

Withdrawal/Redaction Sheet

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. briefing paper	Briefing Paper - Various Topics (1 page)	7/21/97	P5

COLLECTION:
 Clinton Presidential Records
 Domestic Policy Council
 Chris Jennings (Subject File)
 OA/Box Number: 23753 Box 16

FOLDER TITLE:
 Medicaid- Disproportionate Share Hospital Policies (Budget 1997) [2]

gf35

RESTRICTION CODES

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

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

C. Closed in accordance with restrictions contained in donor's deed of gift.
 PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
 RR. Document will be reviewed upon request.

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

b(1) National security classified information [(b)(1) of the FOIA]
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 b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
 b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

July 27, 1997

The Honorable John Tanner, M. C.
House of Representatives
1127 Longworth Building
Washington, DC 20515

Dear Mr. Tanner:

Thank you for writing to express your concern about the proposed limitations on Disproportionate Share Hospital (DSH) payments by the House and Senate budget bills in relation to the state of Tennessee.

It is understood by Congress that because of Tennessee's 1115 waiver expansion it will not be affected by the proposed reductions in DSH.

Thank you again for expressing your concerns on this very important issue.

Sincerely,

Vice President Gore

JOHN TANNER
8TH DISTRICT
TENNESSEE



COMMITTEE
ON
WAYS AND MEANS

CONGRESS OF THE UNITED STATES
HOUSE OF REPRESENTATIVES
WASHINGTON, D.C. 20515-4208

July 8, 1997

Honorable Albert Gore, Jr.
Office of the Vice President
Old Executive Office Building
Washington, D.C. 20501

Dear Mr. Vice President:

Tennessee, as you well know, has been operating a statewide comprehensive health care program under a waiver granted pursuant to section 1115 of the Social Security Act. As a result of this Medicaid waiver, Tennessee has expanded coverage beyond the traditional Medicaid categories to children and other uninsureds and has used DSH funds to help pay for the expanded coverage.

The provisions of the House and Senate budget bills pertaining to limitations on DSH payments use actual DSH spending in FY95 as the base for calculating the new limitations, and then adjust the base in subsequent years. It seems clear that the bills were not intended to affect those funds formerly used for DSH payments that are now being used to fund 1115 waiver expansions. A floor colloquy in the Senate confirmed this as to Tennessee and Hawaii, which had already converted virtually all of their DSH funds to their waiver projects by FY95. A copy of this colloquy is attached.

I have also attached legislative language which would confirm that the amount of DSH funds used to fund the waiver program will be determined by the financial provisions of the waiver. In this way, the DSH provisions of the budget legislation would have no impact on the continued implementation of Tennessee's statewide waiver program. The DSH funds would remain available under the terms of the waiver for as long as the waiver program was in effect.

Any assistance you may be able to offer in conference in clarifying this matter would be appreciated.

Sincerely,

A handwritten signature in black ink, appearing to be "John Tanner".

John Tanner, M. C.

A handwritten signature in black ink, appearing to be "Bart Gordon".

Bart Gordon, M. C.

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MEMPHIS, TN 38128
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the effect, impact and cost implications of competitive bidding, flexible purchasing and inherent reasonableness on the provision of a full range of effective medical products and services to Medicare beneficiaries.

Mr. President, I simply ask my colleague if that is correct?

Mr. ROTH. In response to Senator FRIST'S question, it is the committee's intent that the Medicare Payment Review Commission shall have broad authority to study and make recommendations to Congress on a variety of issues relating to the Medicare Choice program and the Medicare fee-for-service program. The committee recognizes that the previous two advisory committees did not have explicit authority to study issues relating to reimbursement of durable medical equipment and medical supplies. However, it is the committee's intent that the Medicare Payment Review Commission will have broad authority in these and other areas regarding the review of all Medicare reimbursement issues.

DSH PAYMENTS

Mr. FRIST. I would like to take a moment to clarify the intended meaning of the changes in State allotments for disproportionate share hospital [DSH] payments as they impact States that have received waivers to adopt managed care programs statewide, using DSH funds to help finance expanded care to the uninsured. Two such States are Tennessee, which initiated the TennCare program in January 1994, and Hawaii, which has operated the QUEST program since mid-1994.

In these cases, the States combine their DSH allotment and their regular Medicaid dollars to fund capitation payments to managed care providers who are responsible for service not only to existing Medicaid-eligible recipients but to a substantial portion if not most of the children and adults who would not otherwise qualify for Medicaid but who do not have coverage under other insurance programs. Direct DSH payments to hospitals have been essentially eliminated, because the hospitals and other providers receive payments to cover care to the uninsured through the waiver program, either from managed care providers or, in the case of some hospitals, from the State under supplementary pools.

The committee's legislation provides that DSH payments relating to services to persons eligible under the State's Medicaid plan must be made directly to hospitals after October 1, 1997, even where the individuals entitled to the service are enrolled in managed care plans, and cannot be used to determine prepaid capitation payments under the State plan that relate to those services. That provision does not by its terms apply to States operating under waivers where the DSH funds are used to fund a broader range of services to the uninsured. I would like your confirmation of this understanding, for it would be inconsistent with the

TennCare and QUEST programs to apply the new provision to them.

I also seek your concurrence that the adjustments to State DSH allocations are not intended to impact on the funds available to these waiver States to operate their programs. Both Tennessee and Hawaii no longer use their DSH allotments for DSH payments. As a result, CBO's estimates showed no impact on those States of the committee's provision adjusting DSH allotments and payments. That is entirely appropriate, for these States are subject to limitations on their Medicaid funding by reason of the budget terms of their waiver. Moreover, they no longer make DSH payments as we have come to know them, but instead have developed more efficient means of delivering health services and have extended them to a broader segment of the population.

Can the chairman confirm my understanding of these two DSH-related points?

Mr. ROTH. I am happy to confirm the Senator's understanding on both points. There is no intention to alter the manner of distribution of funds under demonstration waiver programs as long as those programs are in effect. Further, we do not intend any change in the budget and finance provisions of these demonstration waivers, where the DSH funds are used to expand coverage to the uninsured.

AMENDMENTS NOS. 452, 453, AND 454, EN BLOC

Mr. DOMENICI. I have three amendments that are going to be accepted. One is for Senators LIEBERMAN, CHAFEE, JEFFORDS, KERREY, BREAUX, WYDEN and KENNEDY, to require Medicaid managed care plans to provide certain comparative information to enrollees. One is for Senator FEINSTEIN to require managed care organizations to provide annual data to enrollees regarding nonhealth expenditures. And a third is a Craig-Bingaman amendment to study medical nutrition therapies by using the National Academy of Sciences to do that.

I send the three amendments to the desk and ask that they be agreed to en bloc.

The PRESIDING OFFICER. Without objection, it is so ordered.

The clerk will report the amendments.

The legislative clerk read as follows:

The Senator from New Mexico [Mr. DOMENICI] proposes amendments numbered 452, 453, and 454, en bloc.

The amendments (Nos. 452, 453, and 454) en bloc are as follows:

AMENDMENT NO. 452

(Purpose: To require Medicaid managed care plans to provide certain comparative information to enrollees)

At the end of proposed section 1941(d) of the Social Security Act (as added by section 5701), add the following:

"(3) PROVISION OF COMPARATIVE INFORMATION.—

"(A) BY STATE.—A State that requires individuals to enroll with managed care entities under this part shall annually provide to all

enrollees and potential enrollees a list identifying the managed care entities that are (or will be) available and information described in subparagraph (C) concerning such entities. Such information shall be presented in a comparative, chart-like form.

"(B) BY ENTITY.—Upon the enrollment, or renewal of enrollment, of an individual with a managed care entity under this part, the entity shall provide such individual with the information described in subparagraph (C) concerning such entity and other entities available in the area, presented in a comparative, chart-like form.

"(C) REQUIRED INFORMATION.—Information under this subparagraph, with respect to a managed care entity for a year, shall include the following:

"(i) BENEFITS.—The benefits covered by the entity, including—

"(I) covered items and services beyond those provided under a traditional fee-for-service program;

"(II) any beneficiary cost sharing; and

"(III) any maximum limitations on out-of-pocket expenses.

"(ii) PREMIUMS.—The net monthly premium, if any, under the entity;

"(iii) SERVICE AREA.—The service area of the entity.

"(iv) QUALITY AND PERFORMANCE.—To the extent available, quality and performance indicators for the benefits under the entity (and how they compare to such indicators under the traditional fee-for-service programs in the area involved), including—

"(I) disenrollment rates for enrollees electing to receive benefits through the entity for the previous 2 years (excluding disenrollment due to death or moving outside the service area of the entity);

"(II) information on enrollee satisfaction;

"(III) information on health process and outcomes;

"(IV) grievance procedures;

"(V) the extent to which an enrollee may select the health care provider of their choice, including health care providers within the network of the entity and out-of-network health care providers (if the entity covers out-of-network items and services); and

"(VI) an indication of enrollee exposure to balance billing and the restrictions on coverage of items and services provided to such enrollee by an out-of-network health care provider.

"(v) SUPPLEMENTAL BENEFITS OPTIONS.—Whether the entity offers optional supplemental benefits and the terms and conditions (including premiums) for such coverage.

"(vi) PHYSICIAN COMPENSATION.—An overall summary description as to the method of compensation of participating physicians.

AMENDMENT NO. 453

(Purpose: To require managed care organizations to provide annual data to enrollees regarding non-health expenditures)

At the end of proposed section 1852(e) of the Social Security Act (as added by section 5001) add the following:

"(6) ANNUAL REPORT ON NON-HEALTH EXPENDITURES.—Each Medicare Choice organization shall at the request of the enrollee annually provide to enrollees a statement disclosing the proportion of the premiums and other revenues received by the organization that are expended for non-health care items and services.

At the end of proposed section 1945 of the Social Security Act (as added by section 5701) add the following:

"(h) ANNUAL REPORT ON NON-HEALTH EXPENDITURES.—Each Medicaid managed care organization shall annually provide to enrollees a statement disclosing the proportion

() The provisions of this subsection limiting the DSH allotments of states shall not apply in the case of any state that was operating a state-wide comprehensive research and demonstration program as of May 1, 1997, for which a waiver of compliance with requirements of Title XIX has been granted under section 1115(a) of the Social Security Act to the extent that disproportionate share funds available to the state are expended through the demonstration rather than through the state plan, nor shall the provisions affect the amount of available federal financial participation in such a program. This paragraph shall apply as long as the demonstration program is in effect, including any extensions of its expiration date, subject to the financial terms and conditions of the current demonstration program.



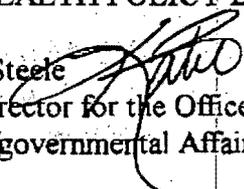
DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

JUL 22 1997

NOTE FOR CHRIS JENNINGS
DEPUTY ASSISTANT TO THE PRESIDENT
FOR HEALTH POLICY DEVELOPMENT

FROM: Kathleen Steele 
Acting Director for the Office
of Intergovernmental Affairs

SUBJECT: Arizona Waiver

According to HCFA, Arizona is requesting a waiver renewal. Arizona had their demo with various modifications and extensions since 1982 (prior to that they did not have a Medicaid program!). The current waivers are extended through September 30, 1997.

The issue with the request is related to budget neutrality. Arizona wants to use past savings, i.e., savings prior to the renewal period effective date, to satisfy the budget neutrality terms. HCFA has given Arizona a verbal heads up that they have not agreed to such a methodology in the past and have asked Arizona to stay within the current budget neutrality guidelines.

However, this issue may fade away depending on the outcome of budget reconciliation. The House version provides for automatic 3-year renewals for 1115 Medicaid demos, given that they satisfy the budget neutrality requirement (does not require HHS to approve methodology)---thus, Arizona would be home free. The Senate version is much broader and provides for permanent extensions of 1115 Medicaid demos.

Please let me know if you have any questions on this or other issues.

Attn: Chris Jennings

July 22, 1997

Members of the Conference Committee on
the Balanced Budget Act of 1997

Dear Conferees:

We are writing to urge you to carve Medicare Disproportionate Share Hospital (DSH) payments, as well as direct and indirect medical education payments, out of Medicare payments to managed care plans and pay them directly to the organizations that incur the costs. The policy justifications for direct payment of medical education adjustments apply equally strongly to the DSH adjustment.

Both the Senate bill and the Commerce Committee version of the House bill gradually reduce Medicare managed care payments -- the Adjusted Average Per Capita Cost (AAPCC) -- by the amount attributable to direct graduate medical education (DGME), indirect medical education (IME) and DSH payments to hospitals. The payments would then be made directly to the organizations qualifying for the adjustments. The Ways and Means bill includes no similar provision.

The rationale for this type of carve-out is simple: these payments are intended to cover the additional costs organizations incur in teaching and in serving large volumes of poor patients. Under current law, these payments are folded into payments to managed care plans, and the plans are under no obligation to pass the funding along in rates paid to teaching and DSH hospitals or other organizations actually providing the services that are under contract with them. The carve-out is intended to ensure that the Medicare support of these important missions reaches those organizations that actually incur the costs.

This rationale is no less applicable to DSH payments than it is to medical education payments. Like teaching hospitals, hospitals that serve the poor are providing a "public good" that is not typically recognized through rates negotiated with commercial plans. Without a direct pass-through, these federal funds are likely to dissipate in the system rather than provide support for those hospitals shouldering the burden of caring for the poor that Congress intended these dollars to support.

Our organizations urge you not to compromise on the AAPCC carve-out in this fashion. DSH payments, as well as GME payments, must be carved out and paid to the organizations that incur the costs. Both the Senate and the Commerce bills phase in the carve-out over a four-year period, providing sufficient time for managed care plans to adjust to the new payment system. We urge you to adopt the Senate and Commerce carve-out provisions intact, which include DSH as well as DGME and IME payments in the carve-out.

Sincerely,

Association of American Medical Colleges
American Hospital Association
National Association of Public Hospitals & Health Systems

Withdrawal/Redaction Marker

Clinton Library

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001. briefing paper	Briefing Paper - Various Topics (1 page)	7/21/97	P5
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**This marker identifies the original location of the withdrawn item listed above.
For a complete list of items withdrawn from this folder, see the
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Domestic Policy Council
Chris Jennings (Subject File)
OA/Box Number: 23753 Box 16

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JEANNE SHAHEEN
GOVERNOR

STATE OF NEW HAMPSHIRE

OFFICE OF THE GOVERNOR

July 14, 1997

Mr. Don Gips
Chief Domestic Policy Adviser
Office of the Vice President
White House
Washington, DC

Dear Mr. Gips: *Don*

Thank you again for your interest and help thus far in facilitating negotiations between New Hampshire and the Health Care Financing Administration of our Section 1115 Waiver. I believe we are now at a critical stage in negotiations, and I would appreciate your continued help to quickly resolve our remaining issues. It is very important to the Governor that our waiver be approved before the close of the federal fiscal year.

Because of recent negotiations between the State, HCFA, HHS, and White House staff, we have significantly narrowed the unresolved issues. There is substantial agreement on the programmatic design of New Hampshire's waiver. Currently, negotiations are focused on budget neutrality. HCFA has emphasized throughout these sessions that they must work within established precedents in approving New Hampshire's waiver proposal. At the most recent meeting, New Hampshire presented a six point plan which I strongly believe works within those established precedents. New Hampshire has worked hard to adjust its proposal to meet HCFA's needs.

Our proposed plan has six key points. Each of these are critical to New Hampshire in its ability to proceed with the waiver, including the insurance buy-in program for uninsured children and adults.

- *Disproportionate Share Base Year.* HCFA proposed that 1996 serve as the base year for disproportionate share. This will not work for New Hampshire. In order to proceed with the waiver, New Hampshire must have 1995 as a base year (or an average of years 1994-1996) for disproportionate share. This base year will allow the state to implement the buy-in program for the uninsured. Both the House and Senate versions of H.R. 2015 use 1995 as the base year for disproportionate share reductions. The Administration's proposal also uses 1995 as a base year for disproportionate share. I strongly believe that there is clear precedent, therefore, for the 1995 base year for disproportionate share. You should be aware that the 1995 base year is even more important to New Hampshire in light of the proposed disproportionate share reductions.
- *1996 Base Year for AFDC Program Spending.* HCFA proposed that New Hampshire use 1996 for other program spending. This is agreeable to New Hampshire.

- *5.6% Trend Factor.* HCFA proposed a 5.6% trend factor which represents the national AFDC trend factor for all states. However, for the first year, HCFA reduced the factor to 3.1% to reflect reductions in the state's Medicaid spending mandated by our legislature. While it is true that there were reductions in New Hampshire, most occurred in long term care programs and are not applicable to this component of the proposed waiver. New Hampshire's own inflation experience is substantially higher than the national average. Nevertheless, the state will accept HCFA's proposal without the adjustment for the initial year.
- *Spending for Children and Families Outside of Budget Neutrality.* As a result of welfare reform, states were given flexibility in Section 1931 to extend eligibility to children and families in a manner similar to that used under Section 1902(r)(2) for children. Because this is current law, New Hampshire requests that children and families falling under this provision be excluded from the test of budget neutrality. HCFA has excluded children under Section 1902(r)(2) in a number of states. This component of New Hampshire's plan also meets the precedent requirement.
- *Spending Flexibility for Disproportionate Share.* One of the key features of New Hampshire's proposal is to use some of the disproportionate share dollars to purchase health coverage for the uninsured. This type of flexibility has been approved in numerous states. It should be noted that New Hampshire will continue to make some payments directly to hospitals. New Hampshire also seeks the flexibility to spend disproportionate share dollars on other state subsidized care in both inpatient and ambulatory settings. HCFA has approved this type of spending flexibility elsewhere, most recently in Los Angeles. This element of New Hampshire's proposal, therefore, also meets HCFA's need to work within established precedent.
- *State Contribution for the Buy-In Program.* One of the most difficult issues in the negotiations has been HCFA's recent request that the state contribute at least some portion of the nonfederal share of the premium for purchasing coverage for the uninsured. New Hampshire proposed that the nonfederal share be contributed on a sliding scale basis by those receiving coverage. In order to move the negotiations forward, New Hampshire has agreed to work with the legislature to enable the state to make some contribution -- most likely through an increase in the tobacco tax. However, HCFA proposed that the state's contribution be one-half of the nonfederal share. This is too high. I understand that HCFA approved twenty percent of the nonfederal share or ten percent of the total in Tennessee for the first \$81 million of premiums collected. Therefore, there is precedent for a lower figure.

New Hampshire has moved substantially from its original position to bring these negotiations to closure. While we can appreciate the Vice President's comments about how aggressive New Hampshire has been in its pursuit of federal Disproportionate Share funds, I believe that the current proposal before HCFA is an honest attempt to put an end to the gaming of the system. Although we are still a high Disproportionate Share state, our use of these dollars keeps with the intent of the program and has decreased substantially over the last several years. If approved, our plan to use Disproportionate Share funds for insurance premiums has the potential to reduce the uninsured population by half and fund care to the poor in a more rational, systemic way.

I hope that HCFA will judge these proposals on their merits and view them as a good faith effort to end the gaming of the system and advance the policy goal of extending affordable health insurance coverage to the uninsured.

It is Governor Shaheen's hope that HCFA can move quickly in resolving the few remaining barriers to approval of New Hampshire's waiver. The continued assistance of the Vice President to expedite a resolution to this process would be very helpful.

Before closing, I want to express our concerns about the changes to the Medicaid program currently pending before the Committee of Conference on H.R. 2015. Specifically, we are concerned about the reductions targeted for Institutes for Mental Disorders (IMDs). The Senate bill requires a much larger reduction in Disproportionate Share Hospital dollars for states that, like New Hampshire, have spent part of their Disproportionate Share Hospital allocations for services provided to poor people in State Psychiatric Hospitals. In 1998 alone, the Senate bill would reduce New Hampshire's Disproportionate Share Hospital allotment from \$341 million (our 1995 spending level) to \$310 million.

This change has two worrisome implications for New Hampshire. First, it lowers our Disproportionate Share cap by nearly 10% from the outset, making the overall reductions very difficult to manage. Second, it would cost the state as much as \$20 million because of the inability to qualify for federal match on uncompensated care spent at our state psychiatric hospital. A \$20 million gap would jeopardize my budget, causing significant cuts to services.

In addition to having a serious impact on our Medicaid program, singling out IMDs is both unfair and discriminatory. New Hampshire has made notable strides in treating mental disorders on par with physical disease. As a state senator, the Governor worked to pass mental health parity legislation requiring insurers to treat eight biologically based mental health diseases as they would any physical illness. Since then, the Congress has enacted similar legislation. This restriction on the use of Disproportionate Share Hospital funds is contrary to that policy.

If the goal is to reign in escalating spending in the Disproportionate Share Hospital program, then Congress can achieve that goal by imposing reductions in allotment caps. The IMD restrictions are unnecessary. States are in the best position to determine how uncompensated care needs are met. The Governor hopes that the White House will agree that this is a position you should support in the Committee of Conference negotiations.

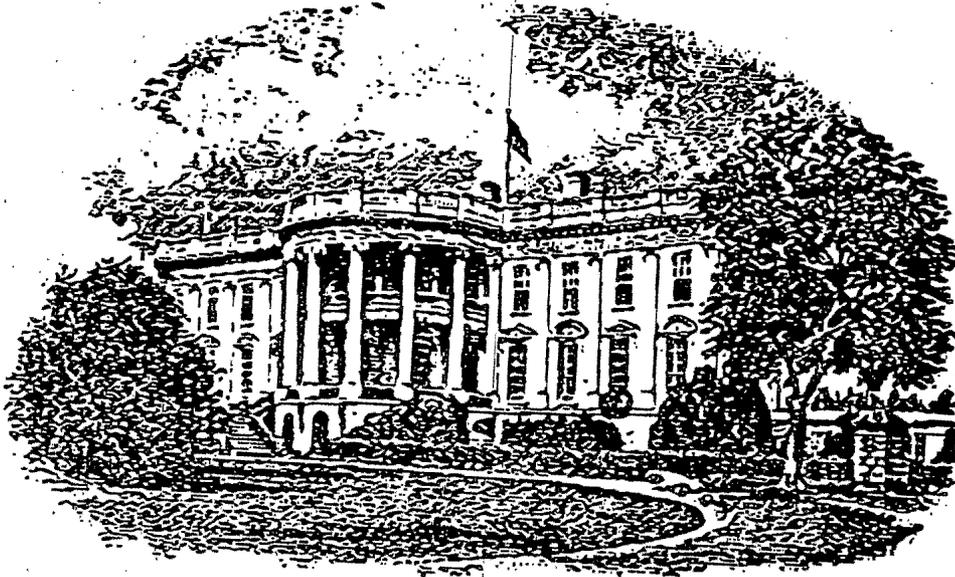
Thanks again for your help on these matters.

Sincerely,



Karen Hicks
Special Assistant for Policy
Office of the Governor

The White House
Office of Presidential Letters and Messages



facsimile from Sarah Knight
phone: 202-456-5514
fax: 202-456-5426

To: Sarah Bianchi

No. of pages (including cover): 4 Date: 8/28/97

Phone: _____ Fax: x65557

Comments: The Gov. Caytono letters.

Sarah

Handwritten: 1/10/97

227401



EXECUTIVE CHAMBERS
HONOLULU

BENJAMIN J. CAYETANO
GOVERNOR

July 11, 1997

The Honorable William J. Clinton
President of the United States
The White House
Washington, D.C. 20510

Dear Mr. President:

I am writing to request your assistance in a matter of great importance to the people of the State of Hawaii. We are currently involved in an effort to increase Hawaii's Federal Matching Assistance Payment (FMAP) rate to help our state better bear the cost of Medicaid services.

Hawaii is currently one of only a dozen states whose FMAP rate is 50 per cent, the lowest rate possible, which is intended for only the wealthiest states. However, Hawaii does not belong in this group. Although per capita income in our state is among the highest, studies by various bodies have demonstrated that our cost of living is as much as one third higher than the continental United States.

Hawaii's situation is very similar to that of Alaska, which also has a high per capita income but a cost of living which is substantially greater than the continental United States. In the case of Alaska, however, the Senate has already recognized this disparity and included an increase in the FMAP rate from 50 per cent to 59.8 per cent for the next three years in the budget bill currently under consideration. A comparable increase in the FMAP rate for Hawaii would achieve parity for Hawaii with Alaska, recognizing the special situation that applies to both of the "off-shore" states.

Various governmental programs have previously recognized Hawaii and Alaska's exceptionally high cost of living:

- Medicaid and Medicare regulations provide for special cost-of-living adjustments for the two states in applying the routine cost limits for nursing home rates;
- The Federal Poverty Level (FPL) is adjusted for these two states to account for cost-of-living differences;



230741

See memo dated

EXECUTIVE CHAMBERS

HONOLULU

August 4, 1997

BENJAMIN J. CAYETANO
GOVERNOR

The Honorable William Jefferson Clinton
President of the United States
The White House
1600 Pennsylvania Avenue, N.W.
Washington, D.C. 20500

Dear Mr. President:

Major fundamental changes in the Medicare program continue to evolve to reach bipartisan agreement. Soon, conferees will meet to decide whether to impose copayments for home health services. Should copayments be included in the final budget package, thousands of vulnerable seniors and disabled individuals who require care will not be able to afford the care they need.

While the Medicare program must be examined to preserve its integrity for future beneficiaries, copayments: a) impose a financial burden on the elderly and disabled; b) constitute a barrier to care for the low to moderate income group; and c) as an unfunded mandate, will increase State Medicaid outlays over the next five years.

As a nation of strength, compassion and fiscal responsibility, our collective efforts should be directed at improving the Medicare system with integrity, without sacrificing the needs of the sick, vulnerable and poor.

Therefore, the State of Hawaii strongly urges your intervention to ensure the rejection of the Medicare copayment proposal for home health services.

With warmest personal regards,

Aloha,

Benjamin J. Cayetano

BENJAMIN J. CAYETANO

AUG - 8 1997

The Honorable William J. Clinton
July 11, 1997
Page 2

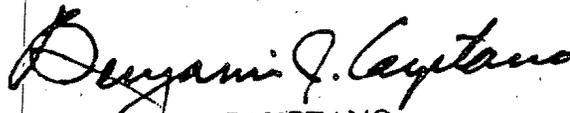
- The Food Stamp program takes these differences into account in defining the thrifty food plan and in establishing standard deductions for Alaska and Hawaii;
- Statutory differences in compensation for civilians in the military make special allowance for the higher living costs in these two states;
- National housing laws take account of the differences in the cost of living in these states for purposes of government-backed insurance limits;
- Provisions on support for the school lunch program authorize higher payments to Alaska and Hawaii based on higher food costs.

These examples demonstrate the recognition that the higher cost of living in the off-shore states should be taken into account in government program policy development. It is time for a similar recognition of this factor in gauging Hawaii's ability to support its health care programs.

Thank you for your consideration in this matter. It is my hope that you will be able to support our position and assist us in securing this change.

With warmest personal regards,

Aloha,


BENJAMIN J. CAYETANO

RICK HOSPITAL
NEW JERSEY SHORE MEDICAL CENTER
SANT PLEASANT HOSPITAL
LIVERVIEW MEDICAL CENTER



JOHN K. LLOYD, M.D.
President

Tel 732 776-4215
Fax 732 776-4583

Meridian Health System
1945 State Route 33
P.O. Box 397
Neptune, NJ 07754-0397

July 8, 1997

The President
The White House
Washington, D.C. 20500

Dear Sir:

I am writing to urge your continued support on the carve-out that would remove GME (graduate medical education) and DSH (disproportionate share hospital) funds from Medicaid Managed Care payments and pay those monies directly to teaching and DSH hospitals.

Thank you for the assistance you have already provided, Mr. President, as we are a hospital with a teaching mission, serving low income citizens.

Very truly yours,

A handwritten signature in cursive script that reads "John K. Lloyd".

John K. Lloyd
President

JKL/s

THE WHITE HOUSE
OFFICE OF LEGISLATIVE AFFAIRS
SENATE LIAISON

--- FAX COVER SHEET ---

NOTE: THE INFORMATION CONTAINED IN THIS FACSIMILE MESSAGE IS CONFIDENTIAL AND INTENDED FOR THE RECIPIENT ONLY.

DATE: 7/24

TO: CHRIS Jennings / Sarah Bianchi

FAX: 6-7431

FROM: _____ Paul Carey _____ Barbara Chow
 _____ Tracey Thornton _____ Ben Freeland
 _____ Mike Williams _____ Rick Gonzales
 _____ Jeff Forbes _____ Stacey Rubin

PHONE (202) 456-6493 FAX (202) 456-2604

RE: Erskine will be meeting w/ the
California Democratic Congressional Delegation
on Wednesday, July 29. Can we
get 1 paragraph background & 3-4
talking points on the Medicaid / DSH
issue (see attached). Thanks.

direct 225-2003

Committee on the Budget

Committee on Banking
and Financial ServicesSubcommittee on Financial
Institutions and Consumer CreditSubcommittee on Capital Markets and
Government Sponsored Enterprises

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CHAIR, CALIFORNIA DEMOCRATIC
CONGRESSIONAL DELEGATION

Medicaid/DSH

The DSH issue is critical to the California Delegation. Last week, 48 of California's 52 Members sent a letter to Speaker Gingrich asking the budget negotiators to adopt Medicaid revision provisions to soften the blow of DSH reductions on heavily-impacted hospitals and allow for an appropriate phase-in period. The letter expresses "the strong and united view of the California delegation that the policy that reduces Federal DSH payments must be designed so that a state like California which has fully directed its DSH programs to hospitals with high proportions of Medicaid and uninsured patients does not face a debilitating reduction in funds."

Members will discuss the importance of this issue and ask for administration support.

Census Sampling

The delegation is pleased with the support the administration has thus far provided on the census sampling issue. California will lose approximately \$1 billion in federal funds for every 1 million undercount of low-income populations. The 1990 undercount deprived the state of a congressional seat to which it was otherwise entitled. House Republicans are intent on stymieing the efforts of the Census Bureau to prepare for sampling. Delegation Members will ask that the President maintain a firm stance against efforts to thwart sampling.

Base Closure and Base Reuse

Prior to 1988, fifteen percent of all Department of Defense jobs (civilian and military) were in California. Yet, the state absorbed 59.89% of the nationwide military job cuts. Nearly half of the state's 63 bases were closed or are in the process of being closed.

Members are concerned that California will again take a disproportionate hit in additional rounds of base closures. Members also are troubled by the slow pace of military base reuse in the state.

NAFTA/Fast Track

Several delegation Members have expressed reluctance to support fast track because of a perception that the administration has failed to keep NAFTA-related promises, such as NADBank implementation and border clean-up. They need assurance that the commitments will be kept.

Welfare Reform/SSI

California, with 12% of the nation's population, is home to 22.1% of the nation's AFDC/TANF recipients. California is also home to 35.3% of the nation's legal aliens and 40% of the undocumented population. Thus, the state is heavily impacted by welfare reform, including SSI cuts.

Karen Skelton
July 18, 1997
p. 2

California Democrats strongly support restoration of SSI benefits to both legal immigrants who were disabled before August 23, 1996 and to those who were lawful residents before August 23, 1996 and become disabled. Members also want to ensure the availability of SSI for legal immigrant seniors.

Members are also concerned with attempts by Republicans to deprive welfare recipients of minimum wage and workplace protections.

Presidential Initiatives

California is the ideal theatre in which to stage various of the President's initiatives, including on race and education. The synergy between California Members of Congress and the administration will highlight the President's programs and help to re-elect California Democrats to the House.

Race -- The nation's largest state is also its most diverse. 57% of Californians are white, 7% african-american, 9.1% Asian, 1% native american and almost 26% Hispanic. Moreover, concerns about racial issues has prompted passage of Propositions 187 and 209 -- the anti-undocumented immigrant and anti-affirmative action initiatives. The impact of Proposition 209 is already evident in the dearth of black and Hispanic students in the entering classes at Boalt Hall and UCLA law schools. The state's largest city, Los Angeles, is still healing and rebuilding from the 1992 riot.

The California Delegation, which includes the Chairs of the Congressional Hispanic Caucus and Congressional Black Caucus, can work with the administration to develop and roll out initiative programs on a stage that is primed for such a production.

Education -- The President's plan to pay for the first two years of college, and to offer tax relief for higher education and job retraining, finds an ideal audience in California. The state has a "master plan" that combines one of the nation's most extensive community college systems with the four-year California State University and the research-oriented University of California.

High-tech job growth in California is revitalizing the moribund economy. California high-tech firms employ more than twice as many workers as Texas, the second ranked high-tech state. High-tech products accounted for nearly 61% of California's \$9 billion in total export sales in 1995. Yet, the pool of technically qualified workers cannot meet the burgeoning demand. The modified "Hope Scholarships" could be highlighted as a means to funnel students into technology oriented programs at community colleges, thus bolstering productivity and employment levels. Several delegation Members can provide examples of local high-tech firms which have jobs that cannot be filled due to the lack of technically qualified workers.

Bipartisan Task Force

Jane Harman and Gary Condit will briefly discuss the delegation's bipartisan task force. Lucille Roybal-Allard and Jerry Lewis appointed Representatives Harman, Condit, Lofgren, Riggs, McKeon and Campbell to identify matters where bipartisan cooperation can be achieved for the benefit of California. Thus far, the task force and entire bipartisan delegation has worked on: elimination of the Medicaid per capita cap from the budget agreement, full funding of the federal component of Bay-Delta, preservation of California's electric deregulation plan, repeal of the 501 c(3) bond cap for California State University, full funding for SCAAP and favorable DSH funding.

The bipartisan task force and delegation Co-Chairs are initiating quarterly meetings with a bipartisan California state legislative task force. The first meeting will be in late August. As California struggles to implement welfare reform, the state legislators will look to the congressional delegation to "fix" those aspects of welfare reform which are untenable in California, including loss of SSI benefits for legal elderly and disabled immigrants. California Members will need administration cooperation to help make welfare reform work in the state.

MEMORANDUM

TO: Don Gips
FROM: Chris Jennings
RE: DISPROPORTIONATE SHARE HOSPITAL (DSH) AMENDMENT
DATE: June 12

Today, at the House Commerce Committee mark up, Representative Green (D-TX) will offer an amendment on reductions in disproportionate share hospital (DSH) payments. The amendment is essentially the President's proposal, which softens the impact on high-DSH states like New Hampshire. The attached table shows the distributional effects.

The main points on the table are:

- New Hampshire's DSH reduction would be nearly four times higher under the Majority's "House Commerce Proposal" than under Green's "Substitute" proposal.
 - This is because, in the year 2002, the Republicans' proposal would reduce high-DSH states 1995 DSH spending by 40%.
- Under the Substitute Proposal, no state gets more than a 4 percent reduction in their total spending as a result of the DSH reductions.

Green's staff suggests that they may get quite a few votes and, if nothing else, will raise the question of the equity of the reductions.

Please call with questions.

Comparison of Effects of DSH Reductions, 2002

(Dollars in millions, fiscal years)

State	House Commerce Proposal		Substitute Proposal	
	\$ 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*	-4695	-3%	-4669	-3%
Alabama	-118	-9%	-58	-4%
Alaska	-2	-1%	-4	-2%
Arizona	-16	-2%	-28	-3%
Arkansas	0	0%	-1	0%
California	-219	-3%	-333	-4%
Colorado	-37	-5%	-32	-4%
Connecticut	-82	-6%	-53	-4%
Delaware	-1	0%	-1	-1%
District of Columbia	-5	-1%	-8	-1%
Florida	-38	-1%	-66	-2%
Georgia	-51	-2%	-89	-4%
Hawaii**	-	-	-	-
Idaho	0	0%	-1	0%
Illinois	-41	-1%	-71	-2%
Indiana	-40	-3%	-54	-4%
Iowa	-2	0%	-3	0%
Kansas	-21	-4%	-18	-3%
Kentucky	-27	-2%	-48	-3%
Louisiana	-352	-12%	-126	-4%
Maine	-42	-7%	-25	-4%
Maryland	-14	-1%	-25	-2%
Massachusetts	-58	-2%	-101	-4%
Michigan	-50	-2%	-87	-3%
Minnesota	-3	0%	-6	0%
Mississippi	-29	-2%	-50	-4%
Missouri	-175	-11%	-69	-4%
Montana	0	0%	0	0%
Nebraska	-1	0%	-2	0%
Nevada	-15	-6%	-10	-4%
New Hampshire	-57	-15%	-16	-4%
New Jersey	-240	-10%	-103	-4%
New Mexico	0	0%	-2	0%
New York	-302	-3%	-502	-4%
North Carolina	-56	-2%	-97	-4%
North Dakota	0	0%	0	0%
Ohio	-76	-2%	-134	-4%
Oklahoma	-3	0%	-6	-1%
Oregon	-4	0%	-7	-1%
Pennsylvania	-106	-3%	-170	-4%
Rhode Island	-12	-2%	-22	-4%
South Carolina	-124	-9%	-59	-4%
South Dakota	0	0%	0	0%
Tennessee**	-	-	-	-
Texas	-383	-7%	-231	-4%
Utah	0	0%	-1	0%
Vermont	-4	-2%	-6	-3%
Virginia	-14	-1%	-24	-2%
Washington	-35	-2%	-61	-4%
West Virginia	-13	-1%	-22	-2%
Wisconsin	0	0%	-2	0%
Wyoming**	-	-	-	-

% 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.

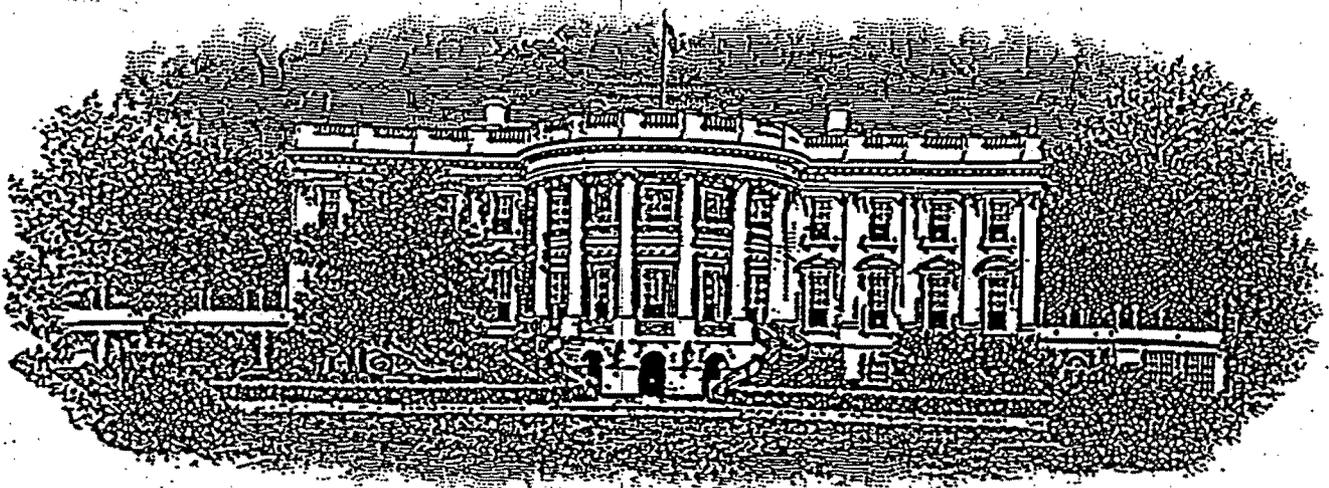
States with less than 1% of spending in DSH are exempt.

Substitute proposal 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

THE WHITE HOUSE



Christopher C. Jennings
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*Industry
Kathy*

Facsimile Transmission Cover Sheet

To: Chris Walker

Fax Number: 456-6221

Telephone Number: 456-7500

Pages (Including Cover): 2

Comments: Brown Letter from Sarah

June 6, 1997

The Honorable Corrine Brown
House of Representatives
1610 Longworth Building
Washington, D.C. 20515

Dear Representative Brown:

Thank you for writing to express your concern about the proposed savings in the Disproportionate Share Hospital payments in the Balanced Budget Agreement. I share your interest in developing the most equitable DSH savings policy possible.

As you know, in response to concerns raised by representatives from Florida and many other states, we dropped the per capita cap policy in the budget agreement. As a result, the Medicaid savings in this agreement have been reduced by over one-third. The savings that currently remain come from administrative flexibility and reducing Disproportionate Share Hospital (DSH) payments.

We are working with states, hospitals, unions, and consumer groups in order to develop the best way to achieve savings in DSH. We appreciate your views on this issue and are entirely open to any further suggestions you might have as well. As we move forward on our balanced budget discussions, we want to work closely with you to assure that these savings are achieved most appropriately.

Thank you again for expressing your views on this important issue.

Sincerely,

President Clinton

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

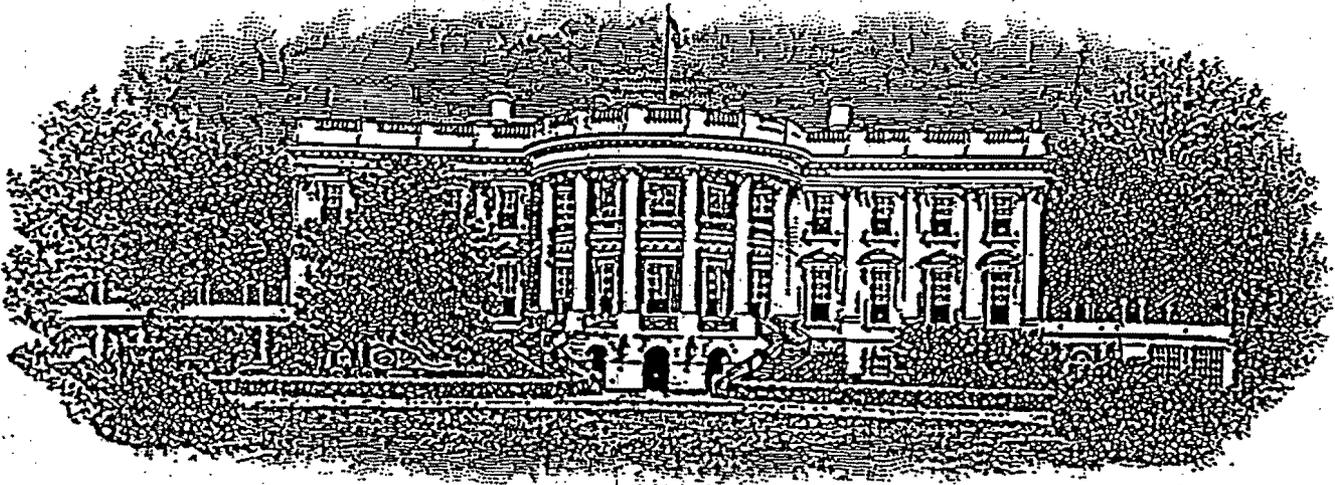
There is bipartisan support behind a series of reforms that help states. These include:

- **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

THE WHITE HOUSE



Christopher C. Jennings
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Facsimile Transmission Cover Sheet

To: Kathy Hudson

Fax Number: (301) 402-0837

Telephone Number: _____

Pages (Including Cover): 12

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CS Jeanne



NATIONAL
ASSOCIATION
OF PUBLIC
HOSPITALS &
HEALTH
SYSTEMS

TO: PLEASE SEE BELOW LIST

FROM: CHRIS BURCH

VIA FAX: TOTAL OF 3 PAGES

NAME:

FAX NUMBER:

PETE WILSON	684-1589
ANN LANGLY	672-5399
SUSAN WHITE	683-0865
TOM JOSEPH	393-2360
KAREN NELSON	225-4099
BRIDGET TAYLOR	225-2525
KEVIN BRENNAN	225-2266
CHRIS JENNINGS	456-7431
DEBBIE CHIANG	690-8168
DON JOHNSON	313-993-8179
BRUCE LESLEY	224-9926
DENNIS SMITH	228-0578
HOWARD COHEN	225-1919
KRISTEN TESTA	

g:\users\naph\leg97\fxcvr30.doc

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PROTECTING SAFETY NET HOSPITALS FROM REDUCTIONS IN MEDICAID DISPROPORTIONATE SHARE HOSPITAL PAYMENTS

May 30, 1997

NATIONAL
ASSOCIATION
OF PUBLIC
HOSPITALS &
HEALTH
SYSTEMS

The National Association of Public Hospitals & Health Systems (NAPH) continues to believe that the level of reductions anticipated for Medicaid Disproportionate Share Hospital (DSH) payments is too high and could seriously jeopardize quality and access to care. If the Congress decides to cut DSH spending as deeply as envisioned in the recent budget agreement, it is *imperative* that the cuts be implemented so that the impact on the highest volume safety net providers can be minimized. These hospitals and health systems have traditionally provided care to Medicaid and uninsured patients at levels far above average. Nearly 90% of the care at NAPH member hospitals is provided to Medicaid, Medicare and uninsured patients. These hospitals also provide a significantly disproportionate volume of care to high risk pregnant women and low income children (including much of the neonatal intensive care available in our nation's urban areas).

For NAPH members, over 40% of the uncompensated care they provide is funded by Medicaid DSH payments. (50% is funded by direct city or county subsidies and 9% by Medicare DSH.) Over the years states have taken advantage of loopholes in the DSH statute to use the funds for a wide variety of other purposes. If the Congress now moves to scale back DSH spending, it is essential that some portion of the remaining funds be directed on a priority basis to those hospitals for whom the program was originally intended.

While we have considered a variety of options in the past, NAPH is now proposing a simple, straightforward way to protect high-volume safety net hospitals from potentially devastating cuts in the DSH program. In light of some recent confusion about NAPH's proposal, it is important to emphasize that this proposal does *not* seek to tell Congress how to allocate DSH cuts among the states. Nor does it propose any limits on states' authority to designate hospitals as disproportionate share hospitals. Rather, it simply requires states to continue to make DSH payments at FY 1995 levels to the priority hospitals.

Priority Use of DSH Funds

States would be required to maintain payments to "priority" DSH hospitals (as defined below) at their FY 1995 levels. These payments to priority hospitals would have to be made from states' DSH allocations first, before funds are spent for any other purposes.

All funds remaining in states' DSH allocations after the priority hospitals are held harmless could be spent for any other purposes consistent with current DSH law. Only in the unlikely event that a state's DSH allocation is insufficient to cover the full cost of maintaining payments to priority DSH hospitals would the state be unable to make payments to other hospitals or for other purposes. In such an event, the hold harmless amount to priority hospitals would equal the total DSH allocation to the state.

This maintenance of effort requirement for priority hospitals would be applied *in the aggregate* to these institutions. In other words, states would be required to maintain overall DSH payments to priority hospitals as a group at the levels paid to them as a group in FY 1995, but would be permitted to reallocate this funding among those hospitals (e.g., in order to comply with hospital-specific DSH limits).

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The amount of priority payments to protected hospitals would increase each year by an amount equal to the rate of growth in the state's overall Medicaid program.

Definition of Priority Hospitals

Eligibility would be limited to hospitals providing the very highest levels of low income care, as measured by their low income utilization rate, or LIUR (defined under current law in Section 1923(b)(3) of the Social Security Act). The LIUR measures the amount of care provided by a hospital to Medicaid and uncompensated patients.

Eligible hospitals would include the following:

- (1) Statewide criteria: Hospitals with a LIUR equal to or greater than one standard deviation above the mean LIUR for all hospitals within the state;
- (2) National floor: Hospitals with a LIUR of, e.g., 30 percent or more; and
- (3) Children's hospitals with either a low income utilization rate meeting the above levels or with a Medicaid utilization rate (as defined in Section 1923(b)(2)) of 20 percent or more.

A national floor (e.g., a LIUR of 25% or 30%) has been proposed by some observers in addition to statewide criteria because in some states, one standard deviation above the mean is higher than that level, and some high-volume hospitals would thus otherwise be omitted. Under this proposal, with both state qualifying criteria and a 30% national floor, the Lewin Group estimates that 377 urban and 363 rural hospitals would qualify.

Other DSH Reforms

In addition to the protections for safety net institutions outlined above, NAPH has also proposed a number of additional reforms to the DSH statute that will serve to conform the program more closely to the realities of today's healthcare marketplace. For example, DSH funding should be paid directly from the states to hospitals, rather than incorporated into rates paid to Medicaid managed care plans, and states should be required to include all Medicaid managed care utilization in the distribution formula.

For further information on NAPH's DSH proposal, contact Julie Raccchio at (202) 347-0066 or Chris Burch or Lynne Fagnani at (202) 408-0223.

MEMORANDUM

TO: Don Gips
cc. Toby Donefield
FROM: Chris Jennings
RE: DISPROPORTIONATE SHARE HOSPITAL (DSH) AMENDMENT
DATE: June 19

Yesterday, we got a call from the House Budget Committee staff. The Chairman, Representative Spratt from South Carolina, is concerned about how the DSH reductions are being taken in both the House and Senate Committees. South Carolina is a high-DSH state; he also has Charlie Bass from New Hampshire on the Budget Committee. He is thinking about floor amendments and asked for technical assistance. Attached is the table that we sent to him.

Given the very different formulas in the House and Senate, there will certainly be discussion of how DSH reductions are taken in conference. In addition, there may well be some amendment on the House or Senate floors regarding this issue. We will keep you apprised of developments so that the Vice President can weigh in on the appropriate vehicle.

Lastly, regardless of what actions are taken in Congress on the DSH formula, the New Hampshire financial situation looks bleak. The vast majority of Members are unsympathetic and we are having difficult time obtaining sufficient support.

We can discuss this further in our upcoming meeting.

Comparison of Effects of DSH Reductions, 2002

(Dollars in millions; fiscal years)

DRAFT

State	House Commerce Proposal			Senate Finance Proposal			Proposal Like President's		
	\$ Change in DSH from 1995 DSH	% Change in DSH from 1995 DSH	% Change in DSH from 1995 Total	\$ Change in DSH from 1995 DSH	% Change in DSH from 1995 DSH	% Change in DSH from 1995 Total	\$ Change in DSH from 1995 DSH	% Change in DSH from 1995 DSH	% Change in DSH from 1995 Total
National*	-4695	-28%	-3%	-4358	-24%	-3%	-4669	-28%	-3%
Alabama	-118	-40%	-9%	-61	-21%	-4%	-58	-20%	-4%
Alaska	-2	-20%	-1%	-2	-15%	-1%	-4	-35%	-2%
Arizona	-16	-20%	-2%	-12	-15%	-1%	-28	-35%	-3%
Arkansas	0	0%	0%	0	0%	0%	-1	-35%	0%
California	-219	-20%	-3%	-201	-18%	-3%	-333	-30%	-4%
Colorado	-37	-40%	-5%	-19	-20%	-2%	-32	-35%	-4%
Connecticut	-82	-40%	-6%	-83	-41%	-7%	-53	-26%	-4%
Delaware	-1	-20%	0%	0	0%	0%	-1	-35%	-1%
District of Columbia	-5	-20%	-1%	0	0%	0%	-8	-35%	-1%
Florida	-38	-20%	-1%	-28	-15%	-1%	-66	-35%	-2%
Georgia	-51	-20%	-2%	-38	-15%	-2%	-89	-35%	-4%
Hawaii**	-	-	-	0	0%	0%	-	-	-
Idaho	0	0%	0%	0	0%	0%	-1	-35%	0%
Illinois	-41	-20%	-1%	-30	-15%	-1%	-71	-35%	-2%
Indiana	-40	-20%	-3%	-30	-15%	-2%	-54	-27%	-4%
Iowa	-2	-20%	0%	0	0%	0%	-3	-35%	0%
Kansas	-21	-40%	-4%	-26	-50%	-5%	-18	-35%	-3%
Kentucky	-27	-20%	-2%	-20	-15%	-1%	-48	-35%	-3%
Louisiana	-352	-40%	-12%	-249	-28%	-8%	-126	-14%	-4%
Maine	-42	-40%	-7%	-43	-41%	-7%	-25	-23%	-4%
Maryland	-14	-20%	-1%	-11	-15%	-1%	-25	-35%	-2%
Massachusetts	-58	-20%	-2%	-43	-15%	-2%	-101	-35%	-4%
Michigan	-50	-20%	-2%	-37	-15%	-1%	-87	-35%	-3%
Minnesota	-3	-20%	0%	0	0%	0%	-6	-35%	0%
Mississippi	-29	-20%	-2%	-22	-15%	-2%	-50	-35%	-4%
Missouri	-175	-40%	-11%	-187	-43%	-11%	-69	-16%	-4%
Montana	0	0%	0%	0	0%	0%	0	-35%	0%
Nebraska	-1	-20%	0%	0	0%	0%	-2	-35%	0%
Nevada	-15	-40%	-6%	0	0%	0%	-10	-26%	-4%
New Hampshire	-57	-40%	-15%	-107	-74%	-29%	-16	-11%	-4%
New Jersey	-240	-40%	-10%	-263	-44%	-11%	-103	-17%	-4%
New Mexico	0	0%	0%	0	0%	0%	-2	-35%	0%
New York	-302	-20%	-3%	-227	-15%	-2%	-502	-33%	-4%
North Carolina	-56	-20%	-2%	-42	-15%	-2%	-97	-35%	-4%
North Dakota	0	0%	0%	0	0%	0%	0	-35%	0%
Ohio	-76	-20%	-2%	-57	-15%	-2%	-134	-35%	-4%
Oklahoma	-3	-20%	0%	0	0%	0%	-6	-35%	-1%
Oregon	-4	-20%	0%	0	0%	0%	-7	-35%	-1%
Pennsylvania	-106	-20%	-3%	-79	-15%	-2%	-170	-32%	-4%
Rhode Island	-12	-20%	-2%	-9	-15%	-2%	-22	-35%	-4%
South Carolina	-124	-40%	-9%	-104	-33%	-7%	-59	-19%	-4%
South Dakota	0	0%	0%	0	0%	0%	0	-35%	0%
Tennessee**	-	-	-	0	0%	0%	-	-	-
Texas	-383	-40%	-7%	-335	-35%	-6%	-231	-24%	-4%
Utah	0	0%	0%	0	0%	0%	-1	-35%	0%
Vermont	-4	-20%	-2%	-3	-15%	-1%	-6	-35%	-3%
Virginia	-14	-20%	-1%	-10	-15%	-1%	-24	-35%	-2%
Washington	-35	-20%	-2%	-26	-15%	-2%	-61	-35%	-4%
West Virginia	-13	-20%	-1%	-10	-15%	-1%	-22	-35%	-2%
Wisconsin	0	0%	0%	0	0%	0%	-2	-35%	0%
Wyoming**	-	-	-	0	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 < 1% exempt

Draft 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

ACHIEVING SUBSTANTIAL SAVINGS IN THE MEDICAID DISPROPORTIONATE SHARE HOSPITAL PROGRAM

*A Discussion Paper Prepared by
The National Association of Public Hospitals*

The Medicaid disproportionate share hospital (DSH) adjustment (§ 1923 of the Social Security Act) was established in 1981 for the purpose of providing additional reimbursement to hospitals serving disproportionate numbers of low income and Medicaid patients. Throughout the early and mid-1980s the program was relatively small, but in the late 1980s and early 1990s, DSH payments grew exponentially due primarily to states' use of provider revenues to draw down large federal matching payments. As of FY 1993, DSH payments totaled \$16.7 billion. In 1991 and again in 1993 Congress limited matching of provider funds and capped future growth in the program.

Despite reports that states have misused DSH funds or inappropriately drawn down federal payments, DSH programs have nevertheless provided crucial funding for hospitals that truly do serve a disproportionate share of indigent and Medicaid patients. This funding has enabled these hospitals to be able to continue to act as an institutional safety net for those with no other access to health care, and to provide highly specialized services -- such as trauma care, burn units, neonatal intensive care and emergency psychiatric services -- that are relied upon by entire communities. As Congress considers further cuts in the Medicaid program, it is more important than ever that this safety net be preserved.

The National Association of Public Hospitals believes that it is possible to achieve substantial savings (\$40 billion over five years) in the DSH program while remaining faithful to Congress' original intent to provide supplemental funding for high volume Medicaid and low income providers. To do so, DSH adjustments should be restructured as a purely federal payment targeted exclusively on the highest volume providers of care to the poor. The following steps could be taken to achieve this goal:

- Modify § 1923 of the Social Security Act (copy of current statute is attached) so that eligibility for DSH payments is limited to:
 - 1) hospitals that have a low income utilization rate (as defined in § 1923(b)(3)) of 25% or more; and
 - 2) children's hospitals with either a low income utilization rate of 25% or more or a Medicaid utilization rate (as currently defined in § 1923(b)(2)) of 25% or more.

Under current law, states are permitted to designate ANY hospital as a DSH facility as long as it has a Medicaid utilization rate of 1 percent or more. Some states have gone so far as to designate ALL hospitals in the state as DSH providers.

Chris Purch 408-0223



- Only those hospitals that meet this criteria would be eligible for DSH payments. States would no longer have the flexibility to designate additional hospitals as DSH providers.
- Federalize DSH payments. Elimination of the state share of the program would not only relieve the burden on states, but it would also eliminate the loopholes that have allowed states to claim large federal payments without putting up real state dollars as match. (See General Accounting Office, Medicaid: States Use Illusory Approaches to Shift Program Costs to Federal Government, GAO/HEHS-94-133, August 1994.) A purely federal program would acknowledge this reality, and ensure that on a net basis the dollars are distributed where they are most needed.
- The amount of funds available for DSH payments in each state would be equal to the sum of the federal share of all FY 1995 DSH payments to hospitals eligible under the new criteria in the state.
- The targeted DSH funds would go to states to be distributed among eligible hospitals as the state sees fit. This would allow states to adapt DSH payment methodologies to reflect changing utilization patterns. The money could not be used for any other purpose than making DSH payments to eligible hospitals.
- NAPH estimates that \$4 billion per year would be sufficient to fund a properly targeted DSH program, as compared to over \$16 billion in current annual DSH payments. This amount represents approximately one-third of the amount currently spent by the federal government on DSH payments and less than one-quarter of total (state and federal) DSH spending.
- Depending on whose numbers you believe, the federal government would save approximately \$4-8 billion per year, or \$20 billion over five years.
- Because so many states are implementing Medicaid managed care programs on a broader and broader scale, Congress should require that Medicaid managed care utilization and revenues be counted both in determining eligibility for DSH payments and in determining the payment methodology within states.
- In states with section 1115 waiver programs, states would be required to ensure that hospitals that meet the eligibility criteria outlined above receive additional compensation -- either through supplemental pool payments, enhanced capitation payments or otherwise -- to compensate them for the additional burdens of providing large volumes of low income care.
- Intergovernmental transfers of DSH funds would be prohibited, to ensure that the money is used for the hospitals, as originally intended by Congress, and not "recaptured" by the state for other uses.

1988 Amendments:

Section 8433(a) of the "Technical and Miscellaneous Revenue Act of 1988," effective November 10, 1988, applicable to any proceeding in which there has not yet been a final determination by the Secretary (as defined for purposes of judicial review) as of November 10, 1988:

Added "(including failure to provide active treatment)" after "residents" in subsection (a).

Added ", and to provide active treatment for," after "health and safety of" in subsection (c)(5).

Substituted "by January 1, 1990" for "within 3 years after the effective date of final regulations implementing this section" in subsection (f).

1987 Amendments:

Section 4211(a)(2) and (3) of the "Omnibus Budget Reconciliation Act of 1987," as corrected by section 411(l)(6)(E) of the "OBRA Technical Corrections" subtitle of the "Medicare Cata-

strophic Coverage Act of 1988," effective as provided by section 4214 of this Act at ¶ 17,798DD, redesignated section 1919 as section 1922, inserted it after section 1921, and added new section 1919 after section 1918.

1986 Amendments:

Section 1919 was added by section 9516(a) of the "Consolidated Omnibus Budget Reconciliation Act of 1985," effective April 7, 1986.

History:

Sec. 9516(a) of the "Consolidated Omnibus Budget Reconciliation Act of 1985" (P.L. 99-272); as amended by sec. 4211(a)(2) and (3) of the "Omnibus Budget Reconciliation Act of 1987" (P.L. 100-203), sec. 411(l)(6)(E) of the "Medicare Catastrophic Coverage Act of 1988" (P.L. 100-360), sec. 8433 of the "Technical and Miscellaneous Revenue Act of 1988" (P.L. 100-647).

[¶ 17,409] ADJUSTMENT IN PAYMENT FOR INPATIENT HOSPITAL SERVICES FURNISHED BY DISPROPORTIONATE SHARE HOSPITALS.

[42 U.S.C. § 1396r-4]

Sec. 1923. (a) IMPLEMENTATION OF REQUIREMENT.—

(1) A State plan under this title shall not be considered to meet the requirement of section 1902(a)(13)(A) (insofar as it requires payments to hospitals to take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs), as of July 1, 1988, unless the State has submitted to the Secretary, by not later than such date, an amendment to such plan that—

(A) specifically defines the hospitals so described (and includes in such definition any disproportionate share hospital described in subsection (b)(1) which meets the requirements of subsection (d)), and

(B) provides, effective for inpatient hospital services provided not later than July 1, 1988, for an appropriate increase in the rate or amount of payment for such services provided by such hospitals, consistent with subsection (c).

(2)(A) In order to be considered to have met such requirement of section 1902(a)(13)(A) as of July 1, 1989, the State must submit to the Secretary by not later than April 1, 1989, the State plan amendment described in paragraph (1), consistent with subsection (c), effective for inpatient hospital services provided on or after July 1, 1989.

(B) In order to be considered to have met such requirement of section 1902(a)(13)(A) as of July 1, 1990, the State must submit to the Secretary by not later than April 1, 1990, the State plan amendment described in paragraph (1), consistent with subsections (c) and (f), effective for inpatient services provided on or after July 1, 1990.

(C) If a State plan under this title provides for payments for inpatient hospital services on a prospective basis (whether per diem, per case, or otherwise), in order for the plan to be considered to have met such requirement of section 1902(a)(13)(A) as of July 1, 1989, the State must submit to the Secretary by not later than April 1, 1989, a State plan amendment that provides, in the case of hospitals defined by the State as disproportionate share hospitals under paragraph (1)(A), for an outlier adjustment in payment amounts for medically necessary inpatient hospital services provided on or after July 1, 1989, involving exceptionally high costs or exceptionally long lengths of stay for individuals under one year of age.

(3) The Secretary shall, not later than 90 days after the date a State submits an amendment under this subsection, review each such amendment for compliance with such requirement and by such date shall approve or disapprove each such amendment. If the

Secretary disapproves such an amendment, the State shall immediately submit a revised amendment which meets such requirement.

(4) The requirement of this subsection may not be waived under section 1915(b)(4).

1993 Amendments:

Section 13621(a)(1)(A) of the "Omnibus Budget Reconciliation Act of 1993," effective as provided in section 13621(a)(2) of these Amendments at ¶ 17,810, deleted "requirement" in subsection (a)(1)(A) and substituted "requirements".

1991 Amendments:

Section 3(b)(2)(A)(i) of the "Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991," effective as provided in section 3(e) of these Amendments at ¶ 17,806, substituted "subsections (c) and (f)," for "subsection (c)," in subsection (a)(2)(B).

1988 Amendments:

Section 302(b)(2) of the "Medicare Catastrophic Coverage Act of 1988," effective July 1, 1988, added new subparagraph (C) to subsection (a)(2).

1987 Amendments:

Section 4112 of the "Omnibus Budget Reconciliation Act of 1987," as corrected by section

411(k)(6) of the "OBRA Technical Corrections" subtitle of the "Medicare Catastrophic Coverage Act of 1988," and section 608(d)(15)(C) (OBRA 1987 technical corrections subsection) of the "Family Support Act of 1988," effective December 22, 1987, added section 1923(a).

History:

Sec. 4112 of the "Omnibus Budget Reconciliation Act of 1987" (P.L. 100-203), as amended by secs. 302(b)(2) and 411(k)(6) of the "Medicare Catastrophic Coverage Act of 1988" (P.L. 100-360), sec. 608(d)(15)(C) (OBRA 1987 technical corrections subsection) of the "Family Support Act of 1988" (P.L. 100-485), and sec. 3(b)(2)(A)(i) of the "Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991" (P.L. 102-234), sec. 13621(a)(1)(A) of the "Omnibus Budget Reconciliation Act of 1993" (P.L. 103-66).

[¶ 17,410] [Hospitals Deemed Disproportionate Share]

[42 U.S.C. § 1396r-4]

Sec. 1923. (b) HOSPITALS DEEMED DISPROPORTIONATE SHARE.—

(1) For purposes of subsection (a)(1), a hospital which meets the requirements of subsection (d) is deemed to be a disproportionate share hospital if—

(A) the hospital's medicaid inpatient utilization rate (as defined in paragraph (2)) is at least one standard deviation above the mean medicaid inpatient utilization rate for hospitals receiving medicaid payments in the State; or

(B) the hospital's low-income utilization rate (as defined in paragraph (3)) exceeds 25 percent.

(2) For purposes of paragraph (1)(A), the term "medicaid inpatient utilization rate" means, for a hospital, a fraction (expressed as a percentage), the numerator of which is the hospital's number of inpatient days attributable to patients who (for such days) were eligible for medical assistance under a State plan approved under this title in a period, and the denominator of which is the total number of the hospital's inpatient days in that period. In this paragraph, the term "inpatient day" includes each day in which an individual (including a newborn) is an inpatient in the hospital, whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere.

(3) For purposes of paragraph (1)(B), the term "low-income utilization rate" means, for a hospital, the sum of—

(A) the fraction (expressed as a percentage)—

(i) the numerator of which is the sum (for a period) of (I) the total revenues paid the hospital for patient services under a State plan under this title and (II) the amount of the cash subsidies for patient services received directly from State and local governments, and

(ii) the denominator of which is the total amount of revenues of the hospital for patient services (including the amount of such cash subsidies) in the period; and

(B) a fraction (expressed as a percentage)—

(i) the numerator of which is the total amount of the hospital's charge for inpatient hospital services which are attributable to charity care in a period less the portion of any cash subsidies described in clause (i)(II) of subparagraph (A) in the period reasonably attributable to inpatient hospital services, and

(ii) the denominator of which is the total amount of the hospital's charges for inpatient hospital services in the hospital in the period.

The numerator under subparagraph (B)(i) shall not include contractual allowances and discounts (other than for indigent patients not eligible for medical assistance under a State plan approved under this title).

(4) The Secretary may not restrict a State's authority to designate hospitals as disproportionate share hospitals under this section. The previous sentence shall not be construed to affect the authority of the Secretary to reduce payments pursuant to section 1903(w)(1)(A)(iii) if the Secretary determines that, as a result of such designations, there is in effect a hold harmless provision described in section 1903(w)(4).

1993 Amendments:

Section 13621(a)(1)(B) of the "Omnibus Budget Reconciliation Act of 1993," effective as provided in section 13621(a)(2) of these Amendments at ¶ 17,810, deleted "requirement" in subsection (b)(1) and substituted "requirements".

1991 Amendments:

Section 3(c) of the "Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991," effective as provided in section 3(e) of these Amendments at ¶ 17,806, added new paragraph (4).

1990 Amendments:

Section 4702 of the "Omnibus Budget Reconciliation Act of 1990," effective July 1, 1990, added the sentence beginning "In this paragraph, the term 'inpatient day' includes . . ." to the end of paragraph (2).

1987 Amendments:

Section 4112 of the "Omnibus Budget Reconciliation Act of 1987," as corrected by section

411(k)(6) of the "OBRA Technical Corrections" subtitle of the "Medicare Catastrophic Coverage Act of 1988" and section 608(d)(26)(D) (technical corrections subsection) of the "Family Support Act of 1988," effective December 22, 1987, added section 1923(b).

History:

Sec. 4112 of the "Omnibus Budget Reconciliation Act of 1987" (P.L. 100-203), as amended by sec. 411(k)(6) of the "Medicare Catastrophic Coverage Act of 1988" (P.L. 100-360), sec. 608(d)(26)(D) of the "Family Support Act of 1988" (P.L. 100-485), sec. 4702 of the "Omnibus Budget Reconciliation Act of 1990" (P.L. 101-508), and sec. 3(c) of the "Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991" (P.L. 102-234), sec. 13621(a)(1)(B) of the "Omnibus Budget Reconciliation Act of 1993" (P.L. 103-66).

[¶ 17,411]

[Payment Adjustment]

[42 U.S.C. § 1396r-4]

Sec. 1923. (c) PAYMENT ADJUSTMENT.—Subject to subsections (f) and (g) in order to be consistent with this subsection, a payment adjustment for a disproportionate share hospital must either—

(1) be in an amount equal to at least the product of (A) the amount paid under the State plan to the hospital for operating costs for inpatient hospital services (of the kind described in section 1886(a)(4)), and (B) the hospital's disproportionate share adjustment percentage (established under section 1886(d)(5)(F)(iv));

(2) provide for a minimum specified additional payment amount (or increased percentage payment) and (without regard to whether the hospital is described in subparagraph (A) or (B) of subsection (b)(1)) for an increase in such a payment amount (or percentage payment) in proportion to the percentage by which the hospital's medicaid utilization rate (as defined in subsection (b)(2)) exceeds one standard deviation above the mean medicaid inpatient utilization rate for hospitals receiving medicaid payments in the State or the hospital's low-income utilization rate (as defined in paragraph (b)(3)); or

(3) provide for a minimum specified additional payment amount (or increased percentage payment) that varies according to type of hospital under a methodology that—

[The next page is 7289-7.]

(A) applies equally to all hospitals of each type; and

(B) results in an adjustment for each type of hospital that is reasonably related to the costs, volume, or proportion of services provided to patients eligible for medical assistance under a State plan approved under this title or to low-income patients.

except that, for purposes of paragraphs (1)(B) and (2)(A) of subsection (a), the payment adjustment for a disproportionate share hospital is consistent with this subsection if the appropriate increase in the rate or amount of payment is equal to at least one-third of the increase otherwise applicable under this subsection (in the case of such paragraph (1)(B)) and at least two-thirds of such increase (in the case of such paragraph (2)(A)). In the case of a hospital described in subsection (d)(2)(A)(i) (relating to children's hospitals), in computing the hospital's disproportionate share adjustment percentage for purposes of paragraph (1)(B) of this subsection, the disproportionate patient percentage (defined in section 1886(d)(5)(F)(vi)) shall be computed by substituting for the fraction described in subclause (I) of such section the fraction described in subclause (II) of that section. If a State elects in a State plan amendment under subsection (a) to provide the payment adjustment described in paragraph (2), the State must include in the amendment a detailed description of the specific methodology to be used in determining the specified additional payment amount (or increased percentage payment) to be made to each hospital qualifying for such a payment adjustment and must publish at least annually the name of each hospital qualifying for such a payment adjustment and the amount of such payment adjustment made for each such hospital.

1993 Amendments:

Section 13621(b)(2)(A) of the "Omnibus Budget Reconciliation Act of 1993," effective as provided in section 13621(b)(3) of these Amendments at § 17,810, deleted "subsection (f)" and substituted "subsections (f) and (g)" at the beginning of subsection (c).

1991 Amendments:

Section 3(b)(2)(A)(ii) of the "Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991," effective as provided in section 3(e) of these Amendments at § 17,806, substituted "Subject to subsection (f), in order" for "In order" at the beginning of subsection (c).

1990 Amendments:

Section 4703(c) of the "Omnibus Budget Reconciliation Act of 1990," effective as if included in the enactment of section 412(a)(2) of the "Omnibus Budget Reconciliation Act of 1987," inserted "or the hospital's low-income utilization rate (as defined in paragraph (b)(3))" after "State" in paragraph (2).

Section 4703(a) of the "Omnibus Budget Reconciliation Act of 1990," effective as if included in the enactment of section 412(a)(2) of the "Omnibus Budget Reconciliation Act of 1987."

Deleted "or" from the end of paragraph (1).

Added "or" to the end of paragraph (2).

Added new paragraph (3).

1987 Amendments:

Section 4112 of the "Omnibus Budget Reconciliation Act of 1987," as corrected by section 411(k)(6)(A) of the "OBRA Technical Corrections" subtitle of the "Medicare Catastrophic Coverage Act of 1988" and sections 608(d)(26)(A) and (E) (technical corrections subsection) of the "Family Support Act of 1988," effective December 22, 1987, added section 1923(c).

History:

Sec. 4112 of the "Omnibus Budget Reconciliation Act of 1987" (P.L. 100-203), as amended by sec. 411(k)(6)(A) of the "Medicare Catastrophic Coverage Act of 1988" (P.L. 100-360) and secs. 608(d)(26)(A) and (E) of the "Family Support Act of 1988" (P.L. 100-485), sec. 4703(a) and (c) of the "Omnibus Budget Reconciliation Act of 1990" (P.L. 101-508), and sec. 3(b)(2)(A)(ii) of the "Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991" (P.L. 102-234), sec. 13621(b)(2)(A) of the "Omnibus Budget Reconciliation Act of 1993" (P.L. 103-66).

[§ 17.412] [Requirement to Qualify as Disproportionate Share Hospital]

[42 U.S.C. § 1396r-4]

Sec. 1923. (d) REQUIREMENTS TO QUALIFY AS DISPROPORTIONATE SHARE HOSPITAL.—

(1) Except as provided in paragraph (2), no hospital may be defined or deemed as a disproportionate share hospital under a State plan under this title or under subsection (b) of this section unless the hospital has at least 2 obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to individuals who are entitled to medical assistance for such services under such State plan.

(2)(A) Paragraph (1) shall not apply to a hospital—

- (i) the inpatients of which are predominantly individuals under 18 years of age; or
- (ii) which does not offer nonemergency obstetric services to the general population as of the date of the enactment of this Act.

(B) In the case of a hospital located in a rural area (as defined for purposes of section 1886 in paragraph (1) the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

(3) No hospital may be defined or deemed as a disproportionate share hospital under a State plan under this title or under subsection (b) or (e) of this section unless the hospital has a medicaid inpatient utilization rate (as defined in subsection (b)(2)) of not less than 1 percent.

1993 Amendments:

Section 13621(a)(1)(C) of the "Omnibus Budget Reconciliation Act of 1993," effective as provided in section 13621(a)(2) of these Amendments at ¶ 17,810, deleted "REQUIREMENT" in the heading to subsection (d) and substituted "REQUIREMENTS".

Section 13621(a)(1)(D) of the "Omnibus Budget Reconciliation Act of 1993," effective as provided in section 13621(a)(2) of these Amendments at ¶ 17,810, inserted new paragraph (3) at the end of subsection (d).

1987 Amendments:

Section 4112 of the "Omnibus Budget Reconciliation Act of 1987," as corrected by section

411(k)(6)(B) of the "OBRA Technical Corrections" subtitle of the "Medicare Catastrophic Coverage Act of 1988" and section 608(d)(26)(F) (technical corrections subsection) of the "Family Support Act of 1988," effective December 22, 1987, added section 1923(d).

History:

Sec. 4112 of the "Omnibus Budget Reconciliation Act of 1987" (P.L. 100-203), as amended by sec. 411(k)(6)(B) of the "Medicare Catastrophic Coverage Act of 1988" (P.L. 100-360) and sec. 608(d)(26)(F) of the "Family Support Act of 1988" (P.L. 100-485), sec. 13621(a)(1)(C) and (D) of the "Omnibus Budget Reconciliation Act of 1993" (P.L. 103-66).

[¶ 17,413]

[Special Rule]

[42 U.S.C. § 1396r-4]

Sec. 1923. (e) SPECIAL RULE.—(1) A State plan shall be considered to meet the requirement of section 1902(a)(13)(A) (insofar as it requires payments to hospitals to take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs) without regard to the requirement of subsection (a) if (A)(i) the plan provided for payment adjustments based on a pooling arrangement involving a majority of the hospitals participating under the plan for disproportionate share hospitals as of January 1, 1984, or (ii) the plan as of January 1, 1987, provided for payment adjustments based on a statewide pooling arrangement involving all acute care hospitals and the arrangement provides for reimbursement of the total amount of uncompensated care provided by each participating hospital, (B) the aggregate amount of the payment adjustments under the plan for such hospitals is not less than the aggregate amount of such adjustments otherwise required to be made under such subsection, and (C) the plan meets the requirement of subsection (d)(3) and such payment adjustments are made consistent with the last sentence of subsection (c).

(2) In the case of a State that used a health insuring organization before January 1, 1986, to administer a portion of its plan on a state-wide basis, beginning on July 1, 1988—

(A) the requirements of subsections (b) and (c) (other than the last sentence of subsection (c)) shall not apply if the aggregate amount of the payment adjustments under the plan for disproportionate share hospitals (as defined under the State plan) is not less than the aggregate amount of payment adjustments otherwise required to be made if such subsections applied.

(B) subsection (d)(2)(B) shall apply to hospitals located in urban areas, as well as in rural areas.

(C) subsection (d)(3) shall apply, and

(D) subsection (g) shall apply.

1993 Amendments:

Section 13621(a)(1)(E) of the "Omnibus Budget Reconciliation Act of 1993," effective as provided in section 13621(a)(2) of these Amendments at ¶ 17,810, in subsection (e)(1):

Deleted "and" before "(B)".

Inserted before the period at the end of "and (C) the plan meets the requirement of subsection (d)(3) and such payment adjustments are made consistent with the last sentence of subsection (c)".

Section 13621(a)(1)(F) of the "Omnibus Budget Reconciliation Act of 1993," effective as provided in section 13621(a)(2) of these Amendments at ¶ 17,810, in subsection (e)(2):

Inserted "(other than the last sentence of subsection (c))" after "(c)" in subparagraph (A).

Deleted "and" at the end of subparagraph (A).

Deleted the period at the end of subparagraph (B) and inserted ", and".

Added at the end new subparagraph (C).

Section 13621(b)(2)(B) of the "Omnibus Budget Reconciliation Act of 1993," effective as provided in section 13621(b)(3) of these Amendments at ¶ 17,810, in subsection (e)(2) (as amended by subsection (a)(1)(F)):

Deleted "and" at the end of subparagraph (B).

Deleted the period at the end of subparagraph (C) and inserted ", and".

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Added at the end new subparagraph (D).

1990 Amendments:

Prior to amendment by section 4703(b) of the "Omnibus Budget Reconciliation Act of 1990," effective as if included in the enactment of section 412(a)(2) of the "Omnibus Budget Reconciliation Act of 1987," the introductory matter in paragraph (2) read as follows:

"(2) In the case of a State that used a health insuring organization before January 1, 1986, to administer a portion of its plan on a state-wide basis, during the 3-year period beginning on July 1, 1988—"

1989 Amendments:

Section 6411(c) of the "Omnibus Budget Reconciliation Act of 1989," effective December 19, 1989:

Added "(A)(i)" after "without regard to the requirement of subsection (a) if".

Added "or (ii) the plan as of January 1, 1987, provided for payment adjustments . . . provided by each participating hospital, and (B)" after "January 1, 1984," in subsection (e)(1).

1987 Amendments:

Section 4112 of the "Omnibus Budget Reconciliation Act of 1987," as corrected by section 411(k)(6) of the "OBRA Technical Corrections" subtitle of the "Medicare Catastrophic Coverage Act of 1988" and section 608(d)(26)(C) (technical corrections subsection) of the "Family Support

§ 1923(e) ¶ 17,413

Act of 1988," effective December 22, 1987, added section 1923(e).

History:

Sec. 4112 of the "Omnibus Budget Reconciliation Act of 1987" (P.L. 100-203), as amended by sec. 411(k)(6) of the "Medicare Catastrophic Coverage Act of 1988" (P.L. 100-360) and sec. 608(d)(26)(C) of the "Family Support Act of

1988" (P.L. 100-485), sec. 6411(c) of the "Omnibus Budget Reconciliation Act of 1989" (P.L. 101-239), sec. 4703(b) of the "Omnibus Budget Reconciliation Act of 1990" (P.L. 101-508), secs. 13621(a)(1)(E) and (F) and 13621(b)(2)(B) of the "Omnibus Budget Reconciliation Act of 1993" (P.L. 103-66).

[§ 17,413A] [Restrictions on Aggregate Payment Adjustments]

[42 U.S.C. § 1396r-4]

Sec. 1923. (f) DENIAL OF FEDERAL FINANCIAL PARTICIPATION FOR PAYMENTS IN EXCESS OF CERTAIN LIMITS.—

(1) IN GENERAL.—

(A) APPLICATION OF STATE-SPECIFIC LIMITS.—Except as provided in subparagraph (D), payment under section 1903(a) shall not be made with respect to any payment adjustment made under this section for hospitals in a State (as defined in paragraph (4)(B)) for quarters—

(i) in fiscal year 1992 (beginning on or after January 1, 1992), unless—

(I) the payment adjustments are made—

(a) in accordance with the State plan in effect or amendments submitted to the Secretary by September 30, 1991,

(b) in accordance with the State plan in effect or amendments submitted to the Secretary by November 26, 1991, or modification thereof, if the amendment designates only disproportionate share hospitals with a medicaid or low-income utilization percentage at or above the Statewide arithmetic mean, or

(c) in accordance with a payment methodology which was established and in effect as of September 30, 1991, or in accordance with legislation or regulations enacted or adopted as of such date; or

(II) the payment adjustments are the minimum adjustments required in order to meet the requirements of subsection (c)(1); or

(ii) in a subsequent fiscal year, to the extent that the total of such payment adjustments exceeds the State disproportionate share hospital (in this subsection referred to as 'DSH') allotment for the year (as specified in paragraph (2)).

(B) NATIONAL DSH PAYMENT LIMIT.—The national DSH payment limit for a fiscal year is equal to 12 percent of the total amount of expenditures under State plans under this title for medical assistance during the fiscal year.

(C) PUBLICATION OF STATE DSH ALLOTMENTS AND NATIONAL DSH PAYMENT LIMIT.—Before the beginning of each fiscal year (beginning with fiscal year 1993), the Secretary shall, consistent with section 1903(d), estimate and publish—

(i) the national DSH payment limit for the fiscal year, and

(ii) the State DSH allotment for each State for the year.

(D) CONDITIONAL EXCEPTION FOR CERTAIN STATES.—Subject to subparagraph (E), beginning with payments for quarters beginning on or after January 1, 1996, and at the option of a State, subparagraph (A) shall not apply in the case of a State which defines a hospital as a disproportionate share hospital under subsection (a)(1) only if the hospital meets any of the following requirements:

(i) The hospital's medicaid inpatient utilization rate (as defined in subsection (b)(2)) is at or above the mean medicaid inpatient utilization rate for all hospitals in the State.

(ii) The hospital's low-income utilization rate (as defined in subsection (b)(3)) is at or above the mean low-income utilization rate for all hospitals in the State.

(iii) The number of inpatient days of the hospital attributable to patients who (for such days) were eligible for medical assistance under the State plan is equal to at least 1 percent of the total number of such days for all hospitals in the State.

(iv) The hospital meets such alternative requirements as the Secretary may establish by regulation, taking into account the special circumstances of children's hospitals, hospitals located in rural areas, and sole community hospitals.

(E) **CONDITION FOR OPTION.**—The option specified in subparagraph (D) shall not apply for payments for a quarter beginning before the date of enactment of legislation establishing a limit on payment adjustments under this section which would apply in the case of a state exercising such option.

(2) DETERMINATION OF STATE DSH ALLOTMENTS.—

(A) **IN GENERAL.**—Subject to subparagraph (B), the State DSH allotment for a fiscal year is equal to the State DSH allotment for the previous fiscal year (or, for fiscal year 1993, the State base allotment as defined in paragraph (4)(C)), increased by—

(i) the State growth factor (as defined in paragraph (4)(E)) for the fiscal year, and

(ii) the State supplemental amount for the fiscal year (as determined under paragraph (3)).

(B) **EXCEPTIONS.**—

(i) **LIMIT TO 12 PERCENT OR BASE ALLOTMENT.**—A State DSH allotment under subparagraph (A) for a fiscal year shall not exceed 12 percent of the total amount of expenditures under the State plan for medical assistance during the fiscal year, except that, in the case of a high DSH State (as defined in paragraph (4)(A)), the State DSH allotment shall equal the State based allotment.

(ii) **EXCEPTION FOR MINIMUM REQUIRED ADJUSTMENT.**—No State DSH allotment shall be less than the minimum amount of payment adjustments the State is required to make in the fiscal year to meet the requirements of subsection (c)(1).

(3) **STATE SUPPLEMENTAL AMOUNTS.**—The Secretary shall determine a supplemental amount for each State that is not a high DSH State for a fiscal year as follows:

(A) **DETERMINATION OF REDISTRIBUTION POOL.**—The Secretary shall subtract from the national DSH payment limit (specified in paragraph (1)(B)) for the fiscal year the following:

(i) the total of the State base allotments for high DSH States;

(ii) the total of State DSH allotments for the previous fiscal year (or, in the case of fiscal year 1993, the total of State base allotments) for all States other than high DSH States;

(iii) the total of the State growth amounts for all States other than high DSH States for the fiscal years; and

(iv) the total additions to State DSH allotments the Secretary estimates will be attributable to paragraph (2)(B)(ii).

(B) **DISTRIBUTION OF POOL BASED ON TOTAL MEDICAID EXPENDITURES FOR MEDICAL ASSISTANCE.**—The supplemental amount for a State for a fiscal year is equal to the lesser of—

(i) the product of the amount determined under subparagraph (A) and the ratio of—

(I) the total amount of expenditures made under the State plan under this title for medical assistance during the fiscal year, to

(II) the total amount of expenditures made under the State plans under this title for medical assistance during the fiscal year for all States which are not high DSH States in the fiscal year, or

(ii) the amount that would raise the State DSH allotment to the maximum permitted under paragraph (2)(B).

(4) DEFINITIONS.—In this subsection:

(A) HIGH DSH STATE.—The term "high DSH State" means, for a fiscal year, a State for which the State base allotment exceeds 12 percent of the total amount of expenditures made under the State plan under this title for medical assistance during the fiscal year.

(B) STATE.—The term "State" means only the 50 States and the District of Columbia but does not include any State whose entire program under this title is operated under a waiver granted under section 1115.

(C) STATE BASE ALLOTMENT.—The term "State base allotment" means, with respect to a State, the greater of—

(i) the total amount of payment adjustments made under subsection (c) under the State plan during fiscal year 1992 (excluding any such payment adjustments for which a reduction may be made under paragraph (1)(A)(i)), or

(ii) \$1,000,000.

The amount under clause (i) shall be determined by the Secretary and shall include only payment adjustments described in paragraph (1)(A)(i)(I).

(D) STATE GROWTH AMOUNT.—The term "State growth amount" means, with respect to a State for a fiscal year, the lesser of—

(i) the product of the State growth factor and the State DSH payment limit for the previous fiscal year, or

(ii) the amount by which 12 percent of the total amount of expenditures made under the State plan under this title for medical assistance during the fiscal year exceeds the State DSH allotment for the previous fiscal year.

(E) STATE GROWTH FACTOR.—The term "State growth factor" means, for a State for a fiscal year, the percentage by which the expenditures described in section 1903(a) in the State in the fiscal year exceed such expenditures in the previous fiscal year.

1991 Amendments:

Subsection (f) was added by section 3(b)(1) of the "Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991," effective as provided in section 3(e) of these Amendments at ¶ 17,806.

History:

Sec. 3(b)(1) of the "Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991" (P.L. 102-234).

[¶ 17,413B]

[Limitations on Payment Adjustments]

[42 U.S.C. § 1396r-4]

Sec. 1923. (g) LIMIT ON AMOUNT OF PAYMENT TO HOSPITAL.—

(1) AMOUNT OF ADJUSTMENT SUBJECT TO UNCOMPENSATED COSTS.—

(A) IN GENERAL.—A payment adjustment during a fiscal year shall not be considered to be consistent with subsection (c) with respect to a hospital if the payment adjustment exceeds the costs incurred during the year of furnishing hospital services (as determined by the Secretary and net of payments under this title, other than under this section, and by uninsured patients) by the hospital to individuals who either are eligible for medical assistance under the State plan or have no health insurance (or other source of third party coverage) for services provided during the year. For purposes of the preceding sentence, payments made to a hospital for services provided to indigent patients made by a State or a unit of local government within a State shall not be considered to be a source of third party payment.

(B) LIMIT TO PUBLIC HOSPITALS DURING TRANSITION PERIOD.—With respect to payment adjustments during a State fiscal year that begins before January 1, 1995, subparagraph (A) shall apply only to hospitals owned or operated by a State (or by an instrumentality or a unit of government within a State).

(C) MODIFICATIONS FOR PRIVATE HOSPITALS.—With respect to hospitals that are not owned or operated by a State (or by an instrumentality or a unit of government within a State), the Secretary may make such modifications to the manner in which the limitation on payment adjustments is applied to such hospitals as the Secretary considers appropriate.

¶ 17,413B § 1923(g)

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N A P H

Medicaid: Public Hospitals.

Thank you call to
Lynn Gage
347-0066MEMORANDUM

TO: Jack Ebeler

FROM: National Association of Public Hospitals
National Association of Children's Hospitals

DATE: November 21, 1995

RE: Medicaid and Medicare Budget Proposals

As President Clinton prepares to respond to the reconciliation bill approved by Congress, and to develop alternatives, the National Association of Public Hospitals (NAPH) and the National Association of Children's Hospitals (NACH) are concerned about the need to provide strong protections for America's metropolitan area safety net health systems. NAPH and NACH continue to be deeply concerned about the impact of significant Medicaid reductions on safety net providers and the patients and communities they serve. While we agree that the rate of future increase in the Medicaid program can be restrained, we believe there is potential for any significant savings to cut too deeply and damage the infrastructure of our nation's health system in many metropolitan areas. (See attached New England Journal editorial from last week.)

Thank you again for meeting with us this morning. As noted, we continue to support your efforts to preserve current entitlements and constrain costs through use of per capita caps. The purpose of this memo is to summarize the principal additional concerns we discussed and to suggest some ways in which those concerns can be addressed in any future compromise legislation.

1. **Medicaid Disproportionate Share Hospital Payments**

A. Treatment of Current Level of DSH Payments

There has been much publicity over the last several years surrounding certain states which have spent DSH funds for purposes unrelated to subsidizing the cost of serving the uninsured and other low income populations. While a number of states have minimal DSH programs, others have come to rely on federal DSH revenues to fund up to half of their entire Medicaid program. These states have been abetted by a provision in current law that permits states to designate as "disproportionate" any hospital with at least one percent Medicaid utilization. As a result of such abuses, NAPH and NACH agree that savings could be achieved by reducing the level of current federal DSH spending.

However, as the President himself has indicated, this step cannot be taken without harming the highest volume safety net hospitals unless the remaining DSH funds are targeted on such providers. Simply reducing DSH funding for all states across the board will not achieve this essential goal of targeting the remaining DSH funds. Some "high DSH" states HAVE in fact allocated most of their DSH funds to hospitals meeting federal statutory DSH standards (see B below). Any arbitrary across-the-board reduction in DSH would thus seriously disadvantage safety net providers in those states, which include California, Colorado, Georgia, Florida and Texas, among others.



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It is our understanding that the Administration has considered adopting an approach that would simply cut DSH payments by 33% across the board for all states. While this approach may appear to be a simple way to achieve significant savings, for the reasons noted above, NAPH and NACH are strongly opposed to it. We recognize the political problems involved with attempting to reduce only those DSH payments that are being spent inappropriately. There is great potential for damage to safety net hospitals, however, in any proposal that involves across-the-board cuts.

The Stenholm-Sabo substitute on the House floor reduced DSH funding but targeted remaining revenues. DSH funds could be removed from the base and remaining funds targeted on the highest volume providers of care to the poor. NAPH and NACH support this approach. Another alternative that could avoid at least some of the political problems would be to permit states to choose between a flat 33% reduction in DSH funding or 100% of the federal share of all DSH payments to hospitals that meet the definition of "high volume" provider (see below). If additional savings are needed, states held harmless by the latter option could be brought to the 33% level in years 4-7 of the budget deal, providing them with an opportunity to plan an orderly transition. Under either alternative, states should be required to target remaining funds on high volume DSH providers.

B. Criteria for Identifying DSH Providers for Targeting

Current law includes criteria at Section 1923(b)(1) for defining those DSH hospitals which we believe the states should be required to support. This criteria could also be used in measuring the proportion of federal funds to be targeted. This approach, which was included in Stenholm-Sabo substitute, adopts (with minor changes) the definition in the current Medicaid statute. It would single out for protection and continued DSH funding those general acute care hospitals with a "low income utilization factor" of at least 25%, and those children's hospitals with a "Medicaid utilization factor" of at least 20%.

2. Expansion of DSH Payments to Outpatient Care

In an earlier policy memo, the Administration requested advice on the possibility of extending DSH payments to cover outpatient or ambulatory care. While we would support expanding payments to include outpatient care to current DSH providers (as in the Stenholm-Sabo substitute), NAPH and NACH cannot support expansion of these payments to additional providers in the context of a proposed reduction in the current level of such payments.

Expansion of DSH to include additional outpatient providers is theoretically attractive, if the pool of available funds could be expanded. For example, the expansion of DSH to FQHCs and rural clinics might be explored if current cost-based FQHC payments to such providers are also folded into the DSH program. However, without such an expansion of DSH payments, the effect would be simply to spread current (or reduced) DSH payments among a much broader number of providers.

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3. Treatment of DSH Payments Under Managed Care

This has emerged as an important issue in states which have moved aggressively to develop Medicaid managed care programs under federal waivers. By permitting states to fold DSH payments into premium payments, those hospitals that have continued to serve low income uninsured patients are significantly damaged, even though the need to serve such patients (and to provide other public health and community-wide services) continues after implementation of the managed care programs. NAPH and NACH recommend that there be a requirement for a methodology to identify Medicaid managed care days for purposes of qualifying for DSH and that DSH payments be made directly to providers, not as part of capitated payments to plans. The Senate proposal included such a methodology, but the final Hill reconciliation bill does not include such a provision.

4. Repeal of 1993 OBRA caps

As the Administration observed in the context of the recent negotiations with Los Angeles County, the 1993 OBRA caps have resulted in serious hardship in certain instances. This has occurred because the calculation of these caps excludes a number of expenses incurred by safety net hospitals in serving uninsured patients and providing outpatient care and community-wide public health services. If federal DSH spending is to be reduced, and overall Medicaid spending to be capped, there is little further policy justification for continuing to impose these caps on individual hospitals. If the goal is to give states flexibility to implement a reduced and retargeted DSH program, these caps should be repealed.

5. Expansion of Managed Care: Level Playing Field for Safety Net Providers

NAPH and NACH recognize that both the Congress and the Administration wish to expand state flexibility to use managed care. We therefore ask that certain minimal protections be adopted for traditional safety net providers. In particular, we request that a state be required to include managed care plans developed or offered by high volume DSH providers (as defined above) or by networks including such providers, if the DSH provider chooses to offer such a plan. (This requirement can be extended to FQHCs and can include incentives, including technical assistance, to develop such plans.)

6. Undocumented Immigrants

It is essential that adequate federal funding continue to be provided for this population in those states with a significant volume of undocumented patients. The reconciliation bill includes a supplemental pool of \$3.5 billion in federal funds targeted to the 15 states with the highest number of undocumented immigrants over the seven year period. These states would be required to use the additional allotments to provide emergency care services to these individuals. NAPH and NACH support this provision; however, we would prefer to see a continuation of the current Medicaid approach to paying for services for this population.

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7. Intergovernmental Transfers (IGTs)

The Senate-passed reconciliation bill included a provision prohibiting states from shifting the burden of their state match requirements to local governments without the consent of such governments. Under the Senate bill, states could not unilaterally mandate intergovernmental transfers (IGTs). The final reconciliation bill includes no similar provision. NAPH believes that the use of IGTs should be restricted in the future only to those uses to which a state has put them in the past.

8. Level of Medicare DSH Spending

The Congressional reconciliation bill significantly reduces the level of Medicare DSH spending, without targeting the remaining funds on those hospitals with the greatest need. Coming on top of the other reductions in Medicare and Medicaid spending, these cuts--30% by FY 1999--will significantly increase pressure on those hospitals that are the most reliant on Medicare and Medicaid payments to treat low income patients. Medicare DSH payments should not be reduced. If some reductions appear necessary, the very highest volume DSH hospitals should be exempted, at least for the first 3-4 years of the duration of the planned budget deal.

9. Exclusion of DSH and GME Payments from AAPCC Calculation

Payments for DSH and GME are currently included in the capitated rates paid to HMOs and MCOs. NAPH and NACH believe that these payments should be made directly to the providers that incur these costs, rather than to health plans under both the Medicare and Medicaid programs. The Congressional reconciliation bill does not address this problem.

10. Counting Managed Care Patients in Calculating Medicare DSH

It is essential that Medicaid and low income Medicare patients should be counted in calculating the Medicare DSH adjustment, even if they are enrolled in a managed care plan. The purpose of the DSH adjustment is to provide support for the additional services often needed by low income patients (including the uninsured). These services will continue to be needed by all such patients whether or not some of a hospital's low income patients are enrolled in a managed care plan. The Senate proposal would have required states to specify a method by which hospitals would be able to identify managed care enrollees for purposes of qualifying and billing Medicare and Medicaid DSH payments, but the approved reconciliation bill does not include the provision.

11. Managed Care Standards for Access and Quality

The Congressional reconciliation bill includes few requirements for states that seek to enroll their Medicaid populations in managed care programs. The requirements are strictly process-related; if states did choose to use managed care programs, they must include in their MediGrant plans descriptions of actuarial methodologies and information on state standards for certifying managed care organizations. NAPH and NACH believe that there must be established substantive federal standards

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governing access to, and the quality of, care provided through managed care plans. There must be assurances about the qualification of plans and plan sponsors, including standards addressing financial viability, adequacy of provider networks and payment to providers, the range of services covered, and access for vulnerable populations.

12. Medicaid Managed Care Standards for Children

NAPH and NACH believe certain standards are required to protect children in a managed care environment. The following provisions were included in the Stenholm-Sabo substitute and were offered in the Senate by Senator Paul Simon:

- Children with special health care needs would be exempt from mandatory enrollment in Medicaid managed care plan. Children with special health care needs are defined as an individual under the age of 19 who is: eligible for disability under Title XVI; is described in section 501(a)(1)(D); or is described in 1902(e)(3).
- Children, including children with special health care needs, who are enrolled in any type of managed care plan must have access to appropriate pediatric providers who are trained and experienced in the care delivery for which the child is referred.

13. GME Trust Fund

Finally, NAPH and NACH both support the creation of the new GME trust fund included in the Congressional budget bill, along with the House's proposed Commission for determining how trust fund payments should be structured.