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JAMES E. DENHAM CHIEF OF STAFF

U.S. House of Representatives
Committee on Commerce
 Room 2125, Rayburn House Office Building
 Washington, DC 20515-6115

October 20, 2000

The Honorable J. Dennis Hastert
 The Speaker
 Room H-232 The Capitol
 U.S. House of Representatives
 Washington, D.C. 20515

Dear Mr. Speaker:

We each have different concerns with various aspects of the Balanced Budget Relief Act of 2000, but today we are writing to express our joint concerns about a provision relating to the Medicare appeals process. We understand the intent of this provision is to improve the appeals process for Medicare fee-for-service beneficiaries, but this language as written could make patients worse off than they are today.

This proposal runs afoul of the principles embodied in many of the patient protection bills that have been considered this Congress, including the Bipartisan Managed Care Improvement Act that we coauthored. Most immediately troubling is the standard for reviewing beneficiary appeals when coverage is denied. While we applaud the creation of an external review process, we believe the process should be truly independent and impartial. Under this provision, the independent reviewers who review these appeals would be bound by random coverage decisions made by the fiscal intermediaries and carriers (insurance companies), even if these decisions were inappropriate to the medical condition of the patient. These generalized coverage decisions may not be appropriate when there are particular complicating individual circumstances or medical conditions present that were not anticipated by the guideline. The Bipartisan Managed Care Improvement Act, which passed with an overwhelming bipartisan majority in the House, allows reviewers to consider, but not be bound by, health plans' coverage guidelines, thereby allowing reviews to focus on the needs of the individual patient.

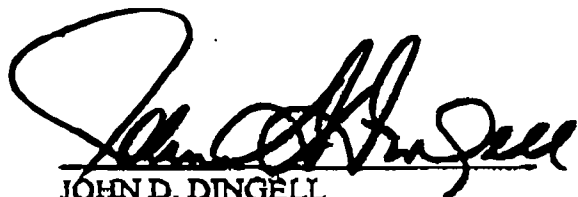
Further, the process outlined in the Balanced Budget Restoration Act places beneficiaries and providers into the same system, which we believe to be a flawed approach. We agree that providers need access to a system on behalf of particular patients. We do not believe they should be able to use the patient appeals system to obtain coverage decisions for procedures, services, or devices that do not relate to a particular patient's treatment.

The Honorable J. Dennis Hastert
Page 2

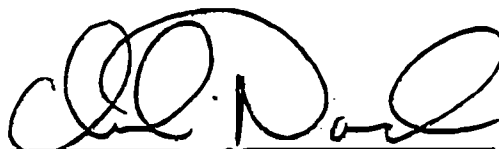
The major changes to the Medicare appeals process envisioned in the Balanced Budget Relief Act of 2000 merit careful consideration and detailed discussion. Until now, this proposal has only been an afterthought included in unrelated legislation, such as prescription drugs, where it was out of the spotlight. Specific deliberation on this proposal is needed because of the significant consequences for the Medicare program, beneficiaries, and providers.

We urge you to ensure that this provision is not included in legislation this year. We intend to work next year to reform the Medicare appeals process so that it adequately protects seniors and is workable for all parties.

Sincerely,



JOHN D. DINGELL
RANKING MEMBER
COMMITTEE ON COMMERCE



CHARLIE NORWOOD
MEMBER
COMMITTEE ON COMMERCE

October 16, 2000

cc: Chris Jennings

John D. Podesta
Chief of Staff to the President
1st Floor, West Wing
The White House
Washington, DC 20500

Dear John:

I am grateful for the opportunity I had last week to speak with you.

The Catholic Health Association of the United States (CHA) supports the President's positions that before adjourning Congress should expand health care coverage for legal immigrants and increase funding for Medicaid disproportionate share hospitals. CHA and the Administration share a common goal with regard to these important matters.

In reviewing, however, the Administration's October 13 comments about programs that would be affected adversely by an excessive and disproportionate allocation of BBA relief funds to Medicare+Choice, I note regrettably that the necessity of a Medicare inpatient market basket update of any kind, let alone the two-year update CHA has advocated, is conspicuously absent. If the Administration does not champion this provision in negotiations with Congress this week, the need to stabilize the traditional Medicare program, already at risk because of current BBA funding reductions, certainly will go unmet.

When five Catholic health systems last week sent a letter to every member of Congress expressing grave concern about the unequal proportionality of BBA relief funds to HMOs, they did so in the hope that the proposed allocation would not be enacted. When CHA advertised the letter in *Roll Call*, we did so because we believe these systems have a unique perspective in that they provide care for millions of seniors under the traditional Medicare program and, as owners of health plans, are also responsible for nearly 100,000 Medicare+Choice enrollees. We dared to go public with this message, because it was the right thing to do.

In spite of its absence from your list, John, the Catholic health ministry continues to encourage the Administration to stabilize the traditional Medicare program by proposing and defending publicly, as well as in negotiations with congressional leadership, a two-year Medicare inpatient market basket update.

With personal best wishes, I am

Sincerely,

Michael D. Place

Rev. Michael D. Place, STD
President and Chief Executive Officer



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Washington, DC 20006-5409

Phone 202-296-3993

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The Arc of the United States

Governmental Affairs Office

*The national organization of and for people with mental retardation
and related disabilities and their families*

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___ Evelyn Powell

☐ URGENT

___ Marty Ford

___ Brenda Walker

☐ PLEASE COMMENT

___ Kathy McGinley

☐ FYI

___ Kim Musheno

DATE: 10/17/00

TO: Chris Jennings

FAX #: 456-5557

NUMBER OF PAGES (INCLUDING COVER SHEET): 5

DOCUMENT DESCRIPTION: _____

REMARKS: _____

MISSION STATEMENT

The Arc of the United States works through education, research and advocacy to improve the quality of life for children and adults with mental retardation and their families and works to prevent both the causes and the effects of mental retardation.



The Arc of the United States

The national organization of and for people with mental retardation and related disabilities and their families

1010 Wayne Avenue, Suite 650
Silver Spring, Maryland 20910
(301) 565-3842 FAX - (301) 565-3843
www.thearc.org

October 17, 2000

The Honorable Trent Lott
Senate Majority Leader

Dear Senator Lott:

The Arc of the United States is the nation's leading national organization on mental retardation and has over 140,000 members and approximately 1,000 state and local chapters nationwide. The Arc represents over seven million children and adults with mental retardation and related developmental disabilities and their families. Many of these children and adults need access to health and health related services and supports so they can continue to live at home in the community.

That is why The Arc has grown increasingly concerned as we watch the so-called Medicare "provider give-back" bill move through Congress. This bill would give Medicare providers \$28 billion over five years. One-third of these funds would go to Medicare managed care plans, yet hundreds of thousands of elderly people and people with disabilities have been dropped by these plans over the last several years.

The Arc strongly believes that any health related legislation that is enacted into law this year should reflect the needs of a broad range of consumers and not just providers. We are disturbed with the fact that Congress can find funds for provider give-backs and Medicare HMOs but not to help families with children with disabilities or adults with disabilities get access to the health and health-related supports and services they need.

We support efforts to include the Family Opportunity Act and strong managed care consumer protections in any final action on health. Both of these initiatives already have strong bipartisan Congressional backing. Because of our strong support for community-based programs, we also support the inclusion of funds for systems change grants to address the institutional bias in Medicaid.

The Arc looks forward to working with you on these initiatives.

Sincerely,

Karen Staley
President

bcc: Jonathan Young
Chris Jennings

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October 17, 2000

The Honorable Tom Daschle
Senate Minority Leader

Dear Senator Daschle:

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October 17, 2000

The Honorable Dick Gephardt
House of Representatives Minority Leader

Dear Rep. Gephardt:

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bcc: Jonathan Young
Chris Jennings

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October 17, 2000

The Honorable Dennis Hastert
Speaker of the House of Representatives

Dear Speaker Hastert:

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President

bcc: Jonathan Young
Chris Jennings

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Office of the Speaker
United States House of Representatives
Washington, DC 20515

cc: Jennings

October 17, 2000

Dear Mr. President,

I was deeply disappointed to read your letter dated October 10, 2000. As you know, I have been a strong advocate of ensuring both that we stabilize the Medicare program in a responsible way and that we enact a meaningful Patient's Bill of Rights. Mr. President, you and I have had several productive conversations about how we can set politics aside and achieve both goals. That is why I was so distraught to read your letter that clearly tried to inject politics into what should be a nonpartisan debate.

Your attempt to link stabilizing the important Medicare+Choice program to the Patient's Bill of Rights is both unfair and unwarranted. I refuse to believe that if we rise above politics that we can't meet both essential objectives. As you know, in 2000, nearly 327,000 Medicare beneficiaries were in plans that pulled out of the Medicare program. As a whole, seniors who lost this choice are upset and looking for assistance in ensuring that this important option remain available to them. Unfortunately, studies show that the seniors who have lost the option of a Medicare+Choice plan tend to be among the most vulnerable in our population.

Mathematica Policy Research shows that of the seniors who lost Medicare+Choice plan options, 73% have incomes of less than \$20,000. Also, the same studies show that these seniors are in "substantially worse health on average" than seniors who did not lose Medicare+Choice plans. In fact, a government Health Care Financing Administration (HCFA)-sponsored study verifies that "the impression that the Medicare FFS population is, on average, in much worse health than the Medicare managed care population is not borne out."

This is not a partisan issue. In fact, Democratic Members have written both to me and to Minority Leader Richard Gephardt seeking a remedy to this very real problem. I regret that your letter criticized "excessive payments to managed care plans," when we are still working out the details of the legislation and have not yet disclosed our proposal. In fact the numbers you outlined were incorrect.

Mr. President, you submitted a list of brand new government-funded programs that should be included as a part of the Medicare refinement package we are crafting. Instead, I would urge you to focus on the urgent need to stabilize the Medicare program and also provide Medicare beneficiaries with needed preventative benefits. Our nation's seniors deserve the peace of mind that comes from regular pap smears, colonoscopy screenings and other important benefits.

I ask you now to work with me to provide these preventative benefits rather than a wholesale expansion of government dollars to new funding initiatives.

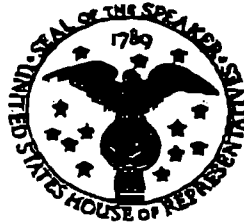
In addition to our shared desire to work out a responsible solution to the crisis in the Medicare+Choice program, I would hope that you remain interested in pursuing a Patient's Bill of Rights this year.

Mr. President, I stand ready to work with you to achieve the dual goals of stabilizing the Medicare program and enacting a Patient's Bill of Rights. If we put progress before partisanship, I believe we can be successful on both fronts.

Sincerely,



J. Dennis Hastert
Speaker of the House



Bunker

SPEAKER'S PRESS OFFICE

DATE: 10/17/00

TO: White House Legislative Affairs

FAX: 456-6220

NUMBER OF PAGES (INCLUDING THE COVER SHEET) 3

FROM:

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PRESS SECRETARY

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☐ AMY ALTHOFF
SPEECH WRITER

☐ PAIGE RALSTON
DEPUTY PRESS SECRETARY

☐ ABBY MOON
PRESS ASSISTANT

☐ OTHER:

Comments: _____

If you have any problems receiving this fax, please call 202/225-2800

**Speaker's Press Office
H-326, The Capitol
Washington, DC 20515**

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HEALTHCARE RIGHTS PROJECT
1101 VERMONT AVENUE, N.W., SUITE 1001
WASHINGTON, DC 20005
(202) 216-0028 FAX (202) 216-0119

FAX COVER SHEET

To: Chris Jennings

From: ✓ Alfred Chiplin ✓ Vicki Gottlich
Toby Edelman Patricia Nemore
Davie Ryan

Fax#: 202-456-5557

Phone#: 202-456-5560

Date: Oct. 19, 2000

RE: Medicare Give-Back Legislation

Number of Pages (Including this cover sheet): 8

Comments: Medicare "give-back" letters from
beneficiary advocates in opposition to the bill -

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HEALTHCARE RIGHTS PROJECT
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Gill Deford
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Toby Edelman
Vicki Gottlich
Patricia Nemore

ADMINISTRATOR

Carmyn S. Boyle

ADVOCACY COORDINATOR

Ellen L. Lang, R.N., M.P.H.

DATA PROJECT DIRECTOR

Larry S. Glatz

Memorandum

OF COUNSEL

Sally Hart*

*Admitted in other jurisdictions

To: Chris Jennings
White House

From: Vicki Gottlich
Alfred Chiplin
Judy Waxman

Re: Medicare "Give-back" bill – Problems for Beneficiaries

Date: October 19, 2000

Here are two recent letters, developed and sent after your meeting with beneficiary groups last week. The letters illustrate the importance of assuring that the Medicare "Give-back" bill achieves the appropriate balance of beneficiary and industry concerns.

The October 16th letter focuses on the amount of money to be given to HMOs and the failure to fund improvements that would further beneficiary access to services. The second letter, dated October 18th, addresses proposed changes in the Medicare appeals process of enormous negative consequence to beneficiaries. (The October 18th letter was sent to both the House and the Senate.)

/

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DATA PROJECT DIRECTOR
Larry S. Glatz

OF COUNSEL

Sally Hart*

October 16, 2000

*Admitted in other jurisdictions

The Honorable Christopher Dodd
United States Senate
Washington, DC
Fax (202) 224-1083

Dear Senator Dodd:

The Center for Medicare Advocacy, Inc., a non-profit organization that represents Medicare beneficiaries, urges you to vote against any Medicare "give-back" bill that raises payments to HMOs at the expense of older people, people with disabilities, and other health care providers.

Although only about 16% of Medicare beneficiaries are enrolled in HMOs, they are slated to receive about one-third of the total funds allocated in the restoration bill. The proposed excessive payments come with no strings attached. HMOs do not have to commit to remain in any market or to maintain benefit levels in order to receive the extra payments.

We in Connecticut know what happens when HMOs are not held accountable for providing services. Over 50,000 Connecticut residents are among the nearly 1 million Medicare beneficiaries nationwide who will lose their HMO at the end of the year. HMOs have decided to terminate their Medicare contracts this year despite an increase of \$1.4 billion in managed care payments in 2000. Increasing HMO payments so drastically now, without requiring HMOs to stay in the program for at least two years and not reduce their level of benefits, still provides no guarantee against another rash of HMO contract terminations at the end of 2001.

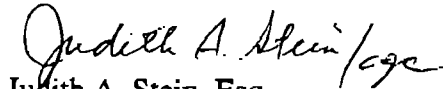
In addition, studies show that HMOs are *overpaid*, not *underpaid*. The General Accounting Office has found that HMOs receive almost \$1,000 per enrollee more than they should be paid. Instead of lowering payment rates, the Balanced Budget Act of 1997 has caused HMO payment rates to grow faster than traditional Medicare per capita spending. Increasing HMO payment rates so disproportionately will only increase the amount of overspending, and will prevent Medicare funds from being spent on services that are needed and that reach beneficiaries more broadly.

If there are to be increases for HMOs, we urge you to tie the increases to a requirement that HMOs remain in a market for at least two years and not reduce benefit levels. Preferably, we urge you to decrease the funding increases allotted for HMOs and, instead, provide more funds for provisions which will improve health care for all Medicare beneficiaries. These provisions include:

- adding a meaningful prescription drug benefit to the Medicare program;
- improving enrollment of low-income Medicare beneficiaries in the Medicaid program;
- eliminating cost sharing for Medicare preventive services;
- increasing access to home health benefits by:
 - modifying the definition of "homebound" and
 - delaying the 15% cut in home health payments;
- improving nursing home quality of care by increasing the staffing ratios.

We thank you for your support. Please feel free to contact me to discuss further any of the above issues.

Sincerely,



Judith A. Stein, Esq.
Executive Director

October 18, 2000

Dear Senator:

The undersigned organizations advocate for strong beneficiary appeal rights in the Medicare program. Limitations on appeal rights included in the proposed Medicare "Give-back" legislation will significantly alter current rights of beneficiaries to challenge denials, reductions, and terminations of Medicare coverage. We urge you to **vote against** this bill.

There are two provisions of major concern. The first, Section 521(c)(3)(B)(ii)(I), makes local coverage determinations binding on qualified independent contractors who make reconsideration decisions for the Medicare program. The second, Section 522(a)(5), limits standing to review national or local coverage determinations. These provisions represent significant changes in Medicare law to the detriment of Medicare beneficiaries.

Local medical review policies are informal decisions about what items, services, and procedures local insurance companies and others – under contract with Medicare for the administration and payment of claims – will cover. These policies are developed by local medical societies, and Medicare carriers and intermediaries. They are not vetted in any way through a national process for purposes of safety and effectiveness, or other medical/scientific scrutiny.

According to the Health Care Financing Administration (HCFA), the agency that administers the Medicare program, there are currently some 8,000 local coverage policies. Elevating these policies in this fashion will result in a lack of uniformity and consistency in program benefits and administration of the Medicare program. Further, there are no standards for Administrative Law Judge (ALJ) or Departmental Appeals Board (DAB) review of these decisions. HCFA is just now beginning the process of trying to collect these local medical policies and currently has no way of knowing what local coverage policies exist or how they impact on coverage and access to service.

Under current law, HCFA review contractors are bound by HCFA rulings, manuals, transmittals, and other HCFA guidance. Review contractors have never been bound by local coverage policies. Binding them by such policies represents a major change in program policy and administration. Doing so represents much more than a technical correction in the Medicare statute.

The bill also contains troublesome language in Section 522(a)(5) about standing to review national or local coverage policies. As proposed, reviews can only be brought by individuals entitled to benefits under Part A or enrolled under Part B, or both, who are in need of the items or services that are the subject of the coverage determinations; or by persons or classes of persons who manufacture, offer, supply, make available or provide items and services that may be marketed for the intended use that is the subject of the determination. As written, this leaves out the medical and scientific community that might advocate for or against certain items or services based on the safety and effectiveness of the item or service at issue. We oppose this change to current law as well.

As you consider whether to support the Medicare BBA refinements legislation, we ask that you weigh the negative consequences that these provisions have on the Medicare appeal rights of your constituents and that you **vote against this bill**.

Sincerely,

Alzheimer's Association
Center for Medicare Advocacy, Inc.
FamiliesUSA
Medicare Rights Center
National Academy of Elder Law Attorneys
National Committee to Preserve Social Security and Medicare
National Council of Senior Citizens
National Senior Citizens Law Center

October 18, 2000

Dear Representative:

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FamiliesUSA
Medicare Rights Center
National Academy of Elder Law Attorneys
National Committee to Preserve Social Security and Medicare
National Council of Senior Citizens
National Senior Citizens Law Center

DATE: 10-19-00



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
ROOM 405H, HUMPHREY BUILDING
200 INDEPENDENCE AVE, SW
WASHINGTON, D.C. 20201

PHONE: (202)690-7450

FAX: (202)690-8425

TO:

Chris Jennings

OFFICE:

495-5557

FAX:

225-3

FROM:

- ☒ JANE HORVATH
☐ KRISTINE BRADSHER
☐ SHARON CLARKIN
☐ DEBORAH DRAYER
☐ JOANNE JEE
☐ LEO LUBERECKI
☐ ROGER MCCLUNG
☐ JACK MITCHELL
☐ ZENO ST CYR
☐ PAUL SELTMAN
☐ STEPHANIE WILSON
☐
☐
☐
☐

(INCLUDING COVER):

27

REMARKS:

RECEIVED

Richard M. Scrushy
Chairman of the Board & Chief Executive Officer

October 19, 2000

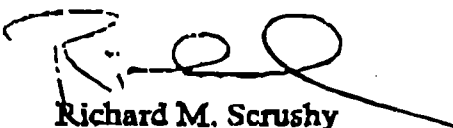
The Honorable Jim McCrery
United States House of Representatives
Washington, DC 20515

Dear Rep. McCrery:

Please accept this as my sincere thanks and appreciation for all of your efforts with the "Medicare Refinement and Benefits Improvement Act of 2000." It is because of men such as yourself that give their attention to matters of concern to all people that we are able to make progress in much needed areas.

Rehabilitation hospitals across the nation will benefit from this legislation but greater still will be the benefit to the patients. Your help and continued support of this issue is again deeply appreciated.

Best regards,


Richard M. Scrushy
Chairman of the Board & Chief Executive Officer

One HealthSouth Parkway • Birmingham, AL 35249
205 987-7116
www.healthsouth.com

HBC
NYSE

Howard J. Braverman, O.D.
President



American Optometric Association

243 N. Lindbergh Blvd. • St. Louis, MO 63141 • (314) 991-4100
FAX: (314) 991-4101

October 19, 2000

The Honorable Bill Archer
1236 Longworth Office Building
U.S. House of Representatives
Washington, DC 20515

Dear Representative Archer:

The American Optometric Association applauds your efforts to include new and important benefits in the pending Medicare Refinement Package. The American Optometric Association (AOA) represents the interests of more than 30,000 Doctors of Optometry and their patients.

We are particularly pleased that the glaucoma eye examination benefit is a part of this package. This bi-partisan supported provision is an important step in preventing blindness due to undetected glaucoma. The National Eye Institute has estimated that almost three million Americans have glaucoma. Half of these people are not aware that they have the disease. Of those who have been diagnosed with glaucoma, about 120,000 are blind. Moreover, glaucoma is a leading cause of blindness in older adults. Although glaucoma can often be controlled if it is diagnosed early, in many Americans the disease goes untreated, leading to visual impairment or blindness. Because there are no early warning signs, this disease often develops undetected until permanent vision loss has occurred.

Again, the AOA appreciates inclusion of this important preventive service in the Medicare Refinement and Benefits Improvement Act. It is an important part of ongoing efforts to improve public health and prevent unnecessary vision loss.

Sincerely,

Howard J. Braverman, O.D.

Metropolitan D.C. Office: 1805 Prince Street • Alexandria, VA 22314 • (703) 738-9200 • FAX: (703) 733-9497
Visit our World Wide Website at <http://www.aonet.org>

THE GLAUCOMA FOUNDATION

BY FAX

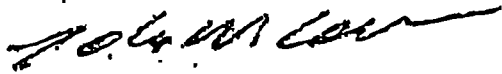
October 19, 2000

Honorable Dennis Hastert, U.S. Congressman
United States House of Representatives
Washington D.C. 20515

Dear Mr. Speaker:

I am writing to urge your support of section 105 of the Ways and Means Committee Budget Refinement Package for Medicare. This provision provides for screening for glaucoma, the nation's leading cause of preventable blindness, for those at risk. The Glaucoma Foundation supports this forward-looking initiative, which will help preserve the precious gift of sight.

Sincerely yours,


John W. Corwin
Executive Director

116 John Street, Suite 1605, New York, New York 10036 • 212-285-0080 • 1-800-GLAUCOMA • FAX: 212-651-1888
EMAIL: info@glaucoma-foundation.org • WEB SITE: http://www.glaucoma-foundation.org

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From-212 285 0110

To-

Page 01



National Kidney Foundation

Making Lives Better

October 19, 2000

The Honorable William M. Thomas
Committee on Ways and Means
1136 Longworth House Office Building
Washington, DC 20515

OFFICE OF SCIENTIFIC
AND PUBLIC POLICY

Dear Representative Thomas:

The National Kidney Foundation (NKF) supports the package of Medicare improvements under consideration in Congress, particularly the provisions described below. NKF is the country's oldest and largest voluntary health agency serving the needs of kidney patients with over 30,000 members from every part of the nation and from every walk of life, including consumers and their families, nurses, dietitians, social workers, physicians, dialysis technicians and concerned members of the lay public.

The National Kidney Foundation urges Members of Congress to vote for the package and exhorts the President to sign the legislation. We especially endorse the following provisions and thank you for including them in the bill.

Two provisions in the Beneficiary Improvement section would be of enormous benefit to kidney patients. They result from recommendations made by the Institute of Medicine of the National Academy of Sciences last December as part of studies mandated by Congress in the Balanced Budget Act of 1997. Section 113 removes the existing time limitation on Medicare coverage for immunosuppressive medications needed by transplant recipients. Without this enhanced benefit, tens of thousands of transplant recipients run an increased risk of rejecting their transplants. Rejection could result in a return to dialysis, which Medicare covers and which costs the government much more than the drugs which preserve the functioning of a transplant. Section 105 authorizes Medicare payments for nutritional counseling for pre-dialysis and post-transplant patients. This could benefit 80,000 Americans who are faced each year with the prospect of irreversible kidney failure and the changes in diet which are required to prepare these patients for that eventuality, as well as 12,000 kidney transplant candidates who receive the Gift of Life annually and thus need to adjust their dietary intake when they become transplant recipients. Nutritional counseling has been shown to reduce morbidity and mortality in these populations.

Section 422 under Part B Improvements provides for an update in the reimbursement rate paid for kidney dialysis treatments as recommended by the Medicare Payment Advisory Commission. NKF has pioneered in the development of practice guidelines which can assist health service professionals in their efforts to improve the quality of care provided to our nation's 250,000 dialysis patients. Dialysis clinics need this reimbursement update in order to be able to implement these recommendations.

Sincerely,

John Davis
CEO

cc: The Honorable Dennis J. Hastert



October 19, 2000

The Honorable Dennis Hastert
Speaker of the U.S. House of Representatives
U.S. Capitol, H-232
Washington, DC 20515

The Honorable Trent Lott
Majority Leader of the U.S. Senate
U.S. Capitol, S-230
Washington, DC 20510

Dear Leader(s):

On behalf of the nation's 1,700 privately-owned and managed hospitals, the Federation of American Hospitals is pleased to offer its strong support of the Medicare, Medicaid & S-CHIP Beneficiary Improvement & Protection Act of 2000. In the wake of the unintentionally negative impact of the Balanced Budget Act of 1997 (BBA), hospitals and health providers across the country have struggled financially, straining their ability to provide quality patient services. This legislation is a major step toward addressing some of the excesses in the BBA, and restoring stability to our health care delivery system.

By providing hospitals with a full inflation update for fiscal year 2001, Congress will allow us to be better prepared to meet the costs of delivering care to the millions of patients that we annually serve. By addressing excessive reductions in Medicaid, in Medicare Disproportionate Share payments, and in payments for indigent care, the bill targets its assistance at the precise payment policies that have so negatively impacted hospitals in recent years. Would hospitals like more relief, for a longer duration, including the restoration of our full inflation update for 2002? Certainly, but we appreciate the significant assistance in this bill. Above all, we want to ensure that the relief that is included in this package becomes law before Congress adjourns.

In addition to the broader provisions that impact all hospitals, the bill also includes significant provisions to assist rural hospitals, hundreds of whom are Federation members. Among numerous important rural provisions, the changes to the Medicare DSH program thresholds that will allow far more rural hospitals to participate, may be the most important. Many struggling hospitals in rural communities, serving predominantly low-income populations, will receive vital new assistance that will allow them to maintain services to poor Medicare patients.

Finally, this summer, after many years of development, hospitals moved to outpatient prospective payment (PPS). Despite improvements under the new outpatient PPS, beneficiary copayments remain high for some services due to historical design flaws in the program. This bill will significantly reduce many of those copayments, lowering costs to seniors.

Federation of American Hospitals
Page 2

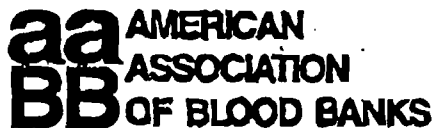
These are just a few of the many positive provisions that have been included in this legislation to help patients and their health care providers. As a result, the Federation strongly supports the Medicare, Medicaid & S-CHIP Beneficiary Improvement & Protection Act of 2000. We will work with Congress and the President to encourage its swift enactment.

We look forward to working with Congress and the Administration to further educate our leaders on the difficulties facing our health providers. Both the President and Congress have shown a significant appreciation for the reimbursement problems facing our hospitals, and we hope that we can continue this dialogue. Only with a sustained bipartisan dialogue can our hospitals, and our biggest insurer - the government - continue to provide the world's finest health care in an increasingly complex fiscal environment.

Sincerely,


Thomas A. Scully
President & CEO

cc. Senate Democratic Leader Thomas Daschle
House Democratic Leader Richard Gephardt
Chairman William Roth
Chairman William Archer
Chairman Thomas Bliley
Chairman William Thomas



October 19, 2000

The Honorable William M. Thomas
Chairman, Ways and Means Health Subcommittee
1136 Longworth House Office Building
U.S. House of Representatives
Washington, DC 20515

The Honorable Michael Bilirakis
Chairman, Commerce Health Subcommittee
2369 Rayburn House Office Building
U.S. House of Representatives
Washington, DC 20515

Dear Chairmen Thomas and Bilirakis:

The American Association of Blood Banks, America's Blood Centers, and the American Red Cross would like to express our support for the Medicare, Medicaid and SCHIP Beneficiary Protection and Improvement Act of 2000. We are pleased that Section 301 of the final conference agreement contains both the House and Senate provisions concerning blood and blood products. We would especially like to thank you, Chairman Roth and Senator Hatch for your tremendous leadership on blood safety and reimbursement concerns.

The blood banking community believes the House provision pertaining to blood is needed to ensure that the Health Care Financing Administration accurately reflects the costs of blood and blood products in the next revision of inpatient reimbursement rates. The Senate provision is needed to ensure that the current system will be able to account for future blood safety costs in a timely manner. We are delighted that the final package contains both these provisions. We strongly support Congressional enactment of the legislation and urge the President to sign the bill into law.

Once again, we appreciate and commend your efforts to address reimbursement for blood and blood products in legislation this year. Your efforts will help ensure that patients across the country have access to state-of-the-art blood products and services and the safest possible blood supply.

Sincerely yours,

American Association of Blood Banks

America's Blood Centers

American Red Cross

cc: Speaker Dennis Hastert

ACUTE LONG TERM HOSPITAL ASSOCIATION

1055 North Fairfax Street, Suite 201 • Alexandria, VA 22314 • Phone (703) 299-5571 • Fax (703) 299-5574

Honorable Jim McCrery
United States House of Representatives
Washington, D.C. 20515

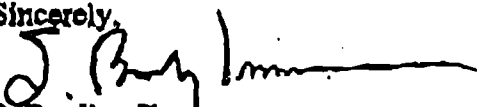
Thursday, October 19, 2000

Dear Representative McCrery:

On behalf of the nearly 100 hospital-members of the Acute Long Term Hospital Association (ALTHA), I would like to express our sincerest gratitude for your leadership and commitment toward ensuring final passage of the Medicare Refinement and Benefits Improvement Act of 2000. We are particularly grateful for your strong efforts to secure inclusion of the following provisions: Sec. 210, which increases potential reimbursements and requires HCFA to develop a workable PPS system by October 1, 2002, and ensures that long term care hospitals, and only long term care hospitals (as defined by law) will be eligible for reimbursement under the new system; Sec. 404, which imposes a 2 grandfather clause on HCFA's pending provider-based status rule, and substitutes HCFA's "75/75 zip code" scheme with a more reasonable 35-mile zone provision; and Sec. 202, which increases reimbursement for bad debt.

Please do all you can to ensure these provisions remain and the bill is passed into law in this session of Congress. Once again, we greatly appreciate your leadership and strong efforts on behalf of our patients and our hospitals.

Sincerely,


S. Bradley Traverso
Executive Director



The Susan G. Komen Breast Cancer Foundation

National Headquarters

October 6, 2000

Honorable William Roth, Chairman
Committee on Finance
United States Senate
SD-219, Dirksen Senate Office Building
Washington, D.C. 20510

Dear Chairman Roth:

On behalf of the Susan G. Komen Breast Cancer Foundation, I am writing to urge you to include funding for digital mammography in the Medicare initiative currently being shaped by Congress.

The Medicare, Medicaid and SCHIP Improvements Act of 2000 provides a valuable opportunity to recognize and promote a new technology that offers many exciting possibilities. The Komen Foundation urges its inclusion in the interest of advancing women's health. Digital mammography creates high definition pictures for detection and diagnosis of breast cancer in its earliest, most curable stages. Doctors can easily transmit images from remote areas to specialists worldwide for expert consultation. Digital mammography also requires fewer tests and yields faster results, which translates into lower exposure to radiation and greater convenience for Medicare beneficiaries.

The Komen Foundation recognizes the limitations of current mammography and has dedicated its own research funding towards the pursuit of new screening and diagnostic technologies, including digital mammography. Now that this cutting-edge technology has received FDA approval and shown promise in the early detection of breast cancer, it is important to distribute it widely and enable women all over the country to receive its benefits. In the closing days of Congress, Komen asks you to please help promote this new scientific advancement for women's health. The estimated cost is only \$87 million over five years.

The mission of the Susan G. Komen Breast Cancer Foundation is to eradicate breast cancer as a life-threatening disease by advancing research, education, screening, and treatment. To this end, the Komen Foundation dedicates millions of dollars annually towards scientific research, education and community outreach. But we cannot do it alone. The eradication of breast cancer as a life-threatening disease requires the support of dedicated Members of Congress like you. Your continued efforts in the battle against breast cancer are deeply appreciated.

Thank you very much.

Sincerely,

Nancy Brinker
Founding Chairman



NATIONAL ASSOCIATION OF LONG TERM HOSPITALS

150 York Street, Stoughton, Massachusetts 02072 (781) 344-0600 Boston line (617) 364-4850 FAX (781) 344-0128

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RICHARD E. JOHNSON, Treas.
New England Sinai Hospital
Stoughton, MA

SUSAN L. GLASSER, Clerk
Spaulding Rehabilitation Hospital
Boston, MA

STANFORD ALLIKER
Carmen County Health Services Center
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SCOTT KATILIS
Hennepin County Lutheran Hospital
St. Paul, MN

CHERYL RUTZYNSKI
Bay Special Care Center
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Barlow Respiratory Hospital
San Angelo, CA

DONALD GOLDBERG
New England Sinai Hospital
Stoughton, MA

ROBERT HARR
Rehabilitation Hospital
at Heather Hill
Chardon, OH

MARY KOTI
TIRR Lifebridge
Houston, TX

ARTHUR MAPLES
Baptist Memorial
Restorative Care Hospital
Memphis, TN

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GENERAL COUNSEL

EDWARD D. KALMAN
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6 Beacon Street
Boston, MA 02108
(617) 227-7860
Fax (617) 227-4208

October 19, 2000

Via Facsimile Only

The Honorable William M. Thomas,
Chairman Committee on House
Administration
1309 Longworth House Office Building
Washington, D.C. 20515-6157

The Honorable William V. Roth, Jr.,
Senator
SH-104 Hart Senate Office Building
Washington, D.C. 20510-0801

The Honorable Michael Bilirakis,
Representative
2369 Rayburn House Office Building
Washington, D.C. 20515-0909

Dear Chairman Thomas,
Senator Roth and
Representative Bilirakis:

I am writing you in my capacity as President of the National Association of Long Term Hospitals ("NALTH") to express the strongest possible support for Medicare program and payment refinements which are presently pending before Congress. Long term hospitals are particularly dependent on Medicare program policy. Typically 60% to 70% of all patients admitted for inpatient services in long term hospitals are Medicare beneficiaries. These individuals constitute perhaps the most profoundly ill and disabled segment of Medicare beneficiaries since they all require an atypically long hospital stay and specialized programs of care.

Chairman Thomas
Senator Roth
Representative Bilirakis
October 19, 2000
Page 2

Congressional proposals relating to long term hospitals implement long standing bipartisan recommendations of policy makers to achieve the development of a long term hospital prospective payment system and, in the interim, to equalize the payment system. These payment and policy changes are desperately needed in order to support the multitude of programs and dedicated personnel who serve this very vulnerable Medicare population.

I wish to underscore that the failure to implement these provisions, at this time in light of past reductions of payments to long term hospitals, would have an immediate and direct adverse affect on hospital employees and programs.

NALTH is appreciative of the thoughtful approach which Congress has taken on these issues and is mindful that it is important that the entire hospital industry achieve a baseline of economic health in order to support the continuum of care which is so important to Medicare beneficiaries.

We believe it is important that the President assume a leadership role with his colleagues in Congress and approve all Medicare refinements proposed by Congress.

I wish to thank members of Congress for all of their efforts to secure and improve the Medicare program with this very important legislation.

Sincerely,

Geraldine Bruckner

Geraldine Brueckner
President

cc: Senate Majority Leader Trent Lott
Speaker of the House J. Dennis Hastert

National Association of
Children's Hospitals



N · A · C · H ·

October 19, 2000

The Honorable William M. Thomas, Chairman
Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

On behalf of the National Association of Children's Hospitals (N.A.C.H.), I am writing to thank you for your recognition of the different financial circumstances of children's hospitals and your efforts to address their concerns with the Medicare outpatient prospective payment system (OPPS).

In particular, we appreciate the inclusion of a change in the application of the Medicare OPPS to children's hospitals in both the Ways and Means Health Subcommittee's "Medicare Benefit and Improvement Act" and the consolidated legislation you are developing to amend those health related provisions of the "Balanced Budget Act of 1997," which threaten to jeopardize the financial stability of different health care providers. Your proposal will treat children's hospitals the same as cancer hospitals for purposes of Medicare OPPS implementation, which will ensure that children's hospitals are effectively held financially harmless.

This legislative action is important to take into account the disproportionately large adverse effect that the Medicare OPPS could have on children's hospitals' ability to serve those children who qualify for Medicare. It is even more important to demonstrate to other payers of health care, which seek to model their reimbursement systems on Medicare's, that without adjustment, the adoption of the OPPS system used by Medicare can put children's hospitals at financial risk and would be inappropriate.

Any change in outpatient reimbursement methodology, such as the new Medicare OPPS, which does not reflect children's unique health care needs, can significantly affect children's hospitals' fiscal health overall, because the volume of outpatient care they provide is substantial and the greatest growth in their patient care is in outpatient services. For example, on average in FY 1998, a typical large freestanding children's acute care hospital provided care for children in more than 220,000 outpatient visits, eight percent more than in FY 1997.

Thank you again for focusing on the unique outpatient needs of children's hospitals.

Sincerely,

Peter D. Willson

Peter D. Willson
Vice President for Public Policy

401 Wythe Street, Alexandria VA 22314
(703) 684-1355 Fax (703) 684-1589

An Affiliate of the National Association of
Children's Hospitals & Related Institutions



**Visiting Nurse Associations
of America®**

October 20, 2000

The Honorable William M. Thomas
Chairman, Health Subcommittee
House Ways and Means Committee
1136 Longworth House Office Building
Washington, D.C. 20515

Dear Chairman Thomas:

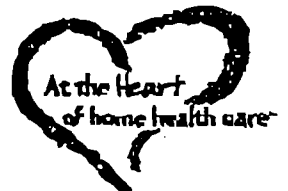
On behalf of the Visiting Nurse Associations of America (VNAA), I would like to thank you for developing legislation to further relieve the unintended adverse effects that the Balanced Budget Act of 1997 (BBA) has had on Visiting Nurse Agencies (VNAs) and other home health care providers.

VNAA supports the "Medicare, Medicaid and SCHIP Beneficiary Protection and Improvement Act of 2000" because of its provisions to:

- Delay the 15% cut until fiscal year (FY) 2003;
- Provide an extension of Periodic Interim Payments (PIP) to PIP providers through November 30, 2000; and
- Increase the Medicare home health prospective payment base rate by 2.2% for the second six months of FY 2001.

VNAA believes a study of the costs of non-routine medical supplies and the appropriateness of bundling such supplies into PPS rates is greatly needed. We are pleased that your legislation accomplishes this goal. VNAA encourages you to expedite this study because of our strong concerns about the cost of supplies used in the treatment of wounds, incontinence, and outpatient therapy.

We also are concerned about the operational ramifications involving health medical equipment (HME) suppliers and home health providers. Currently, there are no electronic measures to determine if patients at admission are receiving supplies from either a HME supplier or a home health provider. Patients who have chronic conditions and have been receiving medical supplies for years are often not clear about the origin of their supplies. Did they originate with the physician?, the hospital?, the HME supplier?, the nurse? Therefore, innocent provision of such supplies by both the HME supplier and the home health agency to the same patient could easily subject providers to medical review and allegations of fraud and abuse. VNAA urges you to suspend medical review of medical supplies until such electronic or other means is operational.



VNAA was very pleased to meet with you, to testify before your subcommittee, and to work with your staff Linda Fishman and John McManus this year. As you know, repeal of the 15% cut is critical to VNAs' survival. We greatly appreciate your assurance to us that cost-effective and ethical home health providers will never be subject to the 15% cut. We ask for your support to achieve full elimination of the 15% cut next year. Full repeal of this provision would ease the concerns of financial lenders, thereby improving cash flow for VNAs during difficult financial times. In addition, please require the Medicare Payment Advisory Commission (MedPAC), rather than the U.S. General Accounting Office (GAO), to conduct the study regarding the 15% cut. We do not believe that the GAO has conducted thorough and fair studies regarding Medicare home health issues.

Finally, we cannot thank you enough for your support of VNAA's recommendation to extend PIP to ease cash flow during the transition to PPS. This provision in your legislation will literally prevent the closure of several VNAs.

VNAA looks forward to continuing to work with you next year and in the future.

Sincerely,



Carolyn S. Markey
President and CEO

cc: Senate Majority Leader Trent Lott
Speaker of the House Dennis Hastert

GE Medical Systems

Anthony R. Joseph
President & CEO

General Electric Company
P.O. Box 414, Milwaukee, WI 53201
414 544-3220 Fax: 414 544-3278
Email: jaffrey.j@mail.ge.com

October 19, 2000

**The Honorable J. Dennis Hastert
Office of the Speaker of the House
H232 Capitol Building
Washington, DC 20515**

**The Honorable Trent Lott
Office of the Senate Majority Leader
S-230 Capitol Building
Washington, DC 20510**

Dear Speaker Hastert and Majority Leader Lott:

GE Medical Systems strongly supports the Medicare Balanced Budget Refinement Leadership Compromise Package that provides for differential reimbursement for new technology associated with screening mammography.

GE Medical Systems – a global leader in medical diagnostic equipment, services, and health care information management – is committed to ensuring that Medicare beneficiaries have access to breast cancer screening using the latest advances in medical technology. In partnership with the U.S. government, we have invested significant resources in the development of digital mammography technology that holds the promise for dramatically improving patient outcomes through early detection and diagnosis of breast cancer. The compromise package provides for adjustment of Medicare payment rates for screening mammography to reflect the costs associated with new technology advances like digital mammography.

We welcome the opportunity to work with the leadership to ensure that access to the benefits of digital mammography technology is a reality for Medicare beneficiaries. Thank you for your support of this important initiative.

Sincerely,

J. J. Immelt
J. J. IMMELT



THE AMERICAN DIETETIC ASSOCIATION

276 WEST JACKSON BOULEVARD
CHICAGO, ILLINOIS 60606-6995
312/899-0040

DIVISION OF GOVERNMENT RELATIONS
1225 EYE STREET, NW #1250
WASHINGTON, DC 20005
202/371-0500

October 19, 2000

The Honorable Bill Roth, Chairman
Senate Finance Committee
Washington, DC 20510

The Honorable Daniel Patrick Moynihan
Senate Finance Committee
Washington, DC 20510

The Honorable Bill Archer, Chairman
House Ways and Means Committee
Washington, DC 20515

The Honorable Charles Rangel
House Ways and Means Committee
Washington, DC 20515

The Honorable Tom Bliley, Chairman
House Commerce Committee
Washington, DC 20515

The Honorable John Dingell
House Commerce Committee
Washington, DC 20515

The Honorable Bill Thomas, Chairman
Health Subcommittee
House Ways and Means Committee
Washington, DC 20515

The Honorable Pete Stark
Health Subcommittee
House Ways and Means Committee
Washington, DC 20515

The Honorable Mike Bilirakis, Chairman
Health Subcommittee
House Commerce Committee
Washington, DC 20515

The Honorable Sherrod Brown
Health Subcommittee
House Commerce Committee
Washington, DC 20515

Dear Chairmen and Ranking Members:

The American Dietetic Association is pleased to support the Medicare, Medicaid and SCHIP Benefits Improvement Act of 2000 which provides critical support to Medicare providers while enhancing benefits for our nation's senior citizens. In particular, we are pleased that the legislation includes coverage of medical nutrition therapy for patients with diabetes and kidney disease. We believe this is an important first step in providing this critical service to all Medicare beneficiaries and we urge enactment of this legislation.

Nutrition therapy has been shown to be effective in the management and treatment of many chronic conditions which affect Medicare beneficiaries, including dyslipidemia, hypertension, heart failure, diabetes and chronic renal insufficiency. Medicare beneficiaries undergoing cancer treatment may also benefit from nutrition therapy aimed at controlling side effects or improving food intake. In fact, a recent study, conducted by the National Academy of Sciences Institute of Medicine and requested by Congress in the Balanced Budget Act of 1997, concluded that medical nutrition therapy — upon physician referral — should be a covered benefit under the Medicare program.



AMERICAN ACADEMY OF OPHTHALMOLOGY

THE EYE M.D.S.....

Federal Affairs Division

October 19, 2000

Suite 700
1101 Vermont Avenue, NW
Washington, DC 20005-3570

The Honorable William M. Thomas
Chairman
House Ways and Means Subcommittee on Health
1136 Longworth House Office Building
Washington, DC 20515

Dear Chairman Thomas:

The American Academy of Ophthalmology congratulates you on completion of a Medicare refinement and benefits improvement bill and we call on Congress to quickly pass the Medicare Refinement and Benefits Improvement Act of 2000.

Although we are disappointed that the committee did not include the much needed relief for specialists from Medicare practice expense cuts scheduled for 2001, we hope to work with you next year to get the Health Care Financing Administration (HCFA) to make the refinements necessary to protect beneficiaries' access to life saving and sight saving procedures that have been adversely impacted. The practice expense cuts come on top of a decade of cuts that specialty physicians like ophthalmologists have experienced in an effort to protect the solvency of the Medicare program. The committee's decision to include several new Medicare benefits and other program improvements for beneficiaries, however, is highly significant and must be commended.

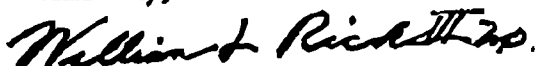
Specifically, this bill reaches out to our nation's seniors to help preserve their sight and independence by providing a glaucoma detection eye examination once every two years to those beneficiaries at high risk of developing glaucoma such as African Americans and those with a family history.

It is time to address the devastating effects of glaucoma. The scientific verdict is in -- treatment for glaucoma is effective and can preserve sight and quality of life. An estimated 120,000 Americans

are legally blind due to glaucoma, and estimates show at least 2 to 3 million people have glaucoma although half are not aware of it. Glaucoma affects 2 to 3 percent of the nation's seniors and another 5 to 10 million individuals have elevated intraocular pressure -- a risk factor for developing glaucoma. African Americans are six to eight times more likely to develop glaucoma than other populations. Other risk factors include family history and advanced age.

Early detection is the key to saving sight and this bill helps those who need it. The Academy is pleased to support the Medicare Refinement and Benefits Improvement Act of 2000.

Sincerely,



William L. Rich III, MD
Secretary for Federal Affairs

Cc: The Honorable J. Dennis Hastert, Speaker of the House
The Honorable Trent Lott, Majority Leader, United States Senate



NATIONAL
MULTIPLE SCLEROSIS
SOCIETY

National Public Policy Office
1100 New York Avenue NW
Suite 1015
Washington, DC 20005-3934
Tel 202 408 1500
Fax 202 408 0696

October 19, 2000

The Honorable Trent Lott
United States Senate
Washington, DC 20510

The Honorable Dennis Hastert
U.S. House of Representatives
Washington, DC 20515

Dear Majority Leader Lott and Speaker Hastert,

The National Multiple Sclerosis Society supports legislation to increase Medicare payments to health care providers. We strongly advocate that members of Congress vote for this legislation, and that the President sign it into law. Medicare reimbursements to health care providers must be increased so that beneficiaries with chronic conditions will have access to necessary health care services.

In addition to increasing access to Medicare health care services, we are also concerned about restoring Medicare coverage for self-injectible drugs and biologicals to beneficiaries who are unable to self-administer. There are three FDA approved self-injectible drugs that can alter the course of the disease, and slow the onset and progression of physical disabilities, Avonex, Betaseron and Copaxone. Each drug annually costs \$10,000 to \$12,000. The National MS Society recommends that patients diagnosed with relapsing-remitting MS begin taking one of these drugs immediately after diagnosis, and stay with the therapy.

Prior to 1997, Medicare carriers had the discretion to determine whether reimbursement was appropriate for self-injectible drugs, if they were administered incident to a physician's care. Since 1997, when Medicare terminated Medicare coverage for self-injectibles, we have worked to restore this coverage arguing that MS patients often experience temporary or permanent physical disabilities that make it very difficult, if not impossible, to self-administer these drugs.

Our understanding is that language in the Medicare bill begins to address this problem. However, the language does not go far enough. The self-injectible provision continues to rely on drug labeling rather than the beneficiary's ability to self-inject. This language leaves many MS beneficiaries without coverage when they are physically unable to self-inject necessary treatments that help to slow the progress of their disease. We believe that if a physician determines that the patient cannot self-inject, then Medicare should cover the drug.

The National Multiple Sclerosis Society, established in 1946, is dedicated to ending the devastating effects of multiple sclerosis. Multiple sclerosis is an often progressive, degenerative

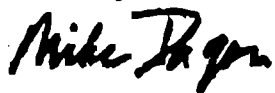
The National MS Society...One thing people with MS can count on.

TOTAL P.03

disease of the central nervous system that affects one-third of a million Americans. Symptoms may be mild, such as numbness in the limbs, or severe, such as paralysis or loss of vision.

Please let us know if we can provide any additional information on administration of self-injectible drug and biologicals or be helpful in any other way.

Sincerely,



Mike Dugan
General, USAF (Ret.)
President and CEO



October 19, 2000

Senator Trent Lott
Senate Majority Leader
S-230 Capitol Building
Washington, DC 20510

Dear Senator Lott,

As the 106th Congress enters its final session, the American Medical Group Association (AMGA) would like to take this opportunity to commend members of Congress for their hard work and diligence on a Medicare "givebacks" bill. The Beneficiary Improvement and Protection Act of 2000 (BIPA) is a positive step in restoring many of the unanticipated cuts suffered by Medicare providers as a result of the Balanced Budget Act of 1997 (BBA). AMGA has had an opportunity to view the bill in its entirety and would like to offer our full endorsement.

AMGA represents over 300 medical practice groups employing over 60,000 physicians in 41 states. Our members are the physician providers for over 30 million patients. AMGA members are among the largest and most prestigious medical groups in the country and include such renowned organizations as the Mayo Foundation, the Palo Alto Medical Foundation, the Lahey Clinic, the Henry Ford Health System, the Cleveland Clinic, and the Permanente Federation, Inc. AMGA's mission is to improve the health care environment by advancing accessible, high quality, cost-effective, patient-centered and physician-directed health care.

There are several aspects of the bill that we feel would greatly benefit our members. AMGA specifically supports the following provisions:

- AMGA supports the elimination of the payment reductions for Indirect Medical Education (IME).
- AMGA supports the clarification of physician certification.
- AMGA supports a Medicare demonstration project for group practices.
- AMGA supports provisions relating to the increased reimbursement for telemedicine services.
- AMGA applauds the additional relief for rural hospitals. This is important to our members that provide access to basic health care services for Medicare and Medicaid beneficiaries.

AMGA believes that many of the managed care provisions will not only be beneficial to our members but will also afford better care to the patients we serve. AMGA specifically supports several provisions in the bill relating to managed care:

Chair
Richard M. Cooper, MHA
The Center Clinic

Chair Elect
Robert Roy, M.D.
The Cleveland Clinic Foundation

Secretary
Gary S. Rappin, M.D.
Virginia Mason Medical Center

Vice President
Stanford R. Kurtz, M.D.
Lahey Clinic

President and Chief Executive Officer
Donald W. Fisher, M.D.
American Medical Group Association, Inc.

Immediate Past Chair
David Dwyer, M.D.
Palo Alto Medical Foundation

Directors
Kenneth P. Han, M.D., Ph.D.
Summa Medical Group, PA

J. Michael Condy, M.D.
Schreyer Medical Group, PA

Francis J. Cassano, M.D.
The Permanente Federation, LLC

Brent A. Fisher, MBA, CM, FACHE
Cleveland University Health Care

G. Richard Gies, Jr., M.D.
Cleveland Medical Center

Mark W. McKay, M.D.
Levinson Health System

Allen D. Kemp, M.D.
Oscar Health System, Inc.

C. David Marshall, M.D.
OhioHealth

Peter E. Porzec, M.D.

Carlton T. Rader
Mayo Foundation

W. Jeffrey Wozniak, MBA
The Permanente Foundation

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(800) 437-6602
Fax: (866) 757-0621

SOUTHEAST REGIONAL OFFICE
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Atlanta, GA 30356
Ph: (770) 954-0152
Fax: (770) 936-9041

Visit us at our Web site
<http://www.amga.org>

- AMGA supports a \$475 floor as well as the \$525 urban floor for metropolitan statistical areas with populations of 250,000 people or more as current reimbursement amounts are inadequate.
- AMGA supports the 10% phase-in of the risk adjuster, which will greatly benefit individuals with chronic conditions.
- AMGA supports expansion of application of entry bonus payments in 2001 that will facilitate greater participation from all health care providers.

AMGA enthusiastically supports and applauds BIPA, and believes that it represents a significant step in the right direction of restoring equity to health care providers. Each of the provisions mentioned above will not only allow AMGA members to continue to participate in the Medicare program but also facilitate it. We encourage members of Congress to work together in a bipartisan manner to make sure this bill is passed and signed into law. We encourage Democrats and Republicans to come together to vote for this bill, as it will greatly enhance the availability of health care services to all Medicare beneficiaries. Lastly, we encourage the President to sign this bill and restore many of the unanticipated cuts of the

AAA

Thank you for your consideration.

Sincerely,



Donald W. Fisher, Ph.D., CAE
President and Chief Executive Officer



**National Association of
Community Health Centers, Inc.®**

October 18, 2000

The Honorable Trent Lott
Majority Leader, United States Senate
S-230 United States Capitol Building
Washington, DC 20510

The Honorable J. Dennis Hastert
Speaker, United States House of Representatives
H-232 United States Capitol Building
Washington, DC 20515

Dear Majority Leader Lott and Speaker Hastert:

On behalf of the National Association of Community Health Centers (NACHC), thank you for your efforts to protect health care access for more than 11.5 million medically underserved Americans by including the Medicaid prospective payment system for Federally qualified health centers in the final version of BBA relief legislation.

As you know, the BBA eliminated a fundamental underpinning of America's health center safety net by phasing-out and eventually terminating the Medicaid cost-based reimbursement system for Federally qualified health centers. Health centers believe that your efforts to include a new prospective payment system for health centers in your BBA relief legislation is essential to their continued survival and will ensure that they remain a viable part of America's health care safety net.

Thank you again for your commitment to protecting health centers through your BBA relief legislation. Enactment of this prospective payment system is essential to protect the struggling health care safety net and will ensure the place of health centers in providing access to care for millions of uninsured Americans. We stand ready to work with you to make meaningful BBA relief for health centers a reality.

Please feel free to contact me if there is anything that I can do for you.

Sincerely,

Thomas J. Van Coverden
President and CEO



National
PACE
Association

October 19, 2000

The Honorable Bill Thomas
Chairman, Health Subcommittee
House Ways and Means Committee
1136 Longworth House Office Building
Washington, D.C. 20515
FAX: (202) 226-1765

Dear Congressman Thomas:

On behalf of the National PACE Association (NPA) and its members, I am writing to express the Association's appreciation for your continued support of the Programs of All-Inclusive Care for the Elderly (PACE) through inclusion of provisions for PACE in The Medicare, Medicaid and SCHIP Benefits Improvement Act of 2000. The Act's provisions to expand the opportunities for flexibility in implementation of PACE programs and to ease the transition of existing demonstration sites to permanent provider status will have an immediate and ongoing positive impact on PACE programs and the frail elderly adults they serve.

Although we have not had an opportunity to study the legislative package in its entirety, your efforts on behalf of Medicare and Medicaid beneficiaries to strengthen those programs should be acknowledged and receive careful consideration from members of Congress and, if enacted, from the President as well as the bill makes its way through the final days of this legislative session.

Sincerely yours,

Judith Baskins
President

Program of All-inclusive Care for the Elderly

Admitted to the University of Texas at Austin
The University of Texas at Dallas
The University of Texas at San Antonio
The University of Texas at San Marcos
The University of Texas at Tyler
The University of Texas at El Paso
The University of Texas at Permian Basin
The University of Texas at San Antonio
The University of Texas at San Antonio
The University of Texas at San Antonio



Health Component Institutions
The University of Texas System Health Science Center at Austin
The University of Texas System Health Science Center at Houston
The University of Texas System Health Science Center at San Antonio
The University of Texas System Health Science Center at San Marcos
The University of Texas System Health Science Center at Tyler

THE UNIVERSITY OF TEXAS SYSTEM

601 COLORADO STREET AUSTIN, TEXAS 78701-2982

Office of Health Affairs
(512) 499-4224
FAX (512) 499-4313

October 19, 2000

Chairman Bill Thomas
House Ways and Means
Health Subcommittee
Room: 1102 LHOB
Washington, DC 20515

Dear Chairman Thomas:

At your request we have reviewed the broad outlines of your legislation to provide much needed relief to health care providers, more specifically your provisions to help our Nation's teaching hospitals. We fully recognize the enormity of this task—seeking to provide assistance that is fair, balanced and appropriate among equally compelling claims from providers all across the health care system. Striking a balance among these competing needs while continuing to address the long-term solvency of the Medicare Trust Fund is the challenge. We appreciate your dedication to these goals and your willingness to consider that assistance to America's teaching hospitals is in the long-term interest of preserving our world preeminence in research and medical advancement.

In particular, we believe the provisions addressing Medicare's Direct (DGME) and Indirect Graduate Medical Education (IME) programs, and those provisions addressing the Medicaid Disproportionate Hospital Share (DSH) program, represent a good faith attempt on the part of Congress to correct the largely unforeseen inequities that arose from the Balanced Budget Act of 1997 (BBA). Each of our Nation's teaching hospitals and academic health centers confronts different financial constraints and pressures, the result of a constantly changing, evolving health system.

We congratulate you for your efforts and skill in writing a balanced legislative package that addresses many of our needs, and we commend your dedication to sound policies in support of academic medicine and the students and patients that we serve.

Sincerely,

A handwritten signature in cursive script, reading "Charles B. Mullins".

Charles B. Mullins, M.D.
Executive Vice Chancellor
for Health Affairs

CBM/lw

BY FAX - 3 PAGES TOTAL

TO: CHRIS JENNINGS, The White House
ELIZABETH HARGRAVE, Senator Daschle
KYLE KINNER, Senator Moynihan
BILL VAUGHAN, Rep. Stark

FROM: ANN HOWARD, Vice President, American Federation of HomeCare Providers
(301-588-1454)

DATE: 10/25/00

RE: OUR LETTER HAS BEEN MISCONSTRUED

I thought that you would like to have a copy of the letter we sent to Rep. Bill Thomas commenting on our understanding of the Republican agreement on Medicare giveback legislation.

We were asked for a letter of support. We do not support the bill. Instead we sent a polite letter saying thanks for what's in there but that the legislation does not address our larger issues of concern. This is no letter of support, rather a letter with grave reservations, albeit diplomatically phrased.

Of course we are always grateful when we are not hurt but the Republican bill provides no relief from the harm caused by the Balanced Budget Act of 1997. It only postpones a future 15 percent cut and adds a bit for inflation the second half of this fiscal year.

I am not pleased. Apparently we are not the only one whose letter was misconstrued as a letter of support. I thought that you would want to have this information

We believe that the obscene amount of funding going to HMOs should be redirected to beneficiaries and to the traditional providers, such as home health agencies who have lost 50+ percent of reimbursement as a result of the BBA 1997. We believe that Congress should fix home care first, not bribe HMOs to stay in the Program so that they will be there as part of a plan to privatize Medicare.



AMERICAN FEDERATION OF HOME CARE PROVIDERS, INC.

www.amerifed.net**ATTENTION: LINDA FISHMAN**

October 19, 2000

Congressman William Thomas
Chairman
House Ways and Means Health Subcommittee
U.S. House of Representatives
Washington, DC 20515

Dear Congressman Thomas:

The American Federation of HomeCare Providers appreciates your addressing several issues of critical importance to Medicare participating home health agencies in your Medicare refinement legislation. Our members are primarily freestanding providers, the majority of which have been severely affected by the Balanced Budget Act of 1997.

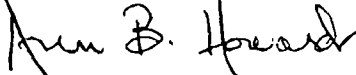
We are pleased that you have included a provision to postpone for another year, to October 1, 2002, the additional 15 percent reimbursement reduction, and that you have provided for an update of 2.2 percent to the HHRG rates for the second half of Fiscal Year 2001, adding back \$1.3 billion in funding over a five-year period. Extension of PIP for two months will assist providers who might otherwise be financially destabilized by the unadjusted rates and payment disruptions in the initial phase of home health PPS. In addition, you have indicated your desire to address the issues of non-routine medical supplies, the definition of "homebound," and branch office policy, commissioning GAO studies in all three cases, and clarified the role of telemedicine in the home care setting. We are appreciative.

It is critical to the survival of home health providers, however, that the 15 percent reduction be permanently eliminated. Additionally, it is imperative that the issue of access to home care services for medically complex and high cost patients be addressed, perhaps as envisioned in Congressman John Peterson's legislation. While your bill addresses issues related to the new prospective payment system, we have outstanding concerns about patients who lost their access through the strictures of the Interim Payment System, which cut \$79 billion from the benefit. And for the sake of the effective administration of the home care benefit, consolidated billing of non-routine medical supplies should be addressed forthwith, by simply eliminating the requirement and reimbursing on a fee schedule basis.

We urge you to continue to work with other Members of Congress and the Administration in the next few days to address these pressing concerns, which as they relate to access for complex and high cost patients can be a matter of life and death. We want to work with you and your colleagues the rest of this session, and early in the next Congress, for restoration of beneficiary access lost under IPS, permanent elimination of the 15 percent cut, and a more rational medical supply policy under PPS.

Again, thank you for your attention to our concerns.

Sincerely yours,

A handwritten signature in cursive script, appearing to read "Ann B. Howard".

Ann B. Howard

Vice President for Policy

ACCOUNTABILITY PROVISIONS FOR MEDICARE+CHOICE

Conference Bill

- **Allocation unjustified.** The Administration continues to believe that the Republicans' Balanced Budget Act refinement bill allocates an excessive share – \$11 billion over 5 years and \$34 billion over 10 years – to Medicare HMOs. This represents 40 percent of the total 5-year spending in the bill and almost 50 percent of the 10-year total -- despite the fact that only 16 percent of Medicare beneficiaries are in HMOs and that no independent study validates that they are underpaid.
- **No accountability.** We also are troubled because the refinement bill contains no accountability provisions to ensure that HMOs remain in the Medicare program and continue to provide benefits. Despite \$1.4 billion in increased payments in last year's bill, Medicare HMOs are dropping 934,000 beneficiaries.
- **Leaves out vulnerable providers and beneficiaries.** The final bill should include more justifiable and necessary beneficiary and provider investments. While there is some justification for increasing managed care payments in low-payment counties, such increases should be tied to provisions to improve accountability.

Managed Care Alternative

- **Only increase payments to HMOs that sign a 3-year contract (2001-2003):**
 - For HMOs that sign a 3-year contract and enter counties that are at the floor (\$415) in 2001, their payment would be increased to \$450 in 2001, with additional updates in 2002 and 2003.
 - For all other HMOs that sign a 3-year contract, their payment would be increased by an additional 1% over the period of the contract.
 - If any HMO that signs a 3-year contract and receives additional payments leaves Medicare and breaks its contract before the end of the 3 years, the plan would be required to return to Medicare twice the amount of the extra payments received.
 - Plans that do not sign a 3-year contract would receive payments as they do under current law with the 1-year contracting cycle. Similarly, these payment increases are available only to coordinate care plans.
- **Ensure higher payments passed along to beneficiaries.** We also propose that plans wanting to return to Medicare in 2001 (or plans that are staying in Medicare but will see increased payments for 2001) submit revised proposals for the package of benefits they will offer to beneficiaries. As part of their benefit proposal, plans would be required to pass increased payments on to beneficiaries by reducing premiums and cost-sharing, enhancing benefits, or reserving funds for benefits in subsequent years.
- **New financial disincentives for dropping out of Medicare.** Finally, we propose new civil monetary penalties of up to \$25,000 per enrollee affected (\$100,000 minimum) for HMOs that default on their one-year contract with Medicare.

TITLE VI—MEDICARE+CHOICE REFORMS AND OTHER MANAGED CARE REFORMS

SUBTITLE A—Medicare+Choice

SEC. ____ . INCREASED PAYMENT FOR ACCOUNTABLE MEDICARE+CHOICE PLANS.

Section 1853 (42 U.S.C. 1395w-23) is amended—

(1) in subsection (a)(1)(A), by striking “and (i)” and inserting “(i), and (j)”; and

(2) by adding at the end the following new subsection:

“(j) INCREASED PAYMENT FOR ACCOUNTABLE MEDICARE+CHOICE COORDINATED CARE PLANS.—

(1) IN GENERAL—In the case of a Medicare+Choice coordinated care plan that enters into a three year contract for the period of 2001 through 2003, the amount of the monthly payment otherwise made under this section (taking into account, if applicable, subsection (i)), shall be increased for each year of the contract period by the amount necessary to ensure that the total monthly payment is equal to the greater of the adjusted minimum amount specified in paragraph (2) or an amount equal to the otherwise applicable rate increased by one-third of 1 percent.

(2) ADJUSTED MINIMUM AMOUNT—For purposes of this subsection, the adjusted minimum amount shall equal--

(A) in 2001, \$450 per month, and

(B) in 2002 and 2003, the adjusted minimum amount for months during the previous year increased by the national per capita Medicare+Choice growth percentage, described in paragraph (c)(6)(A) for that succeeding year.

“(3) PENALTY FOR CONTRACT TERMINATION—In the case of a Medicare+Choice coordinated care plan described in paragraph (1) whose contract is terminated prior to the end of the three-year contract period, the Medicare+Choice organizations that offered such plan shall be return to the Secretary an amount equal to twice the total of the increased payments provided under this section. Such monies shall be deposited in the Federal Hospital Insurance Trust Funds and the Federal Supplementary Medical Insurance Trust Funds in such proportion as the Secretary deems to be fair and equitable.

SEC. ____ . TRANSITION TO REVISED MEDICARE+CHOICE PAYMENT RATES.

(a) ANNOUNCEMENT OF REVISED MEDICARE+CHOICE PAYMENT RATES.—Within 2 weeks after the date of the enactment of this Act, the Secretary of Health and Human Services shall determine, and shall announce (in a manner intended to provide notice to interested parties) Medicare+Choice capitation rates under section 1853 of the Social Security Act (42 17 U.S.C. 1395w-23) for 2001, revised in accordance with the provisions of this Act.

(b) COMPUTATION OF REVISED MEDICARE+CHOICE PAYMENT RATES.—For purposes of determining Medicare+Choice capitation rates under paragraph (a), the Secretary shall add 2.2 percentage points to the National Per Capita Medicare+Choice Growth Percentage Factor utilized in calculating the Medicare+Choice capitation rates announced March 1, 2000. The provisions of section 1853(c)(6)(C) of the Social Security Act shall apply to the National Per

Capita Medicare+Choice Growth Percentage Factor, as revised in the previous sentence, in subsequent years.

(c) **REENTRY INTO PROGRAM PERMITTED FOR MEDICARE+CHOICE PROGRAMS IN 2000.**—A Medicare+Choice organization that provided notice to the Secretary of Health and Human Services before the date of the enactment of this Act that it was terminating its contract under part C of title XVIII of the Social Security Act or was reducing the service area of a Medicare+Choice plan offered under such part shall be permitted to continue participation under such part, or to maintain the service area of such plan, for 2001 if it provides the Secretary with the information described in section 1854(a)(1) of the Social Security Act (42 U.S.C. 1395w–30 24(a)(1)) within two weeks after the date revised rates are announced by the Secretary under subsection (a).

(d) **REVISED SUBMISSION OF PROPOSED PREMIUMS AND RELATED INFORMATION.**—If—

(1) a Medicare+Choice organization provided notice to the Secretary of Health and Human Services as of July 3, 2000, that it was renewing its contract under part C of title XVIII of the Social Security Act for all or part of the service area or areas served under its current contract, and

(2) any part of the service area or areas addressed in such notice includes a payment area for which the Medicare+Choice capitation rate under section 1853(c) of such Act (42 U.S.C. 1395w–23(c)) for 2001, as determined under subsection (a), is higher than the rate previously determined for such year, such organization shall revise its submission of the information described in section 1854(a)(1) of the Social Security Act (42 U.S.C. 1395w–24(a)(1)), and shall submit such revised information to the Secretary, within 2 weeks after the date revised rates are announced by the Secretary under subsection (a). In making such submission, the organization may only reduce premiums and cost-sharing, enhance benefits, or reserve funds utilizing the stabilization fund described in section 1854(f)(2) of such Act.

(e) **DISREGARD OF NEW RATE ANNOUNCEMENT IN APPLYING PASS-THROUGH FOR NEW NATIONAL COVERAGE DETERMINATIONS.**—For purposes of applying section 1852(a)(5) of the Social Security Act (42 U.S.C. 1395w–22(a)(5)), the announcement of revised rates under subsection (a) shall not be treated as an announcement under section 1853(b) of such Act (42 U.S.C. 1395w–23(b)).

SEC. ____. **CIVIL MONETARY PENALTIES FOR CONTRACT DEFAULT BY A MEDICARE+CHOICE ORGANIZATION.**

(a) **IN GENERAL.**—Section 1857(g)(3) is amended at the end by adding the following new subparagraph:

“(D) Civil monetary penalties of up to \$25,000 per enrollee or \$100,000 per organization, whichever is greater, where the finding under subsection (c)(2)(A) is based on the organization’s defaulting on its contract.”



October 23, 2000

The Honorable Bill Archer
U.S. House of Representatives
1236 Longworth House Office Building
Washington, DC 20515

Dear Representative Archer:

Earlier this year, the Alzheimer's Association joined with AARP and the Health Insurance Association of America (HIAA) in support of a proposal to provide an above-the-line tax deduction for long term care insurance premiums as long as it was coupled with a \$3,000 tax credit for family caregivers. The Association is concerned about reports of a new leadership proposal that would substitute a deduction for the credit within this proposal. The original \$3000 tax credit was carefully crafted to target taxpayers with the greatest need, and we oppose any effort to scale back this proposal in a way that would shift help away from those who are most in need.

The Alzheimer's Association supports a meaningful, targeted tax credit because it would provide important recognition and financial support to families who are struggling to meet the long term care needs of their loved ones. Families are the backbone of the long term care system, especially for loved ones who have Alzheimer's disease. At least 70% of people with Alzheimer's disease live at home, where families provide 75% of their care. Caregiving takes a high economic toll on families. It is estimated that caregivers provide \$196 billion worth of services a year, far more than the \$82 billion spent for nursing home care and the \$32 billion paid for home health care.

If Congress is interested in helping with long term care costs of families in greatest need, a \$3000 tax credit would be much more helpful than a deduction. Alzheimer caregivers are not wealthy. A tax credit will help low and moderate income taxpayers who do not have the resources to pay for needed long term care services.

On behalf of Alzheimer caregivers across the country, I urge you to pass the \$3,000 caregiver tax credit proposal. Congress should act now to help millions of family caregivers by enacting this tax credit instead of a less effective tax deduction.

Sincerely,

Stephen McConnell
Vice President, Public Policy & Program Services

ALZHEIMER'S DISEASE AND RELATED DISORDERS ASSOCIATION, INC.

Washington Office: 1319 F St., NW, Suite 710 • Washington, DC 20004 • Phone: (202) 393-7737 • Fax: (202) 393-2109

**Statement
of
Rev. Michael D. Place, STD, President and Chief Executive Officer
The Catholic Health Association of the United States
October 18, 2000**

As Congress and the Administration work to enact a Medicare provider payment relief bill that both agree is necessary, the Catholic Health Association of the United States (CHA) applauds President Clinton for his proposal to restore significant funds that were cut by the 1997 Balanced Budget Act.

The policy choices outlined by the President, especially those that expand health coverage for legal immigrant pregnant women and children, increase funding for hospitals that serve low-income and uninsured persons, and restore a full Medicare inpatient market basket update for two years, are among the key priorities CHA has promoted as critical to any BBA relief package. In detailing his choices with regard to both beneficiaries and providers, the President has introduced into the debate a critical and necessary counterbalance to how relief funds should be allocated.

Recently, five Catholic health systems within CHA's membership sent a letter to Congress expressing grave concern that congressional leaders were allocating in their BBA relief package significant funds to the Medicare + Choice program *at the expense* of hospitals. These nationally recognized systems bring a unique perspective to the allocation issue because, while they sponsor 122 hospitals that provide care for millions of seniors under the traditional Medicare program, they also own health plans that are responsible for nearly 100,000 Medicare + Choice enrollees. The systems' message to Congress and the Administration is precise and unconflicted: *adequately funding the traditional Medicare program must not take a back seat to increasing Medicare + Choice payments*. From their perspective the way to stabilize traditional Medicare is to enact a two-year market basket update for Medicare inpatient services. Both the systems and CHA believe that this provision must be essential component of any agreement on provider payment relief negotiated by Congress and the White House.

For decades, the Catholic health ministry has committed itself to reforming the health care system to ensure coverage for all, but especially for the poor and disenfranchised. Consequently, CHA's positive reaction to the President's proposal is grounded in the Administration's willingness to put on the negotiating table the dual policy imperatives of coverage expansion and increased funding for the traditional Medicare program. Congressional leaders have already put on the table in their House-Senate provider relief bill other key provisions for which CHA has advocated, including increased funding for Medicare disproportionate share hospitals and an increase in the amount of bad debt payments hospitals can claim. Finding an appropriate and successful way to meld all these imperatives is a challenge that must be met with a bipartisan response without further delay.

887-1050