific guidelines and does not get charged by a hospital for its services, or the patient pays a reduced amount of the hospital's charges, the Charity Care program pays the hospital for its unreimbursed costs.¹⁴ Patient eligibility criteria and standards for hospital reimbursement are both detailed in the State plan.¹⁵ The Provider emphasizes that the statutory language includes days in the DSH calculation that pertain to patients eligible under a State plan for Medicaid, as quoted above, and not specifically eligible for Medicaid.

The Provider asserts that New Jersey's Charity Care program is also an essential part of the State satisfying its statutory obligation regarding payments to DSH hospitals.¹⁶ Federal law requires that every State have a federally approved Medicaid plan that details, among other things, the State's methodology for paying for inpatient hospital services. 42 U.S.C. § 1396a. Although such Medicaid plans are formulated by each State, the plans must comply with the federal Medicaid statute and be approved in order to receive federal funds. 42 U.S.C. § 1396a(a).¹⁷ Among the statutory requirements, State plans must satisfy certain standards related to disproportionate share hospitals. Specifically, each State's Medicaid plan must provide payment rates to hospitals that take into account the situation of hospitals that serve a disproportionate number of low income patients with special needs. 42 U.S.C. § 1396a(a)(13). The Provider submits that the purpose of the DSH adjustment (to provide additional reimbursement to those hospitals that serve a disproportionately large percentage of low income patients), is fully served only if Charity Care

¹² Provider's Supplemental Position Paper at 9.

¹³ Provider's Supplemental Position Paper at 14.

¹⁴ Provider's Supplemental Position Paper at 11.

¹⁵ See Provider's Supplemental Position Paper at Exhibit F at 69-73, § 3.31.

¹⁶ Provider's Supplemental Position Paper at 14.

¹⁷ Provider's Supplemental Position Paper at 9.

patients are included in the DSH calculation.¹⁴ The Provider adds that many patients who receive Charity Care are patients who would be eligible for Medicaid except for the fact that their income or resources are too high, based on Medicaid limits. Accordingly, the Provider argues that the Charity Care program is essentially an extension of the Medicaid program; an extension fully sanctioned by the federal government, subject to extensive federal review through the State plan approval process, and paid for with both State Medicaid dollars and federal matching funds.

Finally, the Provider contends that even if all days related to Charity Care patients are not included in the DSH calculation, there are some Charity Care patients that were actually eligible for the standard Medicaid program. Whether through inadvertence or inability to determine eligibility at the relevant time, these patients' expenses were reimbursed by the Charity Care program rather than the standard Medicaid program. At the very least, all patient days related to such patients should be included in the Provider's DSH calculation.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the Charity Care days at issue may not be included in the Provider's DSH calculation based upon a straight forward reading of the pertinent regulation. At 42 C.F.R. § 412.106(b)(4), the regulation specifically includes patient days in the Medicaid proxy that are attributable to patients "entitled to Medicaid." The Provider's own description of Charity Care patients clearly recognizes that they are not eligible for Medicaid coverage. See e.g. Provider Letter Dated November 13, 1997 at 2.

The Intermediary also contends that the Provider's arguments for including Charity Care patient days in the Medicaid proxy are based upon a perceived conflict between the pertinent regulations and the pertinent statute. As noted above, 42 C.F.R. § 412.106(b)(4) includes patient days in the DSH calculation attributable to patients "entitled to Medicaid." The pertinent statute, however, references patient days attributable to patients "eligible for medical assistance under a State plan." 42 U.S.C. § 1395wv(d)(5)(F)(vi)(II). The Provider argues that in New Jersey the definition "entitled to Medicaid" is broadened by patients who receive some level of care under a State plan, albeit, not specifically the Medicaid program. However, an analysis of the regulation does not support that definition.

Finally, the Intermediary contends that the Board is bound by regulations and, therefore, may affirm its rejection of the Charity Care days from the Provider's DSH calculation based upon 42 C.F.R. § 412.106(b)(4). However, the Intermediary also asserts that the Board may not be the proper forum to address this matter, and may consider expediting it for judicial review. 42 C.F.R. § 405.1842.

¹⁴ Provider's Supplemental Position Paper at 15.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. **Law - 42 U.S.C.:**

- § 1395ww(d)(5)(F)(v)(II) - PPS Transition Period; DRG Classification System; Exceptions and Adjustments to PPS
- § 1396a et seq. - State Plans for Medical Assistance

2. **Regulations - 42 C.F.R.:**

- § 405.1835-.1841 - Board Jurisdiction
- § 405.1842 - Expediting Board Proceedings
- § 406.10(b)(2) - Beginning and End of Entitlement
- § 412.105 - Special Treatment: Hospitals that Serve a Disproportionate Share of Low Income Patients
- § 412.106(b)(4) - Determination of a Hospital's Disproportionate Patient Percentage - Second Computation
- § 430.10 - The State Plan

3. **Other:**

- HCFA Ruling 97-2.
- HCFA Letter, FKA-31, February 29, 1996.
- HCFA Memorandum, FKA-31, June 12, 1997.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties' contentions, and evidence presented, finds and concludes as follows:

Patients Who Have Exhausted Medicare Part A Benefits

The Board finds that the Intermediary refused to include patient days attributable to dual eligible patients in the numerator of the Provider's Medicaid proxy. These days pertain to individuals who exhausted their Medicare Part A benefits during an inpatient stay. According to the Provider, Medicare stopped paying for the patients' outlier days in these instances and the New Jersey State Medicaid program began to pay the hospitals. The Provider argues that the outlier days not covered by Medicare but paid by Medicaid should be included in the DSH formula.

The Board agrees with the Provider. The Board finds that where a state's approved Medicaid program assumes responsibility for payment of a provider's inpatient charges that the days associated with those charges are, in fact, "Medicaid days." A fundamental characteristic of health care cost finding, including that employed in the Medicare cost reporting process, requires patient days to be assigned to the program, insurer, or private pay patient responsible for a provider's charges.

The Board also finds that the subject days must be included in the Provider's Medicaid proxy in order for a "correct" DSH adjustment to be determined. That is, in order for the DSH formula to produce results or payment levels anticipated by statute, definitive data must be used. In this regard, the Medicaid proxy must reflect all patient days associated with health care costs and benefits attributable to Medicaid patients that are not paid by Medicare. The Board finds that the days at issue precisely meet these requirements, and their exclusion from the Medicaid proxy results in an understatement of the Provider's DSH adjustment.

The Board rejects the Intermediary's argument that the subject days can not be included in the Medicaid proxy because Medicare Part A paid 100 percent of the applicable DRGs; that is, even though the patients had exhausted Part A benefits during their admissions, DRG reimbursement was not prorated downward. The Board, however, finds the patient days at issue to be outside the DRG payments made by the Intermediary as well as any day outlier payments that may also have been made. As stipulated by the Provider, the days at issue in this case consist of outlier days which, by definition, are outside of DRG reimbursement. Moreover, they are days that were not reimbursed through Medicare's outlier mechanism because Part A benefits had been exhausted.

The Board finds that its position regarding this matter is consistent with the enabling statute and regulations. Controlling authorities at 42 U.S.C. § 1395ww(4)(5)(F)(ii)(II) and 42 C.F.R. § 412.106(b)(4) require days furnished to patients eligible for Medicaid but not entitled to Medicare Part A to be included in the Medicaid proxy. The Board concludes that this exact condition exists in this case. Once the patients had exhausted their Part A benefits they were no longer entitled to have Medicare Part A pay for their inpatient hospital health care costs.¹⁹

¹⁹ The Board distinguishes the term "entitled to Medicare Part A" as used in 42 C.F.R. § 412.106(b)(4) from the term "entitlement" as that term is used, for example, in 42

Concurrently, these same patients became eligible for Medicaid benefits.

Finally, the Board finds that it is not essential to this case that the New Jersey State Medicaid program had actually reimbursed the Provider for the subject outlier days. Consistent with HCFA Ruling 97-2, it is not necessary for a hospital to have received payment in order to include patient days in the Medicaid proxy; it is only necessary for the patient to have been eligible for medical assistance under the State's Medicaid plan.

Charity Care Program Days Under the New Jersey State Plan

The Board finds that the Intermediary refused to include Charity Care program days in the numerator of the Provider's Medicaid proxy because it concluded that these days do not pertain to patients "entitled to Medicaid" as required by 42 C.F.R. § 412.106(b)(4). In support of his position the Intermediary cites the Provider's general description of the Charity Care program as providing medical assistance under the New Jersey State plan for certain indigent individuals who do not meet the State's Medicaid eligibility requirements.

The Board, however, finds that the subject Charity Care days clearly meet the statutory definition of patient days included in the numerator of the Medicaid proxy and, therefore, should be included in the Provider's DSH calculation. The controlling authority at 42 U.S.C. § 1395ww(4)(5)(F)(vi)(U) defines patient days included in the numerator of the Medicaid proxy as those days pertaining to patients "eligible for medical assistance under a State plan approved under subchapter XIX of this chapter." In this regard, the Board finds that the enabling New Jersey State plan was approved under Title XIX of the Social Security Act as required by the statute, and contained the subject Charity Care program which provided medical assistance to eligible persons.

The Board rejects the Intermediary's argument that the Charity Care patients at issue in this case were not entitled to Medicaid. Essentially, the Board finds that any person qualifying for and receiving medical assistance under an approved State plan is, by virtue, entitled to Medicaid. The Board cites 42 C.F.R. § 430.10, which states in part:

[t]he State plan is a comprehensive written statement submitted by the agency describing the nature and scope of its Medicaid program.

42 C.F.R. § 430.10.

The Board understands that the New Jersey State plan contains different eligibility criteria for Charity Care program patients than it does for its other, more typical, program patients.

C.F.R. § 406.10(b)(2). The Board does not believe the referenced word "entitled" used in 42 C.F.R. § 412.106(b)(4) is intended to reflect the absolute end of an individual's health insurance benefits under Medicare.

Moreover, the Board believes this difference is the basis for the Intermediary's argument regarding Charity Care patient entitlement, and the Provider's statement that Charity Care patients are not eligible for Medicaid. In effect, both the Intermediary and the Provider chose to define Medicaid as a type of subset of medical services within the broader context of the State plan. The Board, however, finds no authoritative basis for this distinction. The Board finds that once a State plan is approved, the Federal Government provides matching funds for all medical service costs provided for in that plan, including costs attributable to the subject Charity Care program. The Board notes the Provider's argument that the State did, in fact, receive Federal matching funds for the costs of the Charity Care program days at issue, and that this argument was not disputed by the Intermediary. Moreover, the Board notes HCFA Memorandum, FKA-31, dated June 12, 1997, which explains that Federal funding is an important factor in determining whether or not a patient day is included in the Medicaid proxy. The memorandum states, in part:

[c]onsistent with the Courts of Appeals decisions on the issue of Medicaid days, the HCFA Ruling 97-2 was meant to be inclusive, rather than exclusive. This means that, in calculating the number of Medicaid days, fiscal intermediaries should ask themselves, "Was this person a Medicaid (Title XIX) beneficiary on that day of service?" If the answer is "yes," the day counts in the Medicare disproportionate share adjustment calculation. This does not mean that Title XIX had to be responsible for payment for any particular services. It means that the person had to have been determined by a State agency to be eligible for Federally-funded medical assistance for any one of the services covered under the State Medicaid Title XIX plan.

HCFA Memorandum, FKA-31, June 12, 1997 (emphasis added).

Finally, the Board, having concluded that a State plan necessarily defines a State's Medicaid program, finds no basis for the Intermediary's proposition that the Charity Care days issue may best be suited for expedited judicial review. The Board finds that the provision of 42 C.F.R. § 412.106(b)(4), which bases the DSH calculation on patient days attributable to patients "entitled to Medicaid" is essentially synonymous with 42 U.S.C. § 1395ww(d)(5)(F)(v)(II), which references patient days attributable to patients "eligible for medical assistance under a State plan." The Board notes that on February 27, 1997, HCFA issued Ruling 97-2 to clarify a specific aspect of the DSH calculation. The Board believes this Ruling supports its position since the Ruling apparently uses the aforementioned terms interchangeably.

DECISION AND ORDER

Patients Who Have Exhausted Medicare Part A Benefits

The Intermediary should confirm the number of outlier days of service furnished by the Provider to dual eligible patients after their Medicare Part A benefits had exhausted, and which were eligible for reimbursement under the State's Medicaid plan, and include this number of days in the

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Provider's DSH calculation. The Intermediary's refusal to include ~~these~~ days in the numerator portion of the Provider's Medicaid proxy is reversed.

Charity Care Program Days Under the New Jersey State Plan

The Intermediary should confirm the number of patient days of service furnished by the Provider to patients eligible for medical assistance under the State's Charity Care program, and include this number of days in the Provider's DSH calculation. The Intermediary's refusal to include these days in the numerator portion of the Provider's Medicaid proxy is reversed.

Board Members Participating:

- Irvin W. Kues
- James G. Sleep
- Henry C. Westman, Esquire
- Martin W. Hoover, Jr., Esquire
- Charles R. Barker

FOR THE BOARD:

OCT 30 1998



Irvin W. Kues
Chairman

New Hampshire Fair

TO: NANCY-ANN
fyi: KK

FACSIMILE TRANSMISSION REQUEST

ADDRESSEE: (Name, Organization, Address) KATHY KING HCFA, OA Phone: 202-690-5727	FROM: Health Care Financing Administration Office of Research and Demonstrations  ED HUTTON Phone: 410-786-6626
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TOTAL PAGES: (Without Cover) 6	ADDRESSEE'S FAX MACHINE PHONE NUMBER: (If Known) 202-690-6262	DATE: 10/15
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RE: NH
 MEDIA ARTICLES RELATING TO THE
 STATE'S ABILITY TO FINANCE
 HEALTH REFORM EXPANSION

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Please call: _____ at _____ for pick-up
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 Gary
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Retain copies in files.

Not a... / Morton & Gov. S

Concord Nov. 7th

10/15/97

Shaheen snuffed out Morton's tax offer

He backed another increase in cigarette levy

By SCOTT CALVERT

~~Morton says~~

Health and Human Services Committee member Terry Morton offered to lead a fight in the upcoming legislative session to raise the cigarette tax by another 12 cents a pack but Gov. Jeanne Shaheen told him "no," Morton said yesterday.

Shaheen spokeswoman Song Hattaway said the Democratic governor does not want to disturb the delicate balance of the two-year budget, which runs through June 1998.

Morton, speaking to a group of state hospital employees about the recent layoffs of 58 agency workers, described his offer to Shaheen this way:

"I said, 'I'll take the beat, I'll take the

tax and spender (abed). You just lay back. If I get it to your desk, then you can decide what to do with it.' She said no."

A 13-cent increase would put the tax at 60 cents a pack - where it would be if the legislature last session had followed Shaheen's suggestion of a 15-cent increase. Instead lawmakers raised the levy by 12 cents a pack.

Each penny on the cigarette tax represents about \$1.7 million a year in added revenue. That means 13 cents would yield roughly \$22 million. Under Morton's proposal, all of the new tax revenue would go to his cash-strapped department.

"The governor said she is committed to the budget that was passed and called on

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million reduction. He faces identical cuts in fiscal year 1998, which starts July 1. Add in federal matching funds and the total loss of dollars roughly doubles.

"I'm very worried about '99," he said.

He's frustrated he is not getting help from lawmakers and the governor. "Nobody wants to go out there and have any taxes; nobody wants to spend more money," he told the group of 50 workers. "That's what the problem is."

Morton said another option would be a supplemental budget. But he said the Republican leaders in the Legislature - House Speaker Donna Sytek and Senate President Joe Delahanty - have no intention of letting that happen this session.

"They said no supplemental," he said. "Listen to the governor out on the campaign trail. She'll veto any supplemental. They're already running for '98 elections. There's not likely to be a supplemental. I'd be more concerned they'll cut more."

There is a bill in the House to raise the cigarette tax. Rep. Channing Brown, a Lebanon Republican, wants to raise the tax by 10 cents and include cigars and snuff under the tax for the first time.

But Brown's bill would not help Morton. The added cigarette tax money would be used to offset a cut in the communications tax.

Last session the House agreed to a 20-cent cigarette tax increase, while the Senate approved 18 cents. Instead of reaching a compromise in the middle during the conference committee, Senate Republicans managed to prevail entirely on the cigarette tax.

(Scott Calvert can be reached at 224-5301, ext. 304, or by e-mail at scalvert@cmantor.com.)

TAX Continued from Page A-1

the Legislature not to do any tinkering with the taxes or spending that are contained in the current budget," said Hattaway. "She's sticking by the current budget. That doesn't rule out working on the cigarette tax for future sessions."

Morton also tried "very actively" to get House Democratic Leader Peter Buring to support a 13-cent increase, according to Buring.

Like Shaheen, Buring supported a quarter increase last session and was dismayed with the Republican-dominated Legislature's final decision. But with the budget now in place, he too rejected Morton's suggestion.

"I'm not going to be drawn into, A, trying to pass a tax increase that won't pass... and, B, falling victim to the old tax and spender routine again," Buring said.

He added, "We've just done something really unique in New Hampshire governmental history. We've balanced the budget and dealt with a Republican deficit of really staggering proportions."

Still, Buring said, he plans to remind voters why the tax is not 50 cents:

"Do I also intend to campaign from time to time, pointing out that the Republicans failed to raise the cigarette tax (by 25 cents) and thereby set up a situation in which we cannot deal with some of the real needs of the state? Yeah, I do intend to make that point."

For Morton, an increase in the cigarette tax seems like a good way to address those needs and deflect cuts to his budget inflicted by the Legislature.

He blames the 58 layoffs on \$3.3 million in personnel cuts ordered by the Legislature in June, and he has had to absorb a separate \$5.4-

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CONCORD MONITOR

THURSDAY 6/12/97

Health access bill gets choked

By SCOTT CALVERT
Monitor Staff

About 150,000 New Hampshire residents, including 20,000 children, don't have health insurance. That's more than 10 percent of the state's population. They aren't poor enough to qualify for Medicaid but cannot afford private coverage, either.

There is a potential solution: Tap up to \$80 million a year in federal money so roughly half these people can get coverage from private insurers - without a penny from the state.

Participants would pay a portion, on a sliding scale, and collectively contribute another \$80 million.

Supporters say it's a great opportunity to address a major need without taxing the state treasury. The state, they say, would be foolish not to jump at the chance.

But key legislators, including House Finance Committee Chairman Neal Kurk fear the emergence of what has been likened to socialized health insurance. Not only could private insurers be hurt in the process, critics say, but the state could get stuck with the tab if the federal money dried up.

At the last minute, Kurk and others in the Legislature

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HEALTH *Continued*

blocked the creation of the nonprofit New Hampshire Health Access Corporation. The corporation would have overseen the health insurance program and bid out the underwriting to one or more insurers. Lawmakers would have created the corporation, but its board would be independent. The corporation would have been modeled after the generally successful, but far smaller, Healthy Kids program, which covers about 1,800 children.

"I can't think of any rational reason to turn that down," said a frustrated Terry Morton, Health and Human Services commissioner. Both the Senate and House had approved the bill, and, until Kurk got involved, it seemed destined to become law.

"Here was an opportunity to get up to \$80 million a year in federal funds with no strings attached," Morton said, "and to use that not only to improve the health of citizens of New Hampshire, but to reduce the amounts paid by cities and towns and also hospitals and other providers."

Morton points out that today, when a low-income person goes to the emergency room, someone has to pay the bill. Those costs are often reflected in higher insurance premiums for those who have private coverage. And because people without insurance often fail to receive preventive care, their health costs tend to be higher than necessary.

For now, Morton will continue pursuing the federal money, which Washington has yet to approve. Morton plans to return to the Legislature next January.

The passage of several months is not likely to allay critics' concerns.

Their main opposition appears to stem from the program's scope. Under one outline of the plan, a family of four earning more than \$60,000 could receive a small subsidy.

"Basically, for the first time, the state would consider subsidizing health insurance for middle-class people, as well as poorer people," said Kurk. "I don't understand why we should be subsidizing these people."

Someone making four times the poverty level - about \$83,000 for a family of four - would pay 75 percent of the premium, with the federal money making up the balance. Those earning half that would pay just 25 percent.

Another concern is the impact the program might have on private insurers. If people can get comparable coverage for less, the argument goes, why would they pay more for a private policy? Paula Rogers, a lobbyist for smaller commercial insurers, said the eligibility requirements must guard against such "migration."

"We want people to be insured, but if you're going to have a legislative corporation which will use public funds to subsidize insurance, you want to do that in a way that doesn't discourage the voluntary market," Rogers said.

"The concept is great. Just be cautious."

Supporters say private companies need not worry. For one thing, private insurers could actually expand their business, since they could bid on the chance to underwrite the subsidized policies.

In addition, individuals could not participate unless they had gone without insurance for a year. Employers could not take advantage of the program unless they had not offered their workers insurance for two years.

That, respond critics, does not address young adults and married couples entering the health insurance market for the first time.

Then there is the question of what happens if the federal money runs out once the five-year waiver period ends. "We're all quite cognizant of the fact that they're talking about cutting federal entitlements, and I would classify this as an entitlement," said Rep. Frank Torr, a Dover Republican.

A more immediate concern is that lawmakers have not had a chance to scrutinize how the independent corporation would operate. Before they consider supporting its creation, Kurk and others want the full Legislature to have a chance to sign off on details. They do not want to leave everything up to the 14-member board, which would include representatives of relevant state agencies, insurers, the governor, the medical community and the Legislature.

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CONCORD MONITOR

THURSDAY 6/12/97

(CONTINUED)

Sen. James Squires, a Hollis Republican, sponsored an amendment in the Senate giving the House-Senate Fiscal Committee a say in the program's significant details. The committee would have to sign off on the eligibility criteria as well as the way the corporation's board would contract with private insurers.

The amendment passed.

Much beyond that, Squires said, and lawmakers will be micro-managing things: "It's like a salesman who has to talk to his district manager every time he wants to negotiate a sale."

As Sen. Carolina McCarley, a Rochester Democrat, said: "I'm not sure as legislators we should be suspect of something that's more of a business model."

Gov. Jeanne Shaheen criticized lawmakers for not acting this year.

"With 150,000 people in New Hampshire lacking health insurance, and 20,000 of those being children without access to health care, the governor is extremely disappointed lawmakers didn't seize the opportunity to cover half these people without costing our taxpayers an extra dime," said Ken Hicks, Shaheen's health policy adviser.

Sara Dustin, an advocate for low-income single parents, says lawmakers are being short-sighted. "The failure to pass this bill is going to hurt a lot of people who need a little bit of help so they can stay healthy and stay in the workplace," Dustin said.

The Legislature's move comes at a time when the individual health insurance market in New Hampshire is shrinking and becoming more expensive. Blue Cross-Blue Shield of New Hampshire, the only domestic carrier that sells health insurance to individuals, has raised rates twice in the past six months, citing its growing costs.

The result is that for some people, private health insurance is even further out of their reach.

Until recently, the bill to create the Health Access Corporation appeared headed for easy passage into law. After passing the House and Senate, it returned to the House late last month so members could sign off on Senate changes.

Moments before that was to happen, Kurk realized what was going on. Frantic, he and Commerce Committee Chairman John Hunt - neither of whose committees got to review the bill - managed to keep the House from voting to accept the changes.

That sent the bill to a House-Senate conference committee, where differences in House and Senate versions are supposed to be ironed out. There, both versions got a very chilly reception. One of the House conferees was Torr, who had deep reservations. House Speaker Donna Sytek did her best to make sure the bill would not get through in either version; three of her close aides attended the sessions and conferred often with Torr, who is the vice chairman of Kurk's Finance Committee.

The Senate side included Sen. Richard Danaia, one of only five senators who voted against the bill in the Senate. Danaia, a Manchester Republican, had no kind words when the conference committee met: "That's a major change in the way the state of New Hampshire handles uninsured people. . . . We can't be everything to all people."

The negotiations broke down when Torr and Danaia would agree only to a very limited pilot program. Afraid the pilot would fail and hurt the program's chances next year in the Legislature, Health and Human Services decided to let the bill die.

Yesterday's new conference committee met.

On Tuesday, McCarley had requested another shot at compromise, and her Senate colleagues agreed.

But it was immediately apparent the result would be the same. One of the new Senate representatives, Republican Leo Fraser of Pittsfield, said the program might make sense but not until all the details were worked out.

"I don't see anything good about the bill at this point," he said. Sen. David Wheeler, a Milford Republican who also voted against the bill and was on the committee, chimed in: "I don't think it's the business of the federal government to subsidize insurance."

A short time later, the second conference committee disbanded. The bill was dead once and for all.

Before the group left, Rep. Barbara French, a Henniker Democrat, reminded the group the problem won't go away. "These uninsured adults are out there. They are going to continue to be there."

(Sen. Caverl can be reached at 224-5301, ext. 304, or by e-mail at scaverl@concord.com.)

Human services chief 'shocked' at cuts

Department stands to lose \$100 million

By SCOTT CALVERT
 Monitor staff

Faced with the prospect of receiving about \$100 million less than he originally asked for, Health and Human Services Commissioner Terry Morton said yesterday he anticipates having to trim services in the next two years.

Morton said he does not know what types of services might be cut or how severely or when. He will assess the situation over the next two months.

Gov. Jeanne Shaheen cited Morton's situation when she announced she would allow the budget agreement reached by lawmakers Friday to take effect - but without her signature. She reportedly came close to vetoing the spending plan.

"This budget cuts the Department of Health and Human Services to the bone," Shaheen said at

a press conference yesterday. "As a result of these additional cuts working, women and poor children may not have access to medical care they need, and children and juveniles in need of services could languish on long waiting lists."

Morton said later that "those are the things we will be looking at."

When she released her proposed budget in February, Shaheen recommended that legislators give Morton \$29 million less than he had requested.

The budget hammered out last week by House and Senate negotiators further reduced that amount by \$15 million more.

Factor in the dollar-for-dollar federal match money that would be lost and the funding drop reaches more than \$100 million. The department will get \$2 billion in state and federal money over the next two years.

"I was shocked," Morton said, describing his reaction when he found out what House and Senate negotiators had done to his budget. "If you had seen me Thursday at 5 o'clock, I never would have expected what happened. I didn't expect them to end up with those cuts in our budget."

Rep. Neal Kurk, chairman of the budget conference committee, did not dispute Morton's basic claim. "It's possible that he may have to have some slight reduction in services," Kurk said.

But Kurk, a Weare Republican, said \$10 million of the "cut" actually reflects a drop in the department's costs expected to result from a consultant's study.

Morton said it's too early to tell if that savings will materialize. "The question of whether that money is going to be there is unknown, and to cut spending on the possibility of an unknown item I'm not sure is the smartest thing to do."

Health and Human Services is

by for the largest state agency. Even with the cuts, it will receive \$871 million over the next two years from the state general fund - about 50 cents of every dollar the state spends.

Morton cannot cut willy-nilly if he decides that's necessary. Some of the department's spending is required by law.

For example, the department must keep paying for services for children in its state custody, whether the Legislature approves the necessary funds.

What the department could do is set up a wait list for programs that are not mandated, Morton said.

One factor in Morton's favor is his broad power to transfer money from one account to another without permission from the Legislature. But that assumes he has money left to transfer.

(Scott Calvert can be reached at 224-5301, ext. 304, or by e-mail at scalvert@concord.com.)

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CONCORD Monitor

Sunday

June 22, 1997

On the waiver wire

Terry Morton, commissioner of Health and Human Services, blames Shaheen's election for holding up his attempt to provide health insurance to every New Hampshire child.

Health and Human Services wants to require all welfare recipients who are on Medicaid to join a managed health care company, with the state picking up the tab. Part of this shift would include creative use of federal money and an expansion of Medicaid to include those who presently make too much money to be eligible for Medicaid but can't afford private health insurance.

To institute the program, the federal government must approve the state's waiver application, which

requests exemption from normal Medicaid rules.

Morton said the waiver was about to be approved - until Shaheen was elected. "Had she not been elected, I think we had it approved last year," he said.

With Shaheen's election, the Democratic administration in Washington naturally held up the approval to see what Shaheen wanted, Morton said. But Shaheen had her mind on other things. "That was not the first thing on the agenda. It might have been second or third, but the first thing on her agenda was kindergarten," he said.

Six months later, the waiver still hasn't received approval. However, Morton thinks the Democrat-Democrat connection, combined with Shaheen's concern for children's health, should work in the state's favor in the future. Shaheen and Gore have had several conversations about the waiver application, Morton said. He thinks Gore's interest in the 2000 New Hampshire primary may benefit the state.

*CONCORD MONITOR**June 19, 1997***Budget will absorb deficit over 3 years****Biennium ends with \$3 million surplus**The Associated Press

The following are highlights of the \$5.6 billion, two-year compromise budget:

- **Deficit:** The compromise absorbs this year's deficit over three fiscal years and ends the biennium with a \$3 million surplus.

- **Spending:** The plan contains \$1.9 billion in general tax spending, which is within about 1 percent of the plans proposed by Gov. Jeanne Shaheen, the House and the Senate.

- **Revenues:** The state's special health care trust fund could be lapped if projected health and human services revenues fall short.

- **Taxes:** Shaheen proposed a 25-cent hike in the tobacco tax and extending it to cigars and pipe tobacco; the House approved a 20-cent increase; but the Senate adopted a 12-cent hike and rejected taxing cigars and pipe tobacco. The compromise counts on the 12 cents proposed by the Senate.

The compromise also relies on extending surcharges on taxes on telephone calls, hotel rentals, dining out and real estate sales. It extends the telephone tax to include pay phone calls and closes a loophole in the tax on real estate sales to generate more revenues.

- **Local aid:** The plan contains roughly \$111 million more in key state aid programs than the last two-year budget.

- **Disabled aid:** Money was included to serve 131 of the 171 disabled adults on a waiting list who are in critical need of state ser-

vices.

- **Disabled aid shortfall:** An additional \$2.6 million was included to make up for a shortfall in this year's state aid for catastrophic special education costs.

- **Delinquents:** Delays expanding the youth reformatory in Manchester.

- **Pay raises:** Money was included for pay raises for 10,000 state workers.

- **State troopers:** The plan adds 14 troopers and six civilian positions so six troopers could be reassigned to highway duty.

- **Cuts:** Health and Human Services \$25 million beyond what the governor proposed, essentially funding the department at the 1997 level.

- **Hiring freeze:** Requires most agencies to wait 120 days to fill some vacant positions.

- **State prison:** Legislators and Shaheen agreed to study prison system needs, including overcrowding and the pending closure of the Laconia facility. Another \$1.7 million for 200 additional inmates was cut from the corrections budget and put on "hold" elsewhere in the budget.

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Medicaid Windfall Cut N.H. Deficit

State Officials Used Loophole While Bloating U.S. Budget

By Dan Morgan
Washington Post Staff Writer

The state of New Hampshire isn't high on most lists of culprits contributing to the huge federal budget deficit.

Long dominated by fiscal conservatives wary of the evils of deficit spending and big government—and critical of the spendthrift ways of neighboring "Taxachusetts"—it is one of only two states with neither a sales tax nor a general income tax.

But since 1991 New Hampshire has been able to preserve its unique low-tax status thanks largely to a loophole in Medicaid law that enabled its Republican leaders to get the taxpayers of the United States to cover a yawning state budget deficit.

"It was a scam, no question about it," said Douglas E. Hall, a Republican state legislator who helped devise the scheme in 1991 but now feels it enabled New Hampshire to postpone dealing with its underlying fiscal problems. "We're funding our state judicial system, our highway program and everything else out of a Medicaid loophole, which is being funded out of the [federal] deficit."

In Medicaid, the federal government partially reimburses states for their payments to hospitals, doctors and other providers of care to the medically needy. The reimbursements are based on a formula that varies depending on the wealth of a state. New Hampshire gets 50 cents

See NEW HAMPSHIRE, A6, Col. 1



As governor, Judd Gregg took credit for solving New Hampshire's fiscal crisis, but he did it with U.S. Medicaid dollars.

NEW HAMPSHIRE, From A1

from the federal government for every dollar it pays health service providers.

After a dispute with the Reagan administration, which was trying to limit Medicaid spending, Congress in 1986 barred the federal government from limiting state payments to Medicaid hospitals and in the process created a loophole. Several states soon discovered that they could pay hospitals as much as they wanted, collect matching Medicaid funds from Washington and then recover some of the money they had paid the hospitals in the form of state taxes or donations.

In effect, states padded their payments to the hospitals in order to generate more federal matching funds, then received a kick-back from the hospitals.

Using the device in 1991 and 1992—the loophole has since been largely closed—New Hampshire collected \$407.3 million in additional federal Medicaid matching funds on top of its regular Medicaid stipend from Washington. But only a small amount of the windfall went to expanding Medicaid services to welfare recipients, the disabled and the elderly poor, according to half a dozen state officials.

About \$50 million was distributed to 27 hospitals, but most of that money is still in reserve funds and has not been spent.

The number of Medicaid patients in New Hampshire did increase sharply because of a prolonged recession and new federal requirements to provide Medicaid to pregnant women and children.

And although the state's Medicaid spending did grow from \$227.5 million in 1990 to \$357.8 million in 1992, that growth was nowhere near enough to absorb the huge injection of new federal money—nearly \$200 for each of New Hampshire's 1.1 million people in the state's 1993 fiscal year. Top state officials don't hide the fact that federal Medicaid money was diverted to other purposes, apparently legally.

"If you ask me, did we use this money to create a bigger and better Medicaid program, we did not," said state Health and Social Services Commissioner Harry Bird. "We did do some things at the margins."

What the money from federal taxpayers enabled New Hampshire to do was balance its fiscal 1992 and 1993 budgets without broad new state taxes or deep spending cuts. "We used it to balance our budget," says state Rep. Donna P. Sytek, former chairman of the House Ways and Means Committee. "Probably it wasn't in the spirit of the law. But it was in the letter."

The New Hampshire Medicaid story illustrates the powerful role parochial interests play in boosting the federal deficit and suggests some of the problems President Clinton faces in trying to tame it.

As opposition to new taxes has increased, politicians at every level of government have become more creative in tapping the one source of funds that does not have to be

offset with higher taxes now: the borrowing authority of the U.S. Treasury. Serious as the U.S. deficit may be to posterity, it grows without inflicting immediate pain.

Perhaps for that reason, politicians who regularly preach fiscal responsibility have regularly abandoned their principles when faced with choosing between the interests of their constituents and curbing the growth of the U.S. deficit.

In 1991, for example, then-New Hampshire Gov. Judd Gregg (R) took credit for solving the state's fiscal crisis, even though he did it with federal Medicaid funds. In 1992, he successfully ran for the U.S. Senate as a deficit cutter and self-described "skinfint" who was "going to stand up and be counted on the basis of fiscal conservatism."

New Hampshire Sen. Warren Rudman (R) inserted provisions in a key Medicaid bill during the final hours of the congressional session at the end of 1991 to protect New Hampshire's Medicaid scheme through June of 1993. A co-author of the Gramm-Rudman-Hollings deficit reduction law, Rudman said recently that he had no regrets about his role.

"My attitude was that if that's the way the game is played, we'll play it too," he said. "If we were going to have this loophole, I wasn't going to see New Hampshire stand idly by."

Rudman and former Democratic senator Paul E. Tsongas of Massachusetts now head a new public-interest lobby pressuring Washington to cut the deficit.

New Hampshire's fiscal problems began with the post-1989 collapse of the Boston-centered high-tech boom. The state went from having the nation's highest personal income growth and lowest unemployment rate to leading the nation in welfare cases and personal bankruptcies.

State finances were hurt by a drastic decline in receipts from New Hampshire's business profits tax, the state's largest source of tax revenues. "We got hit worse than Massachusetts," said Hall, a member of the state's House Appropriations Committee. "When the economy went kaplooeey, the bottom fell out."

By late spring of 1991, as Gregg and the legislature got down to serious work on the biennial budget for fiscal 1992 and 1993 that would take effect in July, it appeared that there would be a 1992 revenue shortfall of around \$35 million.

That March, Sytek said, she heard about a loophole in Medicaid law at a conference of state legislators. "They've got this little scheme and you can use it [the federal money] for highways," she quoted a Missouri legislator as telling her.

"When I went back to New Hampshire I mentioned it to Harry Bird. He said it wouldn't be ethical. I told the governor and he said, 'You can't do that.' But in June we were running out of money and the governor said, 'Let's do it.'"

By that time, others in state government

New Hampshire Slashed Its Deficit With Federal Medicaid Money

were thinking along the same lines. Hall recalled that someone had brought him an article about Massachusetts's use of the loophole, and Sytek said an official in Bird's office also "had discovered the loophole, bless his heart."

The Bush administration had tried to block the loophole, but Congress frustrated the effort by forbidding the secretary of health and human services from regulating state taxes on Medicaid providers.

As a result, use of the devices exploded. By 1992, more than 30 states were using provider taxes and "provider donations" to shift at least \$10 billion in Medicaid costs from themselves to federal taxpayers, according to a recent study by Health

"It was a scam, no question about it."

—Douglas E. Hall,
Republican state legislator

Policy Alternatives, a Washington consulting group.

New Hampshire's "Medicaid Enhancement Fund," enacted on June 20, 1991, was the result of a deal between Gregg, Bird, the legislature and Gary Carter, president of the New Hampshire Hospital Association. "We had a hearing and it passed in three days," Sytek said.

For each \$100 the hospitals paid into that enhancement fund as a "tax," the state would send them \$106 as a Medicaid payment. The state would then claim a \$53 federal matching payment—half of the total payment. The enhancement fund approach generated \$6 for the hospitals and \$47 for the state treasury, all of it federal money.

"We figured how much we'd need [from the federal government], then set our provider tax accordingly," said Hall, who stressed that health care considerations did not play the major role.

In August 1991, the state received its first federal payment of \$40.5 million using the device.

A U.S. Health Care Financing Administration official indicated that the agency's hands were tied under the law at that time. As long as a state was paying its medical providers in accordance with an approved state plan, as New Hampshire was, the federal government had to reimburse, she said.

As New Hampshire's economy kept deteriorating in the fall of 1991, estimates of its 1992 budget shortfall rose to \$164 million.

Sytek recalls a Nov. 5, 1991, "summit" meeting, attended by "all the grand poobahs of the House and Senate." With the New Hampshire Republican primary only months away and Gregg planning to run for the U.S. Senate as a fiscal conservative, the possibility of imposing an income tax or sales tax was not seriously considered, she said. Since 1972, no candidate for governor

has been elected without first taking a pledge to oppose any new broad-based tax.

Sytek said her suggestion was "Why don't we just crank up the rate of the Medicaid tax" that had been enacted several months earlier.

The group decided instead on a separate new tax on hospitals, based on Medicaid patient discharges, that would enable the state government to generate enough federal matching funds to fill the hole in the state budget in fiscal 1992 and 1993—which would have been at least 20 percent of the \$700 million derived from general revenues in each of the two years.

On Nov. 12, the legislature, meeting in one-day special session, easily approved the change. The House margin was 263 to 42 and the Senate approved it 19 to 3.

One House member voting against it was state Rep. William Riley (D), a history professor who favors a 2 percent income tax. "I thought it was despicable," he said. "We don't need to dip into this Medicaid scam because we haven't tapped one of the biggest sources there is: the income tax."

But the entire plan was in jeopardy in Washington, where negotiations were winding up between Congress, the Bush administration and the nation's governors over legislation that would sharply limit the ability of states to use such devices.

Working closely with Rudman, the New Hampshire Republicans were determined to protect their Medicaid provision until the start of a new budget-writing cycle this year.

To get protection, New Hampshire needed bill language that would provide a grace period for plans that had been enacted and adopted as late as that November.

"We argued it with the [Senate] Finance Committee staff, Rudman spoke to [Sens. Bob] Packwood [R-Ore.] and [then-Sen. Lloyd] Bentsen [D-Tex.], and Rudman talked to [then-Budget Director Richard] Darman," said former Rudman aide Thomas Polgar.

In the final hours of the 1991 session of Congress, the legislation passed the U.S. Senate by unanimous consent—avoiding debate and a formal vote—after Rudman and dozens of other senators had secured technical changes protecting their states.

"Any time we could do something for the state we were happy," Polgar said. "This happened to be big."

The provisions enacted in November 1991 enabled New Hampshire to generate an additional \$366.6 million in federal funds for its 1992 and 1993 budgets. About \$44 million went to the hospitals and the other \$322.6 million went to filling the hole in the state budget, according to information provided by the Health Care Financing Administration and the state.

State Commissioner of Health and Social Services Bird defended the state's action, saying that the money prevented cuts in programs—including Medicaid. Between 1990 and 1993, he said, Medicaid went from 15 percent of the state's total budget to 19 per-

cent. State Medicaid rolls were swelling in part because of new mandates from Washington requiring states to expand Medicaid services to some groups, Bird said.

"We rejected [paying] the unfunded mandates that Congress had put on the state and sent the bill back to them," he said.

Sen. Gregg did not return two phone calls to his office requesting comment.

Noting that Arkansas and Tennessee—the home states of Clinton and Vice President Gore—set up provider tax schemes, Concord lawyer Tom Rath said: "I don't think there's a lot of hand-wringing. Everybody just says [of new taxes], 'Not on my watch.'"

The Reagan administration's elimination of revenue sharing and other grants to states had cut the U.S. share of the New Hampshire budget from one-third in the early 1980s to one-quarter in the mid-1980s. The Medicaid windfall brought the federal share back to the 1981 level.

"It's difficult to blame most states for using such schemes," said Victor Miller, a Washington consultant. "Tax yields were down and federal fiscal support was drying up. But New Hampshire is different. It's a wealthy state with low taxes and saw the loophole as a way to continue its privileged status."

"My basic concern was that the federal government was getting screwed," said Rep. Bill Zeliff (R-N.H.) who opposed use of the loophole despite Republican loyalties. "We balanced the budget with this loophole. I don't think the federal government can continue to run in this way."

Another loophole in the program may have been the absence of controls over the use of federal funds received by the hospitals handling high volumes of Medicaid patients.

Only two of the 27 New Hampshire hospitals have spent what they got, according to reports submitted to the state. Others are considering a variety of uses for it, including setting up community clinics.

Concord Hospital is considering using its \$3 million to set up a permanent fund, interest from which would be used to pay the rent or depreciation on a hospice to serve members of the community regardless of their eligibility for Medicaid.

Few if any of the hospitals have used the Medicaid windfall to reduce rates to private patients and insurers. Yet hospital officials acknowledge that those rates already include some or all of the cost of caring for indigent patients.

"We never went into this thing to make all that we've gotten," said the hospital association's Carter.

Earlier this month, Gov. Steve Merrill (R) unveiled a new budget that relies on some \$100 million a year in federal Medicaid matching funds generated by the state's payments to hospitals.

Under the more restrictive 1991 law intended to eliminate gimmicks, any tax on the hospitals to offset the payments will have to be broad-based and real. The governor did not reveal details of his plan.

New Hampshire's DSH Program

How New Hampshire Financed its DSH program

- New Hampshire built one of the largest DSH programs in the nation through the combined use of DSH payments, provider taxes, and transfers to and from the state psychiatric hospitals.
- **Provider taxes.** New Hampshire originally taxed hospitals and repaid them with DSH payments, 50% of which were paid by the Federal government. After laws were passed that limited the use of provider taxes, New Hampshire changed its provider tax program into a room and meals tax. In 1993, New Hampshire raised \$346 million from provider taxes, the largest amount second only to New York. The state is currently seeking a waiver from the law for part of this tax.
- **Mental hospital DSH payments.** New Hampshire has made DSH payments to its state psychiatric hospitals, essentially getting Federal matching payments for what would otherwise be state uncompensated care costs. This mental hospital DSH grew to \$98 million in Federal spending or 68% of DSH payments in 1995. In the 1996 appropriations bill, the Secretary of HHS was required to pay up to \$54 million in DSH payments to state-operated psychiatric hospitals. The Secretary had intended to defer and possibly disallow these payments.

What Was the Effect of New Hampshire's DSH program

- Using these financing mechanisms, New Hampshire's DSH spending was 50% of its total Medicaid spending in 1993. In 1995, due to changes in the law, it was down to 39% but still the highest percent of spending in the nation.
- In 1993, New Hampshire led the states in:
 - DSH per state resident (\$339 relative to the national average of \$69),
 - DSH per person under 150% of poverty (\$1,643 relative to the national average of \$269), and
 - DSH per uninsured person (\$2,717 relative to the national average of \$484).
- Through DSH, New Hampshire raised \$163 million more than it paid hospitals in 1993; these funds are surplus and available for states use. One report suggested that New Hampshire used these funds to build highways. In 1993, its spending on highways was over 60% higher than in its spending on health.
- The total state gain was equivalent to 25 percent of the state general fund.
- New Hampshire hospitals profited as well. They gained a net \$21 million over their provider taxes in 1993. Some hospitals put these surplus funds into interest-bearing trusts that could generate income or be used for special purposes.
- NOTE: Preliminary data from 1996 suggest that New Hampshire's DSH spending dropped by over 50% due to the facility-specific limits put in place in 1993.

		1990	1992	1994	1995
New Hampshire	Total DSH:	0	\$392 m	\$380 m	\$292 m
	% Medicaid	0	51%	39%	39%
All States	Total DSH:	\$1.4 b	\$17.5 b	\$16.9 b	\$18.0 b
	% Medicaid	2%	15%	12%	12%



NATIONAL
GOVERNORS'
ASSOCIATION



File IMPs

National Association of State Mental Health Program Directors
86 Canal Center Plaza, Suite 302, Alexandria VA 22314 (703) 739-9333 Fax (703) 548-9517

September 23, 1997

Nancy-Ann Min DeParle, Deputy Administrator
Health Care Financing Administration
Room 314G, Humphrey Building
200 Independence Ave., SW
Washington, DC 20201

Dear Ms. Min DeParle:

Congratulations on your recent nomination to be Administrator of the Health Care Financing Administration (HCFA). The Balanced Budget Act of 1997 ("the Act") provides many opportunities for the development of strong federal-state partnerships on health policy issues, and we look forward to working with you.

We are writing today to urge clarification of the Act's restrictions on the use of Medicaid Disproportionate Share (DSH) funding for Institutions for Mental Disease (IMDs) and other mental health facilities. The Act limits each state's DSH expenditures for mental health to the state's mental health DSH expenditures in FY95 -- both in terms of dollars spent and as a proportion of the state's total DSH expenditures in that year. In addition, beginning in FY 2001, no state may spend more than 50 percent of its total DSH allotment on mental health; in FY 2002, the limitation is 40 percent; and for each succeeding fiscal year, the limitation is 33 percent.

We understand that some HCFA staff have interpreted the DSH mental health restrictions as requiring a "double hit" -- that is, requiring the percentages of DSH mental health spending identified above to be multiplied against themselves to determine the final allowable percentage of DSH mental health spending. This interpretation is not consistent with the language of the conference report that accompanied the Act, and House and Senate committee staff have confirmed that this interpretation is not consistent with Congressional intent in drafting the law. In addition, this interpretation is clearly inconsistent with the context of the DSH provisions and restrictions in the law.

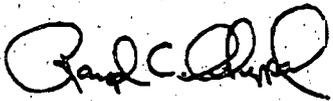
In recent verbal communications with HCFA staff, it was suggested that HCFA intends to interpret the law consistent with Congressional intent. Because this issue is critical to the states' Medicaid planning in the coming fiscal year, we request that HCFA provide written clarification or guidance to the states confirming this understanding as soon as possible.

September 23, 1997

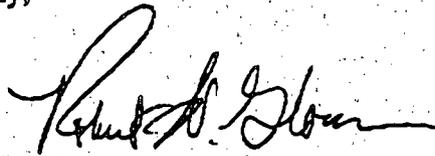
Page 2

Thank you for your attention to this matter. If you have any questions, please don't hesitate to call either of us. In addition, Jenifer Urff, Director of Government Relations at the National Association of State Mental Health Program Directors, and Jennifer Baxendell, Director of Health Legislation at the National Governors' Association, would be pleased to provide any assistance you may need.

Sincerely,



Raymond C. Scheppach
Executive Director
National Governors' Association



Robert W. Glover, Ph.D.
Executive Director
National Association of State Mental Health
Program Directors

Medicaid DSH FL
-1997- (G)

FEDERAL DISPROPORTIONATE SHARE HOSPITAL (DSH) ALLOTMENTS

	Five-Year Allotments			Final Difference	
	House	Senate	Final	From House	From Senate
Alabama	1,185	1,276	1,302	+117	+27
Alaska	45	47	47	+2	+0
Arizona	367	380	406	+39	+26
Arkansas	12	12	12	0	0
California	4,947	4,472	4,947	0	+475
Colorado	373	404	404	+31	+0
Connecticut	824	733	879	+55	+146
Delaware	16	18	18	+2	0
District of Columbia	104	115	115	+11	0
Florida	849	880	956	+106	+75
Georgia	1,144	1,186	1,186	+42	0
Hawaii**	0	0	0	0	0
Idaho	7	7	7	0	0
Illinois	915	948	948	+33	0
Indiana	907	940	940	+33	0
Iowa	34	38	38	+4	0
Kansas	209	143	211	+2	+68
Kentucky	617	639	639	+23	+0
Louisiana	3,547	3,568	3,677	+130	+109
Maine	422	373	455	+33	+82
Maryland	323	335	335	+12	0
Massachusetts	1,299	1,346	1,346	+47	0
Michigan	1,124	1,165	1,165	+41	0
Minnesota	72	80	80	+8	0
Mississippi	648	672	672	+24	0
Missouri	1,759	1,530	1,994	+236	+464
Montana	1	1	1	0	0
Nebraska	23	25	25	+2	0
Nevada	148	184	184	+36	0
New Hampshire	578	416	666	+88	+250
New Jersey	2,418	2,079	2,726	+308	+647
New Mexico	25	25	25	+0	0
New York	6,826	7,076	7,076	+249	0
North Carolina	1,254	1,300	1,300	+46	0
North Dakota	4	4	4	+0	0
Ohio	1,724	1,787	1,787	+63	0
Oklahoma	74	82	82	+8	0
Oregon	88	98	98	+9	0
Pennsylvania	2,387	2,474	2,474	+87	0
Rhode Island	278	288	288	+10	0
South Carolina	1,253	1,202	1,402	+149	+200
South Dakota	4	4	4	0	0
Tennessee**	0	0	0	0	0
Texas	3,860	3,640	4,265	+405	+626
Utah	17	17	17	0	0
Vermont	79	82	88	+9	+6
Virginia	314	326	326	+11	0
Washington	787	816	816	+29	0
West Virginia	289	300	300	+11	0
Wisconsin	33	33	33	0	0
Wyoming**	0	0	0	0	0

EFFECTS OF MEDICAID DSH PROPOSALS ON CERTAIN STATES

STATE		HOUSE	SENATE	OPTION	CHANGE
Alaska	5-Yr Spending: 2002 DSH Cut: 2002 Total Cut:	45 m -20% -1%	47 m -15% -1%	47 m -15% -1%	+2 m (H)
Delaware	5-Yr Spending: 2002 DSH Cut: 2002 Total Cut:	16 m -20% 0%	18 m 0% 0%	18 m 0% 0%	+2 m (H)
Florida	5-Yr Spending: 2002 DSH Cut: 2002 Total Cut:	849 m -20% -1%	880 m -15% -1%	880 m -15% -1%	+31 m (H)
Hawaii	5-Yr Spending: 2002 DSH Cut: 2002 Total Cut:	--	--	--	
Mississippi	5-Yr Spending: 2002 DSH Cut: 2002 Total Cut:	648 m -20% -2%	672 m -15% -2%	672 m -15% -2%	+24 m (H)
New Hampshire	5-Yr Spending: 2002 DSH Cut: 2002 Total Cut:	578 m -40% -15%	416 m -50% -19%	661 m -8% -3%	+83 m (H) +245 m (S)
New Jersey	5-Yr Spending: 2002 DSH Cut: 2002 Total Cut:	2.418 b -40% -10%	2.079 b -44% -11%	2.653 b -12% -3%	+235 m (H) +574 m (S)
Ohio	5-Yr Spending: 2002 DSH Cut: 2002 Total Cut:	1.724 b -20% -2%	1.787 b -15% -2%	1.787 b -15% -2%	+63 m (H)
Oklahoma	5-Yr Spending: 2002 DSH Cut: 2002 Total Cut:	74 m -20% -0%	82 m 0% 0%	82 m 0% 0%	+8 m (H)
Pennsylvania	5-Yr Spending: 2002 DSH Cut: 2002 Total Cut:	2.387 b -20% -3%	2.474 b -15% -2%	2.474 b -15% -2%	+87 m (H)
Texas	5-Yr Spending: 2002 DSH Cut: 2002 Total Cut:	3.860 b -40% -7%	3.640 b -35% -6%	4.081 b -17% -3%	+221 m (H) +441 m (H)
Virginia	5-Yr Spending: 2002 DSH Cut: 2002 Total Cut:	314 m -20% -1%	326 m -15% -1%	326 m -15% -1%	+12 m (H)

"Option" takes House low-DSH reductions and caps total reduction at 3% of 1995 total spending.

STATES AND HEALTH IN THE BUDGET

There is bipartisan support behind a series of reforms that help states. These include:

- **Unprecedented flexibility in Medicaid:** This budget includes major provisions that gives states discretion in operating their programs, including:
 - Repeal of the Boren amendment
 - Repeal of waivers for managed care
 - Review of the EPSDT benefit to evaluate states' concerns with the benefit
 - Possible state flexibility in cost sharing for optional beneficiaries and dual eligibles
- **Net increase in health spending for states.** The Medicaid savings in the budget agreement are \$13.6 billion. The children's health spending — which the Administration fought to direct to states rather than to tax incentives — is \$16 billion over five years. This yields a net increase in Federal funds to states of \$2.4 billion.
- **Children's initiative is a state initiative.** The Administration has supported making Governors and state legislatures the chief architects of the children's program. States will have considerable flexibility — much more than in Medicaid — including:
 - No EPSDT for benefits
 - Cost sharing for children above 150 percent of poverty
 - Freedom to target groups of uninsured children, without regard to Medicaid's rules about statewideness and comparability of benefits
 - No Federal rules for payment rates like upper payments limits or adequacy of rates
 - No managed care restrictions
 - Discretion in setting standards for health plans and providers

HCFA'S
MEDICARE
Priorities

Supporting Materials for HCFA's top ten Medicare Priorities

The attached materials provides information requested during White House Conference Call 7-22

- 1) IME, GME, DSH Carveout from managed care rates and why DSH is needed
- 2) Rationale for Hospital Transfer policy
- 3) Affect of DSH cut on Public Hospitals
- 4) MSP - Mark Miller
- 5) Private Contracts and Consumer Protections
- 6) DME upgrade
- 7) Summary of Provisions that hurt beneficiaries
- 8) HCFA Administrative Resources

DRAFT

Chris - I am still reviewing but wanted you to have this, just in case. When it is final I will send to Mark M + Josh J.

Debra

Talking Points on DSH Carve-out

- o We are opposed to carving out only the GME portions out of the AAPCC rate, and not the DSH portion as well.
- o There is no fair rationale for only carving out GME from the AAPCC and not DSH, and only guaranteeing additional payments to teaching hospitals and not to DSH hospitals. Both teaching and DSH hospitals are entitled to additional reimbursement under traditional FFS Medicare for their unique missions, one to teach the future generations of physicians and conduct medical research, and the other to provide services to low-income individuals that may have few other options for receiving medical care.
- o DSH providers are already set to bear significant cuts in their payments under the Balanced Budget Act. They will bear all other hospital cuts as well as the phase-in of a 10 percent DSH cut over 5 years. These cuts could potentially lead to decreased access to health care for many vulnerable populations.
- o Teaching and DSH hospitals have suffered in recent years from the growth in Medicare managed care for two reasons: 1) when a beneficiary joins a managed care plan, teaching and DSH hospitals are no longer entitled to Medicare's DRG payment rates or the additional payments for IME and DSH, and 2) managed care plans often direct patients away from teaching and DSH hospitals because of their higher costs.
- o The carve-out/giveback proposal does not only pay teaching and DSH hospitals for services rendered, but it puts them on a more even playing field for competing for managed care contracts. With the expansion of Medicaid managed care in recent years, this is especially important for DSH hospitals.
- o Approximately 66 percent of teaching hospitals are also DSH hospitals. Those hospitals in particular suffer a severe competitive disadvantage when trying to compete for managed care patients because of the high costs due to their diverse missions. Providing supplemental GME funds through the carveout will only partially help these institutions in terms of financial viability and for competing for managed care patients.

Talking Points on Hospital Transfer Provision in House Bill

- When hospital prospective payment was established in 1983, the rates were based upon prevailing patterns of care. At that time, few Medicare patients received care in post-acute settings. Most patients stayed in the hospital until they were well enough to go home.
- Since then, patterns of care have changed dramatically. Currently, 40 percent of Medicare patients who are hospitalized receive care in a post-acute setting. Medicare expenditures for post-acute care now exceed 15 percent of all Part A spending. Meanwhile, hospital lengths of stay have been declining.
- Hospitals have used the increase in availability of post-acute care to game the system. When they discharge a patient for post-acute care, some of which used to be provided in the hospital during recuperation, they still keep the full payment. Meanwhile, Medicare pays twice--it pays the hospital for inpatient care but also pays for additional care in a post-acute setting.
- Furthermore, some hospitals also game the system on both ends of the stay by discharging patients to post-acute settings that they own, thereby receiving a DRG payment for the hospital stay, as well as the cost-based reimbursement for the post-acute care delivered in one of its own facilities.
- The hospital transfer policy would keep Medicare from paying twice when hospitals redefine what they provide. For patients that have a shorter lengths of stay than average for the casemix group and who receive post-acute care, hospitals would receive a reduced payment; this payment would be the same as if the patient were transferred to another hospital. Only hospitals that "game" the system and push patients out significantly faster than average would see their payments decline. Hospitals could elect to provide the recuperative care until almost the average length of stay for the casemix group and receive the full payment.

DSH Cuts

Senate proposal: Reduce DSH payments: For the period 10/1/97 to 12/31/98, by 4 percent;
in CY 1999, by 8 percent;
in CY 2000, by 12 percent;
in CY 2001, by 16 percent;
in CY 2002, by 20 percent.

- o Disproportionate Share Hospital (DSH) payments under Medicare go to those hospitals serving a large proportion of low-income patients. Many of these hospitals have higher costs than other hospitals because they are located in poor inner-city areas, have higher uncompensated care costs, and serve a patient population that tends to be more costly.
- o Reducing DSH payments will cause many hospitals that serve as the health care "safety net" to suffer dire financial circumstances and threaten access to care for the poor and uninsured. Because of uncompensated care, their costly patient population, and the dwindling cross-insurer subsidies these hospitals tend to be very close to the financial edge. ProPAC found that more DSH hospitals in large urban areas had negative total hospital margins than almost any other hospital category.
- o Reducing DSH payments will also affect public hospitals more than private hospitals. While DSH represents about 6 percent of PPS payments overall, for urban public hospitals, DSH makes up about 14 percent of PPS payments.

Physician Private Contracts with Medicare Beneficiaries

Senate Bill: The Senate bill would allow physicians who do not provide items and services under Medicare to enter into private contracts with beneficiaries in the traditional fee-for-service program whereby the beneficiary agrees not to submit a claim to Medicare and agrees to pay the physician entirely out of their own pocket, even though the service is covered by Medicare. The Senate bill waives current law balance billing and claims submission provisions for services provided to beneficiaries where a private contract exists.

Discussion: Allowing private agreements would have the following major adverse consequences.

(1) Private agreements would allow physicians to exploit vulnerable beneficiaries.

- o Private agreements are licenses for physicians to extort beneficiaries: "If you want me to treat you, you'll have to sign this agreement which means that you'll have to pay whatever I want to charge and you can't submit a bill to or collect anything from Medicare".
- o Beneficiaries dependent on their physician may not be able to feel that they are able to challenge the physician for fear of risking their relationship with the physician. They would feel compelled to sign the agreement and adhere to it. Allowing private agreements hardly sets up a level playing field between the physician and the beneficiary.

(2) Allowing private agreements would expose beneficiaries to unlimited liability and make meaningless the Medicare coverage they have paid for.

- o Private agreements would expose beneficiaries to full liability out of their own pocket for whatever amount the physician charges, if the beneficiary adhered to it and did not submit the claim to Medicare.
- o While beneficiaries would be responsible for the physician's unlimited charge, they would not even be able to collect Medicare's 80 percent of the fee schedule for the service as would occur if assignment was not accepted. A private agreement is much worse for a beneficiary than not having assignment accepted.
- o The value of a beneficiary's Medicare coverage would be seriously undermined. Beneficiaries would be paying for Medicare coverage but would not be able to receive reimbursement for Medicare covered services provided by a private agreement physician.

Page 2:

- (3) There would effectively be no balance billing limits and the traditional Medicare fee-for-service program could quickly be converted to a defined contribution program on a service-by-service basis, if Medicare were to pay it's 80 percent of the fee schedule to a beneficiary.
- o In this case, physicians would have strong incentives to have private agreements with all their beneficiaries.
 - o This would effectively repeal balance billing limits, which were one of the key elements of physician payment reform in 1989. If balance billing limits are to be repealed in a back-handed way, then the other key elements of the 1989 physician payment reform deal should be revisited, in particular the Medicare physician fee schedule.
 - o This would also rapidly convert the traditional fee-for-service Medicare program to a defined contribution program (i.e., Medicare would pay the beneficiary a fixed amount for each service and the beneficiary would be responsible for all charges above that amount).
- (4) This provision is not needed because physicians can currently enter into private agreements with beneficiaries who decide not to enroll in Medicare Part B. About 5 percent of beneficiaries do not enroll in Part B. There are not balance billing and claims submission requirements for senior citizens who do not enroll in Part B.

Attachment: Private Agreements are Not Allowed Under Current Law

In the traditional Medicare fee-for-service program, which CBO projects will cover 85 percent of beneficiaries in 1998, physicians can accept assignment on a claim-by-claim basis.

Accepting assignment means that the physician agrees to take the Medicare fee schedule as payment-in-full (i.e., not to charge more than the fee schedule). In this case, Medicare's payment of 80 percent of the fee schedule is made to the physician and the physician collects only the 20 percent coinsurance (and any deductible) from the beneficiary. Participating physicians are those who sign agreements with Medicare to accept assignment for all services provided to Medicare beneficiaries for a year. In 1996, 98 percent of Medicare physician dollars were furnished on assigned basis (91 percent were furnished by participating physicians).

If assignment is not accepted, (1) the physician completes a claim form and sends it to Medicare on behalf of a beneficiary (claims submission), and (2) the physician is limited to charge no more than 15 percent above the Medicare fee schedule amount (balance billing amount). Medicare pays its 80 percent of the fee schedule to the beneficiary who is responsible for paying the physician up to 115 percent of the fee schedule (the 80 percent received from Medicare, the 20 percent coinsurance and balance billing amounts). In 1996, assignment was not accepted for claims representing 2 percent of Medicare physician dollars.

Some physicians believe that they can circumvent current law balance billing and claims submission provisions by requiring beneficiaries to enter "private contracts" with them. Private agreements require that as a condition of receiving services from the physician, the beneficiary must agree not to submit a claim to Medicare for the services. In this situation, beneficiaries obligate themselves to pay the entire bill out-of-pocket without even collecting the amount that Medicare would pay if assignment was not accepted.

Private agreements purport to have the beneficiary "opt out" of Medicare on a physician-by-physician basis, even though the beneficiary has Medicare coverage and the services provided are covered by Medicare. However, Medicare does not recognize private agreements as having any legal validity. Medicare has taken a strong position that statutory beneficiary protections cannot be negotiated away by a private agreement with a physician.

The overwhelming majority of physicians who treat Medicare beneficiaries comply with the law. When violations are found, Medicare first attempts to persuade the physicians to change their practices such as by reducing their charges and making refunds to patients of excess charges and submitting claims to Medicare. Those physicians who refuse to abide by the law subject themselves to the risk of sanctions such as civil money penalties and exclusion from Medicare.

Physician Private Agreements with Medicare Beneficiaries

Private agreements would be allowed under the following terms:

- (1) The physician would have to disclose to the carrier that for a period of time (at least 1 year) the physician would "opt out" of Medicare and provide all items and services to Medicare beneficiaries only through private agreements.
- (2) To be valid, a private agreement would need to be a written agreement, dated and signed by the beneficiary before services are rendered, with a copy provided to the beneficiary, clearly indicating in plain and simple language in print large enough to be read by Medicare beneficiaries that the beneficiary:
 - + Agrees not to submit a bill to Medicare, even though the service would be covered by Medicare if the bill were to be submitted,
 - + Agrees to be personally and fully responsible for payment of all services furnished by the physician out of their own pocket or through private insurance, without any reimbursement from Medicare,
 - + Acknowledges that Medigap or other private insurers may not make any payment because no payment is made from Medicare, and
 - + Acknowledges that they have the right to receive services from other physicians for whose services would be paid by Medicare.
- (3) If a beneficiary submits a claim to Medicare, either: (policy decision to be made)
 - (a) The claim would be denied (i.e., all beneficiary submitted claims would be denied on the presumption that they are services covered by private agreements or the claim would be submitted to the carrier by the physician),
 - (b) The claim would be accepted, the Medicare payment amount would be paid to the beneficiary, and the carrier would send a notice to the physician indicating that the private agreement had been invalidated, that balance billing limits apply and notifying the physician about making refunds to the beneficiary for amounts in excess of the balance billing limit.

SEC. 5613. PRIVATE AGREEMENTS FOR ITEMS AND SERVICES.

(a) **IN GENERAL.** -- Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by inserting after section 1804 of such Act (42 U.S.C. 1395b-2) the following:

"PRIVATE AGREEMENTS FOR ITEMS AND SERVICES

"Sec. 1805. (a) **IN GENERAL.** -- Nothing in this title shall prohibit a physician from entering into a private agreement with an individual who is entitled to benefits under part A or enrolled under part B under the following terms:

"(1) The physician shall disclose to the carrier, before the beginning of a year (in a manner specified by the Secretary) that for the following year the physician will provide all items and services to all individuals under this title only through private agreements. Such physician shall have a valid unique identifier, as specified under section 1842(r).

"(2) For purposes of paragraph (1), private agreements shall be written, dated and signed by the individual before any item or service is rendered, with a copy provided to the individual, clearly indicating in plain and simple language and in print large enough to be read by individuals under this title that the individual:

"(A) Agrees not to submit a claim (or to request that the physician submit a claim) under this title for any item or service furnished by the physician, even though the item or service would be covered under this title if the claim were submitted under this title,

"(B) Agrees to be personally responsible for full payment, either out of their own pocket or through private insurance (if applicable) for of all items and services furnished by the physician, without any reimbursement under this title and acknowledges that any claim submitted by the individual under this title will be

denied as a non-covered service,

"(C) Acknowledges that there would be no limits on what a physician can charge the individual and that the limits under section 1848(g) are not applicable,

"(D) Acknowledges that Medigap plans under section 1882 or other insurance which is supplemental to this title may choose not to make any payment because payment is not made under this title, and

"(E) Acknowledges that they have the right to receive services from other physicians whose items or services would be covered under this title.

"(b) APPLICATION OF SECTION 1848(g).--Section 1848(g) shall not apply only with respect to an item or service furnished to an individual under a private agreement fully meeting the terms described in subsection (a)."

(b) CONFORMING AMENDMENT.--Section 1862(a) (42 U.S.C. 1395y(a)) of the Social Security Act is amended--

(1) by striking "or" at the end of paragraph (14),

(2) by striking the period at the end of paragraph (15) and inserting "," and

(3) by adding at the end the following paragraph:

"(16) which are for items or services which are furnished pursuant to a private agreement described in section 1805(a)."

(c) EFFECTIVE DATE.--The amendments made by this section apply to private agreements covering items and services furnished on or after January 1, 1998.

Medicare Provisions which Compromise Beneficiary Protections

Outlined below are provisions included in the Republican Medicare agreement which would compromise beneficiary protections.

1. **Private Fee for Service Plans.** The Republican Medicare agreement includes a private fee-for-service option under the Medicare Choices program. The Administration supports increasing Medicare beneficiary choices but does not support putting beneficiaries at risk of substantial out-of-pocket costs. The proposed private fee-for-service option lacks beneficiary protections such as quality requirements, limits on the beneficiary premium, and limits on what a doctor can charge a beneficiary. As all of these protections apply to current Medicare risk plans, the question remains why these plans and beneficiaries should be treated differently.
2. **Medigap.** The Republican Medicare agreement fails to guarantee Medigap coverage for beneficiaries who try managed care and does not provide Medigap options for newly Medicare-eligible disabled beneficiaries.

- a. *Assure Medigap Coverage for Seniors and Disabled Persons who Try Managed Care.* Currently, Medicare beneficiaries who disenroll from health plans are not guaranteed Medigap coverage. Beneficiaries, therefore, are reluctant to try managed care since they may not be able to get Medigap again if they disenroll. The Administration's proposal addressed this problem by guaranteeing Medigap coverage to all beneficiaries who disenroll from managed care and making Medigap part of an annual open enrollment process.

The Republican agreement fails to address this Medigap problem. The Republican agreement differentiates between Medicare members currently enrolled in managed care and beneficiaries currently in traditional Medicare. For beneficiaries who are currently enrolled in managed care, the agreement provides no guarantee for Medigap coverage. Beneficiaries who join a health plan in the future, however, will be assured Medigap coverage if they disenroll in the first twelve months. This Medigap protection for new managed care members applies only once - to the first time a beneficiary chooses a health plan. The Republican agreement fails to address this Medigap coverage issue in a meaningful way. Further, the Republican agreement fails to encourage Seniors and disabled persons to take advantage of Medicare choices and, by failing to guarantee Medigap coverage, places beneficiaries at risk of unexpected out-of-pocket costs.

- b. *No Coverage for Newly Enrolled Disabled Persons.* Currently, disabled persons under age sixty-five are not guaranteed Medigap coverage. The Administration addressed this problem by guaranteeing that disabled persons, like Seniors, may purchase Medigap when they become eligible for Medicare. The Republican agreement fails to guarantee issue

Medigap coverage for newly enrolled disabled Medicare members. This means that Medigap insurers could continue to deny coverage to disabled people or charge unaffordable premiums. Disabled members, therefore, face unexpected out-of-pocket costs as they may not be able to obtain Medigap coverage. The President's plan follows the lead of eleven states which have already guaranteed Medigap coverage for disabled persons.

3. **Medical Savings Accounts (MSAs).** The Republican agreement establishes a MSA demonstration for 500,000 beneficiaries. Beneficiaries in this MSA demonstration will be required to buy an insurance plan with a deductible of up to \$6,000 and will deposit the remaining funds in an account. The remaining funds, after the purchase of the insurance plan, may be withdrawn to pay for medical expenses. The beneficiary may also withdraw funds, subject to a penalty, for non-medical expenses. The Republican MSA demonstration places beneficiaries in a precarious position. If a beneficiary experiences an unexpected illness or accident, they may not have adequate funds in their medical account to make an out-of-pocket payment as high as \$6,000 when they require medical care.
4. **Mammography Copays.** The Republican agreement requires Medicare beneficiaries to pay a co-payment for mammography services. The Administration does not support requiring women to make out-of-pocket payments to receive cost effective and essential mammograms. Research indicates that cost-sharing deters women, particularly lower income women, from getting mammograms. The Administration is committed to women taking advantage of this important and effective preventive benefit without additional out-of-pocket cost.
5. **Durable Medical Equipment (DME) Upgrade.** The Republican Medicare agreement allows durable medical equipment (DME) suppliers who accept assignment to bill beneficiaries beyond their 20% coinsurance for "upgraded" DME items. This breaks a long-standing precedent of providers who accept assignment accepting Medicare as payment in full. The Administration recognizes the potential for suppliers to take advantage of beneficiaries by promoting the sale of items that are upgraded, placing beneficiaries at risk of substantial out-of-pocket costs. Further, the provision is unnecessary since beneficiaries already have the option of choosing upgraded DME on unassigned claims.
6. **Private Agreements Between Physicians and Beneficiaries.** The Republican agreement allows physicians who do not participate in Medicare to require beneficiaries to enter into "private contracts" with them in order to receive services. In signing the agreement, the beneficiary agrees not to submit a claim to Medicare for the services. The beneficiary would be obligated to pay the entire bill out-of-pocket, without collecting any money that Medicare would have paid, even though the beneficiary has full Medicare coverage. Under this proposal, beneficiaries are at risk of substantial out-of-pocket payments.
7. **Establish \$1,500 Physical and Occupational Therapy Cap.** The Republican proposal establishes a \$1,500 limit to apply to PT/OT that beneficiaries receive in rehabilitation

agencies, skilled nursing facilities, home health agencies, and physician offices. The Administration opposes this provision which would either increase out-of-pocket payments or result in a significant reduction in services. The \$1,500 limit represents 15-20 PT/OT visits. In many cases, an individual who has suffered from a stroke has 35 visits. In order to receive these services integral to their recovery, the beneficiary would have to pay for the remaining visits out-of-pocket.

Significant Resources Needed to Implement New Provisions in the Reconciliation Bill

MEDICARE

The FY98 Reconciliation Bills currently being considered by Congress include some of the most comprehensive changes made to the Medicare program since its inception in 1965. Not only do the bills cut \$115 billion in spending over 5 years, they also make significant structural changes to the program. The Health Care Financing Administration, charged with administering the Medicare program, will face a significant challenge in implementing these provisions. Current resources will not be sufficient to implement the proposals effectively.

There is significant precedent for funding such administrative costs through the Medicare trust funds. In addition, given the lack of flexibility in discretionary funds, this type of approach may be the only way to fund the resources needed to ensure the Medicare proposals are implemented smoothly and efficiently. In the past, projects such as the Medicare Integrity Program and Social Health Maintenance Organizations have been funded in this manner.

Some of the new or significantly modified proposals compared to the President's plan submitted in February are outlined below. In order to implement these proposals quickly, HCFA needs additional resources. These represent only a portion of the new or substantially modified Medicare proposals, yet they require about \$120 million to implement in FY98.

COMBINED COSTS

To implement the new or substantially modified proposals for Medicare,¹ Medicaid (\$3.5 million) and the Children's Health Initiative (\$6.5 million) combined, HCFA would need over \$150 million.

Senate Medicare Provisions:

Move PPS Update to Calendar Year. While moving the entire PPS rate to a calendar year would be implementable, simply moving the update will create a heavy administrative burden. The PPS rate is derived by accounting for the effects of all changes to the rate, such as the wage index, DSH, the update, and others. A final budget neutrality factor then is applied. All new rates must be published as proposed and final rules. Therefore, if the update is applied at a time that is different from other changes (such as DSH), a proposed and final rule for both rates are needed (for a 10/1 effective date and a 1/1 effective date). This presents a considerable drain on HCFA

¹Not all of the new and substantially modified Medicare proposals are discussed in this paper. The attached list of Medicare proposals would require approximately another \$20 million to implement. Hence, the Medicare (\$140 million) and Medicaid (\$3.5 million) proposals, and the Children's Health Initiative (\$6.5 million) would require about \$150 million to implement.

resources, both for HCFA staff and for contractor resources to make appropriate changes to the claims processing systems. HCFA staff estimate that an additional \$860,000 will be required to develop and publish an additional rule in 1998.

Beneficiary Copayment for Part B Home Health Services. Significant changes to the regional home health intermediaries (RHHIs) claims processing and accounting systems would be required. In addition, RHHIs would need to instruct home health agencies on methods for collecting and forwarding the \$5 dollar copayment. Beneficiaries also must be educated as to which home health services required the copayment. HCFA staff estimate that over \$1 million will be required to accomplish this in 1998.

Demonstration on Income-Related Part B Deductible. HCFA would be required to conduct a demonstration in which individuals who would be subject to the income-related premium could elect instead to have an income-related deductible. HCFA estimates the cost associated with this demonstration would total approximately \$2 million in 1998.

Both House & Senate Medicare Provisions:

Gradual Reallocation of Home Health from Part A to Part B. This requires the Secretary to conduct yearly estimates of: 1) the amount of home health services that would have been paid under Part A, if Part A home health services were all home health services, and 2) Part A home health services were limited to post-institutional stays, up to 100 visits. Such estimations are complex to determine and would entail significant computer systems changes. Significant HCFA resources, such as full-time employees dedicated to conducting the yearly estimates, also would be necessary. HCFA estimates that \$2.5 million in additional resources would be required to implement this provision in 1998 alone.

Establish PPS for Rehabilitation Hospitals. A considerable data collection effort would be needed to determine classifications and payment under a PPS. Formats for reporting cost data (coding system) would need to be developed. HCFA then would instruct hospitals on the new coding system. Data collection would be required for at least a year to create the PPS. Developing and implementing the actual PPS, based on the data collection efforts, would demand significant agency resources. Annual collection of bill data and cost report data under the PPS also would utilize agency resources. HCFA estimates about \$12.5 million in additional resources are required to implement this provision in 1998.

Lab Speciality Carriers. HCFA would be required to designate up to 5 regional specialty carriers to process carrier-paid laboratory claims (except for physician office labs). A transition to specialty carriers for a subset of lab claims would be very burdensome administratively and expensive to implement. HCFA estimates a cost of \$41 million based on experience with the DMERCs.

Data Collection and Processing Requirements Related to Risk Adjustment. HCFA would be required to collect and process encounter data submitted by managed care plans in order to risk adjust payments to those plans. HCFA estimates a cost of \$7 million in 1998.

Periodic Auditing of ACRs. The Secretary would be required to annually audit financial records (including data related to utilization and adjusted community rate (ACR) proposals) of at least one-third of Medicare Plus/Choice plans. HCFA estimates a cost of \$4 million for 1998 audits.

Additional Plans to Certify and Monitor. Because of the less stringent definition of provider sponsored organization (PSO) under the House and Senate bills, HCFA would have to certify and monitor a greater number of Medicare Plus/Choice plans. The Senate bill also includes private fee-for-service plans as an additional option. HCFA estimates a cost of \$20 million to certify and monitor additional plans in 1998.

Other Demonstrations. The bills call for the implementation of more than 20 new demonstrations and research projects, covering the spectrum of Medicare. Some of these include: demonstrations on telemedicine, the income-related Part B deductible, and the project to establish a PPS for long-term care hospitals. HCFA estimates a cost of \$25 million to conduct all of the demonstrations and projects in 1998.

Medical Savings Accounts. Both the House and the Senate bills require a demonstration of MSAs. The House bill limits participation to 500,000; the Senate bill to 100,000. HCFA estimates the cost of implementing and evaluating the House demo to be \$9.3 million, while the costs of implementing and evaluating the Senate demo to be \$6 million. 1998 costs for both will total \$4 million.

MEDICAID

The Senate and House bills call for more federal oversight into managed care operations than the Administration had requested. The Medicaid provisions listed below would increase HCFA's oversight duties, regulation drafting, and technical advisory duties beyond what HCFA anticipated, facilitating the need for \$3.5 million in additional appropriations.

Senate Medicaid Provisions:

State Contracts. The Senate bill has requirements on State managed care contracts including a new default enrollment process that requires States to select plans with providers who have a history of serving Medicaid or other poor beneficiaries.

Access Standards for Managed Care Plans. The Senate bill provides specific plan access standards including provider-enrollee ratios and maximum travel times. HCFA will have to draft new regulations.

Incentive Program for Managed Care Plans. The Secretary and the State would establish a program to award managed care plans with incentive payments, public recognition, or new enrollees. HCFA would have to provide considerable technical assistance to operate this program.

Sanctions. The Senate bill provides that States or the Secretary would establish sanctions against managed care plans that substantially fail to deliver necessary care. The State would establish sanctions against plans that repeatedly fail to deliver necessary care.

Protection for Providers. Managed care plans are prohibited from discriminating against a provider solely based on license if he or she is valid under State law.

House Medicaid Provisions:

Grievance Appeals Board. The House bill requires plans to have a grievance appeals board made up of plan representatives, consumers, and health experts to resolve disputes in 30 days.

Both House & Senate Medicaid Provisions:

Fraud and Abuse. States would be required to have conflict-of-interest safeguards with respect to officers and employees relating to managed care contracts that are at least as effective as Federal safeguards that apply to procurement officials. HCFA will have to write regulations providing details as to what is a conflict.

Monitoring Marketing by Managed Care Plans. Managed care plans are prohibited from distributing marketing materials that contain false or misleading information. No cold calls or tie-ins with other insurance are permitted. Each plan must market its entire service area.

Exclusion of Certain Managed Care Plan Employees. A plan may not knowingly have a director, officer, or person with more than 5 percent of equity who has been debarred or suspended by the Federal government.

CHILDREN'S HEALTH INITIATIVE

Both the House and the Senate bills create a new Children's Health Initiative to be administered by HCFA. Program costs are estimated at about \$6.5 million.

Additional Medicare Provisions to be Paid for out of the Trust Funds

These provisions are not summarized in this package, but their cost is included in the \$150 million number on page one of "Significant Resources Needed to Implement New Provisions in the Reconciliation Bill."

Commission on Long-Term Solvency of Medicare Program

Senate Sec. 5021

House Sec. 10721

Not Codified

Permanent Exclusion for those Convicted of 3 Health Care Related Crimes

W & M Sec. 10301

Commerce Sec. 4301

Title XVIII Sec. 1128 (c) (3)

Advisory Opinions Regarding Self-Referral

W & M Sec. 10309

Commerce Sec. 4309

Title XVIII Sec. 1877 (g)

Nondiscrimination in Post-Hospital Referral to HHAs

Commerce Sec. 4310

Title XVIII Sec. 1861 (ee) (2)

HI Coverage for Certain Public Retirees

W & M Sec. 10543

Title XVIII Sec. 1818 (d)

Screening Pap Smear & Pelvic Exams

W & M Sec. 10102

Commerce Sec. 4102

Amends Title XVIII Sec. 1861 (nn) and 1833 (b)

Prostate Cancer Screening Tests

W & M Sec. 10103, Creates new subparagraph 1861(s) (2) (P), subsection (oo)

Commerce Sec. 4103, Amends 1833 (h) (1) (A)

Standardized Medicare Coverage: Bone Mass Measurements

W & M Sec. 10106

Commerce Sec. 4106

Senate Sec 5104

Creates new paragraph 1861 (s) (15), subsection (rr) and Amends 1848 (j) (3)

Resource-Based Physician Practice Expenses

W & M Sec. 10605

Senate Sec. 5505

Amends Title XVIII 1848 (c) (2)