HEALTH—
MEDICARE MODERNIZATION

October 18, 1999

[Roth, Moynihan]
Chairman
U.S. Committee on Finance
Washington, D.C. 20510

Dear Chairman Roth:

It was a pleasure to meet with you and Senator Moynihan on October 5 to discuss our mutual commitment to strengthening and modernizing Medicare. It continues to be my hope that the Congress will take action this year to, at minimum, make a down-payment on needed reforms of the program. I look forward to working with you toward that end.

In 1997, the Medicare trustees projected that Medicare would become insolvent in 2001. Working together across party lines, the Congress passed and I enacted important reforms that contributed towards extending the life of the Medicare trust fund to 2015. As with any major legislation, the Balanced Budget Act (BBA) included some policies that are flawed or have had unintended consequences that are posing immediate problems to some providers and beneficiaries. In addition, the program faces the long-term demographic and health care challenges that will inevitably result as the baby-boom generation ages into Medicare. As we worked together in 1997 to address the immediate threat to Medicare, we must work together now to address its short-term and long-term challenges.

Preparing and strengthening Medicare for the next century is and will continue to be a top priority for my Administration. For this reason, I proposed a plan that makes the program more competitive and efficient, modernizes its benefits to include the provision of a long-overdue prescription drug benefit, and dedicates a portion of the surplus to help secure program solvency for at least another 10 years. However, I also share your belief that we need to take prompt action -- whether in the context of broader or more limited reforms that offset costs and protect the Medicare trust fund -- to moderate the excessive provider payment reductions in the Balanced Budget Act (BBA) of 1997.

You have requested a summary of the administrative actions that I plan to take to moderate the impact of the BBA. In the letter that you sent to me last Thursday, you also asked about four specific issues related to payment for hospital outpatient departments, managed care, skilled nursing facilities, and disproportionate share hospitals.

Attached is a summary of the 25 administrative actions that the Administration is currently implementing or will take to address Medicare provider payment issues. As you will note, the Department of Health and Human Services is taking virtually all the administrative actions possible under the law that have a policy justification, which will

accrue to the benefit of hospitals, skilled nursing homes, home health agencies, and other providers.

We are finishing our review of our administrative authority to address the 5.7 percent reduction in hospital outpatient department payments. We believe that the Congressional intent was for this policy to be implemented in a way that is budget neutral for hospitals and I favor a policy that achieves this goal.

With regards to managed care, we share your commitment expanding choice and achieving stability in the Medicare+Choice marketplace. The BBA required that payments to managed care plans be risk adjusted. To ease the transition to this system, we proposed a 5-year, gradual phase-in of the risk adjustment system. This phase-in forgoes approximately $4.5 billion in payment reductions that would have occurred if risk adjustment were fully implemented immediately. The Medicare Payment Advisory Commission and other experts support the Administration's risk adjustment plan. Consistent with this position, most policy experts believe that a further slow-down of its implementation is unwarranted. However, we remain committed to making any and all changes that improve its methodology. Moreover, as you know, any administrative and legislative changes that increase payment rates to providers in the fee-for-service program will also increase payments to managed care plans.

On the issue of skilled nursing facilities, we agree that nursing home payments for the sickest Medicare beneficiaries are not adequate. I intend to take all actions possible to address this. Administratively, we can and will use the results of a study that is about to be completed to adjust payments as soon as possible. As you know, however, without additional statutory authority, these adjustments are required to be budget neutral.

Finally, it appears that there has been confusion about the current policy for disproportionate share hospital (DSH) payments. Hospitals across a considerable number of states have misconstrued how to calculate DSH payments. As a result, the Department of Health and Human Services (HHS) has concluded that this resulted from unclear guidance. Thus, as reported last Friday, HHS will not recoup past overpayments as a result of this unclear guidance and will issue new, clearer guidance as soon as possible.

We believe that our administrative actions can complement legislative modifications to refine BBA payment policies. These legislative modifications should be targeted to address unintended consequences of the BBA that can expect to adversely affect beneficiary access to quality care. They should also be offset and not erode our progress in strengthening the Medicare trust fund.

I hope and expect that our work together will lay the foundation for much broader and needed reforms to address the demographic and health care challenges confronting the program. We look forward to working with you, as well as the House Ways and Means and Commerce Committees, as we jointly strive to moderate the impact of BBA on the nation's health care provider community.

ADMINISTRATIVE ACTIONS BY THE CLINTON ADMINISTRATION TO MODERATE IMPACT OF THE BALANCED BUDGET ACT OF 1997 ON MEDICARE PROVIDERS

	ISSUE	STATUS
	HOSPITALS: GENERAL	
✓	Capping hospital transfer policy at 10 DRGs for 2 years, through '02	Now being implemented
✓	Stop administrative recoupment of DSH payments based on unclear guidance	Now being implemented
	HOSPITALS: OUTPATIENT	
**	Eliminate the 5.7 percent payment reduction resulting from drafting problem in the Balanced Budget Act	Under review
✓	Delay implementation of the volume control mechanism for 2 years, which would reduce payment reductions	Planned for regulation early next year*
✓	Moderate payment reductions for rural, cancer and other hospitals experiencing large changes, in budget-neutral manner, in transition to prospective payment system (PPS)	Planned for regulation early next year*
✓	Delay implementation of prospective payment system for cancer hospitals until additional data are collected	Planned for regulation early next year*
✓	Make technical refinements to the Ambulatory Payment Classification (APC) system	Planned for regulation early next year*
✓	Allow for temporary cost-based APCs for certain new technologies	Planned for regulation early next year*
✓	Create additional APCs for certain high-cost drugs (e.g., chemotheraphy drugs)	Planned for regulation early next year*
✓	Create separate APCs to pay for blood and blood products	Planned for regulation early next year*
✓	Pay, at least temporarily, for corneal tissue at acquisition costs rather than as part of the payment for overall corneal transplant surgery	Planned for regulation early next year*
✓	Eliminate use of diagnostic codes in payments for medical visits and reassess in the future	Planned for regulation early next year*
	SKILLED NURSING FACILITIES	
✓	Increase payment for high acuity patients	Will be implemented
✓	Exclude certain types of services furnished in hospital outpatient departments from SNF PPS: CT scans, MRIs, cardiac catheterizations, emergency services, major ambulatory surgical procedures, and radiation therapy	Now being implemented
	HOME HEALTH	
✓	Delay tracking patients and prorating payments	Now being implemented
✓	Provide for extended interim payment system repayment schedules for agencies	Now being implemented
✓	Postponing the requirement for surety bonds until October 1, 2000	Now being implemented
✓	Change surety bond requirement to $50,000, not 15 percent of annual agency Medicare revenues	Now being implemented

	ISSUE	STATUS
✓	Eliminate the sequential billing rule	Will be implemented
✓	Phase in reporting of services in 15-minute increments	Will be implemented
	PHYSICIANS	
**	Improve annual updates in payments for physicians' services to correct for erroneous projections through administrative actions	Under review
	RURAL PROVIDERS	
✓	Change the average wage threshold percentages so more rural hospitals can reclassify	Will be implemented
✓	Use same wage index for inpatient and outpatient PPS	Planned for regulation early next year*
✓	Provide stop-loss protection in the transition to the outpatient PPS	In regulation early next year*
**	Modify Health Professional Shortage Area designations	Under review
	AMBULATORY SURGICAL CENTERS	
X	Postpone implementation based on 1999 survey	
	MANAGED CARE	
✓	Phase-in risk adjustment over a 5-year period	Now being implemented
✓	Extending EverCare frail elderly demonstration through 12/31/01 and exempt from risk adjustment during this extension	Now being implemented
X	Phase-in risk adjustment over a 7-year period	
✓	Improve beneficiary protections and access to information	Now being implemented
✓	Ease provider participation rules	Now being implemented

"X" indicates that this policy is not advisable, as described in the attachment.

*Federal law requires that the Administration cannot commit to changes in a proposed rule before the final publication.

**Under review.

FAX COVER SHEET

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COMMENTS: I forwarded an e-mail from Sam & Mary - Sam had to get spch to staff Sec, but he wants to try & incorporate some hate crime language into the spch in the morning.

Q&A for event is also attached if that allows you to stay @ home a little later tomorrow morning.

One last thing → Nicole wants to talk for abt 20 min before I am mtg about Partial Birth Abortions.

See you tomorrow -

Anna