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The Honorable J. Dennis Hastert
Speaker of the House
of Representatives
Washington, D.C. 20515

Dear Mr. Speaker:

Enclosed for the consideration of the Congress is the Administration's draft bill, the "Medicare Balanced Budget Refinement Act of 2000". Key features of the bill are outlined below. The provisions of the bill are described in greater detail in the enclosed section-by-section summary.

The bill would amend title XVIII of the Social Security Act to increase Medicare reimbursement for hospitals, skilled nursing facilities, home health care agencies, and other providers. The bill includes $9 billion ($19 billion over 10 years) for proposals that are primarily designed for immediate payment increases that would start to benefit providers in fiscal year 2001 by delaying further payment reductions enacted in the Balanced Budget Act of 1997 (the "BBA"), many of which are scheduled to occur on October 1, 2000. It also includes $11 billion ($21 billion over 10 years) in unspecified funding for use in developing additional policies that target, or make permanent corrections to, flawed BBA policies.

In addition, the bill would (1) amend the Public Health Service Act to make appropriations for research grants into prevention and cure of type I diabetes and for grants for diabetes prevention and treatment services through Indian health facilities ($30 million would be appropriated for each of FYs 2003 through 2007 for each grant program); and (2) amend the Ricky Ray Hemophilia Relief Fund Act of 1998 to make appropriations to the Fund for FY 2001.

The President remains committed to a comprehensive plan to make Medicare more competitive and efficient, add a long-overdue, voluntary prescription drug benefit, and transfer part of the on-budget surplus to the Hospital Insurance Trust Fund to help pay for the retirement of the baby boom generation. The improved status of the Medicare Trust Fund makes it possible to pay for the provider payment restorations included in this bill and help offset the cost of a prescription drug benefit while still achieving the President's Medicare reform goal of extending the Trust Fund's life beyond 2030.

We urge the Congress to give the draft bill its prompt and favorable consideration.

The Office of Management and Budget has advised that there is no objection to the submission of this legislative proposal to the Congress, and that its enactment would be in accord with the program of the President.

Sincerely,

Donna E. Shalala

Enclosures

GCL DRAFT (7/06/00)

MEDICARE BALANCED BUDGET REFINEMENT ACT OF 2000

Section-by-Section Summary

NOTE: Except as otherwise specified, terms used in this summary have the following meanings:

- "the Act" means the Social Security Act;
- "the Secretary" means the Secretary of Health and Human Services;
- "BBA" means the Balanced Budget Act of 1997; and
- "BBRA" means the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, as enacted by section 1000(a)(6) of P.L. 106-113.

TITLE I—INCREASE IN PAYMENTS FOR CERTAIN MEDICARE SERVICES

Title I of the bill would make various amendments to title XVIII to provide increases in payment rates for FY 2001 for certain Medicare-covered services and to delay certain payment reductions enacted in the BBA.

The amendments proposed in sections 101, 103, and 105 (providing for updates for PPS hospital service payments, disproportionate share hospital (DSH) payments, and payments for skilled nursing facility services) share a common format. In subsection (a) of each, an amendment is made to the title XVIII provision which establishes the formula for the payment rate or payment update factor for the service involved for FY 2001. Because of the need to allow sufficient time for fiscal intermediaries to implement these changes, subsection (b) of these sections provides a special payment rule for the covered services furnished during FY 2001. Under subsection (b), the Secretary would make payments for covered services using the current law update formula for the first six months of FY 2001 and for the second six months of the fiscal year, using a formula that doubles the payment increase established by the subsection (a) amendment. The increase made by the subsection (a) amendments (but not the subsection (b) amendments) would be built into the base of each facility's payment system, thereby increasing the base for all future updates. Other sections of title I are structured similarly.

SEC. 101. ELIMINATION OF REDUCTION IN MARKET BASKET UPDATE FOR PPS HOSPITALS FOR FY 2001.

Subsection (a) would amend section 1886(b)(3)(B)(i)(XVI) to increase the prospective payment system (PPS) hospital update factor for FY 2001. Under current law, the update factor for FY 2001 is equal to the market basket percentage increase (the "market basket") minus 1.1 percentage points for hospitals other than sole community hospitals (the sole community hospital update factor is equal to the full market basket). Subsection (a) would change the update factor for FY

2001 for PPS hospitals in all areas to equal the full market basket. This would be the level to which future updates would apply.

Subsection (b) would provide that for purposes of making payments for such inpatient hospital services for FY 2001, the Secretary would use the current law update factor with respect to discharges occurring during the first half of the fiscal year, and for discharges occurring during the second half of the fiscal year, would use a factor equal to the market basket plus 1.1 percentage points for hospitals other than sole community hospitals, and equal to the market basket for sole community hospitals.

SEC. 102. ADDITIONAL MODIFICATION OF TRANSITION FOR INDIRECT MEDICAL EDUCATION (IME) PERCENTAGE ADJUSTMENT.

Subsection (a) would provide that for purposes of making payments to PPS hospitals with indirect costs of medical education, the calculation of the indirect teaching adjustment factor under section 1886(d)(5)(B)(ii) would be performed with respect to discharges occurring in the second half of FY 2001 as if the "c" variable equaled 1.66 instead of the current law value of 1.54. This amendment is designed to provide PPS hospitals with the same IME payment increase rate (under which there is a 6.5 percent IME payment increase for each 10 percent increase in a hospital's ratio of interns and residents to beds) that they received for FY 2000.

Subsection (b) would amend section 1886(d)(2)(C)(i) to provide that the FY 2001 IME increase will not be taken into account for purposes of standardizing the update for the national adjusted DRG prospective payment rate.

SEC. 103. ELIMINATION OF REDUCTION IN DSH PAYMENTS FOR FISCAL YEAR 2001.

Subsection (a) would amend section 1886(d)(5)(F)(ix)(III) to eliminate the 3 percent reduction that would otherwise apply for FY 2001 payments to PPS hospitals that serve a disproportionate number of low-income patients ("DSH payments").

Subsection (b) would provide that for purposes of making DSH payments for FY 2001, the Secretary would make adjustments as provided under current law with respect to discharges occurring during the first half of the fiscal year, and for discharges occurring during the second half of the fiscal year, would increase the payment amount by 3 percent.

Subsection (c) would amend section 1886(d)(2)(C)(iv) to provide that the special payment adjustments made for FY 2001 under subsection (b) would be taken into account for purposes of standardizing the update for the national adjusted DRG prospective payment rate.

Subsection (d) would amend the table in section 1923(f)(2) (which specifies caps for the Federal share of Medicaid DSH payments for each State and the District of Columbia) to freeze the

Federal share caps at the levels in effect for FY 2000.

SEC. 104. MODIFICATION OF PAYMENT RATE FOR PUERTO RICO HOSPITALS.

Subsection (a) would amend section 1886(d)(9)(A) (which establishes the payment formula for operating costs of inpatient hospital services of Puerto Rico PPS hospitals based 50 percent on national rates and 50 percent on local rates) to establish a new formula using a payment blend for FY 2001 and subsequent fiscal years based 75 percent on national rates and 25 percent on local rates.

Subsection (b) would provide that for purposes of making payments for the operating costs of inpatient hospital services of a Puerto Rico PPS hospital for FY 2001, the Secretary would use the current law payment blend with respect to discharges occurring during the first half of the fiscal year, and for discharges occurring during the second half of the fiscal year, would base payments completely on national rates.

SEC. 105. ELIMINATION OF REDUCTION IN SKILLED NURSING FACILITY (SNF) MARKET BASKET UPDATE FOR FY 2001.

Subsection (a) would amend section 1888(e)(4)(E)(ii) to increase the update factor for covered skilled nursing facility services for FY 2001. Under current law, the update factor for FY 2001 is equal to the skilled nursing facility market basket percentage change (the "SNF market basket") minus one percentage point. Under the amendment made by subsection (a), the update would equal the full SNF market basket. This would be the level to which future updates would apply.

Subsection (b) would provide that for purposes of making payments for covered SNF services for FY 2001, the Secretary would use the current law update with respect to discharges occurring during the first half of the fiscal year, and for discharges occurring during the second half of the fiscal year, would use an update equal to the SNF market basket plus one percentage point.

SEC. 106. ONE-YEAR EXTENSION OF MORATORIUM IN CAPS FOR THERAPY SERVICES.

Subsection (a) would amend section 1833(g)(4) to extend for one year (through the end of 2002) the moratorium in the application of provisions that would cap payment amounts for certain outpatient physical therapy, speech language pathology, and occupational therapy services.

Subsection (b) would amend section 4541(d)(2) of the BBA to extend by one year the due date for a report by the Secretary to the Congress including recommendations on the establishment of a revised coverage policy for outpatient therapy services.

SEC. 107. DELAY BY AN ADDITIONAL YEAR THE APPLICATION OF 15

PERCENT REDUCTION IN PAYMENT LIMITS FOR HOME HEALTH SERVICES.

Section 107 would amend section 1895(b)(3)(A)(i) to delay by one year the 15 percent reduction to home health payments that is scheduled to go into effect one year after the home health prospective payment system is implemented.

SEC. 108. ELIMINATION OF REDUCTION IN HOME HEALTH MARKET BASKET UPDATE FOR HOME HEALTH SERVICES FOR FY 2001.

Subsection (a) would amend section 1861(v)(1)(L) to increase the payment update for home health services for FY 2001. Under current law, the update factor for FY 2001 is equal to the home health market basket index (the "home health market basket") minus 1.1 percentage points. Subsection (a) would change what the update factor for FY 2001 for home health services would be under the interim payment system (IPS) to the full home health market basket. This would increase the expenditure base that is used to calculate the initial home health PPS rates.

Subsection (b)(1) would provide that for purposes of making payments for home health services for FY 2001 under the prospective payment system, with respect to episodes (1) ending during the first half of FY 2001, the Secretary would use the final standardized and budget neutral prospective payment amounts for 60 day episodes for FY 2001 as published in the July 3, 2000 *Federal Register*; and (2) with respect to episodes ending during the second half of FY 2001, the Secretary would use such standardized amounts, increased by 1.7 percent. Because the home health prospective payment system begins with FY 2001, there is not an equal distribution of episodes ending in the first and last six months of FY 2001. The figure of 1.7 percent is an actuarially determined amount that would be equivalent to an increase in the episode rate if the full home health market basket had applied for all of FY 2001 under the IPS, the expenditure base to which the PPS is budget neutral.

Subsection (b)(2) would provide that the adjustments made under paragraph (1) for the last six months of FY 2001 would not be taken into account for purposes of making payments, determinations, or budget neutrality adjustments under section 1895 (other than for FY 2001).

SEC. 109. UPDATE IN RENAL DIALYSIS COMPOSITE RATE.

Section 109 would amend section 1881(b)(7) to provide an additional 1.2 percent increase over current law payment rates for outpatient renal dialysis services for 2001.

SEC. 110. GUARANTEE OF ADDITIONAL ADJUSTMENTS TO PAYMENTS FOR PROVIDERS FROM BUDGET SURPLUS.

Section 110 would provide for the availability of funding for adjustments to payment policies established under the BBA and for additional improvements to the Medicare program and

payments for Medicare-covered services (including the services of rural health providers). The funding amounts would be made available from amounts in excess of estimated social security surpluses, and would total $11,000,000,000 over the five year period beginning with FY 2001, and $21,000,000,000 over the ten year period beginning with such fiscal year.

TITLE II—FUNDING FOR CERTAIN DIABETES PROGRAMS AND FOR THE RICKY RAY HEMOPHILIA RELIEF FUND

SEC. 201. APPROPRIATIONS FOR TYPE I DIABETES RESEARCH.

Section 201 would amend section 330B(b) of the Public Health Service Act (authorizing research grants into prevention and cure of type I diabetes) to appropriate $30,000,000 for this program for each of FYs 2003 through 2007.

SEC. 202. APPROPRIATIONS FOR DIABETES PROGRAMS FOR INDIANS.

Section 202 would amend section 330C(c) of the Public Health Service Act (authorizing grants for diabetes prevention and treatment services through Indian health facilities) to appropriate $30,000,000 for this program for each of FYs 2003 through 2007.

SEC. 203. APPROPRIATIONS FOR RICKY RAY HEMOPHILIA RELIEF FUND.

Section 203 would amend section 101(e) of the Ricky Ray Hemophilia Relief Fund Act of 1998, to appropriate to the Fund $475,000,000 for FY 2001, to remain available until expended.

GCL DRAFT 7/06/00

A BILL

To amend the Medicare program under title XVIII of the Social Security Act to provide for increased payments for certain Medicare services, and to provide funding for certain diabetes programs and for the Ricky Ray Hemophilia Relief Fund.

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

SECTION 1. SHORT TITLE; REFERENCES IN ACT; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Medicare Balanced Budget Refinement Act of 2000".

(b) REFERENCES.—Except where otherwise specifically provided, references in this Act shall be considered to be made to the Social Security Act, or to a section or other provision thereof.

TITLE I—INCREASE IN PAYMENTS FOR CERTAIN MEDICARE SERVICES

SEC. 101. ELIMINATION OF REDUCTION IN MARKET BASKET UPDATE FOR PPS HOSPITAL SERVICES FOR FY 2001.

(a) ELIMINATION OF REDUCTION.—Subject to subsection (b), section 1886(b)(3)(B)(i)(XVI) (42 U.S.C. 1395ww(b)(3)(B)(i)(XVI)) is amended by striking "minus 1.1 percentage points" and the remaining text preceding the final comma and inserting "for all hospitals in all areas".

(b) SPECIAL RULE FOR PAYMENT FOR INPATIENT HOSPITAL SERVICES FOR FY 2001.—Notwithstanding the amendment made by subsection (a), for purposes of making

payments for FY 2001 for inpatient hospital services furnished by section 1886(d) hospitals, the "applicable percentage increase" referred to in section 1886(b)(3)(B)(i)(42 U.S.C. 1395ww(b)(3)(B)(i))—

(1) for discharges occurring on or after October 1, 2000 and before April 1, 2001, shall be determined in accordance with section 1886(b)(3)(B)(i)(XVI) (42 U.S.C. 1395ww(b)(3)(B)(i)(XVI)) as such section read prior to the enactment of this Act; and

(2) for discharges occurring on or after April 1, 2001 and before October 1, 2001, shall be equal to the market basket percentage increase plus 1.1 percentage points for hospitals (other than sole community hospitals) in all areas, and the market basket percentage increase for sole community hospitals.

SEC. 102. ADDITIONAL MODIFICATION OF TRANSITION FOR INDIRECT MEDICAL EDUCATION (IME) PERCENTAGE ADJUSTMENT.

(a) SPECIAL ADJUSTMENT FOR PURPOSES OF MAINTAINING 6.5 PERCENT IME PAYMENT FOR FISCAL YEAR 2001.—Notwithstanding section 1886(d)(5)(B)(ii)(V) (42 U.S.C. 1395ww(d)(5)(B)(ii)(V)), for purposes of making payments for section 1886(d) hospitals with indirect costs of medical education, the indirect teaching adjustment factor referred to in section 1886(d)(5)(B)(ii) (42 U.S.C. 1395ww(d)(5)(B)(ii)) shall be determined as if the "c" referred to in subclause (V) of such section equaled 1.66 instead of 1.54. for discharges occurring on or after April 1, 2001 and before October 1, 2001.

(b) CONFORMING AMENDMENT RELATING TO DETERMINATION OF STANDARDIZED AMOUNT.—Section 1886(d)(2)(C)(i) (42 U.S.C. 1395ww(d)(2)(C)(i)) is amended by inserting "or any payment under such paragraph resulting from the application of

section 102(a) of the Medicare Balanced Budget Refinement Act of 2000" after "Balanced Budget Refinement Act of 1999"."

SEC. 103. ELIMINATION OF REDUCTION IN DSH PAYMENTS FOR FISCAL YEAR 2001.

(a) ELIMINATION OF REDUCTION.—Subject to subsection (b), section 1886(d)(5)(F)(ix)(III) (42 U.S.C. 1395ww(d)(5)(F)(ix)(III)) is amended by striking "during each of fiscal years 2000 and 2001" and inserting "during fiscal year 2000".

(b) SPECIAL RULE FOR DSH PAYMENT FOR FY 2001.—Notwithstanding the amendment made by subsection (a), for purposes of making disproportionate share payments for section 1886(d) hospitals for fiscal year 2001, the additional payment amount otherwise determined under section 1886(d)(5)(F)(ii) (42 U.S.C. 1395ww(d)(5)(F)(ii))—

(1) for discharges occurring on or after October 1, 2000 and before April 1, 2001, shall be adjusted as provided by section 1886(d)(5)(F)(ix)(III) (42 U.S.C. 1395ww(d)(5)(F)(ix)(III)) as such section read prior to the enactment of this Act; and

(2) for discharges occurring on or after April 1, 2001 and before October 1, 2001, shall be increased by 3 percent.

(c) CONFORMING AMENDMENT RELATING TO DETERMINATION OF STANDARDIZED AMOUNT.—Section 1886(d)(2)(C)(iv) (42 U.S.C. 1395ww(d)(2)(C)(iv)), is amended by inserting "or the enactment of section 103(b) of the Medicare Balanced Budget Refinement Act of 2000" after "Omnibus Budget Reconciliation Act of 1990".

(d) FREEZE IN MEDICAID DSH ALLOTMENTS FOR FISCAL YEAR 2001.—The table in section 1923(f)(2) (42 U.S.C. 1396r-4(f)(2)), as amended by section 601 of the Medicare,

Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, as enacted by section 1000(a)(6) of P.L. 106-113), is amended by replacing the values in the column labeled FY 01 with the values in the column labeled FY 00 for each State and the District of Columbia.

SEC. 104. MODIFICATION OF PAYMENT RATE FOR PUERTO RICO HOSPITALS.

(a) MODIFICATION OF PAYMENT RATE.—Subject to subsection (b), section 1886(d)(9)(A) (42 U.S.C. 1395ww(d)(9)(A)) is amended—

(1) in clause (i), by striking "October 1, 1997, 50 percent (" and inserting "October 1, 2000, 25 percent (and for discharges between October 1, 1997 and September 30, 2000, 50 percent"; and

(2) in clause (ii), in the matter preceding subclause (I), by striking "October 1, 1997, 50 percent (" and inserting "October 1, 2000, 75 percent (and for discharges between October 1, 1997 and September 30, 2000, 50 percent".

(b) SPECIAL RULE FOR PAYMENT FOR FY 2001.—Notwithstanding the amendment made by subsection (a), for purposes of making payments for the operating costs of inpatient hospital services of a section 1886(d) Puerto Rico hospital for fiscal year 2001, the amount referred to in section 1886(d)(9)(A) (42 U.S.C. 1395ww(d)(9)(A)) in the matter preceding clause (i)—

(1) for discharges occurring on or after October 1, 2000 and before April 1, 2001, shall be determined in accordance with section 1886(d)(9)(A) (42 U.S.C. 1395ww(d)(9)(A)) as such section read prior to the enactment of this Act; and

(2) for discharges occurring on or after April 1, 2001 and before October 1, 2001,

shall be determined—

(A) using 0 percent of the Puerto Rico adjusted DRG prospective payment rate referred to in section 1886(d)(9)(A)(i) (42 U.S.C. 1395ww(d)(9)(A)(i)); and

(B) using 100 percent of the discharge-weighted average referred to in section 1886(d)(9)(A)(ii) (42 U.S.C. 1395ww(d)(9)(A)(ii)).

SEC. 105. ELIMINATION OF REDUCTION IN SKILLED NURSING FACILITY (SNF) MARKET BASKET UPDATE FOR FY 2001.

(a) ELIMINATION OF REDUCTION.—Subject to subsection (b), section 1888(e)(4)(E)(ii) (42 U.S.C. 1395ww(e)(4)(E)(ii)) is amended—

(1) by redesignating subclauses (II) and (III) as subclauses (III) and (IV) respectively;

(2) in subclause (III), as redesignated, by striking "for each of fiscal years 2001 and 2002" and inserting "for fiscal year 2002"; and

(3) by inserting after subclause (I) the following new subclause:

"(II) for fiscal year 2001, the rate computed for the previous fiscal year increased by the skilled nursing facility market basket percentage change for the fiscal year involved;".

(b) SPECIAL RULE FOR PAYMENT FOR SKILLED NURSING FACILITY SERVICES FOR FY 2001.—Notwithstanding subsection (a), for purposes of making payments for covered skilled nursing facility services for fiscal year 2001, the Federal per diem rate referred to in section 1888(e)(4)(E)(ii) (42 U.S.C. 1395ww(e)(4)(E)(ii))—

(1) for the period beginning on October 1, 2000 and ending on March 31, 2001,

shall be the rate determined in accordance with section 1888(e)(4)(E)(ii)(II) (42 U.S.C. 1395ww(e)(4)(E)(ii)(II)) as such section read prior to the enactment of this Act; and

(2) for the period beginning on April 1, 2001 and ending on September 30, 2001, shall be the rate computed for FY 2000 pursuant to section 1888(e)(4)(E)(ii)(I) (42 U.S.C. 1395ww(e)(4)(E)(ii)(I)) increased by the skilled nursing facility market basket percentage change for fiscal year 2001 plus 1 percentage point.

SEC. 106. ONE-YEAR EXTENSION OF MORATORIUM IN CAPS FOR THERAPY SERVICES.

(a) EXTENSION OF MORATORIUM.—Section 1833(g)(4) (42 U.S.C. 1395l(g)(4)) is amended by striking "and 2001" and inserting "through 2002".

(b) EXTENSION OF REPORT.—Section 4541(d)(2) of the Balanced Budget Act of 1997 is amended by striking "2001" and inserting "2002".

SEC. 107. DELAY BY AN ADDITIONAL YEAR THE APPLICATION OF 15 PERCENT REDUCTION IN PAYMENT LIMITS FOR HOME HEALTH SERVICES.

Section 1895(b)(3)(A)(i) (42 U.S.C. 1395fff(b)(3)(A)(i)) is amended—

(1) by redesignating subclause (II) as subclause (III);

(2) in subclause (III), as redesignated, by striking "period described in subclause (I)" and inserting "period described in subclause (II)"; and

(3) by inserting after subclause (I) the following new subclause:

"(II) For the period beginning 12 months after the beginning of the period described in subclause (I), such amount (or

amounts) shall be equal to the amount (or amounts) determined under subclause (I), updated under subparagraph (B).".

SEC. 108. ELIMINATION OF REDUCTION IN HOME HEALTH MARKET BASKET UPDATE FOR HOME HEALTH SERVICES FOR FY 2001.

(a) ELIMINATION OF REDUCTION.—Subject to subsection (b)(1), section 1861(v)(1)(L) (42 U.S.C. 1395x(v)(1)(L)) is amended—

(1) by striking "2001," in clause (x); and

(2) by inserting after clause (x) the following new clause:

"(xi) Notwithstanding any other provision of this subparagraph, the update to any limit under this subparagraph for cost reporting periods beginning during fiscal year 2001 shall be the home health market basket index.".

(b) PAYMENT FOR HOME HEALTH SERVICES FOR FY 2001 BASED ON ADJUSTED PROSPECTIVE PAYMENT AMOUNTS.—

(1) IN GENERAL.—Notwithstanding the amendment made by subsection (a), for purposes of making payments for home health services for fiscal year 2001, the Secretary shall—

(A) with respect to episodes ending on or before October 1, 2000 and before April 1, 2001, make payments for home health services using the final standardized and budget neutral prospective payment amounts for 60 day episodes for fiscal year 2001 as published by the Secretary in the July 3, 2000 *Federal Register*; and

(B) with respect to episodes ending on or after April 1, 2001 and before October 1, 2001, make payments for home health services using the standardized amounts described in subparagraph (A), increased by 1.7 percent.

(2) NO EFFECT ON OTHER PAYMENTS OR DETERMINATIONS.—The Secretary shall not take the provisions of paragraph (1) into account for purposes of payments, determinations, or budget neutrality adjustments under section 1895.

SEC. 109. UPDATE IN RENAL DIALYSIS COMPOSITE RATE.

The last sentence of section 1881(b)(7) (42 U.S.C. 1395rr(b)(7)) is amended by striking "for such services furnished on or after January 1, 2001, by 1.2 percent" and inserting "for such services furnished on or after January 1, 2001, by 2.4 percent".

SEC. 110. GUARANTEE OF ADDITIONAL ADJUSTMENTS TO PAYMENTS FOR PROVIDERS FROM BUDGET SURPLUS.

Notwithstanding any other provision of law, from amounts estimated to be in excess of social security surpluses estimated under the Balanced Budget and Emergency Deficit Control Act of 1985 for the 5 fiscal year and 10 fiscal year periods beginning in fiscal year 2001, there shall be made available for further adjustments to payment policies established by the Balanced Budget Act of 1997, amounts that would provide for additional improvements to the medicare program carried out under title XVIII of the Social Security Act and payments for services furnished under such title XVIII to medicare program beneficiaries (including payments for services of rural health providers) in the aggregate amounts over such 5 fiscal year and 10 fiscal year periods of $11,000,000,000 and $21,000,000,000 respectively.

TITLE II—FUNDING FOR CERTAIN DIABETES PROGRAMS AND FOR THE RICKY RAY HEMOPHILIA RELIEF FUND

SEC. 201. APPROPRIATIONS FOR TYPE I DIABETES RESEARCH.

Section 330B(b) of the Public Health Service Act (42 U.S.C. 254c-2(b)) is amended by adding at the end the following: "There is appropriated, out of any money in the Treasury not otherwise appropriated, $30,000,000 for each of fiscal years 2003 through 2007 for grants under this section.".

SEC. 202. APPROPRIATIONS FOR DIABETES PROGRAMS FOR INDIANS.

Section 330C(c) of the Public Health Service Act (42 U.S.C. 254c-3(c)) is amended by adding at the end the following: "There is appropriated, out of any money in the Treasury not otherwise appropriated, $30,000,000 for each of fiscal years 2003 through 2007 for grants under this section.".

SEC. 203. APPROPRIATIONS FOR RICKY RAY HEMOPHILIA RELIEF FUND.

Section 101(e) of the Ricky Ray Hemophilia Relief Fund Act of 1998 (42 U.S.C. 300c-22 note) is amended by adding at the end the following: "There is appropriated to the Fund $475,000,000 for fiscal year 2001, to remain available until expended.".

Total Pages: 6

LRM ID: RJP273

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
Washington, D.C. 20503-0001

SPECIAL

Wednesday, April 5, 2000

LEGISLATIVE REFERRAL MEMORANDUM

TO: Legislative Liaison Officer - See Distribution below

FROM: Robert J. Pellicci (for) Assistant Director for Legislative Reference

OMB CONTACT: Robert J. Pellicci
E-Mail: Robert_J._Pellicci@omb.eop.gov
PHONE: (202)395-4871 FAX: (202)395-6148

SUBJECT: **HEALTH & HUMAN SERVICES Report on Medicaid coverage for Asymptomatic HIV-Positive Individuals**

HHS response to Congressional letter

DEADLINE: **10:00 a.m. Monday, April 10, 2000**

In accordance with OMB Circular A-19, OMB requests the views of your agency on the above subject before advising on its relationship to the program of the President. **Please advise us if this item will affect direct spending or receipts for purposes of the "Pay-As-You-Go" provisions of Title XIII of the Omnibus Budget Reconciliation Act of 1990.**

COMMENTS: Secretary Shalala response to Rep. Pelosi (and 64 others) regarding legislation to expand Medicaid coverage to cover HIV-positive, asymptomatic individuals.

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LRM ID: RJP273 **SUBJECT:** HEALTH & HUMAN SERVICES Report on Medicaid coverage for Asymptomatic HIV-Positive Individuals

RESPONSE TO
LEGISLATIVE REFERRAL
MEMORANDUM

If your response to this request for views is short (e.g., concur/no comment), we prefer that you respond by e-mail or by faxing us this response sheet. If the response is short and you prefer to call, please call the branch-wide line shown below (NOT the analyst's line) to leave a message with a legislative assistant.

You may also respond by:
(1) calling the analyst/attorney's direct line (you will be connected to voice mail if the analyst does not answer); or
(2) sending us a memo or letter
Please include the LRM number shown above, and the subject shown below.

TO: **Robert J. Pellicci Phone: 395-4871 Fax: 395-6148**
Office of Management and Budget
Branch-Wide Line (to reach legislative assistant): 395-7362

FROM: _____ **(Date)**

_____ **(Name)**

_____ **(Agency)**

_____ **(Telephone)**

The following is the response of our agency to your request for views on the above-captioned subject:

_____ **Concur**

_____ **No Objection**

_____ **No Comment**

_____ **See proposed edits on pages** _____

_____ **Other:** _____

_____ **FAX RETURN of** _____ **pages, attached to this response sheet**

(Name)
(location)
(city, state zip)

Dear (Dear):

Thank you for your letter requesting that the Department reconsider expanding Medicaid eligibility to cover HIV-positive persons who do not meet the current Medicaid definition of disability. I apologize for the delay in this response.

You point out that recent evidence emphasizes the health benefits of highly active antiretroviral therapy to persons living with HIV disease and that mounting evidence indicates that the new therapies compare favorably with the cost effectiveness of medical interventions for other diseases such as coronary disease.

This Administration shares your concern regarding the importance of making antiretroviral therapy available to persons with HIV disease at the appropriate stage of disease. As referenced in your letter, Dr. Earl Fox, Administrator of the Health Resources and Services Administration, testified before Congress, and requested additional funding for the AIDS Drug Assistance Program (ADAP) and other programs that serve persons with HIV disease who are not eligible for Medicaid. In fact, in the President's budget for fiscal year (FY) 2001, the Administration has requested an additional $26 million for ADAP over the amount allocated for FY 2000 resulting in a total of $554 million.

As you know, the President fully supported H.R1180/S.331, the Ticket to Work and Work Incentives Improvement Act of 1999. The bill, which was signed into law by the President on December 17, 1999, provides health care coverage to people with disabilities so that eligible persons can continue to be productive members of the work force for as long as possible. This bill includes a $250 million, 6-year demonstration program which would allow participating States to provide Medicaid to working individuals with health conditions that have not yet rendered them disabled, but that can be expected to cause the level of disability required to qualify for SSI/SSDI, and therefore Medicaid. This demonstration is intended to help people who need coverage to prevent deterioration in their health condition and it allows States to target specific diseases such as HIV.

Your letter also discusses legislation that has been introduced in Congress (H.R. 1591 and S. 902.) These bills would provide States additional options to expand their Medicaid programs to include non-disabled individuals who are HIV-positive and meet State income guidelines. I applaud your efforts in this area which will stimulate the necessary dialogue in Congress around this important issue.

You suggest that the Department could use the H.R. 1591 and S. 902 legislation as a model for administrative action to expand Medicaid coverage of persons with early-stage HIV disease. I agree that legislation is the most direct and easiest means of providing health care to this population. The Department's authority to expand Medicaid eligibility in the absence of legislative action is limited by statute to demonstration or wavier authority. As you know, on February 24, we announced the approval of the State of Maine's request for a demonstration waiver to expand Medicaid eligibility to non-disabled persons with HIV disease. The waiver program will provide a comprehensive package of services to approximately 300 HIV-positive persons in the State of Maine. The Department is currently preparing guidelines so that other States interested in creating an 1115 waiver for HIV positive persons can benefit from what we learned in the process with Maine.

I will continue to work with the Congress, States, pharmaceutical manufacturers, advocacy groups, and others to find innovative ways to help ensure that persons with HIV disease will receive the treatment they need.

A similar letter is also being sent to other members who co-signed your letter.

Sincerely,

Donna E. Shalala

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

July 30, 1999

99 AUG -2 AM 9:56

The Honorable Donna Shalala
Secretary of the Department of
Health and Human Services
200 Independence Ave., S.W.
Washington, D.C. 20201

Dear Madame Secretary:

Last year several of us were joined by 64 of our colleagues in urging you to expand Medicaid to cover HIV-positive, asymptomatic individuals. Today we write you again and urge you to consider this policy change in light of new research and widely supported legislation in Congress.

As you know, HIV treatment guidelines issued by the Department of Health and Human Services in 1997 recommend the use of antiviral therapy *early* in the course of HIV infection, before development of symptoms. Yet because Medicaid does not define individuals with early infection as disabled, many low income individuals are unable to receive HIV-related drugs and health care through the program.

Research presented at the 12th World AIDS Conference in Geneva in Summer of 1998 provided evidence that early therapy for individuals infected with HIV saves lives and is cost effective. Since we wrote you after the conference last year, there have been several additional developments that warrant a new look at Medicaid expansion.

First, the unmet need for primary care and anti-retroviral therapy is more thoroughly documented. In February of this year, Dr. Earl Fox, Administrator of the Health Resources and Services Administration, testified that there are waiting lines at 10 state AIDS Drug Assistance Programs, and 12 states have capped enrollment in the program. Clearly, our system of care must be expanded to reach more of those battling HIV infection.

Second, Dr. Richard Moore of Johns Hopkins University last month presented evidence to Congress on the cost per life years saved by triple combination therapy for HIV that compared favorably with the cost effectiveness of other medical interventions, including Lovastatin to prevent coronary disease, mammography, and renal hemodialysis.

Third, legislation has been introduced in Congress (H.R. 1591 and S. 902) that would give states the option of expanding their Medicaid programs to include HIV-positive asymptomatic individuals who meet state income guidelines. By giving states the option, rather than a mandate, to expand Medicaid, this legislation would allow for gradual

expansion of Medicaid, enabling the Department to monitor costs and savings from early treatment.

This legislation could serve as a model for administrative action to expand Medicaid. While states may now apply for a waiver to offer early HIV services through Medicaid, this process is lengthy and challenging, and no state waiver applications have yet been approved.

Providing states with the option to include low income, HIV-positive, asymptomatic individuals in their Medicaid programs will extend medically indicated, life-enhancing care to people with HIV disease. We urge you to take administrative action to expand Medicaid to these individuals. This action would be consistent with full implementation of the HIV treatment guidelines issued by your Department two years ago.

Thank you for considering Departmental action to expand Medicaid for people with HIV disease.

Sincerely,

Nancy Pelosi

Richard Gephardt

Henry Waxman

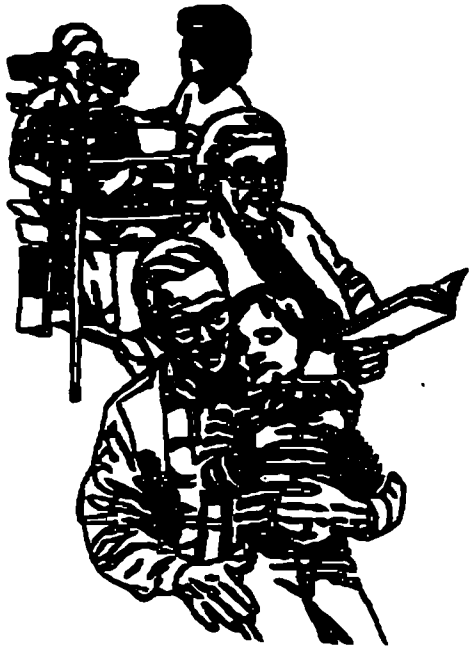
Donna Christensen

Robert Underwood

Elijah Cummings

na 13-99-0054

HEALTH CARE FINANCING ADMINISTRATION



To Sandy
Jim Deborah
fyi

ADDRESSEE:

Debra

PHONE: _____

FROM: Peter

OFFICE OF THE ADMINISTRATOR
200 INDEPENDENCE AVE., S.W.
ROOM 314G
WASHINGTON, DC 20201

PHONE: 202-690-6726
FAX : 202-690-6262

TOTAL PAGES:	ADDRESSEE'S FAX MACHINE NUMBER:	DATE:

REMARKS:

Medicaid Waiver

Talking Points
Secretarial Calls Regarding
the Approval of the Maine HIV Demonstration

- I am calling to congratulate Maine on being the first State in the nation to allow persons with HIV, who would not otherwise be eligible for Medicaid, to enroll in Medicaid.

- HCFA today has approved Maine's Medicaid demonstration project to expand Medicaid coverage for persons who are HIV-positive.

- We anticipate that approximately 300 persons living with HIV will be able to participate in the demonstration.

- Under Medicaid law, most HIV-positive individuals do not qualify for the program until they become disabled.

- Maine's Section 1115 waiver of those rules will use early intervention with AIDS-fighting drugs to keep persons with HIV from becoming disabled and to help them live longer, healthier lives.

- To be eligible to participate in the Maine program, individuals must have been diagnosed with HIV with a gross income of up to 300 percent of the federal poverty guideline (the FPG for an individual at 300% of poverty is approximately $25,000.)

- I am very pleased that Maine is leading the way in helping the HIV+ population.

HHS NEWS

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

FOR IMMEDIATE RELEASE
Thursday, Feb. 24, 2000

Contact: HCFA Press Office
(202) 690-6145

HHS APPROVES MAINE MEDICAID PLAN TO PROVIDE EARLY TREATMENT FOR HIV

HHS Secretary Donna E. Shalala today approved Maine's Medicaid demonstration plan to launch an early intervention and treatment program for individuals in need who are HIV-positive, but do not yet have AIDS and who are not already eligible for Medicaid. Maine is the first state to offer a plan to enroll low-income HIV-positive individuals in the Medicaid program before they become disabled or impoverished

Recent research has shown that early intervention with AIDS-fighting drugs, including anti-retroviral therapies, can slow the progress of the disease and increase life expectancy for many HIV-positive individuals. However, many people with HIV generally do not qualify for Medicaid -- the state/federal partnership that provides health insurance to low-income young, aged, blind and disabled Americans -- until they are considered disabled. This demonstration program will make drug therapies and treatment services available to HIV-positive people earlier in the course of their disease, delaying the onset of disability for many of these individuals.

"Since 1993, we have made unprecedented progress in the battle against HIV and AIDS," Secretary Shalala said. "Better research, prevention and treatment is helping people with this disease live longer, healthier lives, even as we continue our search for a cure. I'm especially pleased today to approve a new approach in Maine which can give more people living with HIV access to promising therapies."

Early intervention is also expected to reduce the need for costly hospitalization and to prevent the onset of opportunistic infections. HHS will closely monitor the Maine demonstration to identify any cost-savings to Medicaid during the five years of the demonstration.

"By making treatment available early to people with HIV, we can vastly improve the quality of their lives," said Nancy-Ann DeParle, administrator of the Health Care Financing Administration, which oversees the Medicaid program. "I'm pleased to be able to work with Maine to promote early treatment of HIV positive individuals to help them cope with this devastating disease."

Since 1993, HHS has approved 18 comprehensive Medicaid demonstrations and several sub-state demonstrations, which have expanded health insurance coverage to more than 2 million people. And last year, President Clinton signed the Ticket to Work and Work Improvement Incentives Act, which creates an option for states to let Americans with disabilities buy in to the Medicaid program; extends Medicare coverage for people receiving disability insurance payments who return to work; and creates an expanded Medicaid demonstration program to help expand coverage to people with serious illnesses before they become disabled, to allow them to keep working.

- More -

Maine's Medicaid agency plans to begin the five-year demonstration project this September. To be eligible, a participant must be HIV-positive and have an income of less than 300 percent of the federal poverty level (the federal poverty level is $8,350 for a person under age 65). The benefit package will include highly active anti-retroviral therapy, office visits, lab services, case management, hospitalizations, mental health and substance abuse services

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Note: For other HHS Press Releases and Fact Sheets pertaining to the subject of this announcement, please visit our Press Release and Fact Sheet search engine at *http://www.hhs.gov/news/press/*.

Internal use only

FINAL
February 24, 2000
Maine Waiver Q&As

1. Q. Maine has been trying to improve services to people with HIV for a long time. What finally got approved today?

A. HCFA today has approved the nation's first Medicaid demonstration project to grant access to Medicaid for persons who are HIV-positive, but do not yet have AIDS and are not otherwise Medicaid eligible. Under Medicaid law, most HIV-positive individuals do not qualify for the program until they become disabled. This Section 1115 waiver of the law will use early intervention with AIDS-fighting drugs to prevent or delay persons with HIV from becoming disabled and to help them live longer, healthier lives. To be eligible to participate in the Maine program, individuals must have been diagnosed with HIV with a gross income of up to 300 percent of the federal poverty guideline (the yearly FPG for an individual is $8,350.)

2. Q. The Administration said in April 1997 that it would find a way within 30 days to do a pilot project to provide new drug treatment to people with HIV. Now, nearly three years later you've announced a tiny project. Why haven't you made a better effort to fulfill your promise?

A. Since 1993, the Clinton-Gore Administration has made unprecedented progress in the battle against HIV and AIDS. Better research, prevention and treatment are helping people with this disease live longer, healthier lives, even as we continue our search for a cure.

While we tried very hard in 1997 to design a large Medicaid demonstration, the budget neutrality requirements simply could not be met. Because of this, we began to work with interested states like Maine to find ways to achieve a budget-neutral demonstration on a smaller scale.

We also worked on other fronts to expand treatment available to people living with HIV and AIDS. Our Ryan White and AIDS Drug Assistance Program (ADAP), for example, have increased dramatically: now serving 500,000 people, with an FY 2001 budget request of $1.7 billion for Ryan White and $554 million for ADAP.

And last year, the President signed the new Ticket to Work and Work Incentives Improvement Act. This new law creates an option for states to let disabled Americans buy into the Medicaid program; extends Medicare coverage for people receiving disability insurance payments who return to work; and creates an expanded Medicaid demonstration program to help expand coverage to people with serious illnesses before they become disabled, to allow them to keep working.

3. Q. If this waiver is such a good thing for people's health *and* it might save money, why limit it to such a tiny group of people?

A. The state believes it can only serve approximately 300 people and remain within state budget criteria. The state does, however, have the option of adjusting the enrollment numbers over the course of the demonstration depending upon its cost experience.

4. Q. Why do participants in this demonstration receive fewer benefits than the regular Maine Medicaid population?

A. The population for this demonstration will be small initially to maintain budget neutrality. However, those in the demonstration will still receive a comprehensive set of benefits that include physician visits, inpatient care, emergency care, pharmaceuticals, lab and x-rays, mental health and substance abuse treatment. These benefits will be available to demonstration enrollees to treat conditions that are HIV-related and for conditions that are not HIV-related. If a person on the program develops full-blown AIDS and needs additional benefits, such as nursing home care, he or she will be eligible for the full array of benefits.

Remember that this is the first Medicaid HIV demonstration covering those people diagnosed HIV positive in the nation. Given the requirement of budget neutrality and the high cost of providing care to those with HIV disease, the state requested a somewhat limited set of benefits for a group that could not be otherwise eligible for Medicaid. The Secretary remains committed to maintaining a full benefits package for all those who are categorically eligible for Medicaid.

5. Q. How will participants for the demonstration be selected? Will the waiver enrollees be the neediest, sickest, or first to apply? Is this fair?

A. Demonstration participants are those diagnosed with HIV infection and have an income below 300% of the federal poverty guideline ($8,350 for an individual person). Participants must also otherwise be ineligible for the traditional Medicaid program. Enrollment for the waiver will be based on first come first served basis. There is no cap on those individuals who are otherwise eligible for Medicaid to enroll in Medicaid.

BACKGROUND: Because the state anticipates only being able to serve around 300 qualified individuals, we expect a waiting list will develop. We are working with the state to develop appropriate measures are taken to ensure continuity of care or treatment. HCFA and the state are continuing to discuss the implementation of the waiting list. It is difficult to predict how many people in the state will be on a waiting list at any one time.

6. Q. Are you allowing beneficiaries in Maine to choose between enrolling in the original Medicaid program and the Medicaid waiver? Is that something you'll let other states do?

A. The Medicaid rules are the same in all 50 states: if a person is entitled to the original Medicaid program, that person should be enrolled in original Medicaid. This waiver doesn't change that simple rule. Rather, the Maine waiver broadens eligibility to people who otherwise would not be eligible for Medicaid or who would lose Medicaid eligibility because of assets and earnings limits, thereby allowing them to get needed treatment before they become too sick to carry on normal productive lives.

BACKGROUND: In Maine, some people may be currently enrolled in original Medicaid because they have "spent down" to meet the medically needy income level. Under the waiver, if these people earn a higher level of income and become ineligible for the original Medicaid, then they may still qualify for health services under the waiver. As with any other Medicaid waiver, the individual will have to be determined ineligible for original Medicaid before that person can be enrolled in the waiver expansion. We are applying the same rules in all States.

7. Q. Will other programs like this take an equal amount of review time in HHS?

A. Maine submitted its waiver request in October 1998. Because Maine's proposal was the first of its kind and because of the complexity of the budgetary and beneficiary protection issues, there were many issues that needed to be worked through with the state. We will review each waiver request in a careful and timely way. We will continue to work with states, Congress, patient advocates, pharmaceutical manufacturers and others to find innovative ways to expand coverage for low-income individuals with HIV.

8. Q. Why aren't you doing more to help people with HIV?

A. The Clinton Administration has responded aggressively to the significant threat posed by HIV/AIDS with increased attention to research, prevention and treatment. Overall funding for major AIDS-related programs has increased by 127 percent under the Clinton Administration, with funding for AIDS care under the HHS Health Resources and Services Administration-administered Ryan White CARE Act increasing by 313 percent and assistance for the purchase of AIDS drugs increasing by 915 percent. At the same time, the Administration has sharpened the focus of its AIDS programs, establishing a new Office of National AIDS Policy at the White House, and creating a permanent Office of AIDS Research at the National Institutes of Health. In addition to hosting a White House Conference on HIV/AIDS launched a comprehensive AIDS vaccine research initiative and approved the nation's first large-scale trial for an AIDS prevention

vaccine. The Administration has also made great strides in addressing the Global HIV/AIDs epidemics, initiating a $100 million cross-agenda initiative in FY2000.

9. Q. Isn't this just offering low-cost health insurance to people who aren't even sick yet?

A. No. People who test positive for the Human Immunodeficiency Virus will develop AIDS at some point in their lives. The goal of this demonstration is to improve the quality of live for those persons by offering access to advanced drug treatment like anti-retroviral therapies *before* they become too sick to carry on normal, productive lives. The expectation is that early treatment and case management services provided to individuals diagnosed HIV positive would reduce expensive hospitalizations and improve the quality of life for individuals who are able to enroll in the demonstration.

10. Q. How many people are expected to benefit from this waiver?

A. HCFA will work with the state to set an initial enrollment limit. The state is in the process of finalizing its budget projections, but expects the number of enrollees to be approximately 300 people.

11. Q. Why did HCFA cap enrollment in this waiver? Doesn't this prevent needy HIV+ people from accessing treatment that can keep them healthy?

A. Maine is expanding enrollment in its Medicaid program to include individuals with incomes up to 300 percent of the federal poverty level, regardless of their categorical eligibility for Medicaid. Because this is the first demonstration of its kind and because of the expensive nature of current drug therapies that treat HIV disease, the state felt it was appropriate to have a limit on the number of people who can enroll in order to control program costs. However, there is no cap on the enrollment of those HIV positive individuals who are entitled to Medicaid, only enrollment in the demonstration is limited.

12. Q. Why did HCFA permit an enrollment cap in this waiver when it refused to approve similar caps in other states such as Wisconsin?

A. The enrollment is not capped for people entitled to Medicaid and HCFA has never approved an enrollment limit on those who are entitled to Medicaid under the law or could have become eligible through a state plan amendment. This enrollment limit in this demonstration applies to people who would not be otherwise eligible for Medicaid. Those already eligible for Medicaid must be enrolled in the non-demonstration Medicaid program. The Wisconsin case is completely different from Maine. Wisconsin had asked to cap the enrollment of those entitled to Medicaid without the waiver. Maine asked to cap enrollment only of those who would never be eligible for Medicaid under current law. We have allowed other states to do what Maine has requested.

13. Q. If the state decides to lower the enrollment limit, won't HIV+ people receiving treatment be forced to discontinue their needed treatment?

A. No. While the state has the flexibility to lower the enrollment ceiling in the future, those already on the demonstration program may not be disenrolled. We believed, and Maine agreed, that it is critically important to maintain treatment for those already enrolled -especially because of the medical effects of discontinuing HIV treatment and the importance of the continuity of treatment.

14. Q. In December 1998, the Vice President said that there was no way to make a waiver budget neutral. Today you are saying that it is budget neutral. What changed?

A. Maine was the first state to present HCFA with a demonstration proposal to provide expanded Medicaid coverage for early treatment to those with HIV. Maine took specific steps to control their costs, including:

* offering a comprehensive benefit package tailored specifically to the needs of those with diagnosed with HIV;
* securing a cost-saving drug discount from pharmaceutical companies; and
* capping enrollment.

The Maine HIV/AIDS waiver project was reviewed by a comprehensive, Administration-wide team. The Administration's best estimates show that the waiver will be budget neutral.

BACKGROUND
Please note, the savings to be gained through the pharmaceutical discount will be made final later in the waiver process. Also, the "Administration-wide team" included participation from HCFA's Office of the Actuary and a budget neutrality team from HHS and OMB.

15. Q. What happens if the waiver is eventually found not to be budget neutral?

A. Under Administration policy, states may not spend more federal funds under an 1115 waiver than the state would have spent in the absence of the waiver. HCFA works closely with states to estimate how much spending would have occurred under normal Medicaid operations over a five-year period. We also work to determine how much the waiver would cost over the same time period. We will not approve a waiver unless we determine that it will be budget neutral. However, if a state were to spend more than the cap allowed, the state would be responsible for all of the additional spending.

16. Q. How much will the program cost?

A. The program is budget neutral, and as such, will generate no service program costs to the Medicaid program above current law estimates of Medicaid spending in absence of the demonstration program. We have estimated that over the next 5-year period, the state and federal government would have spent $56 million to provide health care coverage to individuals diagnosed with HIV under the non-demonstration Medicaid program. The budget neutrality is preserved through a cap on overall expenditures set at $56 million.

17. Q. Will HCFA consider demonstration projects that provide early treatment for other diseases, such as cancer?

A. Under the 1115 waiver process, HCFA will consider any demonstration project from a state which proposes to expand Medicaid coverage. However, any demonstration proposal must meet budget neutrality requirements and must provide a comprehensive set of benefits.

In addition, HCFA will be releasing a request for proposals during the summer of 2000 to states that wish to participate in the Demonstration to Maintain Independence. This Demonstration, created by Section 204 of the Ticket to Work and Work Incentives Improvement Act of 1999 (P.L. 106-170), allows states to provide Medicaid benefits and services to workers who have specific physical or mental impairments that, without medical assistance, will lead to disability. This new authority will allow states to assist working individuals by providing the necessary benefits and services required for people to manage the progression of their conditions and remain employed. Examples of specific physical or mental impairments that could be covered under this demonstration include HIV, depression and diabetes. It is likely that this demonstration will be able to provide coverage to those with HIV as well.

18. Q. How will this demonstration ensure that people with HIV disease are receiving access to quality care?

A. Maine has constructed a detailed access and quality monitoring plan for the demonstration. Through examples such as system pharmacy edits to ensure the most effective use of combination drug therapy and compliance to that drug regime, consultation from a Clinical Advisory Committee, utilization reviews, periodic enrollee surveys, and grievance tracking, the state will have both periodic and immediate monitoring capability for the program.

19. Q. Will demonstration participants have their choice of health care providers?

A. Yes. The Maine HIV demonstration covering those people diagnosed HIV positive, will operate on a fee-for service basis through Maine's current Medicaid provider network.

20. Q. Were advocacy groups and other community groups involved in planning this waiver?

A. Throughout the state's process of developing the program, Maine consulted with numerous advisory groups and community organizations. All these groups included representatives of HIV community providers, advocacy groups, people living with HIV and advisors to state agencies who administer public funds for HIV-related services. These groups were asked for input regarding the needs of the target population, the service package, and what additional sources of information might be useful. Committee meetings were held which included various state agency staff as well as case managers, clinicians, support program providers, and people living with HIV. These groups viewed and commented on the demonstration proposal.

21. Q. How will the people in Maine gain access to the program?

A. The state will provide information to potential program enrollees via a comprehensive outreach and marketing strategy. In addition, information regarding enrollment into the program will be available at social services offices throughout the state, as well as at the state agency.

22. Q. When does the state plan to implement its program?

A. The state plans to implement the program in September 2000. HCFA will work with the state toward this goal.

23. Q. Do other states have programs like this?

A. No, not currently. Some states, however, have expressed an interest in this type of waiver and we will work closely with them to ensure early access to drug therapies and needed health care to help these individuals live healthy and productive lives. We do anticipate that with the approval of Maine's project, other states may submit similar proposals.

24. Q. Isn't it true that the Department is approving this waiver contrary to existing policy for political reasons?

A. No. Let's be clear. This Administration has a long record of developing and implementing innovative health care programs. The approval of this waiver represents years of effort by the federal government and the state. In order to meet the unique challenge posed by HIV, we have worked to develop new approaches. However, we have remained firm on the fundamental Administration policies involving waivers, such as budget neutrality. The waiver was only approved after all of the Administration's waiver criteria were met. As a result of the federal government's and the state's hard work, some of those living with HIV will have access to needed drug therapies and treatment services.

25. Q: How is this Maine demonstration different from the other options on the Work Improvement Act? Why does it have to be budget neutral?

A: This proposal predates the Ticket to Work and Work Improvement Act, AND it is not limited to people who intend to return to work.

It is being approved under existing waiver authority for Medicaid (section 1115) which allows states to try a variety of different approaches to expanding and approving coverage, on the condition that they not cost the Treasury additional money. Since 1993, HHS has approved 18 comprehensive Medicaid demonstrations and several sub-state demonstrations, which have expanded health insurance coverage to more than two million people. Budget neutrality is a condition of approval for all waiver requests.

26. Q. How many people do you expect would otherwise be enrolled in the demonstration but will not be able to benefit of the enrollment cap?

A. It is important to remember that those who are eligible for Medicaid will always be able to receive treatment for HIV. This demonstration is targeted at people who would not otherwise be eligible for Medicaid, and we are pleased that we are able to expand health care coverage to those who may not otherwise have such coverage. Also, depending on its cost experience, the state could increase the size of the program, as long as it remains budget neutral.

BACKGROUND
There are no good estimates of state level HIV status, although we believe the population in Maine is small (1200 with HIV.)

27. Q. Is it true that all the enrollees in the demonstration will be new to Medicaid?

No. In fact, we anticipate that some of the enrollees will have been enrolled in Medicaid already under the "spend down" criteria. These individuals are those that have impoverished themselves in order to become eligible for Medicaid. It is possible that some of these individuals will obtain jobs that will increase their income thereby becoming ineligible for original Medicaid but eligible for the waiver.

AIDS Action

1906 Sunderland Place, NW
Washington, DC 20036
Phone: 202/530-8030 x3030
Fax:
www.aidsaction.org

Fax

To: Sandy Thurman From: Jeff Jacobs

Fax: 202-456-2439 Pages: 3, including cover

Phone: Date: 2/9/00

Re: Medicaid Managed Care Regs

☐ Urgent ☐ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle

Sandy -- Hard copy to follow. Hope all is well and take care.

until it's over
AIDS ACTION

February 9, 2000

Nancy Ann Min De Parle
Administrator
Health Care Financing Administration
Room 413 G Hubert H. Humphrey Building
200 Independence Ave., SW
Washington, D.C. 20201

Dear Ms. DeParle:

On behalf of AIDS Action, the national voice on AIDS, representing all people affected by HIV/AIDS and the 3,200 community-based organizations that serve them, I am writing to strongly urge that forthcoming regulations for the Medicaid program stemming from the Balanced Budget Act of 1997 (BBA) must explicitly include a requirement that all health plans and managed care organizations serving children and adults with HIV/AIDS through Medicaid must comply with federal standards of care for the treatment of HIV infection. Such a requirement should include "Guidelines on the Use of Antiretroviral Agents in HIV-infected Adults and Adolescents", "Guidelines for the Use of Antiretroviral Agents in Pediatric HIV Infection", and "USPHS/IDSA Guidelines for the Prevention of Opportunistic Infections in Persons with Human Immunodeficiency Virus".

As you know, Medicaid is the single largest source of health care for people living with HIV/AIDS in the United States. Despite the existence of federal AIDS programs such as the AIDS Drug Assistance Programs (ADAPs) and the other components of the Ryan White Care Act, Medicaid serves as the foundation of AIDS care through its provision of comprehensive benefits and drug therapies. 50 percent of adults with AIDS and 90 percent of all children with AIDS are Medicaid beneficiaries. Increasingly, adults and children with HIV disease are receiving Medicaid services through managed care programs.

Just as importantly, the standard of care for persons with HIV/AIDS is ever changing. The dramatic advances in groundbreaking new therapies are remarkable and at the same time involve complex, powerful and potentially toxic combination drug regimens. While thoughtful, appropriate administration of these treatment protocols can be life saving, they can also be life-threatening if prescribed by providers with limited knowledge and experience in making treatment decisions. It was that concern that prompted the National Institutes of Health, the Public Health Service, the Henry J. Kaiser Foundation, along with leading research, public health officials and HIV advocates to develop comprehensive federal treatment guidelines, which are regularly reviewed, modified and updated.

1906 Sunderland Place, NW Washington, DC 20036 P 202 530 8030 F 202 530 8031 www.aidsaction.org

Providing Medicaid enrollees who are living with HIV diseases with the standard of care as indicated by federal HIV treatment guidelines will maximize the delivery of health services to those living with HIV/AIDS who obtain care from the Medicaid program. That standard of care for HIV disease has been developed by the nation's leading federal health officials and scientific and medical experts and must become the required standard for Medicaid managed care programs.

The current federal HIV treatment guidelines are evidence-based, and there is research that clearly demonstrates that clinical expertise in managing HIV/AIDS patients translates into better outcomes relative to the frequency and duration of hospitalizations, number and severity of disease complications, and improvements in survival. Without a requirement that each state Medicaid program provide the federal standard of HIV/AIDS care to Medicaid beneficiaries living with HIV/AIDS, we expect there to continue to be unacceptable variations among state Medicaid programs in regard to the quality of HIV care available.

Recently, HCFA issued a State Medicaid Directors Letter that underscored the importance of the federal treatment guidelines and experienced providers to HIV care. While we were pleased to see this guidance, we believe that stronger steps are necessary by HCFA to ensure that all people living with HIV/AIDS receive care consistent with these broadly accepted clinical standards.

Some state Medicaid programs have been so unresponsive to the cost and complexity of HIV care that experienced providers have been forced from the program and the care of HIV-infected beneficiaries has clearly been compromised. We believe that including a requirement in the BBA regulations requiring compliance with federal standards of care would have a significant impact on improving both uniformity and quality of care received by people living with HIV/AIDS in Medicaid across the nation.

Thank you for your considerations. Should you have questions about this issue, please feel free to contact me or Lisa Cox, Senior Legislative Representative, at 202-530-8030.

Sincerely,

Jeff Jacobs
Director, Government Affairs

Cc: The Honorable Donna Shalala
Mr. Chris Jennings
Ms. Sandra Thurman
Mr. Timothy Westmoreland
Mr. Michael Hash
Mr. Henry Claypool
Mr. Dan Mendelson

the National Association of People with AIDS

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January 13, 2000

Nancy Ann Min De Parle
Administrator
Health Care Financing Administration
Room 413 G Hubert H. Humphrey Building
200 Independence Ave., SW
Washington, D.C. 20201

Dear Ms. DeParle:

I am writing on behalf of the National Association of People with AIDS (NAPWA) to express our strong belief that forthcoming regulations for the Medicaid program stemming from the Balanced Budget Act of 1997 (BBA) must explicitly reference a requirement that all health plans and managed care organizations serving children and adults with HIV/AIDS through Medicaid must comply with federal standards of care for the treatment of HIV infection. Such a requirement should include "Guidelines on the Use of Antiretroviral Agents in HIV-infected Adults and Adolescents", "Guidelines for the Use of Antiretroviral Agents in Pediatric HIV Infection", and "USPHS/IDSA Guidelines for the Prevention of Opportunistic Infections in Persons with Human Immunodeficiency Virus".

As you know, Medicaid is the single largest source of health care for people living with HIV/AIDS in the United States. The treatment of HIV disease requires experienced and knowledgeable providers. On-going treatment advances and new clinical data increase the complexity of treatment decisions. Moreover, failure to appropriately treat HIV-infected patients has negative implications for the public health in addition to serious medical consequences for people living with HIV. The current federal HIV treatment guidelines are evidence-based, and there is research that clearly demonstrates that clinical expertise in managing HIV/AIDS patients translates into better outcomes relative to the frequency and duration of hospitalizations, number and severity of disease complications, and improvements in survival. Without a requirement that each state Medicaid program provide the federal standard of HIV/AIDS care to Medicaid beneficiaries living with HIV/AIDS, we expect there to continue to be unacceptable variations among state Medicaid programs in regard to the quality of HIV care available.

Recently, HCFA issued a State Medicaid Directors Letter that underscored the importance of the federal treatment guidelines and experienced providers to HIV care. While we were pleased to see this guidance, we believe that stronger steps are necessary by HCFA to ensure that all people living with HIV/AIDS receive care consistent with these broadly accepted clinical standards.

Some state Medicaid programs have been so unresponsive to the cost and complexity of HIV care that experienced providers have been forced from the program and the care of HIV-infected beneficiaries has clearly been compromised. We believe that including a requirement in the BBA regulations requiring compliance with federal standards of care would have a significant impact on improving both uniformity and quality of care received by people living with HIV/AIDS in Medicaid across the nation.

Should you have questions about this issue, please feel free to contact me or Jeffrey S. Crowley, Deputy Executive Director for Programs at 202.898.0414.

Sincerely,

A. Cornelius Baker
Executive Director

Cc: The Honorable Donna Shalala
Mr. Chris Jennings
Ms. Sandra Thurman
Mr. Timothy Westmoreland
Mr. Michael Hash
Mr. Henry Claypool
Mr. Dan Mendelson