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b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

THE WHITE HOUSE

WASHINGTON

November 18, 1999

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:

Yesterday, in preparation for the release of your package, we worked on a draft document summarizing major provisions of the Balanced Budget Refinement Act (BBRA). It included placeholder language that was not finalized and cleared by me.

In response to an urgent request for background information, the draft BBRA summary document was sent to congressional staff without my authorization. This document was not given by any Administration official to any media, consumer or provider representatives – nor will it be.

I am personally extremely embarrassed about this situation and hope that you will accept my apologies for this mistake. As you know, we have worked together constructively through the process of developing the Balanced Budget Refinement Act. You have been straightforward in your dealings with the Administration and we have done everything possible to reciprocate. I want to once again thank you for your leadership in developing and drafting this legislation.

Sincerely,

Chris Jennings
Deputy Assistant to the President
For Health Policy

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Sincerely,

Chris Jennings
Deputy Assistant to the President
For Health Policy

GREATER NEW YORK HOSPITAL ASSOCIATION
GNYHA

FACSIMILE TRANSMISSION

355 West 57th Street / New York, N.Y. 10019 / (212) 246-7100 / FAX (212) 262-6350
Kenneth E. Raske, President

Date: Nov. 17, 1999

Time:

TO: Chris Jennings
FAX # 202-456-5557

FROM: **Kenneth E. Raske**
President

Phone: 212-246-7100
e-Mail: raske@gnyha.org

We are transmitting 4 pages including this cover sheet. If you have not received all of the pages, PLEASE CALL OUR OFFICE AS SOON AS POSSIBLE.

MESSAGE:

Hard Copy [ ] will [x] will not be sent by mail.

November 17, 1999

To: Chris Jennings

From: Ken Raske

Re: Medicare Disproportionate Share Hospital Payments

Chris, attached is a copy of a memo I faxed a few days ago on the Medicare DSH issue and our exposure on the crucial issues going forward that were still open.

Based upon conversations, we have every reason to believe that HCFA will very soon be issuing a policy guidance that will go against us on this critical issue, which will mean the loss of $170 million in Medicare DSH payments per year to the hospitals in New York serving the greatest numbers of poor patients.

We would greatly appreciate anything you can do, at 11:59, to help us avert this disaster.

Please call if I can provide any information or further clarification.

cc: Senator Charles E. Schumer
Dennis Rivera

November
Twelve
1999

VIA FACSIMILE

To: Chris Jennings

From: Ken Raske

Re: Unresolved Medicare Disproportionate Share Hospital (DSH) Issues

Chris, I thank you once again for your extraordinary efforts in this ongoing fight to achieve meaningful BBA relief. You have been absolutely incredible and we are extremely appreciative of your skills, tenacity, and commitment.

We have all been totally occupied with the legislative effort. I write to nudge back onto our respective radar screens the lack of resolution of the HCFA interpretation of Medicaid days in the Medicare disproportionate share hospital (DSH) calculation from January 1, 2000 forward. As you know, we shared a legal analysis with HCFA (the one you have seen) that lays out the solid foundation for continuing to include Home Relief days in the DSH calculation as Medicaid days pursuant to the specific terms of our 1115 waiver, which clearly converted the population into a Federally participating category. The urgency of my request at this time is that HCFA is expected to issue an agency clarification on its position very soon, and it is critical that any input be given immediately.

We met with Mike Hash and his staff, including HCFA's general counsel, Sherry Kanner, on November 2, 1999. Our counsel, Peter Nadel, laid out the legal foundation for the continued inclusion of these days. Mike made clear at the outset that he was not in a position to share any of HCFA's current thinking on the issue, though as you know, HCFA in the past has said it does not believe the 1115 waiver should qualify days that would not be qualified absent the waiver. Viewed in a positive light, HCFA staff's silence leaves them maximum room to take a position.

As you know, if they carve out the days, it will devastate hospitals in New York, with an estimated annual Medicare loss of $170 million from hospitals serving poor and indigent communities. This amounts to almost 3% of current PPS revenue Statewide, and 4% in New York City. In the Bronx and Brooklyn, the loss would be 5% of total PPS revenue. The range of DSH loss varies from single digits to more than 50% in particular hospitals. We cited for them the estimated losses for particular hospitals, matched against operating gains and losses reported for 1998. In many cases, millions of dollars of prospective DSH loss would be heaped on institutions that lost millions of dollars in 1998. North General Hospital in Harlem, for example, lost close to $5 million, or 5%, in 1998 operating income; the DSH loss, if applied, would cause a further cut in the hospital's revenue of an estimated $3.9 million. In cases of hospitals that had positive operating gains in 1998, the prospective annual DSH loss would far exceed such gain. The numbers, and implications for New York's safety net, are staggering.

We noted at the meeting that if Congress were proposing an overnight cut of 3% to 5% of total PPS revenue at hospitals serving the poor, we would guess that HCFA staff would recoil in horror, yet that would be the very outcome of their application of an unfavorable interpretation of the law.

Since there is an ample legal foundation to make a favorable interpretation, we implored them to do so.

Chris, anything you can do to urgently impart the White House's view of the importance of keeping DSH payments intact, and firmly within the boundaries of the law, would be greatly appreciated. Please let me know if I can supply additional information or explanation.

Cc: Dennis Rivera

THE WHITE HOUSE

WASHINGTON

November 15, 1999

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

Dear Mr. Speaker:

We are pleased that we have been able to work out a strong, bipartisan agreement on the Balanced Budget Refinement Act of 1999. All parties to the agreement, in particular Mr. Thomas, Mr. Bliley, Mr. Dingell, Mr. Rangel, Mr. Stark, Mrs. Johnson, Mr. McCrery, Senator Roth, Senator Moynihan and Senator Nickles, played critical roles in achieving this outcome. We know that this was as high a priority for you as it has been for the President and we appreciate your leadership.

As you know, a technical drafting change in the BBA has resulted in some confusion over the outpatient payment formula that could result in a reduction in payments. Aside from correcting a payment formula flaw, the hospital outpatient PPS was not designed to impose an additional reduction in aggregate payments. We continue to believe that such a reduction would be unwise. During our deliberations on the Balanced Budget Refinement Act, we agreed to resolve any confusion through a Congressional intent clarification provision. Earlier today, language to this effect was worked out between the White House and Mr. Thomas.

As Office of Management and Budget (OMB) Director Lew indicated in his letter to Mr. Thomas on October 18, findings or clarifications by Congress do not change the law and do not result in scoring. Therefore, the attached clarifying language on the hospital outpatient department policy would not be scored by OMB. With this in mind, we would not characterize such legislation as having an adverse effect in any way on the Social Security surplus.

Achieving a bipartisan consensus on addressing the unintended consequences of the BBA is an important accomplishment. The President hopes that we can build on this achievement and pass legislation to strengthen and modernize Medicare.

Sincerely,

John D. Podesta
Chief of Staff to the President

Enclosure

SEC. 201. CONGRESSIONAL POLICIES REGARDING IMPLEMENTATION OF CERTAIN PROVISIONS.

(a) INTENTION REGARDING BASE AMOUNTS IN APPLYING THE HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM.—With respect to determining the amount of copayments described in paragraph (3)(A)(ii) of section 1833(t) of the Social Security Act, as added by section 4523(a) of Balanced Budget Act of 1997, Congress finds that such amount should be determined without regard to such section, in a budget neutral manner with respect to aggregate payments to hospitals, and that the Secretary of Health and Human Services has the authority to determine such amount without regard to such section.

67431

Date: _____

FAX

Health Division

Office of Management and Budget
Executive Office of the President
Washington, DC 20503

To: Devorah

From: Greg White

Number of Pages (excluding cover) 3

Subject:

Comment:

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Health News Daily

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TODAY'S NEWS

Pfizer *Zeldox* cardiovascular safety study to be filed in first quarter, potentially setting the stage for late 2000 approval of the anti-psychotic, company vice chairman-R&D tells analysts ..... **Story Below**

HHS would be directed to find offsets to hospital outpatient provisions of the BBA revision package, under final legislative language agreed to by the White House and Rep. Thomas ..... **Page 2**

Pfizer *Zeldox* Amended Submission Could Receive FDA Approval By End Of 2000

Pfizer plans to submit an amended NDA for ***Zeldox*** (ziprasidone) during the first quarter of 2000, which would put the anti-psychotic on track for approval by the end of next year.

Pfizer's resubmission will address FDA's concern regarding electrocardiographic changes observed with Zeldox use. FDA issued a "not approvable" letter for the product in June 1998.

Results of head-to-head trials requested by the agency demonstrate that "Zeldox' ECG effects are comparable to those shown by other marketed anti-psychotics," that they "are not clinically significant and that the overall integrated benefit to risk ratio for Zeldox compares quite favorably to the other newer anti-psychotic agents," Pfizer Vice Chairman-R&D John Niblack said Nov. 16 at a meeting for securities analysts at Pfizer headquarters in New York City.

Pfizer conducted a head-to-head trial comparing the QTc prolongation associated with Zeldox to Lilly's ***Zyprexa*** (olanzapine) and Janssen's ***Risperdal*** (risperidone). FDA is required to review responses to "not approvable" letters within six months, under user fee guidelines.

Despite the regulatory delay, Pfizer continues to project over $1 bil. in revenues for Zeldox. The drug treats positive, negative and depressive symptoms of psychosis, has demonstrated long-term efficacy, causes minimal weight gain, and has a lipid lowering profile about equal to that of Merck's ***Mevacor***, Niblack maintained.

Pfizer could further develop its presence in the anti-psychotic market through its proposed acquisition of Warner-Lambert.

One of Warner-Lambert's highest profile R&D projects is pregabalin, the successor product to its anti-epileptic ***Neurontin*** (gabapentin). Warner-Lambert is pursuing indications for the treatment of psychotic disorders and pain, in addition to epilepsy, for pregabalin.

Pfizer moved up its analyst meeting, which was originally scheduled for Nov. 20, in part to promote the Pfizer/Warner-Lambert combination. American Home Products and Warner-Lambert announced plans to merge Nov. 4; the deal was challenged by a hostile bid from Pfizer.

During the Nov. 16 meeting, Pfizer focused on the company's near and longer term development pipeline.

The anti-migraine agent ***Relpax***, which was deemed "approvable" Oct. 27, could be Pfizer's next product to reach the market. The company expects labeling discussions with FDA to be finalized early next year. Warner-Lambert negotiated co-promotion rights to Relpax as part of the ***Lipitor*** agreement with Pfizer. However, Warner-Lambert maintains that its

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interest in Relpax has declined after seeing the terms of FDA's "approvable" designation.

Inhaled insulin, the second generation COX-2 inhibitor valdecoxib (which Pfizer is co-developing with Searle), the anti-fungal *Vfend* and the overactive bladder treatment darifenacin round out Pfizer's Phase III stage research projects..

Pfizer has 64 projects in early development and 27 later stage candidates, Niblack told the analysts. Pfizer expects to achieve 20 additional supplemental indications before 2003. The company currently invests $2.8 bil. in research and development annually, which would increase to $4 bil. after a merger with Warner-Lambert. ◆◆

House Could Vote On Final BBA Revision Package As Early As Nov. 17

The Administration and House Ways & Means/Health Subcommittee Chairman Bill Thomas (R-Calif.) have agreed to legislative language giving HHS the authority to make hospital outpatient payments budget-neutral under the BBA revision package.

The White House said Nov. 16 that it would not score the outpatient hospital payment reduction as a cost to the federal budget. The move cleared the way for finalizing the agreement between the Administration and Congress on Balanced Budget Act refinement legislation.

House Majority Leader Dick Armey (R-Tex.) said the bill could be brought up for a vote in the House Nov. 17. One likely scenario is that the bill could be rolled into one of the outstanding appropriations bills.

The "clarifying language on the hospital outpatient department policy would not be scored by OMB," White House Chief of Staff John Podesta says in a Nov. 16 letter to House Speaker Dennis Hastert (R-Ill.). "With this in mind, we would not characterize such legislation as having an adverse effect in any way on the Social Security surplus."

The agreement means that Congress does not have to find a way to pay for the $4.2 bil. five-year price tag associated with the outpatient payment change.

The legislative package, which Thomas said could be filed late Nov. 16, provides additional Medicare funding for hospitals, home health agencies, managed care entities and skilled nursing facilities. Thomas said the package is likely to cost around $12.8 bil. over five years, and not more than $1 bil. in the first year. Final Congressional Budget Office estimates will be available when the bill is filed.

Several changes have been made to the bill since White House and congressional leaders reached a tentative agreement on the measure last week, according to Thomas. Among the changes are slight revisions in planned increases to skilled nursing facilities and some modification to home health agency provisions. Thomas called the package a "reasonable and appropriate refinement."

Looking forward to the next congressional session, Thomas said he plans on working with HCFA to finalize implementation of various requirements under the 1997 BBA law, once the agency no longer has to focus on Y2K computer issues. Thomas said he also is "looking forward to modernizing Medicare in a number of ways" in legislative initiatives planned for next year. ◆◆

BRIEFS

FDA Office of Financial Management: Former Immigration and Naturalization Service Assistant Commissioner for Budget Jeffrey Weber is appointed director, Office of Financial Management. He will report to Deputy Commissioner Robert Byrd, effective Nov. 22....

North Dakota CHIP: State seeks to enroll an additional 1,900 children in its CHIP plan, bringing total enrollees to 2,400, under an expansion approved by HHS. In this second phase, a separate program will be created for children up to age 18 in families with incomes below 140% of the federal poverty level who are not otherwise Medicaid-eligible....

Progestational drugs: FDA is revoking its 1989 guidance requiring a boxed warning on an increased risk of birth defects associated with use of progestational drugs during the first four months of pregnancy. The agency cites a lack of scientific data and questions about the appropriateness of considering all progestational drugs as a single class for

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labeling purposes. FDA received no comments on its April proposal to withdraw the guidance....

Novartis *Habitrol* switch: FDA approves the Rx-to-OTC switch of Novartis Consumer Health's ***Habitrol*** nicotine replacement transdermal patch Nov. 12. The 21, 14 and 7 mg/day patches are indicated for adults age 18 and older for smoking cessation. The product will compete with SmithKline Beecham's ***NicoDerm CQ*** patch system (also 21, 14 and 7 mg/day), McNeil Consumer Products' ***Nicotrol*** (15 mg/day) and store brands made by Perrigo....

FTC "andro" settlement: Federal Trade Commission settles charges against Met-Rx USA and AST Nutritional Concepts that the firms were making unsubstantiated safety claims for their androstenedione body-building supplements that contain other steroid hormones and, in some cases, stimulants such as ephedra and caffeine. In two separate cases, FTC asserted the companies were claiming on Internet sites that their androgen supplements increase strength and muscle mass "safely and with minimal or no negative side effects." Met-Rx and AST have agreed to disclose the potential risks related to the products in all advertising, labeling and promotional materials under the settlement....

Human tumor assay systems: Medicare Coverage Advisory Committee concludes that HTASs "demonstrate clinical utility for directing treatment for chronic lymphocytic leukemia and promise for other solid and hematologic tumors," at a Nov. 15-16 meeting of its Laboratory and Diagnostic Services Panel in Baltimore. HTASs are *in vitro* tests used to evaluate tumor sensitivity or resistance to specific chemotherapeutic drug regimens. The panel found current clinical evidence most compelling for CLL but its recommendation leaves open the possibility that HCFA's coverage policy may provide payment for a wide range of tumors. HTAS marketers include Oncotech and Impath....

Glaxo Wellcome *Lotronex*: Alosetron is unanimously recommended by FDA's Gastrointestinal Drugs Advisory Committee for treatment of irritable bowel syndrome (primarily diarrhea) in women Nov. 16. The committee rejected extending the indication to patients alternating between diarrhea and constipation, because of insufficient efficacy data; also 27% of patients had constipation as an adverse event in *Phase II/III* trials, which led to 10% of patients withdrawing, FDA said. The committee also recommended patient compliance studies and quality-of-life studies postmarketing....

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Mike wants to talk to you about this.

Medicare Disproportionate Share Hospital (DSH) Payments

I. Background

- As set forth in section 1886(d)(5)(F) of the Social Security Act (the Act), the Medicare disproportionate share hospital (DSH) calculation is a complicated formula made up of two computations: 1) patient days furnished to those entitled to both Medicare Part A and Supplemental Security Income, and 2) patient days associated with those who are eligible for Medicaid under an approved Title XIX State plan but who are not entitled to Medicare Part A. This calculation does not include days furnished under general assistance or other State-only health programs, charity care, Medicaid DSH, and certain section 1115 demonstrations.

- On September 29, 1999, the Health Care Financing Administration's (HCFA's) Office of Financial Management through the 10 Regional Offices, conducted a survey of the fiscal intermediaries to ascertain how patient days were used in calculating Medicare DSH. This survey was initiated as a result of information suggesting that many intermediaries had been erroneously calculating Medicare DSH payments. An earlier survey, conducted in November 1998, had shown that only the two Pennsylvania intermediaries (Mutual and Veritus) were including ineligible days in Medicare DSH calculations.

- The September 1999 survey indicated that there was inconsistent implementation of the instructions concerning how hospitals are to claim patient days for purposes of the Medicare DSH calculation. Preliminary results of the survey showed that intermediaries in as many as 20 States calculated Medicare DSH payments in a manner inconsistent with the intended policy. (Information received after the decision described below was made indicates that approximately 13 States may have been affected by this misapplication of the policy.)

- The survey results showed that HCFA guidance on this issue was neither clear nor well-understood. Given the complexities of Medicare DSH statutory and regulatory provisions, and their interface with Medicaid State plans and section 1115 demonstrations, HCFA concluded that it was reasonable that the affected entities would be confused about these policies.

II. Approach to Resolving the Issue

- To ensure that section 1886(d)(5)(F) of the Act is being consistently implemented, HCFA (in consultation with the Department, including the Office of Inspector General and the Office of General Counsel) decided to issue a clarification of its existing policy. Consistent with this approach, HCFA also decided, with respect to past applications of the policy, not to hold hospitals that had claimed and timely appealed ineligible days responsible for the unclear guidance. These decisions should result in a uniform application of the Medicare DSH calculation going forward. The clarification will specify clearly and in detail how days that may have been counted inappropriately are to be treated for both past and future periods.

III. Steps Taken in October 1999 and Next Steps

- **Steps Already Taken** -- HCFA issued a letter, dated October 15, 1999, to Senator Roth explaining the hold harmless policy. HCFA also issued a letter, dated October 29, 1999, to the intermediaries that explained the moratorium, in effect until January 1, 2000, on disallowances of Medicare DSH payments. These letters committed HCFA to providing further guidance to States and implementing instructions to intermediaries health plans and hospitals.

- **Issuance of Clarifying Guidance** -- HCFA will issue a clarifying Program Memorandum (PM) to intermediaries explaining the allowable Medicaid days in the Medicare DSH calculation. The PM is a clarification of existing law and policy that hospitals should have applied to the Medicare DSH calculations contained in their cost reports. The goal of this guidance is to clearly re-state existing policy, not to make new policy. (A copy of the draft PM is located at *Attachment A*.)

IV. Impact of the Clarification on Hospitals Days -- Included in and Excluded from the DSH Calculation on a Prospective Basis

- Although HCFA has discretion to include or exclude certain days, HCFA has chosen to issue clarifying guidance consistent with its existing policy.

- *Attachment B* sets forth the technical definitions of the days included in, and excluded from, the calculation. The PM discusses and charts these days and how they fit into the calculation. The PM defines "eligible days" to exclude days furnished under general assistance or other State-only health programs, charity care, certain section 1115 demonstrations, and certain Child Health Insurance Program (non-Medicaid programs).

V. Impact of the Clarification on Hospitals -- Only Certain Hospitals Will Be Granted Relief on Both a Retrospective and a Prospective Basis

- **Only Certain Hospitals Will Be Held Harmless** -- Hospitals will be held harmless if they: (1) claimed and received payment for otherwise ineligible days, or (2) appealed the denial of payment for otherwise ineligible days. HCFA has discretion with respect to the breadth of the hold harmless policy concerning additional Medicare DSH payments resulting from days that were inappropriately counted prior to the issuance of the clarifying instructions. In general, HCFA is proposing a broad hold harmless policy.

  For cost reporting periods beginning on or before December 31, 1999, where a hospital failed to either claim, in the first instance, the days in question, or to appeal, upon denial of payment for the days in question, the calculation of its Medicare DSH payments, no relief is available under the hold harmless policy. A hospital may argue that it was futile to claim or appeal the days in question in light of its fiscal intermediary's refusal to include those days in the Medicare DSH calculation. However, where a

hospital failed to claim or appeal the days in question, there is no reasonable expectation of receiving payment for those days. The absence of a reasonable expectation, and the need to limit the ability of hospitals to claim retroactively days for which they did not previously receive payment or make timely appeal, led HCFA to conclude that a hospital must have either claimed and received payment for otherwise ineligible days, or appealed the denial of payment for otherwise ineligible days, in order to receive relief under the hold harmless policy. HCFA is aware that there may be some criticism from hospitals that could have, but did not, claim or appeal the otherwise ineligible days.

- *Attachment C* discusses the hospitals to be granted relief on both a retrospective and a prospective basis.

Program Memorandum Intermediaries

DRAFT

Department of Health and Human Services (DHHS)
HEALTH CARE FINANCING ADMINISTRATION (HCFA)

Transmittal No. AB-99-

Date: November 1999

CHANGE REQUEST #1052

SUBJECT: Clarification of Allowable Medicaid Days in the Medicare Disproportionate Share (DSH) Adjustment Calculation–ACTION

A review of practices and policies regarding Medicare disproportionate share payment determinations led HCFA to conclude that it is necessary to clarify the definition of eligible Medicaid days in Medicare disproportionate share policy and communicate this information to fiscal intermediaries, hospitals, and Medicaid State agencies and managed care organizations. **This clarification applies to cost reporting periods beginning on or after January 1, 2000.** The purpose of this memorandum is to address those details that may need further clarification and also to communicate the hold harmless position for cost reporting periods beginning before January 1, 2000. A similar memorandum will be sent to the Medicaid State agencies.

CLARIFICATION FOR COST REPORTING PERIODS BEGINNING ON OR AFTER JANUARY 1, 2000

Background

Under section 1886(d)(5)(F) of the Social Security Act, the Medicare disproportionate share patient percentage is made up of two computations. The first computation includes patient days that were furnished to patients who, during a given month, were entitled to both Medicare Part A and Supplemental Security Income (SSI) (excluding State supplementation). This number is divided by the number of covered patient days utilized by patients under Medicare Part A for that same period. The second computation includes patient days associated with beneficiaries who were eligible for medical assistance (Medicaid) under a State plan approved under Title XIX but who were not entitled to Medicare Part A. (See 42 CFR 412.106(b)(4).) This number is divided by the total number of patient days for that same period.

Included Days

In calculating the number of Medicaid days, the hospital must determine whether the patient was eligible for Medicaid under a State plan approved under Title XIX on the day of service. If the patient was so eligible, the day counts in the Medicare disproportionate share adjustment calculation. The statutory formula for "Medicaid days" reflects several key

concepts. First, the focus is on the patient's eligibility for Medicaid benefits as determined by the State, not the hospital's "eligibility" for some form of Medicaid payment. Second, the focus is on the patient's eligibility for medical assistance under an approved Title XIX State plan, not the patient's eligibility for general assistance under a State-only program. Third, the focus is on eligibility for medical assistance under an approved Title XIX State plan, not medical assistance under a State-only program or other program. Thus, for a day to be counted, the patient must be eligible on that day for medical assistance benefits under the Federal-State cooperative program known as Medicaid (benefits under an approved Title XIX State plan). In other words, for purposes of the Medicare disproportionate share adjustment calculation, the term "Medicaid days" refers to days on which the patient is eligible for medical assistance benefits under an approved Title XIX State plan. The term "Medicaid days" does not refer to all days that have some relation to the Medicaid program, through a matching payment or otherwise; if a patient is not eligible for medical assistance benefits under an approved Title XIX State plan, the patient day cannot become a "Medicaid day" simply by virtue of some other association with the Medicaid program.

Medicaid days, for purposes of the Medicare disproportionate share adjustment calculation, include all days during which a patient is eligible, under a State plan approved under Title XIX, for Medicaid benefits, even if Medicaid did not make payment for any services. Thus, Medicaid days include, but are not limited to, days that are determined to be medically necessary but for which payment is denied by Medicaid because the provider did not bill timely, days that are beyond the number of days a State will pay, days that are utilized by a Medicaid beneficiary prior to an admission approval but for which a valid enrollment is determined within the prescribed period, and days for which payment is made by a third party. In addition, we recognize in the calculation days that are utilized by a Medicaid beneficiary who is eligible for Medicaid under a State plan approved under Title XIX through a managed care organization (MCO) or health maintenance organization (HMO).

However, in accordance with 42 CFR 412.106(b)(4), a day does not count in the Medicare disproportionate share adjustment calculation if the patient was entitled to both Medicare Part A and Medicaid on that day. Therefore, once the eligibility of the patient for Medicaid under a State plan approved under Title XIX has been verified, you must determine whether any of the days are dual entitlement days and, to the extent that they are, subtract them from the other days in the calculation.

Excluded Days

Many States operate programs that include both State-only and Federal-State eligibility groups in an integrated program. For example, some States provide medical assistance to beneficiaries of State-funded income support programs either through the same administrative processes as Medicaid or with Medicaid funds in the form of payments that do not depend on patient eligibility for Medicaid per se. These beneficiaries, however, are not eligible for Medicaid under a State plan approved under Title XIX, and, therefore, days

utilized by these beneficiaries do not count in the Medicare disproportionate share adjustment calculation. If a hospital is unable to distinguish between Medicaid beneficiaries and State-only or Federal-State medical assistance beneficiaries, then it must contact the State.

Similarly, some States have a demonstration project (also referred to as a section 1115 waiver) under which medical assistance is furnished to expanded eligibility populations that are not eligible for Medicaid under the State plan approved under Title XIX. Inpatient hospital days for these individuals are not to be included as Medicaid days for purposes of the Medicare disproportionate share adjustment calculation. State records must distinguish between individuals who are eligible for Medicaid under a State plan approved under Title XIX and individuals who are eligible only under a demonstration project. However, where the demonstration project includes an expanded eligibility population that could be made eligible for Medicaid under a State plan approved under Title XIX, but is instead made eligible for Medicaid through the demonstration project, then the days utilized by that population are to be recognized for purposes of calculating the Medicare disproportionate share adjustment.

In addition, if a given patient day affects the level of Medicaid DSH payments to the hospital but the patient is not eligible for Medicaid under a State plan approved under Title XIX on that day, the day is not included in the Medicare DSH calculation.

It should be noted that the types of days discussed above are not necessarily the only types of excluded days. Please see the attached chart, which summarizes some, but not necessarily all, of the types of days to be excluded from (or included in) the Medicare DSH adjustment calculation.

To provide consistency in both components of the calculation, any days that are added to the Medicaid day count must also be added to the total day count, to the extent that they have not been previously so added.

Regardless of the type of allowable Medicaid day, the hospital bears the burden of proof and must verify with the State that the patient was eligible under one of the allowable categories during each day of the patient's stay. The hospital is responsible for and must provide adequate documentation to substantiate the number of Medicaid days claimed. Days for patients that cannot be verified by State records to have fallen within a period wherein the patient was eligible for Medicaid as described in this memorandum cannot be counted.

DRAFT

HOLD HARMLESS FOR COST REPORTING PERIODS BEGINNING BEFORE JANUARY 1, 2000

In accordance with the hold harmless position communicated by HCFA on October 15, 1999, for cost reporting periods beginning before January 1, 2000, you are not to disallow, within the parameters discussed below, the portion of Medicare DSH adjustment payments previously made to hospitals attributable to the erroneous inclusion of general assistance or other State-only health program, charity care, Medicaid DSH, and/or ineligible waiver or demonstration population days (as explained in the attached chart) in the Medicaid days factor used in the Medicare DSH formula. This is consistent with HCFA's determination that hospitals and intermediaries relied, for the most part, on Medicaid days data obtained from State Medicaid agencies to compute Medicare DSH payments and some of those agencies commingled these types of otherwise ineligible days with the Medicaid Title XIX days in the data transmitted to the hospitals and/or intermediaries. Although HCFA has decided to allow the hospitals to be held harmless for receiving additional payments resulting from the inclusion of these types of days, this decision is not intended to hold hospitals harmless for any other aspect of the calculation of Medicare DHS payments or any other Medicare payments.

Hospitals That Received Payments Reflecting the Erroneous Inclusion of Days at Issue

In practical terms this means that you will not reopen any cost reports for cost reporting periods beginning before January 1, 2000 to disallow the portion of the Medicare DSH payment attributable to the erroneous inclusion of general assistance or other State-only health program, charity care, Medicaid DSH, and/or ineligible waiver or demonstration population days if the hospital received payments for those days. If, prior to October 15, 1999, you reopened a settled cost report to disallow the portion of Medicare DSH payment attributable to the inclusion of these types of days, reopen that cost report again and refund the amounts collected. Do not, however, pay the hospitals interest on the amounts previously recouped as result of the disallowance.

You are to continue to allow these types of days in the Medicare DSH calculation for all open cost reports in accordance with the practice followed for the hospital at issue before October 15, 1999. However, the actual number of general assistance and other State-only health program, charity care, Medicaid DSH, and/or ineligible waiver or demonstration days, as well as Medicaid Title XIX days you allow for the open cost reports must be supported by auditable documentation provided by the hospital. For example, if, for a given hospital, a portion of Medicare DSH payment was attributable to the erroneous inclusion of ineligible waiver days for only the out-of-State or HMO population in cost reports settled before October 15, 1999, you are to include the ineligible waiver days for only that population when settling open cost reports for cost reporting periods beginning before January 1, 2000.

Hospitals That Did Not Receive Payments Reflecting the Erroneous Inclusion of Days at Issue

If a hospital did not receive any payment based on the erroneous inclusion of general assistance or other State-only health program, charity care, Medicaid DSH, and/or waiver or demonstration population days for cost reports that were settled before October 15, 1999, and the hospital did not file a jurisdictionally proper appeal to the Provider Reimbursement Review Board (PRRB) on this issue, you are not to pay the hospital based on the inclusion of these types of days for any open cost report for cost reporting periods beginning before January 1, 2000. Furthermore, on or after October 15, 1999, you are not to accept reopening requests for previously settled cost reports pertaining to the inclusion of these types of days in the Medicare DSH formula.

If for cost reporting periods beginning before January 1, 2000, a hospital that did not receive payments reflecting the erroneous inclusion of general assistance or other State-only health program, charity care, Medicaid DSH, and/or waiver or demonstration population days filed a jurisdictionally proper appeal before October 15, 1999 (or January 1, 2000, so long as before October 15, 1999 the hospital filed an appeal on the same issue for previous cost reporting period) to the PRRB on the issue of the exclusion of these types of days from the Medicare DSH formula, reopen the cost report at issue and revise the Medicare DSH payment to include these types of days as Medicaid days. The actual number of these types of days you use in this revision must be properly supported by adequate documentation provided by the hospital. Do not, however, reopen a cost report and revise the Medicare DSH payment to include these types of days as Medicaid days if, on or after October 15, 1999, a hospital added the issue pertaining to the exclusion of these types of days to a jurisdictionally proper appeal pending before PRRB on other Medicare DSH issues or other unrelated issues.

You are to continue paying the Medicare DSH adjustment based on the inclusion of general assistance or other State-only health program, charity care, Medicaid DSH, and/or waiver or demonstration population days for all open cost reports for cost reporting periods beginning before January 1, 2000, to any hospital which filed a jurisdictionally proper appeal to the PRRB specifically for this issue on previously settled cost reports.

If a hospital has filed a jurisdictionally proper appeal relative to the HCFA 97-2 ruling and the hospital has otherwise received payment for the portion of Medicare DSH attributable to the inclusion of general assistance or other State-only health programs, charity care, Medicaid DSH, and/or ineligible waiver or demonstration population days based on its paid Medicaid days, include these types of days of unpaid days for the cost reports affected by the HCFA 97-2 appeal.

DRAFT

The *effective date* for this Program Memorandum (PM) is for cost reporting periods beginning on or after January 1, 2000.

The *implementation date* for this PM is January 1, 2000.

Funding is available through a Supplemental Budget Request for costs required for implementation.

PM may be discarded after January 31, 2001.

SPECIAL INSTRUCTIONS TO THE INTERMEDIARIES FOR PUBLISHING THE PM: The intermediaries are required to distribute the content of this PM to all the hospitals immediately upon receipt of the PM.

DRAFT

Attachment

TYPE OF DAY	DESCRIPTION	ELIGIBLE TITLE XIX DAY
General Assistance Patient Days	Days for patients covered under a State-only (or county-only) general assistance program (whether or not any payment is available for health care services under the program). These patients are not Medicaid-eligible under the State plan.	No.
Other State-Only Health Program Patient Days	Days for patients covered under a State-only health program. These patients are not Medicaid-eligible under the State plan.	No.
Charity Care Patient Days	Days for patients not eligible for Medicaid or any other third-party payer, and claimed as uncompensated care by a hospital. These patients are not Medicaid-eligible under the State plan.	No.
1115 Waiver and Demonstration Population Patient Days	Days for patients who are not eligible for Medicaid under an approved State plan, but are eligible for benefits only under an approved demonstration project because they are in a "demonstration population" that could not be included in an approved State plan but whose costs are nonetheless considered matchable based on section 1115 authority.	No.
Hypothetical 1902(r)(2) and 1931(b) Days	Days included in an 1115 demonstration project that could have been included in a State plan under a 1902(r)(2) or 1931(b) election (and may have been considered, for budget neutrality purposes, as if they were) but were not actually included in a State plan amendment.	Yes.
Actual 1902(r)(2) and 1931(b) Days	Days for patients eligible under a State plan based on a 1902(r)(2) or 1931(b) election. These patients are Medicaid-eligible under the Title XIX State plan under the authority of these provisions, which is exercised by the State in the context of the approved State plan.	Yes.
Medicaid Optional Targeted Low Income Children (CHIP-related) Days	Days for patients who are Title XIX-eligible and who meet the definition of "optional targeted low income children" under section 1905(u)(2). The difference between these children and other Title XIX children is the enhanced FMAP rate available to the State. These children are fully Medicaid-eligible under the State	Yes.

	plan.	
Separate CHIP Days	Days for patients who are eligible for benefits under a non-Medicaid State program furnishing child health assistance to targeted low-income children. These children are, by definition, not Medicaid-eligible under a State plan.	No.
1915(c) Eligible Patient (the "217" group) Days	Days for patients in the eligibility group under the State plan for individuals under a Home and Community Based Services waiver. This group includes individuals who would be Medicaid-eligible if they were in a medical institution. Under this special eligibility group, they are Medicaid-eligible under the State plan.	Yes.
Retroactive Eligible Days	Days for patients not enrolled in the Medicaid program at the time of service, but found retroactively eligible for Medicaid benefits for the days at issue. These patients are Medicaid-eligible under the State plan.	Yes.
Medicaid Managed Care Organization Days	Days for patients who are eligible for Medicaid under a State plan when the payment to the hospital is made by an MCO for the service. An MCO is the financing mechanism for Medicaid benefits, and payment for the service through the MCO does not affect eligibility.	Yes.
Medicaid DSH Days	Days for patients who are not eligible for Medicaid benefits, but are considered in the calculation of Medicaid DSH payments by the State. These patients are not Medicaid-eligible. Sometimes Medicaid State plans specify that Medicaid DSH payments are based upon a hospital's amount of charity care or general assistance days.This, however, is not "payment" for those days, and does not mean that the patient is eligible for Medicaid benefits or can be counted as such in the Medicare formula.	No.

ATTACHMENT B

Definition of Certain Days that are Included or Excluded from the Medicare DSH Calculation

This attachment is intended to highlight and explain why certain types of Medicare days are either included in, or excluded from, the DSH calculation. Of course, hospitals will be held harmless retrospectively (consistent with attachment C). The following distinctions are relevant for prospective purposes only.

Selected Days that Are Included

1) Actual 1902(r)(2) and 1931(b) Days under a State Plan Amendment

Type of Day -- Actual section 1902(r)(2) and 1931(b) days are associated with patients eligible for Medicaid under a State plan approved under Title XIX based on a State's election of these authorities in its approved State plan

Rationale for Inclusion

- *Required by Statue* -- These days are included in the Medicare DSH calculation. The statute provides no discretion with regard to including these days in the calculation because this is done under a State Plan option.

2) Hypothetical 1902(r)(2) and 1931(b) Days under an 1115 Waiver

Type of Day -- In many Section 1115 demonstrations, a given population is made eligible for Medicaid under the waiver that otherwise could have been made eligible under section 1902(r)(2) or 1931(b) in a State plan amendment. These populations are referred to as a "hypothetical."

Rationale for Inclusion

- *Consistent with Existing HCFA Policy* – HCFA does have the option to exclude these days. However, under existing policy, HCFA included them in the calculation because "hypothetical" days are considered analogous to actual days. For instance, budget neutrality calculations generally include the section 1902(r)(2) and 1931(b) days in the baseline costs to account for costs that could have been incurred for these persons. Therefore, for purposes of budget neutrality, these types of days are considered to be "hypothetically eligible" under the State plan. It is important to note that the STCs for the hypothetical populations for the demonstration that expand eligibility only to hypothetical populations do not specify that the hypothetical days count towards the Medicare DSH day.

Selected Days that Are Excluded

1) 1115 Demonstration Days – Language Included in the Special Terms and Conditions
(OR, TN, HI, MA, DE, VT)

Type of Day -- Section 1115 demonstration days sometimes allow certain individuals to be enrolled in Medicaid who could not be made eligible for medical assistance under a State plan approved under Title XIX.

Rationale for Exclusion

- *Exclusion is Consistent with HCFA Policy* -- The section 1115(a)(2) waiver authority and "cost not otherwise matchable" authority is not within the scope of a Title XIX State Plan. Thus, demonstration populations are not included as eligible in the approved Title XIX State plan, but rather operate as an overlay on that plan.

- *Terms and Conditions Are Clear* -- All Section 1115 demonstration projects (with the exceptions of the ones below) that include this type of eligibility expansion require States to implement procedures so that hospitals can distinguish individuals who are eligible under the State plan (including those eligible under section 1902(r) and related provisions) from individuals who are only eligible due to the demonstration.

- *Differs from Hypothetical Days* – Hypothetical days are those involving a population that could have been made eligible under a State plan in absence of the waiver (primarily through the use of disregards.) This is not true for a demonstration day, and HCFA has never considered a demonstration day to be equivalent to a State plan day. Therefore, HCFA does not include the demonstration days in the DSH calculation. [OGC has expressed some concern that excluding demonstration days is made more difficult by our policy on hypotheticals because it highlights the fact that there is a policy choice on demonstration days. Also, the distinction between the two types of days is fine and will be lost on some.]

2) 1115 Demonstration Days – Language *Not* Included in the Special Terms and Conditions (NY and MO)

Type of Day: Same as above, except that the STCs did not include specific language excluding the days. Although there is a policy choice, HCFA strongly believes that these days should be excluded from the DSH calculation. NY and MO will argue the contrary position.

Rationale for Exclusion

- *Omission from the Term and Condition Language is Not Relevant* -- NY and MO will argue that, in light of the absence of the STC at issue from their waivers, they should be treated

United States Senate

COMMITTEE ON FINANCE

DANIEL PATRICK MOYNIHAN
Ranking Minority Member

To: Chris Jennings

From: David Podoff

Total Pages (including cover): 8

Fax #: 456-5557

Date: 11/23/99 Time: 4:00 pm

Comments: Medicare DSH Letter

203 HART SENATE OFFICE BUILDING
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TEL: (202) 224-5315
FAX: (202) 228-3904

Congress of the United States
Washington, DC 20515

November 23, 1999

Dear Madam Secretary:

We are writing to express our deep concern about an anticipated Health Care Financing Administration (HCFA) clarification related to Medicare disproportionate share hospital (DSH) payments that we understand is in its final clearance stages. The policy would preclude the counting of New York general assistance hospital days as Medicaid days for purposes of Medicare DSH payments, even though New York has expanded its Medicaid program to include its general assistance "Home Relief" population. This would have a devastating impact on New York State DSH hospitals – it could cut as much as $170 million per year – and would wipe out any financial gains resulting from legislation that offsets some of the unintended cuts of the Balanced Budget Act of 1997. We believe that it is wrong.

The number of inpatient days attributable to Medicaid recipients serves as the basis, in part, for Medicare DSH payments. As you know, in mid-October, HCFA announced it would not recoup payments from DSH hospitals in states where inpatient days of care provided to general assistance recipients were included as Medicaid days in the DSH calculation. We are very grateful for this decision which precluded huge and ruinous financial recoupments from New York DSH hospitals. We understand, however, that HCFA is planning to issue a new directive stating that inpatient days for general assistance patients covered under a Medicaid waiver program must be excluded from the Medicare DSH calculation from January 1, 2000 forward.

We believe that HCFA's policy is misguided and wrong. In 1997, HCFA approved New York's 1115 waiver to implement mandatory Medicaid managed care. As part of the waiver, New York expanded its Medicaid program to include coverage of the Home Relief population. There is no basis for distinguishing inpatient hospital days attributable to waiver eligibles from those for other Medicaid eligibility groups. Thus, Home Relief days should be counted as Medicaid days under the Medicare DSH methodology.

In New York, DSH hospitals are vital safety net providers of charity care and care to the Medicaid population. If HCFA's policy is implemented, Medicare funds for New York's DSH hospitals will be cut drastically. This amounts to an unconscionable funding cut for hospitals serving low-income patients that would result in disastrous consequences for these institutions and the needy communities they serve. We urge you to prevail immediately upon HCFA to change this policy.

Sincerely,

Charles B. Rangel

Daniel Patrick Moynihan

Charles E. Schumer

The Honorable Donna E. Shalala
The Department of Health and Human Services
Washington, DC 20201

Enclosure

cc: Christopher Jennings

Rosenman

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PETER F. NADEL
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October 18, 1999

By Hand

Mr. Kenneth E. Raske
President
Greater New York Hospital Association
555 West 57th Street
New York, New York 10019

Re: Medicare Disproportionate Share Hospital Payments

Dear Mr. Raske:

You have asked us to advise you as to the proper calculation of hospitals' "disproportionate share hospital" ("DSH") payments under § 1886(d)(5)(F) of the Medicare Act. The specific issue is whether individuals eligible for the New York Home Relief program are to be considered Medicaid-eligible individuals in the statutory formula used to calculate hospitals' Medicare DSH payments. We understand that the Health Care Financing Administration ("HCFA") may be considering a policy that Home Relief recipients are not Medicaid-eligible for this purpose and therefore may not be included in the calculation of DSH payments, notwithstanding HCFA's approval, effective July 15, 1997, of a demonstration program under § 1115 of the Social Security Act, which HCFA has acknowledged extends Medicaid eligibility to Home Relief recipients.

For the reasons set forth below, our conclusion is that Home Relief patients are properly included in the Medicare DSH calculation during the § 1115 demonstration period.

The Medicare DSH Payment

Under § 1886(d)(5)(F) of the Medicare Act, an eligible hospital's DSH payment is calculated by determining the hospital's disproportionate patient percentage, which is the sum of a "Medicare fraction" and a "Medicaid fraction." The Medicare fraction counts the number of a hospital's Medicare patients that receive Supplemental Security Income. The Medicaid fraction -- the issue here -- consists of the number of patient days for

patients who for those days "were eligible for medical assistance under a State plan approved under title XIX, but who were not entitled to benefits under part A of this title" (§ 1886(d)(5)(F)(vi)(II)), divided by the total number of patient days for that same period. HCFA Regulation 42 C.F.R. § 412.106(b)(4)(i) specifies that for purposes of computing the Medicaid fraction, "[a] patient is deemed eligible for Medicaid on a given day if the patient is eligible for medical assistance under an approved State Medicaid plan on such day . . . ."

The § 1115 Demonstration:
Extension of Medicaid Eligibility to Home Relief Recipients

By letter dated July 15, 1997, HCFA informed the New York Commissioner of Health that the State's proposed demonstration program entitled "The Partnership Plan: A Public-Private Initiative Ensuring Health Care for Needy New Yorkers" (the "Partnership Plan") had been approved for the period beginning July 15, 1997 through March 31, 2003. An attachment to the July 15 letter specifies that, pursuant to § 1115(a)(2) of the Act, certain State expenditures under the Partnership Plan, including "expenditures to provide Medicaid coverage for Home Relief Adults eligible for the Partnership Plan" (which are not otherwise included as Medicaid expenditures), "shall, for the period of this project, be regarded as expenditures under the State's title XIX plan." The attachment notes that "This [Home Relief] population would not otherwise be eligible for Medicaid" (emphasis added).

HCFA again confirmed that Home Relief recipients (and certain others) are regarded as Medicaid-eligible under the Partnership Plan in a letter dated May 26, 1999 to the State Department of Health, approving implementation of the § 1115 demonstration in New York City. The letter notes that:

> "When fully implemented, [The Partnership Plan] is expected to enroll about 85 percent of the currently Medicaid-eligible residents in managed care plans. In addition, the plan will also extend Medicaid eligibility to a significant number of currently uninsured New Yorkers." (Emphasis added.)

The expansion of Medicaid eligibility to Home Relief recipients also is described in other Partnership Plan documents. HCFA's New York Statewide Health Reform Demonstration Fact Sheet, posted on HCFA's website, notes that a feature of the Partnership Plan is "The conversion of the State's 370,000 Home Relief (Safety Net) population (low-income adults with no categorical linkage to Medicaid) to a Federal Title XIX eligibility group" (emphasis added). And Attachment I to the approved Partnership Plan specifies the persons and services subject to the budget neutrality cap under the § 1115 demonstration as including "Partnership Plan expansion eligibles." Such "expansion

eligibles" are defined as "persons who were not eligible [for Medicaid] under the base year period State plan, but who became eligible by virtue of the demonstration" (subject to an exception for CHIP enrollees not here relevant).

Thus, since July 15, 1997, HCFA has acknowledged that Home Relief recipients are Medicaid-eligible under the New York Title XIX State plan.

Inclusion of Home Relief Patient Days in the Medicare DSH Calculation

As noted above, a component of the Medicaid fraction in the Medicare DSH calculation is the number of patient days for patients who for those days "were eligible for medical assistance under a State plan approved under Title XIX . . . ." Because, as discussed above, HCFA has acknowledged that Home Relief recipients in New York; as of July 15, 1997, are "eligible for medical assistance" under the approved New York State plan, it seems clear that Home Relief patient days should be included as Medicaid patient days in the calculation of New York hospitals' Medicare DSH Adjustments.

We understand that HCFA may take a contrary view. If challenged, HCFA would argue that the court should defer to its interpretation that patients eligible for Medicaid by virtue of a § 1115 demonstration program are not, for purposes of the Medicare DSH formula, "eligible for medical assistance under a State plan approved under Title XIX."

Under the principles set forth in Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc., 467 U.S. 837 (1984), courts will defer to HCFA's interpretations of the Medicare and Medicaid Acts when the statutory provisions at issue are unclear or ambiguous. Here, however, there are substantial arguments that there is no ambiguity. Congress specified one and only one exception to the patients whose days are included in the calculation, i.e., patients "eligible for medical assistance under a State plan approved under title XIX, but who were not entitled to benefits under part A of this title" (§ 1886 (d)(5)(F)(vi)(II) (emphasis added)). Significantly, Congress did not add a second exception for those Medicaid patients "who became Medicaid-eligible by virtue of a § 1115 demonstration program" (or for any other optional group of Medicaid-eligible individuals under a State's approved Medicaid plan). In the absence of ambiguity -- and here there is none -- HCFA's possible interpretation, which would require a sub silentio exception for

Home Relief Medicaid patients to be read into the statute, should not be entitled to judicial deference.[1]

One could argue, as a matter of policy, that the current DSH formula is not the best measure of the additional costs that hospitals incur serving low-income patients -- for example, that it is underinclusive by excluding uncompensated care furnished to the uninsured, or that it is overinclusive by including patient days for individuals who are Medicaid-eligible by virtue of a § 1115 demonstration program. But states have always had different eligibility requirements for Medicaid, and to our knowledge, HCFA has not sought to exclude from the DSH formula individuals eligible for Medicaid under one of the optional eligibility categories. There is no more basis in the statutory language for excluding from the DSH formula those individuals eligible under a § 1115 demonstration than for excluding those covered under any other optional eligibility category.

HCFA has acknowledged that such policy questions concerning the patient days to be included in the DSH formula are to be addressed by the Congress. See 64 Fed. Reg. 24716, 24745 (5/7/99) ("any adjustment to the DSH formula or data sources should be directed and supported by the Congress"). Congress, however, has not excluded Medicaid-eligibles under a § 1115 waiver (or any other Medicaid-eligible individuals), and has instead provided for inclusion of all such Medicaid patient days (except those eligible for Medicare Part A). In the absence of an express statutory limitation, there are substantial arguments that HCFA may not exclude patient days for those individuals eligible for Medicaid under a § 1115 demonstration.[2]

---

1 When HCFA interpreted the statutory DSH formula to include only days paid by the Program, the courts rejected HCFA's interpretation and instead applied the statute as written: all Medicaid patient days, regardless of whether payment was made for those days, must be included. See, e.g., Cabell Huntington Hosp., Inc. v. Shalala, 101 F.3d 984 (4th Cir. 1996); Jewish Hosp., Inc. v. Secretary of Health and Human Servs., 19 F.3d 270 (6th Cir. 1994). HCFA ultimately agreed, and announced that all Medicaid patient days would be counted. See HCFA Ruling No. 97-2 (Feb. 27, 1997), Medicare & Medicaid Guide (CCH) ¶ 45,105 [1997-1 Transfer Binder].

2 We understand that HCFA has suggested that certain Terms and Conditions of the approved § 1115 demonstration program are contrary to the plain meaning of such program; i.e., that Home Relief patients are not Medicaid-eligible for purpose of the Medicare DSH calculation. We have reviewed such Terms and Conditions and see no basis for HCFA's suggestion. In any event, even if there were included such a statement in a

(continued)

Finally, the position that Home Relief patient days must be included in the calculation of Medicare DSH payments is consistent with Congress' purpose in providing for DSH payments, i.e., to compensate hospitals for the disparity between the costs that hospitals must incur in treating high- and low-income Medicare patients, the latter being in generally poorer health and costlier to treat. See, e.g., Cabell Huntington Hosp., supra, 101 F.3d at 985-86. Home Relief recipients are without question low-income individuals (and since at least July 15, 1997, as HCFA has acknowledged, Medicaid-eligible), and the purpose of the DSH provision is not compromised, and arguably is advanced, by the inclusion of their patient days in the DSH calculation.

In sum, we believe it to be very clear that Home Relief patients are properly included in the calculation of hospitals' Medicare DSH payments under the State's § 1115 demonstration program.

Please let me know if you wish to discuss these or related matters further.

Sincerely,

Peter F. Nadel

(continued from previous page . . .)

Partnership Plan document, it is difficult to see how such a statement could supersede the intent of Congress expressed in the Medicare Act.

GREATER NEW YORK HOSPITAL ASSOCIATION
GNYHA

555 West 57th Street / New York, N.Y. 10019 / (212) 246-7100 / FAX (212) 262-6350
Kenneth E. Raske, President

FACSIMILE TRANSMISSION

Date: Nov. 22, 1999

Time:

TO: Chris Jennings
FAX # 202-456-5557

FROM: **Kenneth E. Raske**
President

Phone: 212-246-7100
e-Mail: raske@gnyha.org

We are transmitting 2 pages including this cover sheet. If you have not received all of the pages, PLEASE CALL OUR OFFICE AS SOON AS POSSIBLE.

MESSAGE: The attached letter to Nancy-Ann Min DeParle at HCFA, F.Y.I.

Main Number (212) 246-7100
Fax Number (212) 262-6350

Hard Copy [ ] will [x] will not be sent by mail.

THE HEALTHCARE EDUCATION PROJECT
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November
Nineteen
1999

VIA FACSIMILE

Nancy-Ann Min DeParle
Administrator
U.S. Health Care Financing Administration
200 Independence Avenue, S.W., Room 314-G
Washington, D.C. 20201

Re: Medicare Disproportionate Share Hospital Payments

Dear Ms. DeParle:

We write to request an opportunity to meet and discuss with you the prospective formula to be used to calculate Medicare disproportionate share hospital (DSH) payments and the inclusion of Home Relief days under New York's 1115 waiver. As you and Ken discussed yesterday, this issue is of absolutely paramount importance to hospitals in New York serving low income patients, and we believe that HCFA's policy should be to continue current calculations under certain circumstances. Given the importance of this issue to health care in New York, we would very much appreciate the opportunity to review them with you. We are available the first half of next Wednesday, November 24, 1999 and would like to suggest this as a meeting date. We hope that your schedule might accommodate us.

Thank you very much.

Sincerely,

Dennis Rivera
1199/SEIU

Kenneth E. Raske
GNYHA

FAX

AAHSA

AMERICAN ASSOCIATION OF HOMES AND SERVICES FOR THE AGING
901 E STREET NW, SUITE 500, WASHINGTON, DC 20004-2011
202-783-2242 FAX 202-783-2255

Date: November 23, 1999

From: Michael Rodgers Dept. Code: 27

To: Chris Jennings

Total number of pages (including transmittal sheet): 4

If you do not receive a complete, legible transmission please call Bryan Martin at 202-508-9437

Fax Number: 456-5557

Message (if applicable):

AAHSA's 38th Annual Meeting & Exposition
October 25-28, 1999
Chicago * Navy Pier Convention Center

American Association
of Homes and Services
for the Aging

News Release

November 23, 1999 FOR IMMEDIATE RELEASE

Contact: Robert Greenwood, AAHSA, 202-508-9475

CONGRESS AGREES TO KEY BBA FIXES FOR NURSING HOMES AND HOME HEALTH PROVIDERS IN FINAL BUDGET DEAL

AAHSA grassroots efforts drive home effect of cuts on vulnerable Medicare beneficiaries

WASHINGTON, DC – The American Association of Homes and Services for the Aging applauds the hard work of Congress in passing legislation to address the unintended consequences to Medicare beneficiaries as a result of the Balanced Budget Act of 1997. The BBA, which took effect this year, particularly made it difficult for nursing homes to care for medically-complex residents.

"We congratulate the members of Congress who worked on this legislation and listened to the difficulties AAHSA members and other health care providers were having because of the Balanced Budget Act," said AAHSA President Len Fishman. "Our members' willingness to help their elected leaders understand the problems posed by the BBA was key to our successful advocacy efforts."

AASHA particularly expresses thanks to many members of Congress for their work in crafting this legislation. Senate Minority Leader Thomas Daschle (D-SD) included many key provisions AAHSA has advocated for this year in the bill he introduced. Sen. William Roth (R-DE) was instrumental in raising many of the issues included in the final bill in legislation he introduced this summer. Rep. Bill Thomas (R-CA) was steadfast in his insistence that Congress act on this issue before it adjourned. Rep. Nancy Johnson (R-CT) was key in providing carve-outs for certain high-cost, non therapy ancillary services whose costs were not adequately reflected in the new Medicare prospective payment system.

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AAHSA also appreciates the leadership of the President and Vice President on this issue and their willingness to work with Congress to ensure that these measures were put in place this year.

For nursing homes:

- The reimbursement rate was raised for care provided to the most medically-complex residents and for residents requiring some rehabilitation therapies.
- An across-the-board increase of four percent in payments to nursing homes for fiscal years 2000 and 2001.
- Costs for prosthetics, chemotherapy drugs, and ambulance services were "carved out" of the Medicare prospective payment system and can now be billed to Medicare directly.
- An option for facilities to move immediately to payment at the full federal rate was included, which would help facilities that have significantly changed their operations since 1995, the BBA base year.
- A two-year suspension in implementing the $1,500 a year cap on physical therapy (including speech) and occupational therapy.

For home care providers:

- A one-year delay in the 15 percent cut in reimbursement rates scheduled to take effect October1, 2000
- Costs for durable medical equipment were "carved out" of the Medicare prospective payment system and can now be billed to Medicare directly.
- Surety bonds will be required for either $50,000 or 10 percent of program revenues, whichever is lower.
- Three-year period to pay back overpayments, with first year interest-free.

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The American Association of Homes and Services for the Aging (AAHSA) consists of over 5,300 not-for-profit nursing homes, continuing care retirement communities, assisted living and senior housing facilities, and community service organizations. More than half of AAHSA 's members are religiously sponsored. Every day, AAHSA members serve one million older persons across the country. AAHSA 's Web site is www.aahsa.org.

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Preliminary CBO Estimate of Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999

by fiscal year, in billions of dollars

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Section		2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2000-2004	2000-2009
101	SNF: Incr 15 RUGs 20% 4/00-9/00 & all RUGs by 4% 10/00-9/02	0.2	0.4	0.6	0.1	0.0	0.0	0.0	0.0	0.0	0.0	1.4	1.4
102	SNF: Higher of curr law & 100% federal rate	0.1	0.4	0.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.7	0.7
103	SNF: Separate billing of certain ambulance, protheses, & chemo	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
104	SNF: Part B addon in case mix demo states	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
105	SNF: Facilities with 60% of patients with special popa	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
106	MedPAC Study	no direct spending										0.0	0.0
107	HHS Study	no direct spending										0.0	0.0
111	IME: 6.5 in 00, 6.25 in 01; 6.5 in 02 et seq.	0.2	0.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.6	0.6
112	Hosp: DSH-3% in FY 01, 4% in FY 02	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1
121	Wage-adjust 75th pctile cap for TEFRA hosps	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.3	0.8
122	Hosp: LTC & Psych Bonus payments	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
123	PPS for long term care hospitals	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
124	PPS for psych hospitals	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
125	Rehab PPS: on a per discharge basis	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
131	Hospice: Temporary increase in pmt rates in 2001 and 2002	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
132	GAO Study of hospice payment rates	no direct spending										0.0	0.0
141	MedPAC study, nonphysician clinical training	no direct spending										0.0	0.0
151	NW MS Regional Med Ctr deemed a RRC	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
152	Reclassify certain counties in NC, NY, IN, IL, OH, TX, & VT	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.3	0.8
153	Adjust wage index in Hattiesburg MS	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
154	Adjust wage indexes in PA	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
159	SNF: Special pmnt for Baldwin or Mobile County Alabama 2000-2001	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
201(a-j)	HOPD: Temporary outlier payment system for drugs and devices	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
201(k)	HOPD: Extend capital/operating reductions until PPS is implemented	-0.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	-0.3	-0.3
201(l)	HOPD: Eliminate 1st-year reduction in HOPD Payments	0.2	0.9	0.9	0.9	1.0	1.0	1.1	1.1	1.2	1.3	3.9	9.6
202	HOPD: Corridors with floors for rurals < 100 and exemption for cancer hosps, w/o FDO in 1996 payment/cost ratio	0.1	0.3	0.5	0.4	0.2	0.0	0.0	0.0	0.0	0.0	1.4	1.5
203	Study: HOPD PPS for Rural/Cancer hospitals	no direct spending										0.0	0.0
204	HOPD: Pgm pays copays above hospital inpatient deductible	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.3

Preliminary CBO Estimate of Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999

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Section		2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2000-2004	2000-2009
211	MD: SGR technical fix; -0.2% budget neutrality adj	0.0	0.3	0.1	-0.1	-0.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0
212	Physician: Relative practice expense	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
213	GAO Study: Resources for Outpt Cancer Therapy	no direct spending										0.0	0.0
221(a)	Therapy: 2 year moratorium on caps	0.2	0.3	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.6	0.6
221(b)	Therapy: Referrals to Occupational Therapy	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
222	Dialysis Update: 1.2% CY2000 & 1.2% CY2001	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.3	0.8
223	Moratorium on Inherent Reasonableness	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
224	Pap smears (increase payment)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.3
225	Refinement of ambulance demonstration project	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
226	ASC: Phase-in PPS for ASC over 3 years	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
227	Immunosuppressive drugs: $150m attributable to Part B	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1
228	Temporary increase in pmt rates for DME & Oxygen in 2001 and 2002	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
229	Studies & reports	no direct spending										0.0	0.0
301	HH: Pay $10 per bene in FY 2000, half 4/1/00 & half @ settlement	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
302	HH: Delay 15% reduction to one year after PPS	0.0	1.0	0.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.3	1.3
303	HH: Increase PBL to HHAs at/below natl median PBL by 2% in 00	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
304	HH: Surety bonds: lesser of $50,000 or 10%, 1 bond for XVIII & XIX	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1
305	HH: exclude DME from consolidated billing	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
306	HH: Tech Amendment re: update in 2002 and 2003	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
307	MedPAC study	no direct spending										0.0	0.0
311	GAF-adj Nat avg per-resident amt; 70% floor; freeze in 01&02, then 3yrs @CPI-2% if above 140%	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
312	Pediatric Neurology GME	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
321	BBA Technical Corrections	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
401	Conversion of urban hospital to rural status	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
402	Hosp geographic reclassification standards	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
403a	Crit Access Hosps: 96 hour avg LOS	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.4
403b	Crit Access Hosps: ownership	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1
403c	Crit Access Hosps: Conversion of closed hospitals	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1

Preliminary CBO Estimate of Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1998

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Section		2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2000-2004	2000-2009
403d	Crit Access Hosps: all-inclusive rate for OPD svcs	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
403e	Crit Access Hosps: elim cost-sharing for clin. lab svcs	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
403f	Crit Access Hosps: Swing beds	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
404	5-Year extension of Medicare-dependent hospital pgm	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.2
405	Phase in 1996 Cost Base for SCH Now Paid Federal Rate	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.3
406	Update SCHs @ MB in FY01.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.3
407a,b,c	GME: Increase # of residents in rural programs	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.2
407d	GME: Reassign Residents in closed program	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
408	Swing beds in hosps w/ 51-100 beds	0.0	0.0	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1
409	Grants to rural hospitals	no direct spending										0.0	0.0
410	GAO Study on geographic reclassification	no direct spending										0.0	0.0
411	MedPAC Study of rural providers	no direct spending										0.0	0.0
412	Paramedic services in rural areas	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
413	Tele-Medicine demonstration provision	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
501	M+C: Enrollment Flexibility: terminating plans, institutionalized, svc changes	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
502	M+C: effective date of enrollment elections	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
503	Cost contracts: 2 year extension	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
511	M+C: phase-in risk adjusters @ 90/10, 90/10, 80/20, silent	0.0	0.2	0.3	0.5	0.3	0.0	0.0	0.0	0.0	0.0	1.3	1.3
512	M+C: Boost Pmts for plans serving counties w/o plans	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1
513	M+C: modify 5-year rule	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
514	Continued publication of AAPCC Data	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
515	M+C: Allow variations in benefits	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
516	M+C: Delay ACR Submission Deadline	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
517	M+C update at FFS minus 0.3 in 2002	0.0	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.8
518	M+C: Public/private sector accreditation deemed	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
519	M+C: Information fairs	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
520	M+C: Quality Assurance for PPS, Pvt FFS, & MSAs	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
521	M+C: Nonapplicability of discharge planning	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
522	M+C User Fees	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
523	Clarify that Fraternal Benefit Plans can offer FFS +Choice option	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
524	M+C: Physician referral rules	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

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Section		2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2000-2004	2000-2009
531	S/HMOs, extend 18 mths after report; raise enrollment cap	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1
532	Extend Community Nursing Organization demo for 2 yrs	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
533	M+C: Competitive Bidding demo	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1
534	Muni Health Services Demo: 2 year extension	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1
535	Coordinated Care Demo	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
536	Medigap protections for PACE enrollees	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
541	M+C: Payments for nurse & allied health training	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
551	Study: VA and DoD spending for Medicare beneficiaries	no direct spending										0.0	0.0
552	MedPAC studies	no direct spending										0.0	0.0
553	GAO Studies	no direct spending										0.0	0.0
	Medicare+Choice interaction	0.0	1.2	0.8	0.6	0.4	0.5	0.5	0.6	0.7	0.8	2.9	6.2
	Subtotal, Gross Outlays	1.0	6.1	4.6	3.2	2.2	2.2	2.3	2.5	2.7	2.9	17.2	29.7
	Part B Premium interaction	0.0	-0.6	-0.6	-0.5	-0.4	-0.4	-0.4	-0.5	-0.5	-0.5	-2.1	-4.4
	Subtotal, Net Medicare Outlays	1.0	5.5	4.0	2.7	1.8	1.8	1.8	2.0	2.2	2.3	15.1	25.3
	Medicaid:												
	Interaction with Part B Premium and Cost Sharing	0.0	0.1	0.1	0.1	0.0	0.1	0.1	0.1	0.1	0.1	0.3	0.8
601	Increase DSH allotments for certain states and DC	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.3
602	Transitional administrative costs	0.1	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.2
603	Medicaid costs from delaying phase-out for FQHC/RHC policy	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1
604	Reimbursement for utilization and quality control services	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
605	DSH: No enhanced match under SCHIP	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
606	Option to defer effective date for Outpatient Drug Agreements	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
607	DSH: make transition rule permanent	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
608	Technical corrections	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Subtotal, Medicaid	0.1	0.2	0.2	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.7	1.2

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	SCHIP:												
7[illegible]01	Stabilize allocation formula	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
7[illegible]02	Increase allotment for Commonwealths and Territories	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.3
7[illegible]03	Data collection and evaluation	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1
7[illegible]04	Change acronym to SCHIP	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
7[illegible]05	Technical corrections	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Subtotal, SCHIP	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.1	0.2	0.4
	Total, Direct Spending	**1.2**	**5.8**	**4.2**	**2.9**	**2.0**	**2.0**	**2.0**	**2.2**	**2.3**	**2.5**	**16.0**	**27.0**

PAUL D. WELLSTONE
MINNESOTA

MINNESOTA TOLL FREE NUMBER:
1-800-642-6041

United States Senate

WASHINGTON, DC 20510-2303

COMMITTEES:
LABOR AND HUMAN RESOURCES
SMALL BUSINESS
INDIAN AFFAIRS
VETERANS' AFFAIRS
FOREIGN RELATIONS

FAX

TO: Chris Jennings
The White House

FAX #: 456-5557

DATE: October 29, 1999

FROM: JOHN H. GILMAN
Phone: 202-224-5641
Fax: 202-224-8438

MESSAGE: Attached letter sent to the President this morning and will be announced later this morning.

TOTAL PAGES: 3 (Including Cover Sheet)

Please contact 202-224-5641 if there were any problems with this fax.

PAUL D. WELLSTONE
MINNESOTA

MINNESOTA TOLL FREE NUMBER:
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United States Senate

WASHINGTON, DC 20510-2303

COMMITTEES:
LABOR AND HUMAN RESOURCES
SMALL BUSINESS
INDIAN AFFAIRS
VETERANS' AFFAIRS
FOREIGN RELATIONS

November 1, 1999

President Bill Clinton
1600 Pennsylvania Avenue
Washington, DC 20500

Dear President Clinton:

As you meet and negotiate with leaders from the House and Senate, I urge you to insist on Balanced Budget Act adjustments that will provide needed relief to health care providers across the nation and ensure the solvency of our health care system.

Although the Senate Finance Committee, along with the House Ways and Means Committee, corrected some of the inequities resulting from the passage of the Balance Budget Act of 1997 (BBA), much remains to be done. Further corrections are needed to assure citizens of Minnesota and other states that the health care institutions they rely on--hospitals, nursing homes, home health agencies, and hospice services-- will be there when they need them. That is why I ask you to include the following provisions, in addition to those already included in the Finance Committee bill, in any BBA Adjustment package you agree to.

For Hospitals

- Create a 3 year transition period that would set the stop-loss percentages for the Hospital Outpatient Prospective Payment System (PPS) at 5%, 10% and 15%. This will protect hospitals from potentially damaging and dramatic decreases in Medicare revenues.

- Freeze the decrease in Medicare Disproportionate Share Hospitals (DSH) payment at 2% until 2003. This will soften the blow of BBA reductions in Medicare payments to hospitals serving a disproportionate share of low income patients.

- Freeze the Indirect Medical Education (IME) adjustment for teaching hospitals at 6.5% for 8 years. Without this freeze, teaching hospitals will receive inadequate reimbursements to train new physicians.

For Skilled Nursing Facilities

- Increase the total number of rehabilitation and special care Resource Utilization Groups (RUGs) eligible for add-on payments by including the remaining RUGs and higher add-ons for RUGs as specified in S. 1678, Section 401(a). This fixes BBA miscalculations that failed to anticipate the high costs of caring for patients with complex problems.

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- Unbundle the following services: ambulance, MRI, CT Scan, surgery, chemotherapy, and prostheses. This allows separate billing for these high cost services, rather than forcing nursing homes to spread their estimated costs among all patients.

For Home Health and Hospice Care

- Delay the 15% reduction for home health care agencies by 2 years. BBA mandated a Prospective Payment System and a 15% cut in total payments, which if done simultaneously would threaten the viability of home health care agencies; delaying the reduction allows agencies to adjust to these changes over time.

- Give the full market basket increase to hospice facilities. The annual update calculation used to reimburse hospice facilities for Medicare services was decreased under BBA in a way that did not adequately account for the actual increases in costs for providing goods and services.

For Health Centers and Rural Health Clinics

- Establish a new prospective payment system for federally-qualified health centers and rural health clinics to assure preservation of these safety net providers.

Demonstration Projects

- Extend the Community Nursing Organization demonstration project for three years. This four state demonstration project coordinates care to provide additional benefits to recipients at less cost than traditional Medicare. The extension will continue these services while allowing HCFA to perform a comprehensive independent review.

Unless the important adjustments already in the marked-up Finance Committee bill, plus those additional adjustments listed above, are adopted, I fear the result will be a loss to our rural health infrastructure, a devastating decline in our ability to train new physicians and nurses, and a dangerous deterioration in delivering health care services generally. Those losses will be felt not only by those on Medicare or Medicaid, but by all our citizens, and for years to come.

Finally, Mr. President, I strongly urge you to insist on including a comprehensive Medicare prescription drug benefit in any negotiations you have with Congressional leaders. It is a national disgrace for senior citizens from Minnesota to be forced to travel to Canada to purchase life sustaining American-made prescription drugs at a price they can afford. The time is past due for an affordable prescription drug benefit to be available to all Medicare beneficiaries, and I ask you to push for its adoption before the end of this session.

Thank you for your help in these efforts.

Sincerely,

Paul Wellstone

Paul D. Wellstone
U.S. Senator

HEALTH CARE FINANCING ADMINISTRATION

ADDRESSEE:	FROM: Melissa
Devorah	OFFICE OF THE ADMINISTRATOR 200 INDEPENDENCE AVE., S.W. ROOM 314G WASHINGTON, DC 20201
PHONE:_____	PHONE: 202-690-6726 FAX : 202-690-6262

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

REMARKS:

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Deputy Administrator
Washington, D.C. 20201

DATE: OCT 26 1999

TO: June Gibbs Brown
Inspector General

FROM: Michael M. Hash
Deputy Administrator

SUBJECT: Office of Inspector General (OIG) Draft Reports: "Review of Medicare Home Health Services in California, Illinois, New York, and Texas," (A-04-99-01194) and "Medicare Beneficiary Access to Home Health Agencies," (OEI-02-99-00530)

We appreciate the opportunity to comment on the above-referenced reports. Both studies were conducted at our request, and they address important questions for us and home care beneficiaries, providers, and advocates regarding program integrity and access to care.

In the past year, we have taken a series of steps to strengthen the home health benefit for Medicare beneficiaries. Home health care enables seniors and disabled Americans, and the frailest beneficiaries, to receive many services in their homes as covered under Medicare law. We are committed to protecting the benefit for those who qualify for it.

General Comments

The Balanced Budget Act of 1997 (BBA) addressed a number of concerns regarding Medicare payment for home health services. For example, it stopped the practice of billing for care delivered in low cost, rural areas from urban offices at high urban-area rates. It tightened eligibility rules so patients who only need blood drawn no longer qualify for the entire range of home health services. And, it created an interim payment system to be used while we develop a prospective payment system. We expect to publish a proposed regulation by the end of this month and to have the prospective payment system in place by the October 1, 2000 statutory deadline.

The interim payment system is a first step toward giving home health agencies incentives to provide care efficiently. Before the BBA, reimbursement was based on the costs they incurred in providing care, subject to a per visit limit, and this encouraged agencies to provide more visits and to increase costs up to the limits. The interim system includes a new, aggregate per beneficiary limit designed to provide incentives for efficiency that will be continued under the episode-based prospective payment system. Last year Congress increased the cost limits in an effort to help agencies during the transition to

prospective payment. We are also taking the steps discussed above to help agencies adjust to these changes, and in March we held a town hall meeting to hear directly from home health providers about their concerns. Another is scheduled for this November.

To date, evaluations by the Government Accounting Office (GAO) and Department of Health and Human Services have found that BBA changes are not causing significant quality or access problems. Our monitoring of employment data shows that freestanding home health agencies have made small reductions in their workforce, back to the level seen in 1996. However, we have heard reports from beneficiary groups, our regional offices, and others regarding home health agencies that have inappropriately denied or curtailed care, and incorrectly told beneficiaries that they are not eligible for services. We are also hearing reports from beneficiary advocates and others that some high cost patients are having trouble finding home health agencies to provide the care they need. This may result from a misunderstanding of the new incentives to provide care efficiently. The Congressional Budget Office attributes some of the lower home health spending to the fact that agencies are incorrectly treating the new aggregate per beneficiary limit as though it applies to each individual patient.

We have, therefore, provided home health agencies with guidance on the new incentives and their obligation to serve all beneficiaries equitably. We have instructed our claims processing contractors to work with agencies to further help them understand how the limits work. Because home health beneficiaries are among the most vulnerable, we are continuing ongoing detailed monitoring of beneficiary access and agency closures.

Our specific comments on each report are attached.

Attachment

"Review of Medicare Home Health Services in California, Illinois, New York, and Texas," (A-04-99-01194)

We believe we have made great progress in reducing payment errors in home health in the four states studied. As with the national error rate reflected in the 1998 Chief Financial Officers Act report, the payment error rate has been reduced by more than half in just two years. More progress must be made on this front, but the increased compliance with Medicare rules reflects the hard work of many partners in the system--home health providers themselves, contractors, agency employees, law enforcement, and beneficiaries--to ensure that we pay correctly.

The nature of the errors identified is instructive and helpful in our efforts to continue to assure that we pay Medicare claims properly. Errors resulting from services not reasonable and necessary declined 70 percent, as did errors resulting from determinations that the beneficiary was not homebound and errors resulting from a lack of physician orders. However, these were partially offset in the OIG's calculations by a new error category. A number of errors in the sample (128, or 5.8 percent as a component of the 19 percent error rate) are attributable to a lack of response from home health agencies that have left the program. Because the OIG could not locate these agencies or their owners, they failed to provide any medical records at all. Our records reflect that these home health agencies have merged with other operations or have closed altogether, generally ceasing operations in the earlier part of 1999.

We agree that it is a problem that these records could not be obtained. Typically, when records are not produced to substantiate a claim, the claim is determined to be an error. But in these cases, we can not establish that the agency management or owners received the request for the records, because the OIG could not locate them. The report does not provide detail on the steps taken by the OIG to obtain a current address, though it does say that the auditors made numerous attempts to find the agencies, even going so far as to contact beneficiaries themselves.

We are particularly concerned about this finding because it represents the most significant error category in the OIG's audit, and because agencies leaving the program with uncollected overpayments has been of concern to us. Most of the 12 agencies in this category, according to our records, do have outstanding overpayments and we will be unable to collect on these overpayments if we cannot locate the owners.

Further, if these agencies were located and their records reviewed, it is possible that the error rate estimate by the OIG would have been lower. For example, if the records from these agencies contained the same percentage of errors as those in the sample as a whole, the error rate estimate could have dropped several points. Therefore, we plan to work with the OIG to obtain further information on these agencies and determine if the

available sources at contractors, survey agencies and regional offices can yield further data to assist us in obtaining records and updated addresses for owners and records retention sites.

OIG Recommendation

HCFA should revise Medicare regulations to require the certifying physician to examine the patient before ordering home health services and see the patient at least once every 60 days.

HCFA Response

We agree with the OIG's concern for the importance of the physician role and share their concern that some errors can be attributed to the lack of adequate physician supervision. We will be considering options to address this issue in the near future including increased physician education as well as other mechanisms to encourage physician involvement. While we agree with the need for more physician involvement, this requirement would require a change in a law and potentially increase program costs. We would need to consider the impact on beneficiaries, particularly in rural areas. We will need to determine whether payment errors occur more frequently, and with what impact, when physicians do not examine patients prior to signing a plan of care than when they do provide such an examination. We also believe our reliance on composite review of Outcome and Assessment Information Set data and physician plans of care in medical review will cause agencies and physicians to form clearer relationships in care planning and service delivery.

OIG Recommendation

HCFA should consider the 19 percent rate of improper or highly questionable services as a factor before making any changes to the current payments under the interim payment system (IPS).

HCFA Response

Under current law, we lack the statutory authority to make changes to current payments under IPS. As a result, we have not recommended any changes to the IPS at this time.

OIG Recommendation

HCFA should consider making an equitable adjustment to the proposed home health agency prospective payment system rates or update factors to take into account the improper and highly questionable payments that were included in the base year calculations.

HCFA Response

We do not concur with the recommendation because HCFA has already taken several steps to ensure accurate and fair payments. First, the law requires us to use most recent audited cost report data available for the base year. In this connection, we conducted a statistically representative sample of home health agency cost reports. We conducted comprehensive audits of the cost reports submitted by the sample home health agencies. The scope of these audits went well beyond our usual level of effort and the industry has complained that this level of audit resulted in a higher level of disallowances than ordinarily would be the case. Thus, we believe that the cost report data we are using to establish the costs of individual service components of the rates has been properly analyzed and does not reflect significant excess cost.

Second, we believe that the OIG's current report demonstrates that agency responses to the IPS have significantly reduced the level of questionable claims and payments. The combination of these two factors and the imposition of an additional 15 percent reduction in payments as required by law appears to us to create a payment situation in which further examination and manipulation of the cost base is no longer necessary for pricing the services. Instead, we believe that the Congress has set the overall price of services and intends that it be updated annually by a market basket adjustment. On the other hand, we recognize that this is an issue that merits further review and we are asking for further comments on it in the Notice of Proposed Rule Making we are publishing.

OIG Recommendation

HCFA should instruct the intermediaries to collect the overpayment identified in our sample.

HCFA Response

We concur, subject to the need for further development of claims for terminated home health agencies, as discussed above.

"Medicare Beneficiary Access to Home Health Agencies," (OEI-02-99-00530)

We are encouraged that this report documents that access to home health services have, in large measure, been maintained. As noted above, we are undertaking a number of activities to assess and monitor access to care and appreciate the data presented in this report. It adds to the other information we have and are gathering in order to allow us to understand and develop appropriate responses to access problems if and when they occur. We reiterate our commitment to ensuring beneficiaries have access to Medicare covered benefits.

Access to care must be viewed in the context of historical coverage and utilization. Unfortunately, there are always instances when a beneficiary with one set of needs does not find a home health agency available which can meet them. These situations occurred even before IPS. However, we do not have an "access" baseline to which we can now compare changes. Available data such as expenditure levels or total numbers of home health providers are not appropriate proxies. For example, as evidenced by the companion OIG report being issued, inappropriate utilization has decreased by more than 50 percent over a period of a few years. We believe that the reasons home health agencies may be giving for declining patients who they may previously have accepted for care must be understood in this context.

We continue to collect and analyze data relating to access, not only for home health beneficiaries who are discharged from the hospital, but also for those home health beneficiaries who come from the community. We encourage the OIG as well as the GAO, to continue working with us on these issues.

We are particularly interested in knowing more about the concerns of discharge planners suggesting some agencies may not be providing adequate services to the Medicare beneficiaries under their care. We urge OIG to study, as we will do, the available data to determine if home health patients are returning to the hospital more frequently than in the past.

Medicare law and regulations require that home health agencies provide all Medicare covered care when they agree to care for a beneficiary who qualifies for the home health benefit. We have reminded agencies repeatedly of this responsibility since we implemented the changes in the payment system required by the BBA. In addition, to assure the quality of home care, we now require agencies to use a standard assessment tool that will allow both Medicare and the agencies to identify patterns involving the quality of care that individual agencies provide and the outcomes for their patients. That tool will help us identify and take appropriate steps to ensure the quality of care for beneficiaries.

James P. McGovern

Congress of the United States
Third District-Massachusetts
www.house.gov/mcgovern

416 Cannon House Office Building
Washington, D.C. 20515
(202) 225-6101
FAX: (202) 225-5759

To: Deborah Date: 11/4

Fax #: 456-5557 Number of Pages (including cover): 1

James McGovern
Member of Congress

Cindy Buhl
Legislative Director

Giles Giovinazzi
Legislative Assistant

Ed Augustus
Chief of Staff

Michael Mershon
Press Secretary

Jamie Hoag
Legislative Correspondent

Daniel Holt
Scheduler

Keith Stern
Legislative Assistant

MESSAGE:

This is our outlier bill w/o offset. We changed the funding from $250 million p/year for 3 yrs to $250 million for 3 yrs ($175 m, $37.5 & $37.5 million). We're still working with Rep Stark etc. Please call me after you read this.

Keith
226-8184

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F:\M6\MCGOVE\MCGOVE.013 H.L.C.

AMENDMENT TO H.R. 3075, AS REPORTED OFFERED BY MR. MCGOVERN OF MASSACHUSETTS

At the appropriate place, insert the following new sections (and conform the table of contents accordingly):

SEC. . ADDITIONAL PAYMENTS TO HOME HEALTH AGENCIES FOR MOST EXPENSIVE CASES.

(a) PAYMENTS FOR OUTLIERS.—

(1) IN GENERAL.—Subject to paragraph (2), from amounts appropriated pursuant to subsection (e), the Secretary of Health and Human Services shall pay an additional amount to home health agencies furnishing qualified home health services during a cost reporting period beginning on or after October 1, 1997, under the medicare program (under title XVIII of the Social Security Act).

(2) LIMITATION OF PAYMENTS.—No payment shall be made under this section to a home health agency that, as of the date of the enactment of this Act, has ceased furnishing home health services for which payment may be made under the medicare program (under such title).

(b) DESCRIPTION OF QUALIFIED SERVICES.—For purposes of additional payment amounts under this section by the Secretary to home health agencies, qualified

home health services are home health services furnished under the medicare program for the treatment of conditions within a diagnosis described in subsection (c).

(c) DESCRIPTION OF DIAGNOSIS.—A diagnosis described in this subsection is one of the following diagnoses as classified in St. Anthony's ICD–9–CM Code Book for Physician Payment:

(1) diabetes mellitus (ICD–9–CM code 250).

(2) essential hypertension (ICD–9–CM code 401).

(3) other forms of chronic ischemic heart disease (ICD–9–CM code 414).

(4) heart failure (ICD–9–CM code 428).

(5) acute, but ill-defined cerebrovascular disease (ICD–9–CM code 436).

(6) pneumonia, organism unspecified (ICD–9–CM code 486).

(7) chronic airway obstruction, not elsewhere classified (ICD–9–CM code 496).

(8) chronic ulcer of skin (ICD–9–CM code 707).

(9) symptoms involving urinary system (ICD–9–CM code 788).

(10) fracture of neck of femur (ICD–9–CM code 820).

(d) DETERMINATION OF AGENCY-SPECIFIC PAYMENT AMOUNT.—

(1) CERTIFICATION OF QUANTITY OF QUALIFIED HOME HEALTH SERVICES FURNISHED.—

(A) IN GENERAL.—With respect to a fiscal year, a home health agency may submit to the Secretary a certification of the number of patients to whom the agency furnished qualified home health services during the agency's cost reporting period beginning in that fiscal year.

(B) DEADLINE FOR SUBMISSION.—

(i) IN GENERAL.—Such certification shall be submitted to the Secretary during the 30-day period beginning on the date the agency submits to the Secretary a cost report for the cost reporting period beginning in such fiscal year.

(ii) TRANSITION RULE.—In the case of an agency with a cost reporting period beginning on or after October 1, 1997, that ends before the date of the enactment of this Act, with respect to such cost reporting period, the 30-day period under clause (i) begins 60 days after the date of the enactment of this Act.

(2) DETERMINATION OF AGGREGATE QUALIFIED HOME HEALTH SERVICES FURNISHED.—From data contained in certifications submitted under paragraph (1) with respect to cost reporting periods beginning in fiscal years 1998, 1999, and 2000, the Secretary shall determine, with respect to a fiscal year, the number of patients who have received qualified home health services furnished by agencies submitting such certifications for that fiscal year. The Secretary shall make such determination by not later than 120 days after all cost reports for that fiscal year have been received.

(3) AGENCY-SPECIFIC PERCENTAGE OF AGGREGATE AMOUNT.—For each home health agency submitting a certification under paragraph (1) for a fiscal year described in paragraph (2), the Secretary shall determine an agency-specific percentage by dividing the number of patients certified by the home health agency for that fiscal year by the national total specified in paragraph (2) for that fiscal year.

(4) PAYMENT AMOUNT.—The Secretary shall pay for a fiscal year described in paragraph (2) to a home health agency making the certification under paragraph (1) an amount equal to the product of the percentage determined under paragraph (3) and the

amount appropriated for such fiscal year under subsection (e).

(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated from the Federal Hospital Insurance Trust Fund (established under section 1817 of the Social Security Act (42 U.S.C. 1395i)) for making additional payments to home health agencies under this section, the following amounts:

(1) $175,000,000 for fiscal year 2000.

(2) $37,500,000 for fiscal year 2001.

(3) $37,500,000 for fiscal year 2002.

(f) TERMINATION.—The Secretary shall not make additional payments under this section for cost reporting periods, or portions of cost reporting periods, beginning on or after the date of the implementation of the prospective payment system for home health services under section 1895 of the Social Security Act (42 U.S.C. 1395fff).

(g) LIMITATION ON JUDICIAL REVIEW.—There shall be no administrative or judicial review under section 1869 of the Social Security Act (42 U.S.C. 1395ff), section 1878 of such Act (42 U.S.C. 1395oo), or otherwise of any action of the Secretary with respect to the determination of an additional payment amount under this section.

SEC. . MEDICARE CENTERS.

(a) IN GENERAL.—Title XVIII is amended by inserting after section 1896 the following new section:

"MEDICARE CENTERS

"SEC. 1897. (a) IN GENERAL.—The Secretary shall use a competitive process to contract with specific hospitals or other entities for furnishing services related to surgical procedures, and for furnished services (unrelated to surgical procedures) to hospital inpatients that the Secretary determines to be appropriate. Such services may include any services covered under this title that the Secretary determines to be appropriate, including post-hospital services.

"(b) QUALITY STANDARDS.—Only entities that meet quality standards established by the Secretary shall be eligible to contract under this section. In considering quality, the Secretary shall take into account the quality, experience, and quantity of services of physicians who provide services in more than one entity. Contracting entities shall implement a quality improvement plan approved by the Secretary.

"(c) PAYMENT.—Payment under this section shall be made on the basis of negotiated all-inclusive rates. The amount of payment made by the Secretary to an entity under this title for services covered under a contract shall

be less than the aggregate amount of the payments that the Secretary would have otherwise made for the services.

"(d) CONTRACT PERIOD.—A contract period shall be 3 years (subject to renewal), as long as the entity continues to meet quality and other contractual standards.

"(e) INCENTIVES FOR USE OF CENTERS.—The Secretary may permit entities under a contract under this section to furnish additional services or waive beneficiary cost-sharing, subject to the approval of the Secretary.

"(f) LIMIT ON NUMBER OF CENTERS.—The Secretary shall limit the number of centers in a geographic area to the number needed to meet projected demand for contracted services.".

(b) EFFECTIVE DATES.—

(1) The amendment made by subsection (a) applies to services furnished on or after October 1, 2001.

(2) By October 1, 2001, the Secretary shall enter into contracts under the amendment made by subsection (a) for coronary artery by-pass surgery and other heart procedures, knee replacement surgery, and hip replacement surgery, in geographic areas nationwide such that at least 20 percent of the projected number of those procedures can be provided under such contracts.

OFFICE OF SENATOR BARBARA A. MIKULSKI
UNITED STATES SENATE
709 HART SENATE OFFICE BUILDING
WASHINGTON, D.C. 20510-2003

FAX TRANSMITTAL FORM

DATE: 11/4/99

TIME SENSITIVE

PAGE(S) (INCLUDING THIS FORM 11

IS/ARE FOR: Chris Jennings 456-5557

FROM: Jenny Lucy

IF THIS TRANSMITTAL IS INCOMPLETE, PLEASE CALL (202) 224-4654

****

(ADDITIONAL INFORMATION):

THE FOLLOWING

Pls. See Attached

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	Jenny Luray to Chris Jennings re: BBA (partial) (1 page)	11/04	P6/b(6)

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

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

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

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

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

MEMORANDUM

Date: 11/4
To: Chris Jennings
From: Jenny Luray
RE: BBA

First, you were impressive at the Dem. Senators meeting – Mikulski remarked about it.

You asked about her priorities. She has two (although the second is hers only):

1) SNFs

- she favors the Senate Finance provisions (the add-on and increased payments for Special Care, Extensive Services and Rehab RUGS as well as allowing facilities to choose the better of the federal or transition rates.)

2) A Demo Project for Medicare+Choice in Maryland

- This is a low-cost HCFA demo to make it more attractive for managed care companies to service rural Maryland
- We met with Rich Tarplin and Jane Horvath who had no problem with the concept but advised us to put the demo in legislation to ensure that HCFA would undertake it
- Roth's office is getting it scored by CBO. Should have it back tomorrow
- Roth/Moynihan seem to have no major issues with it. The time factor mainly prevented us from getting in the Finance mark
- I've attached summary info plus legislative language
- Would make Mikulski very happy to get this enacted. Would also help her to support a BBA fix with less HMO money.
- Any help you can provide would be terrific! Let me know what you think about it.
- My direct line: 224-8868. Pager: P6/(b)(6) [001]

Summary of Demo Project for Medicare+Choice

* Creates 2 service areas: Western Maryland, Eastern Shore/Southern Maryland

Counties in Service Area 1: (Western Maryland)	Allegany Garrett	Washington
Counties in Service Area 2: (Eastern Shore/Southern Maryland)	Calvert Caroline Cecil Dorchester Kent Queen Anne's	Somerset St. Mary's Talbot Wicomoco Worcester

* Medicare+Choice companies bid to provide benefits to entire service area for length of contract

  - contract is 3 - 4 years and is exclusive

  - plans are bidding on a standardized benefit package including prescription drug coverage

* Payment is based on the average payment of counties in the service area

  - no floor or ceiling for bid, but average payment for service area is a guideline

  - yearly payment increases based on growth in Medicare, rather than current method

* Benefit package remains stable for entire contract period

* Beneficiaries have frequent enrollment and disenrollment options

* Secretary will have authority to allow the contractor to annex a county not listed in above service areas should all existing HMOs withdraw from that county (e.g. Carroll, Frederick, Charles)

* Demo is based on a successful Arizona Medicaid demo project

BARBARA A. MIKULSKI
MARYLAND

SUITE 709
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WASHINGTON, DC 20510

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United States Senate

WASHINGTON, DC 20510-2003

November 3, 1999

The Honorable William V. Roth, Jr.
Chairman
Senate Finance Committee
Washington, D.C. 20510-6200

Dear Mr. Chairman,

As we discussed, I have enclosed information about the Medicare+Choice demonstration project. As you may know, 14,000 Maryland seniors will lose their HMO as of January 1, 2000. This demonstration project is the best solution for Maryland seniors and its inclusion in the manager's package of BBA legislation is my top priority.

The demonstration project was developed through extensive discussions with GAO, HHS, and HCFA. It is based on the Arizona Medicaid program which operates successfully throughout rural Arizona. We have contacted several health plans in Maryland who have expressed support for this project. They feel it provides needed stability and also addresses the unique problems that health plans in rural areas face in the Medicare+Choice program.

The demonstration project would provide an exclusive contract for a defined service area over a 3 to 4 year period. Maryland's two defined service areas reflect the counties that will no longer have Medicare HMO options. Plans would bid for the exclusive contract using the average payment to the counties in that service area as a guideline. HHS would not be required to award a contract should the bids be considered unreasonable. The yearly payment increases would be based on the growth in Medicare, rather than the current method. The plans would submit a bid based on a standardized benefit package which would remain stable throughout the contract period. Because this a relatively new concept, beneficiaries would have more frequent enrollment and disenrollment options than under the current program.

While I am still awaiting a CBO score of this legislation, HCFA and HHS feel that this could be implemented with little to no budgetary impact. This demonstration project will not only provide stable Medicare HMO services to the 14,000 Maryland seniors who will lose their Medicare HMO shortly, but could also serve as a model for other states with rural areas. I look forward to working with you closely on this urgent issue.

Sincerely,

Barbara A. Mikulski
United States Senator

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O:\JGS\JGS99.364 S.L.C.

AMENDMENT NO. ____ Calendar No. ____

Purpose: To establish a demonstration project regarding the offering of Medicare+Choice plans in certain areas.

IN THE SENATE OF THE UNITED STATES—106th Cong., 1st Sess.

(no.) _____

(title) _____

Referred to the Committee on _____
and ordered to be printed

Ordered to lie on the table and to be printed

AMENDMENT intended to be proposed by Ms. MIKULSKI

Viz:

At the appropriate place, insert the following:

SEC. ____. MEDICARE+CHOICE DEMONSTRATION PROJECT.

(a) ESTABLISHMENT OF PROJECT.—

(1) IN GENERAL.—There is established a demonstration project under which the Secretary of Health and Human Services (in this section referred to as the "Secretary") shall accept bids and award contracts under subsection (b)(1) to Medicare+Choice organizations for the exclusive of-

fering of Medicare+Choice plans in each service area described in subsection (b)(2).

(2) IMPLEMENTATION.—Not later than 6 months after the date of enactment of this Act, the Secretary shall implement the project established under subsection (a).

(b) PROJECT IMPLEMENTATION.—

(1) BIDS AND CONTRACTS.—

(A) BIDS.—In implementing the demonstration project under this section, the Secretary shall conduct a competition under which the Secretary accepts bids from Medicare+Choice organizations in each service area described in paragraph (2) and awards contracts in such areas under subparagraph (B).

(B) CONTRACTS.—

(i) IN GENERAL.—Except as provided in clause (ii), the Secretary shall award a contract to a Medicare+Choice organization in each service area under which the Medicare+Choice plan offered by the organization is the only Medicare+Choice plan available to Medicare+Choice eligible indi-

viduals residing in the service area covered by the contract.

(ii) EXCEPTION.—The Secretary is not required to award a contract in a service area if the bid submitted under subparagraph (A) does not meet such criteria as the Secretary may specify.

(2) SERVICE AREAS.—Subject to paragraph (3), the service areas described in this paragraph are as follows:

(A) WESTERN MARYLAND.—The area that includes the following counties of Maryland:

(i) Allegany.

(ii) Garrett.

(iii) Washington.

(B) EASTERN SHORE AND SOUTHERN MARYLAND.—The area that includes the following counties of Maryland:

(i) Calvert.

(ii) Caroline.

(iii) Cecil.

(iv) Dorchester.

(v) Kent.

(vi) Queen Anne's.

(vii) Somerset.

○

(viii) St. Mary's.

(ix) Talbot.

(x) Wicomoco.

(xi) Worchester.

(3) EXPANSION OF SERVICE AREA.—A service area described in paragraph (2) may be expanded to include a county of Maryland that is adjacent to a county included in such area if—

(A) there is not any Medicare+Choice plan offered in the county; and

(B) the Secretary and the Medicare+Choice organization with a contract under this section that covers the service area jointly agree to the expansion.

(4) DURATION OF CONTRACT.—A contract awarded under this section shall be for a period of 3 or 4 years, as determined by the Secretary.

(5) PAYMENT.—

(A) IN GENERAL.—The Secretary, taking into account the guidelines described in subparagraph (B), shall determine the amount of payment for each Medicare+Choice eligible individual enrolled in a Medicare+Choice plan offered by an organization with a contract under

this section for each service area described in paragraph (2).

(B) GUIDELINES.—The guidelines described in this subparagraph are as follows:

(i) INITIAL YEAR.—During the first year of a contract under this section, the amount of payment for each Medicare+Choice eligible individual enrolled in a Medicare+Choice plan offered by an organization under the contract should be equal to the amount of payment that the Secretary estimates would have been made (without regard to the program under this section) for the individual under section 1853 of the Social Security Act (42 U.S.C. 1395w–23) if the individual was enrolled in a Medicare+Choice plan in the area covered by the contract during such year.

(ii) SUBSEQUENT YEARS.—During each subsequent year of a contract under this section, the amount of payment for each Medicare+Choice eligible individual enrolled in a Medicare+Choice plan offered by an organization under the contract

○

should be equal to the amount of payment for the individual under the contract for the previous year increased by the Secretary's estimate of the national average percentage increase in total payments made for each individual under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) for the year.

(6) BENEFITS.—The Medicare+Choice plan offered by each Medicare+Choice organization with a contract under this section shall—

(i) be available to each Medicare+Choice eligible individual residing in the service area covered by the contract;

(ii) provide the same benefits to each individual enrolled in such plan; and

(iii) include coverage for outpatient prescription drugs.

(7) ENROLLMENT AND DISENROLLMENT.—Each Medicare+Choice eligible individual residing in a service area covered by a contract under this section may enroll and disenroll from the Medicare+Choice plan offered in the service area on a liberal basis (as determined by the Secretary).

○

(c) EXCLUSIVE CONTRACT.—During any period in which the Secretary has in effect a contract with a Medicare+Choice organization under this section for a service area described in subsection (b)(2), the Secretary may not enter into or renew a contract with any other Medicare+Choice organization in such area under—

(1) the demonstration project under this section; or

(2) part C of title XVIII of the Social Security Act (42 U.S.C. 1395w–21 et seq.).

(d) MEDICARE+CHOICE PROGRAM REQUIREMENTS.—

(1) IN GENERAL.—Subject to paragraph (2), and except as otherwise provided in this section, the provisions of part C of title XVIII of the Social Security Act (42 U.S.C. 1395w–21 et seq.) shall apply to the offering of a Medicare+Choice plan under a contract entered into under this section.

(2) WAIVER AUTHORITY.—The Secretary may waive such requirements of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) as may be necessary for the purposes of carrying out the demonstration project under this section.

(e) REPORT TO CONGRESS.—

(1) IN GENERAL.—Not later than 2 years after the Secretary implements the demonstration project under this section, and every 2 years thereafter, the Secretary shall submit to Congress a report regarding the demonstration project.

(2) CONTENTS OF REPORT.—The report described in paragraph (1) shall contain the following:

(A) A description of the demonstration project conducted under this section.

(B) An evaluation of—

(i) the cost-effectiveness of the demonstration project;

(ii) the quality of the health care services provided to medicare beneficiaries under the demonstration project; and

(iii) the level of satisfaction of each beneficiary and Medicare+Choice organization participating in the demonstration project.

(C) Any other information regarding the demonstration project conducted under this section that the Secretary determines is appropriate.

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TOM DASCHLE
U.S. Senator for South Dakota

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1313 West Main
Rapid City, SD 57701
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Washington, DC 20510
202-224-2321
1-800-424-9094

TELECOPY COVER SHEET

DATE:

TO: Chris

FAX NO:

FROM: Jane

Senator Tom Daschle
509 Hart Senate Office Building
Washington, DC 20510
Telephone: (202) 224-2321
FAX: (202) 224-7895

PAGES TO FOLLOW:

MESSAGE: Attached is the list of topics from last year's book — some will be the same, some dropped. I also attach a sample page from the book

OPTIONS FOR BUDGETARY SAVINGS -- 2000

FUNCTION 550: Health

- Reduce Funding for the National Health Service Corps
- Reduce the Floor on the Federal Matching Rate in Medicaid
- Reduce the Enhanced Federal Matching Rates for Certain Administrative Functions in Medicaid
- Restrict the Allocation of Common Administrative Costs to Medicaid
- Reduce Spending for Medicaid Administration
- Convert Medicaid and Medicare DSH Payments into a Block Grant
- Reduce Subsidies for Health Professions Education
- Combine and Reduce Public Health Service Block Grants
- Establish New User Fees for Medical Devices Regulated by the FDA

FUNCTION 570: Medicare

- o Reduce Medicare's Payments for the Indirect Costs of Patient Care That Are Related to Hospitals' Teaching Programs
- o Reduce Medicare's Direct Payments for Medical Education
- o Eliminate Additional Capital-Related Payments for Hospitals with Residency Programs
- o Convert Medicare Payments for Graduate Medical Education to a Block Grant and Slow Their Rate of Growth *
- o Eliminate Medicare's Additional Payments to Sole Community Hospitals
- o Institute a Single Global Payment for Hospitals' and Physicians' Services Provided During an Inpatient Stay
- o Increase and Extend the Reductions in the Medicare PPS Market Basket
- o Reduce Medicare's Payments for Hospitals' Inpatient Capital-Related Costs
- o Eliminate Medicare's Payments to Hospitals for Enrollees' Bad Debts
- o Eliminate Medicare's Payments to Nonhospital Providers for Enrollees' Bad Debts
- o Reduce Medicare Expenditures for Prescription Drugs (lower payment
- o Index Medicare's Deductible for Physicians' Services
- o Simplify and Limit Medicare's Cost-Sharing Requirements combined deductible $750, 20% cost sharing. $2000 out of pocket
- o Restrict Medigap Coverage

Medigap can't cover the above

- o Collect Deductible and Coinsurance Amounts on Clinical Laboratory Services Under Medicare

- o Impose a Copayment Requirement on Home Health Visits Under Medicare

- o Prohibit First-Dollar Coverage Under Medigap Policies
  can't cover first $1500

- o Increase the Premium for ~~Physicians' Services~~ Part B Under Medicare to 30 Percent of Program Costs

- o Tie the Premium for Physicians' Services Under Medicare to Enrollees' Income

- o Increase Medicare's Age of Eligibility to Match Social Security's Normal Retirement Age

- o Permit Early Buy-In to Medicare Along with an Increase in the Normal Age of Eligibility

570-14 COLLECT DEDUCTIBLE AND COINSURANCE AMOUNTS ON CLINICAL LABORATORY SERVICES UNDER MEDICARE

	Outlay Savings (Millions of dollars)
Annual	
2000	590
2001	990
2002	1,050
2003	1,130
2004	1,240
2005	1,350
2006	1,510
2007	1,640
2008	1,810
2009	2,020
Cumulative	
2000-2004	5,000
2000-2009	13,330

SPENDING CATEGORY

Mandatory

RELATED OPTIONS

570-12 and 570-15

Medicare currently pays 100 percent of the approved fee for clinical laboratory services provided to enrollees. Medicare's payment is set by a fee schedule, and providers must accept that fee as full payment for the service. For most other services provided under Medicare's Supplementary Medical Insurance (SMI) program, beneficiaries are subject to both a deductible and a coinsurance rate of 20 percent.

Imposing the SMI program's usual deductible and coinsurance requirements on laboratory services would yield appreciable savings. If this policy was in place beginning on January 1, 2000, federal savings would be $590 million in 2000, $5.0 billion over five years, and $13.3 billion over 10 years.

In addition to reducing Medicare's costs, this option would make cost-sharing requirements under the SMI program more uniform and therefore easier to understand. Moreover, enrollees might be somewhat less likely to undergo laboratory tests with little expected benefit if they paid part of those costs.

However, enrollees' use of laboratory services would probably not be substantially affected because decisions about what tests are appropriate are generally left to physicians, whose judgments do not appear to depend on enrollees' cost-sharing liabilities. Hence, the Congressional Budget Office assumes that a small part of the expected savings under this option would stem from more prudent use of laboratory services, but the greater part would reflect the transfer to enrollees of costs now borne by Medicare. Billing costs for some providers, such as independent laboratories, would be higher under the option because they would have to bill both Medicare and enrollees to collect their full fees. (Currently, they have no need to bill enrollees directly for clinical laboratory services.) In addition, states' Medicaid costs would increase for enrollees who also received Medicaid benefits.

CJ

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

THE DIRECTOR

November 5, 1999

The Honorable Richard A. Gephardt
Democratic Leader
United States House of Representatives
Washington, D.C. 20515

Dear Mr. Leader:

This letter responds to your request on our views of the Balanced Budget Act adjustment bills that are currently being considered in Congress. As you know, the President is committed to moderating policies in the Balanced Budget Act of 1997 that are flawed or have unintended consequences for Medicare beneficiaries and providers. The Administration has taken numerous administrative actions to this end and believes that the Congress should not conclude its first session until necessary legislative changes are made.

Most of the Administration's specific policy suggestions and concerns with the House and Senate bills have been discussed at the staff level, and we will continue that collaboration. I want to take this opportunity to restate our commitment to broader Medicare reform and concern about the potential effect of the adjustment bills on the budget and Medicare trust fund.

The problems caused by the 1997 Balanced Budget Act that we have mutually identified are serious and require immediate action. However, even greater challenges are presented by the demographic and health changes of the 21st century. The doubling of the Medicare population in the next 30 years and advances in medicine will strain Medicare's ability to provide basic health services to seniors and people with disabilities. This is why the President developed a plan to strengthen and modernize Medicare, including adding a long-overdue, voluntary prescription drug benefit. This plan remains one of the Administration's top priorities and we hope to work with you to ensure its passage in 2000.

In the absence of broader reforms, the Administration continues to believe that legislation to correct problems with the Balanced Budget Act policies should be paid for and not undermine the solvency of the Medicare trust fund. The President's Medicare reform plan included a set of proposals to modernize traditional Medicare and reduce costs which would help in this regard. Other offsets, which could include appropriate tax offsets, could also be used. Regardless of the approach, I strongly encourage you to protect the progress we have made in extending the life of the Medicare trust fund and not reverse the gains which we have worked so hard together to achieve.

There are several provisions of the bills that we have identified in staff discussions that could be modified or eliminated. I want to reiterate our concern about a further slow-down of the implementation of the managed care risk adjustment system. 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 our planned phase-in. These experts also believe that Medicare continues to overpay managed care plan. In light of this, we think that increased payments to managed care plans through this mandated slow-down of risk adjustment are unwarranted at this time.

The Administration would also support the inclusion of language to clarify the intent of Congress for determining aggregate payments to hospitals under OPD PPS. A technical drafting error in the BBA language authorizing the PPS system has produced some confusion over the aggregate payment formula for this system. The enactment of clarifying language on the subject would be most useful in eliminating the confusion caused by this drafting error.

BBA was an historic and major, bipartisan achievement. Because of its magnitude, it is not surprising that there are a number of modifications that we mutually agree are necessary to address its unintended and negative consequences. The Administration looks forward to working with you on these modifications to ensure that Medicare continues to provide high-quality, accessible health care.

Sincerely,

Jacob J. Lew
Director

DATE: 11-5

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: _____

ROOM: _____

PHONE: _____

FAX: 456-5557

FROM:

[X] **JANE HORVATH**
[ ] **SHARON CLARKIN**
[ ] **BOB GUIDOS**
[ ] **JOANNE JEE**
[ ] **GREG JONES**
[ ] **ANDREA LEVARIO**
[ ] **ROGER MCCLUNG**
[ ] **JACK MITCHELL**
[ ] **TANISHA PARKER**
[ ] **PAUL SELTMAN**
[ ] **STEPHANIE WILSON**
[ ]

(INCLUDING COVER): _____

REMARKS:

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

November 4, 1999

The Honorable Dennis Hastert
Speaker of the U. S. House of Representatives
The Capitol
Washington, D.C. 20515

Dear Mr. Speaker:

We are writing to ask that you not bring the Medicare Balanced Budget Act legislation (HR 3075 as amended in negotiations with Commerce Committee Republicans) to the floor under suspension of the rules, but instead provide a rule permitting Democratic amendments and a motion to recommit. Because Democrats were not included in the negotiations between the Ways and Means and Commerce Committee Republican members, it is particularly important that we be offered the opportunity for floor amendments.

While the Republican bills that have been introduced provide a great deal of needed relief, we believe that

(1) some additional relief to providers,

(2) some beneficiary improvements (in particular help with the high cost of pharmaceuticals), and

(3) some alternative policies

are desperately needed.

The amendments we propose would provide an additional $2.4 billion in **paid-for** relief, with some going to beneficiaries in lower pharmaceutical prices and other program improvements. Our amendments would also eliminate several policies in the Republican bill which the Administration has identified as unworkable or which would hurt Medicare beneficiaries.

As fiscally responsible Democrats, we are concerned that the Republican bill is not paid for, and we urge you to find a way to pay for it, rather than further spending Social Security surpluses. For example, because it is not currently paid for, the Ways and Means bill (HR 3075) shortens the solvency of the Medicare Part A Trust Fund by at least a year, and increases Part B premiums for seniors.

Therefore, to avoid this problem, we pay for the additional relief offered by our amendments. Thus we do not hurt Medicare's solvency. The $2.4 billion in relief over five years is paid for by $2.4 billion in Medicare savings from the President's budget proposal of last January. These savings come from Medicare anti-fraud, waste, and abuse proposals.

Providing Needed Additional Relief

The $2.4 billion provides important, much needed additional relief to

> –beneficiaries to meet the cost of fighting cancer and the high costs of pharmaceutical insurance[1]

---

[1]We assume that the bill the Majority brings to the floor will include an expansion of Medicare's coverage of immuno-suppressive drugs, so that transplant patients do not suffer organ rejection. If this provision is not included, we ask permission to include it and pay for it with additional anti-fraud and abuse provisions.

–teaching hospitals,

– safety net hospitals, which have the lowest overall operating margins,

–rural hospitals, which have the lowest Medicare margins,

–skilled nursing homes,

–home health agencies which are serving the sickest patients,

–a more rational rehabilitation cap program that will help our most severely disabled stroke patients and amputees,

–help for hospice agencies facing sky-rocketing pharmaceutical costs for end-of-life painkillers, and

–the Medicaid and Children's Health Insurance Program, to help the providers serving the low income and to help Puerto Rico and the Possessions with more adequate payment rates.

This additional relief will further ensure that Medicare beneficiaries are buffered from the cuts in the 1997 BBA and will allow Medicare beneficiaries to continue to receive high quality care.

The attached memo describes these amendments in more detail.

Help Seniors with the High Cost of Pharmaceuticals

We believe we need to help all Medicare beneficiaries with a prescription drug insurance benefit, but that is a larger issue that cannot be addressed in this limited BBA corrections legislation. We hope, Mr. Speaker, that you will make this a priority issue for the Second Session of this Congress.

In the meantime, we do believe that this bill gives us the one opportunity this year to help seniors with the exorbitant cost of prescription drugs. We propose an amendment which was offered in the Ways and Means Committee by Rep. Karen Thurman (and supported by all the Democratic members of the Committee) that makes the Allen-Turner-Waxman-Berry pharmaceutical discount bill (HR 664) germane to Medicare. Basically, the amendment says that if a drug manufacturer wants to sell pharmaceuticals to a hospital participating in Medicare, it must also make available to pharmacies for sale to seniors drugs at the best available price for which they offer that drug. By some estimates, this type of program could lower drug costs to seniors by as much as 40%.

If we can't pass a major Medicare drug reform bill this fall, we can at least give seniors a chance for the discounts available to large buyers.

Preventing Bad Policies

If the Majority bill includes certain provisions, we ask that the rule governing debate permits us to strike those anti-beneficiary and anti-consumer provisions:

Specifically, we are concerned that the Administration has warned that the hospital out-patient department (HOPD) provisions of the Ways and Means bill are so complicated that they will delay the start of HOPD Prospective Payment (PPS) by at least a year. Such a delay in the PPS will cost beneficiaries about $1.4 billion, with patients' share of total HOPD payments running about 50%. We would move to strike the House HOPD provisions in favor of the Senate's more administrable proposals, but keep the amount of relief to hospitals and patients at the House level.

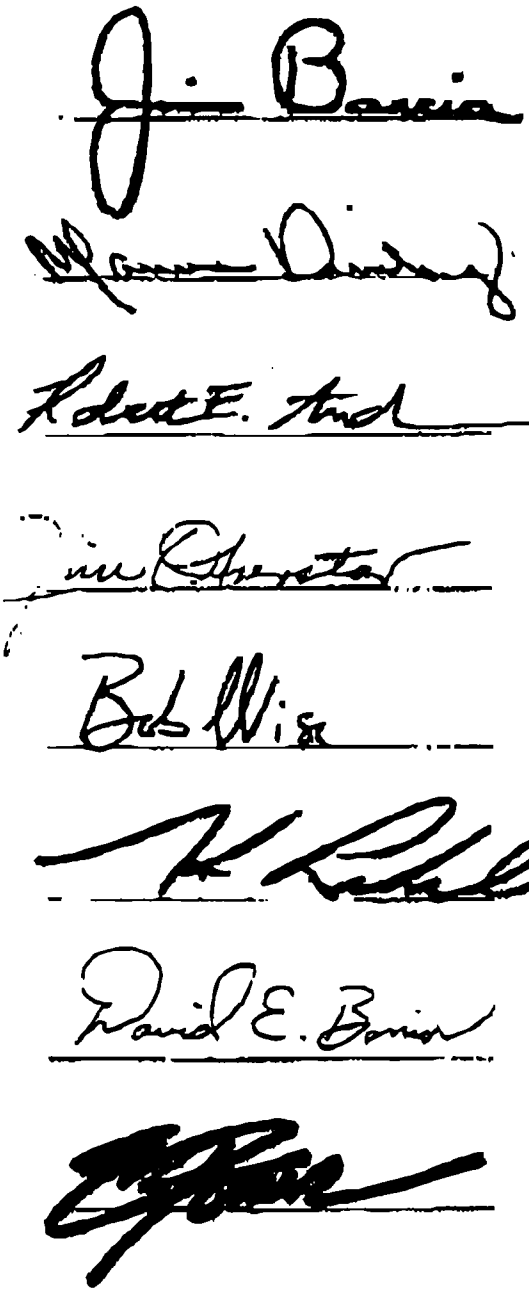
Second, if the Majority bill includes the Commerce Republicans' provision giving 'deemed status' to HMOs, we would strike that provision. An overwhelming number of House members have just voted in favor of higher quality in managed care plans. Therefore, we find it incredible that the majority may be proposing an amendment to the BBA which would weaken our ability to ensure

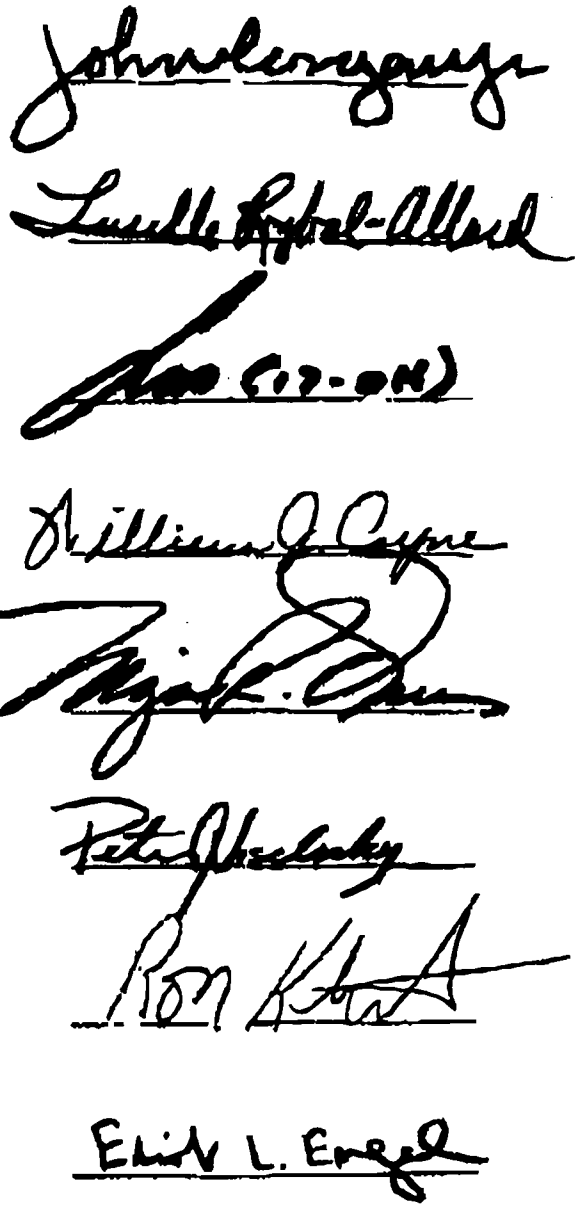
quality by turning over approval of these plans to participate in Medicare to private groups which are often dominated by the very industry they are supposed to be regulating. If such 'deemed status' language is included, we will seek to strike it in order to protect beneficiaries.

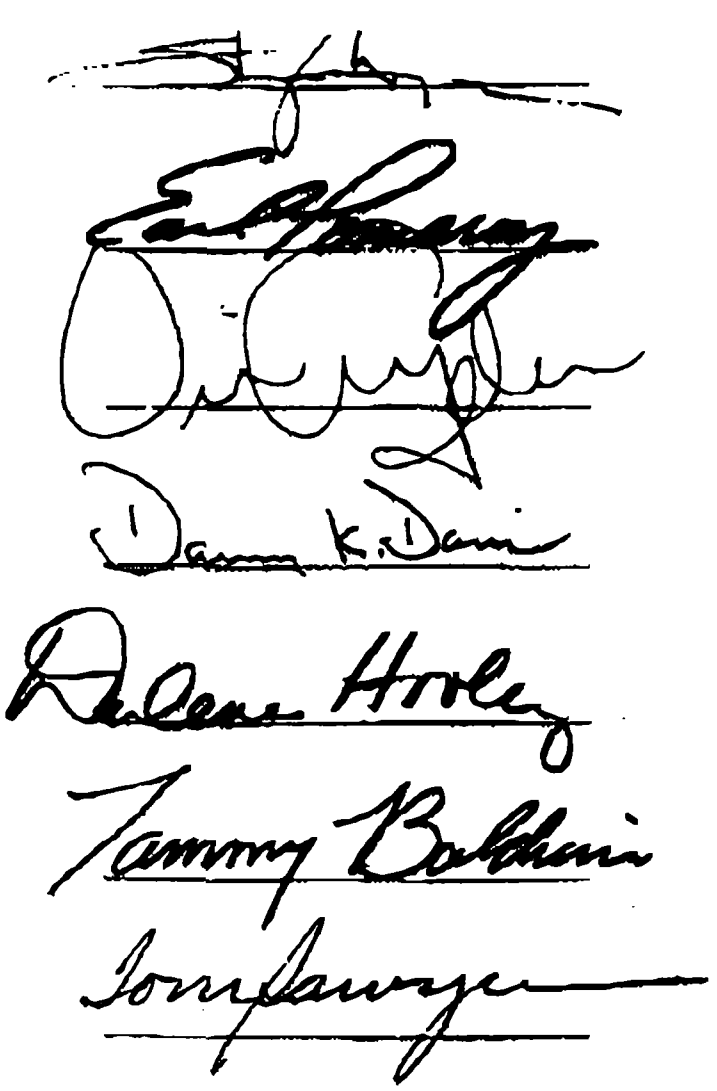
Third, as mentioned above, we propose to strike the unworkable $1500 limit on rehabilitation caps for two years while the Secretary develops a rational therapy payment plan. This is the same approach as taken by the Senate Finance Committee.

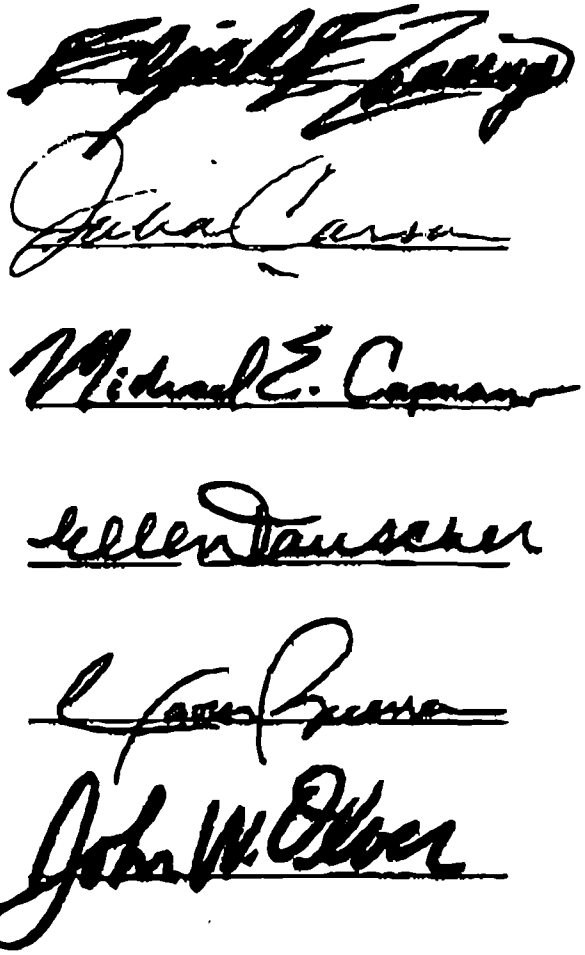
In conclusion, our beneficiaries and providers need the improvements made by the Democratic amendment. We urge you to make it in order. Thank you for your consideration.

Sincerely,









Marion Berry

Lois Capps

Sam Farr

Earl F. Hilliard

David Phelps

Lynn N. Rivers

Dennis J. Kucinich

Tom Allen

John Spratt

Shelley Berkley

Neil Abercrombie

Anna G. Eshoo

Edward J. Markey

Richard E. Neal

Sandy Levin

Henry A. Waxman

George Miller

Bob Borski

Cecil B. Malony

Martin O. Sabo

Paul E. Kanjorski

Bart Gordon

Michael R. McNulty

J. L. Dixon

Matthew G. Martinez

Tom Lantos

Donald M. Payne

Carlos Romero Barceló

[illegible]

Jerrold Nadler

Howard L. Berman

Gary L. Ackerman

Jim Moody

Ted Strickland

Barbara Lee

John P. Tierney

Jan Schakowsky

Hal Dossett

Cass Ballenger

Lynn Woolsey

Lois McDonald

Carrie P. Meek

Bob Wexler

Mike Thompson

Carolyn C. Kilpatrick

Michael P. Forbes

Rosa L. DeLauro

Ben Cardin

Frank Pallone Jr.

Robert Wexler

Karen Thurman

John Lewis

Debbie Stabenow

Marion Berry

Tom Barrett

Peter Deutsch

Joe Hoeffel

Dana DeGette

Jim McDermott

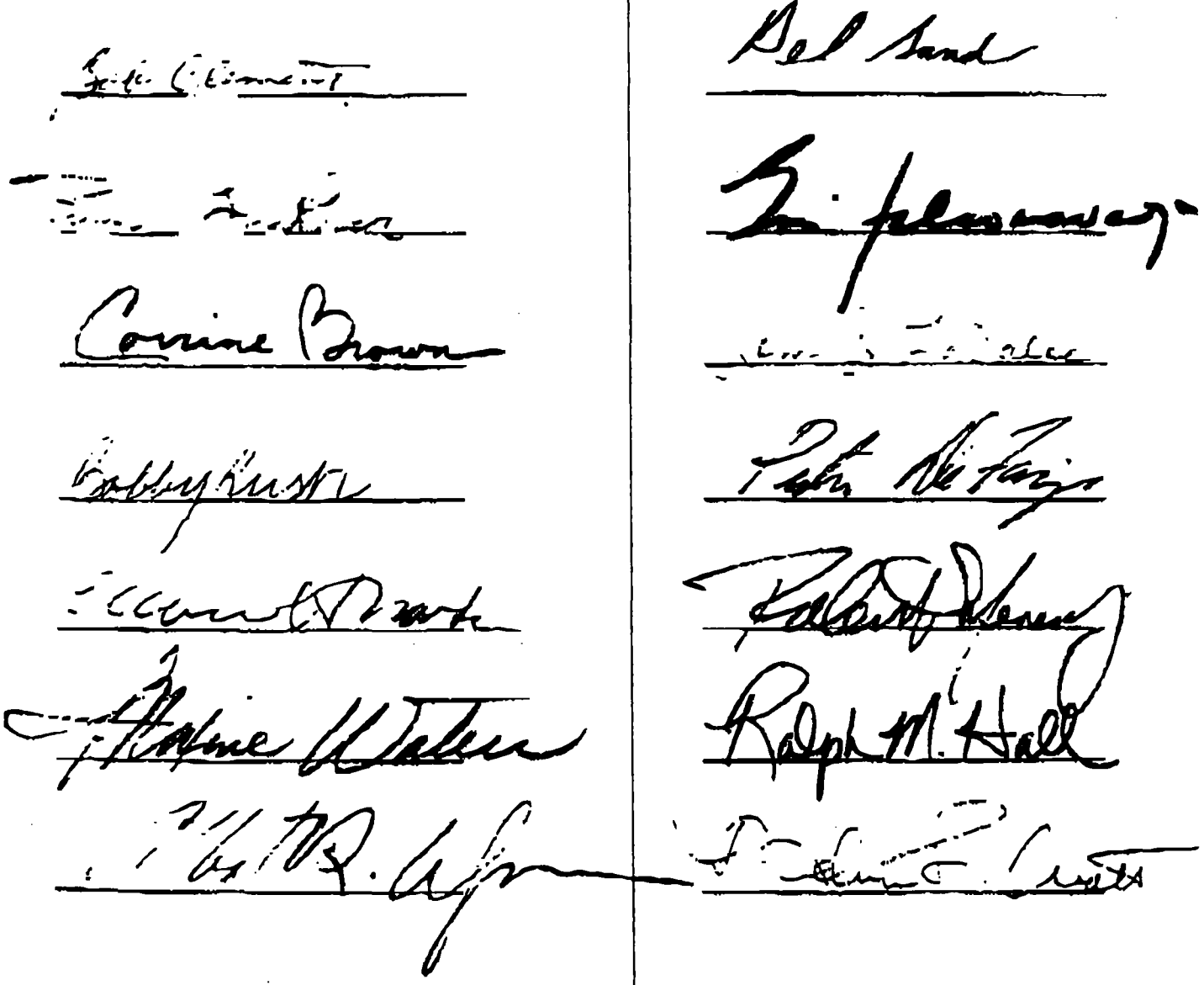
Jim Maloney

James Clair

[illegible]

Wilton Gilchrist

Karen McCarthy



Issue Area	**In addition to HR 3075, a $2.4 billion paid-for package** [dollars expressed as additions to costs in HR 3075]
Hospitals	Freeze indirect medical education cut for 1 year more than HR 3075 ($0.2)
	Freeze disproportionate share hospital cuts for 1 year more than HR 3075 ($0)
	Carve out DSH payments from payments to M+C plans. Moves about $1 billion per year to the nation's safety net hospitals; is not in HR 3075 ($0)
Rural Hospitals	Tanner Amendment to protect rural and cancer hospitals against outpatient department PPS cuts (HR 3075 phases in cuts to these hospitals, still leaving huge payment reductions) ($0.2)
$1500 Therapy Caps	Strike HR 3075 limits by suspending caps for 2 years while a new, more rational system is developed (net $0)
Community Health Centers & Rural CHCs	Establish a PPS system which protects CHCs against State Medicaid cuts ($0.2)
Nursing Homes	Raise HR 3075's payment to high acuity cases from 10% to 30% ($0.1)
	Raise HR 3075's nursing home inflation adjustment from 0.8% in FY01 to 1% ($0.1) and authorize extra payments for hi cost of living in Hawaii and Alaska.

Physicians	Study of why payment rates in certain States and Puerto Rico are low.
Home Health	Provide $250 million "outlier" pool for home health agencies that treat tough cases ($0.3) HR 1917, by Rep. Jim McGovern and 102 cosposnors.
Hospice	Eliminate 1% cut in FY 01 and 02 ($0.2)
Medicaid	Help for Medicaid DSH formula errors in NM, DC, MN, and WY ($0.2)
	Permanent fix for CA Medicaid DSH problem $0
	Help families not lose Medicaid coverage as a result of delinking of welfare and Medicaid eligibility ($0.2)
CHIPs	Increase CHIPs amount for Possessions and provide technical fix to CHIPs formula ($0.1)
Beneficiary Improvements	Immuno-suppressive drugs, cover without a time limit ($0.3)
	Allow States to require M+C plans to cover certain benefits (like MA used to do with Rx) ($0)
	Allow people abandoned by M+C plans to buy a medi-gap policy which covers Rx ($0)
	Coverage of cancer treatment for low- income women ($0.3) HR 1070, by Rep. Eshoo and Lazio and 271 cosponsors

Pay-fors	3 Medicare items from President's budget: mental health partial hospitalization reform, Medicare Secondary Payer data match, and pay for outpatient drugs at 83% of average wholesale price. ($2.4)

THE WHITE HOUSE

WASHINGTON

November 4, 1999

MEMORANDUM TO THE PRESIDENT

FROM: Chris Jennings

SUBJECT: H.R. 3075, the Medicare Balanced Budget Refinement Act of 1999

CC: John Podesta, Steve Ricchetti, Maria Echaveste, Jack Lew, Gene Sperling, Bruce Reed, Larry Stein, Joel Johnson, and Mary Beth Cahill

Today, the House passed its version of the Medicare provider give-backs legislation by a vote of 388 to 25. It costs $11.8 billion over 5 years. It provides relief for hospitals, nursing homes, home health providers, physicians, therapy providers, and rural health providers. With very few exceptions (such as an unnecessary and ill-advised payment increase for managed care and inadequate and controversial policies regarding teaching hospitals), most of the provisions included are workable with relatively small adjustments.

The primary challenges continue to be the lack of offsets for these new costs, the fact that no resources are being transferred to the Medicare trust fund to avoid a negative impact on the financial health of the Medicare program, and the front-loaded nature of the give-backs. On the last point, like the Senate, about half of the $11.8 billion expenditures in the House bill are spent in the first two years, with most of this in 2001.

Since the Congress has forward-funded so much of its 2000 budget, probably cannot live under the unrealistic appropriations caps, and is considering tax policies that reduce revenue significantly, the availability of on-budget surplus dollars for 2001 is – or is almost – nonexistent. As a consequence, the dollars dedicated to 2001 spending ($4.3 billion in the House and $5.6 billion in the Senate) may need to be pushed into 2002 and beyond so that your FY 2001 budget has resources available for high-priority initiatives. Even though the 5-year total expenditures would likely be the same, this approach would still likely alienate many providers who are expecting administrative and legislative payment increases out of Washington this year and next year.

We are assessing whether the Congress feels strongly abut the 2001 spending issue and if the Republican leadership will impose their own fiscal restraints for the early years of its budget. So far, the Congress appears largely unwilling to impose any fiscal restraints (or pay-for requirements) on itself on this issue.

Attached is an OMB letter we sent to the Congress today. As you will note, it does not reference the 2001 issue because we do not want to be the only ones raising it. We will keep you apprised of developments.

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

THE DIRECTOR

November 5, 1999

The Honorable Richard A. Gephardt
Democratic Leader
United States House of Representatives
Washington, D.C. 20515

Dear Mr. Leader:

This letter responds to your request on our views of the Balanced Budget Act adjustment bills that are currently being considered in Congress. As you know, the President is committed to moderating policies in the Balanced Budget Act of 1997 that are flawed or have unintended consequences for Medicare beneficiaries and providers. The Administration has taken numerous administrative actions to this end and believes that the Congress should not conclude its first session until necessary legislative changes are made.

Most of the Administration's specific policy suggestions and concerns with the House and Senate bills have been discussed at the staff level, and we will continue that collaboration. I want to take this opportunity to restate our commitment to broader Medicare reform and concern about the potential effect of the adjustment bills on the budget and Medicare trust fund.

The problems caused by the 1997 Balanced Budget Act that we have mutually identified are serious and require immediate action. However, even greater challenges are presented by the demographic and health changes of the 21st century. The doubling of the Medicare population in the next 30 years and advances in medicine will strain Medicare's ability to provide basic health services to seniors and people with disabilities. This is why the President developed a plan to strengthen and modernize Medicare, including adding a long-overdue, voluntary prescription drug benefit. This plan remains one of the Administration's top priorities and we hope to work with you to ensure its passage in 2000.

In the absence of broader reforms, the Administration continues to believe that legislation to correct problems with the Balanced Budget Act policies should be paid for and not undermine the solvency of the Medicare trust fund. The President's Medicare reform plan included a set of proposals to modernize traditional Medicare and reduce costs which would help in this regard. Other offsets, which could include appropriate tax offsets, could also be used. Regardless of the approach, I strongly encourage you to protect the progress we have made in extending the life of the Medicare trust fund and not reverse the gains which we have worked so hard together to achieve.

There are several provisions of the bills that we have identified in staff discussions that could be modified or eliminated. I want to reiterate our concern about a further slow-down of the implementation of the managed care risk adjustment system. 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 our planned phase-in. These experts also believe that Medicare continues to overpay managed care plan. In light of this, we think that increased payments to managed care plans through this mandated slow-down of risk adjustment are unwarranted at this time.

The Administration would also support the inclusion of language to clarify the intent of Congress for determining aggregate payments to hospitals under OPD PPS. A technical drafting error in the BBA language authorizing the PPS system has produced some confusion over the aggregate payment formula for this system. The enactment of clarifying language on the subject would be most useful in eliminating the confusion caused by this drafting error.

BBA was an historic and major, bipartisan achievement. Because of its magnitude, it is not surprising that there are a number of modifications that we mutually agree are necessary to address its unintended and negative consequences. The Administration looks forward to working with you on these modifications to ensure that Medicare continues to provide high-quality, accessible health care.

Sincerely,

Jacob J. Lew
Director

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Thomas J. Hayes
Executive Vice President-Corporate Affairs
Chief Financial Officer

MEMORANDUM

To: Christopher Jennings
Deputy Assistant to the President for Health Policy Development

From: Thomas J. Hayes
Executive Vice President
Continuum Health Partners

Re: Targeted BBA Relief to All High Need Hospitals

Date: October 25, 1999

I am writing to follow up on our meeting concerning the need to target BBA relief to those hospitals serving large numbers of Medicare and Medicaid patients, a disproportionate percentage of whom are low-income.

The attached calculation shows the fiscal impact of adding "high need" hospitals to the "rural" BBA relief provisions of the Roth-Moynihan bill. This analysis has been shared with Senator Schumer and Senate Finance Committee Democratic staff.

Our definition of "high need" includes all hospitals, regardless of locale or geographic status, whose Medicare and Medicaid inpatient days are at least 65% of total days and whose DSH percentage is at least 40%. Of the 533 hospitals nationwide that meet this test, 95 hospitals (highlighted in bold on the attached spreadsheet) are already covered by the Roth-Moynihan rural criteria. We estimate that the cost of restoring the FFY 2000 PPS update reduction for the remaining 438 hospitals would be $121 million.

We have been unable to develop a precise estimate of the impact of holding the high need group harmless from outpatient PPS on the same permanent basis as rural and cancer hospitals.

We very much appreciate your responding to Tom Downey's request to meet with us. Hospitals that disproportionately depend on Medicare and Medicaid revenue and also serve disproportionate numbers of low income patients cannot absorb the current level of BBA cuts (even with the IME adjustment in the Roth-Moynihan bill) without a serious disruption in services, and ultimately, patient care. The Administration's support for targeted BBA relief for high need hospitals will help ensure that Medicare patients and other medically vulnerable patients continue to have access to care.

Attachments
cc: Tom Downey
Jennings 102599

Estimated Cost of Extending PPS Update Restorations for Rural Hospitals to All High Need Hospitals

Number of Hospitals	Hospital Type	Estimated Cost of Restoration, FFY 2000
95	*High Need* Hospitals Already Eligible for PPS Update Restoration Under Roth-Moynihan *	$ 6,458,285
438	*High Need* Hospitals Currently Ineligible for PPS Update Restoration Under Roth-Moynihan **	$ 121,065,678
533	Total	$ 127,523,963

* Includes 21 Medicare Dependent Small Rural Hospitals, 70 Sole Community Hospitals, 3 Sole Community and Rural Referral Centers, and 1 Essential Access Community Hospital.

** Includes 16 Rural Referral Centers and 422 Short Term PPS Hospitals.

Cost estimates are based on the incremental cost of restoring the 1.8 percent reduction to the PPS market basket update for FFY 2000.

To qualify as "High Need", a hospital must have Medicare and Medicaid inpatient days equal to at least 65 percent of total days and a DSH percentage of 40 percent or higher.

High Need Hospitals (>65% inpatient days from Medicare + Medicaid; DSH %>40)

	Hospital	State	Year 2000 BBA Cut	Year 2002 BBA Cut	% of Medicare Days	% of Medicaid Days	% of MR/MA Days	DSH %
1	***BULLOCK COUNTY HOSPITAL***	AL	-$241,537	-$310,625	46.67%	27.20%	73.87%	70.48%
2	CITIZENS BAPTIST MEDICAL CENTER	AL	-$1,055,949	-$1,314,093	50.19%	17.43%	67.63%	46.25%
3	CLAY COUNTY HOSPITAL	AL	-$586,655	-$779,632	55.05%	14.82%	69.87%	40.05%
4	CRENSHAW BAPTIST HOSPITAL	AL	-$288,120	-$327,768	55.23%	23.57%	78.81%	52.49%
5	D C H REGIONAL MEDICAL CENTER	AL	-$7,158,735	-$8,026,824	51.85%	20.63%	72.49%	43.07%
6	DALE MEDICAL CENTER	AL	-$850,787	-$1,001,662	52.03%	23.33%	75.36%	47.66%
7	EDGE REGIONAL MEDICAL CENTER	AL	-$996,537	-$1,109,406	63.89%	13.83%	77.73%	45.94%
8	ELBA GENERAL HOSPITAL	AL	-$180,011	-$202,329	50.65%	15.70%	66.35%	49.11%
9	EVERGREEN MEDICAL CENTER	AL	-$422,620	-$543,179	59.81%	16.20%	76.01%	49.86%
10	***GEORGIANA DOCTORS HOSPITAL***	AL	-$224,673	-$285,592	73.29%	11.00%	84.30%	42.55%
11	GROVE HILL MEMORIAL HOSPITAL	AL	-$183,704	-$228,452	37.46%	34.69%	72.15%	65.56%
12	HALE COUNTY HOSPITAL	AL	-$193,191	-$363,906	62.60%	19.15%	81.76%	64.18%
13	HILL HOSPITAL OF SUMTER COUNTY	AL	-$129,986	-$127,469	48.01%	19.77%	67.78%	60.51%
14	J PAUL JONES HOSPITAL	AL	-$105,249	-$130,478	70.52%	16.64%	87.15%	52.04%
15	JACKSON MEDICAL CENTER	AL	-$180,981	-$277,938	40.58%	37.00%	77.59%	66.62%
16	L V STABLER MEMORIAL HOSPITAL	AL	-$1,519,327	-$1,666,412	61.49%	16.22%	77.70%	40.64%
17	*NORTH BALDWIN HOSPITAL*	AL	-$282,423	-$263,869	39.86%	28.55%	68.41%	42.89%
18	NORTHWEST MEDICAL CENTER	AL	-$961,970	-$1,062,746	60.63%	16.61%	77.24%	40.95%
19	UNIV OF SOUTH AL CHILDRENS AND WOMENS	AL	-$43,725	-$50,164	1.24%	71.25%	72.49%	95.27%
20	UNIV OF SOUTH ALABAMA MEDICAL CENTER	AL	-$3,403,406	-$4,507,206	18.25%	49.25%	67.49%	77.46%
21	VAUGHAN PERRY HOSPITAL & NURSING HOME	AL	-$92,598	-$113,506	58.52%	18.89%	77.41%	63.01%
22	WEDOWEE HOSPITAL	AL	-$74,857	-$90,843	60.16%	8.46%	68.62%	41.65%
23	BAPTIST MEM HOSPITAL FORREST CITY INC	AR	-$524,858	-$452,675	43.01%	22.34%	65.35%	60.62%
24	BAPTIST MEMORIAL HOSPITAL OSCEOLA	AR	-$386,152	-$508,127	56.83%	12.03%	68.87%	40.51%
25	CHICOT MEMORIAL HOSPITAL	AR	-$464,695	-$611,442	57.75%	13.27%	71.03%	51.14%
26	CRITTENDEN MEMORIAL HOSPITAL	AR	-$1,809,266	-$2,158,757	53.19%	13.05%	66.25%	41.53%
27	DELTA MEMORIAL HOSPITAL ASSOCIATION	AR	-$353,696	-$404,208	50.47%	17.58%	68.05%	49.20%
28	***HELENA REGIONAL MEDICAL CENTER***	AR	-$685,348	-$768,408	50.99%	17.99%	68.99%	56.55%
29	NEWPORT HOSPITAL AND CLINIC INC	AR	-$710,962	-$909,779	64.25%	11.33%	75.58%	53.43%
30	COMMUNITY HOSPITAL MEDICAL CENTER	AZ	-$482,137	-$587,993	12.97%	54.98%	67.95%	46.11%
31	***PAGE HOSPITAL***	AZ	-$116,593	-$150,927	20.65%	47.58%	68.24%	51.30%
32	PHOENIX MEMORIAL HOSPITAL	AZ	-$2,223,525	-$2,734,331	21.37%	47.20%	68.56%	55.86%
33	***SAGE MEMORIAL HOSPITAL***	AZ	-$74,593	-$125,155	26.54%	46.05%	72.59%	71.87%
34	***SE ARIZONA MEDICAL CENTER***	AZ	-$159,045	-$204,133	30.54%	36.91%	67.46%	57.74%
35	***WINSLOW MEMORIAL HOSPITAL***	AZ	-$167,235	-$161,455	36.95%	43.17%	80.12%	54.17%
36	ALHAMBRA HOSPITAL AND MEDICAL CENTER	CA	-$1,951,430	-$2,512,652	51.28%	25.80%	77.08%	65.75%
37	BELLFLOWER MEDICAL CENTER	CA	-$1,614,131	-$1,807,166	34.41%	49.68%	84.09%	73.87%
38	BEVERLY HOSPITAL	CA	-$2,719,061	-$2,886,220	34.18%	36.12%	70.29%	54.88%
39	BROTMAN MEDICAL CENTER	CA	-$5,795,552	-$7,823,241	54.03%	21.49%	75.52%	43.02%
40	CALIFORNIA HOSPITAL MEDICAL CENTER LA	CA	-$2,876,223	-$3,587,569	14.58%	62.94%	77.52%	83.84%
41	CENTRAL VALLEY GENERAL HOSPITAL	CA	-$789,667	-$912,067	29.67%	46.87%	76.54%	62.63%
42	COAST PLAZA DOCTORS HOSPITAL	CA	-$1,004,919	-$1,296,023	45.66%	28.27%	73.94%	51.80%
43	***COLUSA COMMUNITY HOSPITAL***	CA	-$348,138	-$416,042	43.70%	27.66%	71.36%	43.75%
44	COMMUNITY HOSP OF HUNTINGTON PARK	CA	-$1,534,035	-$1,742,021	18.29%	71.83%	90.12%	116.79%
45	CONTRA COSTA REG'L MED CTR (MERRITHEW MEM HOSP)	CA	-$3,158,270	-$3,838,919	18.20%	50.37%	68.57%	80.17%
46	CORCORAN DISTRICT HOSPITAL	CA	-$188,982	-$231,161	51.05%	20.89%	71.95%	56.94%
47	COVINA VALLEY COMMUNITY HOSPITAL	CA	-$1,562,614	-$2,759,525	49.60%	38.08%	87.68%	70.59%
48	DANIEL FREEMAN MEMORIAL HOSPITAL	CA	-$6,097,878	-$7,515,471	40.35%	32.53%	72.88%	53.44%
49	DELANO REGIONAL MEDICAL CENTER	CA	-$1,218,659	-$1,578,549	38.32%	29.17%	67.49%	64.71%
50	DOCTORS HOSPITAL OF WEST COVINA, INC	CA	-$585,830	-$781,553	29.50%	43.77%	73.26%	74.92%
51	EAST LOS ANGELES DOCTORS HOSPITAL	CA	-$579,436	-$701,035	25.83%	47.78%	73.62%	72.27%
52	EL CENTRO REGIONAL MEDICAL CENTER	CA	-$2,130,212	-$2,522,486	38.04%	29.78%	67.82%	59.44%
53	FREMONT MEDICAL CENTER	CA	-$2,378,643	-$2,872,368	45.50%	22.86%	68.35%	40.12%
54	FRESNO COMMUNITY HOSP & MEDICAL CNTR	CA	-$7,496,275	-$8,744,115	39.37%	30.82%	70.19%	55.10%
55	GARFIELD MEDICAL CENTER	CA	-$6,154,214	-$7,485,858	33.50%	46.18%	79.68%	100.54%
56	GENERAL HOSPITAL	CA	-$1,442,530	-$1,588,035	39.15%	27.37%	66.52%	42.79%
57	***GEORGE L. MEE MEMORIAL HOSPITAL***	CA	-$317,461	-$403,690	24.19%	45.98%	70.17%	62.45%
58	GLENDALE MEM HOSPITAL & HLTH CENTER	CA	-$5,297,546	-$6,643,539	42.78%	29.79%	72.57%	54.33%
59	GOOD SAMARITAN HOSPITAL	CA	-$241,204	-$28,413	38.22%	58.70%	96.92%	93.20%
60	GRANADA HILLS COMMUNITY HOSPITAL	CA	-$2,025,879	-$2,447,776	40.21%	39.80%	80.02%	44.25%
61	GREATER EL MONTE COMMUNITY HOSPITAL	CA	-$1,261,166	-$1,521,561	22.73%	65.32%	88.05%	92.05%
62	HAWTHORNE HOSPITAL	CA	-$863,265	-$786,094	42.55%	47.52%	90.07%	75.10%
63	JOHN F KENNEDY MEMORIAL HOSPITAL	CA	-$2,231,664	-$2,656,164	32.44%	47.31%	79.75%	70.04%
64	KAWEAH DELTA DISTRICT HOSPITAL	CA	-$5,584,143	-$6,415,664	42.95%	24.97%	67.92%	42.30%
65	KERN MEDICAL CENTER	CA	-$1,946,592	-$2,418,542	10.28%	62.72%	73.00%	100.91%
66	L A COUNTY HIGH DESERT HOSPITAL	CA	-$408,854	-$448,040	6.81%	60.80%	67.60%	77.50%
67	LINDSAY HOSPITAL MEDICAL CENTER	CA	-$333,177	-$363,679	28.61%	46.15%	74.76%	54.02%
68	LONG BEACH DOCTORS HOSPITAL	CA	-$485,468	-$558,754	47.50%	44.86%	92.37%	70.49%
69	LOS ANGELES METROPOLITAN MEDICAL CTR	CA	-$1,613,719	-$1,916,870	27.03%	69.69%	96.72%	115.83%
70	MADERA COMMUNITY HOSPITAL	CA	-$1,518,711	-$1,877,465	38.70%	30.76%	69.46%	57.14%
71	MEDICAL CENTER OF NORTH HOLLYWOOD-AMI	CA	-$1,317,842	-$1,637,192	25.10%	46.39%	71.49%	70.03%
72	***MEMORIAL HOSPITAL – LOS BANOS***	CA	-$732,773	-$898,900	50.38%	31.28%	81.65%	45.36%
73	MEMORIAL HOSPITAL OF GARDENA	CA	-$1,406,459	-$1,668,356	41.52%	31.51%	73.03%	66.43%
74	MISSION COMMUNITY HOSPITAL - PANORAMA	CA	-$2,170,982	-$2,582,980	38.98%	59.34%	98.32%	91.90%
75	MONTEREY PARK HOSPITAL	CA	-$1,850,740	-$1,906,748	31.41%	49.56%	80.97%	79.99%
76	MORENO VALLEY MEDICAL CENTER	CA	-$1,265,119	-$1,552,021	27.23%	38.47%	65.70%	49.97%

Hospitals in bold italics are eligible for relief under the Roth-Moynihan bill.

High Need Hospitals (>65% inpatient days from Medicare + Medicaid; DSH %>40)

	Hospital	State	Year 2000 BBA Cut	Year 2002 BBA Cut	% of Medicare Days	% of Medicaid Days	% of MR/MA Days	DSH %
77	MT ZION HOSP & MED CTR OF THE UCSF	CA	-$6,437,779	-$7,657,588	48.46%	20.37%	68.84%	41.74%
78	NATIVIDAD MEDICAL CENTER	CA	-$1,046,168	-$1,166,364	14.86%	55.41%	70.27%	89.00%
79	NORTHRIDGE HOSPITAL MED CTR-SHERMAN WY	CA	-$2,018,565	-$2,073,074	42.62%	37.50%	80.13%	55.48%
80	OROVILLE HOSPITAL	CA	-$2,054,865	-$2,559,445	45.75%	28.42%	74.18%	41.12%
81	PACIFIC ALLIANCE MEDICAL CENTER	CA	-$1,798,710	-$2,211,040	33.58%	60.19%	93.77%	121.55%
82	***PALO VERDE HOSPITAL***	CA	-$475,026	-$580,970	39.86%	32.22%	72.07%	55.85%
83	PARADISE VALLEY HOSPITAL	CA	-$2,778,813	-$3,303,322	39.00%	41.75%	80.75%	84.75%
84	PIONEERS MEMORIAL HOSPITAL DISTRICT	CA	-$1,427,814	-$1,661,615	36.07%	33.30%	69.36%	57.97%
85	ROBERT F KENNEDY MEDICAL CENTER	CA	-$2,419,389	-$2,934,060	41.62%	39.19%	80.81%	70.36%
86	SAN FRANCISCO GENERAL HOSPITAL	CA	-$5,382,116	-$5,347,151	17.39%	58.11%	75.50%	83.02%
87	SAN JOAQUIN GENERAL HOSPITAL	CA	-$2,103,400	-$2,833,445	15.66%	62.30%	77.96%	85.04%
88	SAN LUIS OBISPO GENERAL HOSPITAL	CA	-$364,571	-$436,878	18.01%	51.21%	69.23%	87.09%
89	SAN MATEO COUNTY GENERAL HOSPITAL	CA	-$1,453,167	-$1,753,359	23.89%	52.86%	76.74%	59.54%
90	SANGER HOSPITAL	CA	-$135,202	-$163,172	36.60%	48.31%	84.90%	73.35%
91	SANTA ANA HOSPITAL MEDICAL CENTER INC	CA	-$628,485	-$746,623	13.77%	74.93%	88.70%	108.02%
92	SANTA CLARA VALLEY MEDICAL CENTER	CA	-$4,804,647	-$5,578,785	15.15%	60.69%	75.84%	83.85%
93	SANTA MARTA HOSPITAL	CA	-$2,177,636	-$2,542,779	38.48%	35.42%	73.89%	67.42%
94	SHARP CHULA VISTA MEDICAL CENTER	CA	-$3,490,250	-$4,143,739	38.20%	27.49%	65.69%	51.28%
95	SIERRA KINGS DISTRICT HOSPITAL	CA	-$385,567	-$470,345	25.65%	54.16%	79.81%	40.83%
96	SIERRA VIEW DISTRICT HOSPITAL	CA	-$2,987,746	-$3,660,007	49.51%	31.39%	80.90%	47.20%
97	ST FRANCIS MEDICAL CENTER	CA	-$5,898,529	-$7,572,290	24.99%	55.19%	80.17%	87.92%
98	ST FRANCIS MEMORIAL HOSPITAL	CA	-$3,887,653	-$4,448,824	56.50%	15.33%	71.84%	42.24%
99	ST LUKES HOSPITAL	CA	-$3,004,666	-$3,076,169	29.27%	39.12%	68.39%	75.05%
100	ST MARY MEDICAL CENTER	CA	-$4,924,405	-$6,125,829	32.01%	35.03%	67.04%	56.49%
101	ST ROSE HOSPITAL	CA	-$3,316,703	-$3,526,780	39.28%	39.22%	78.50%	54.99%
102	ST VINCENT MEDICAL CENTER	CA	-$6,045,912	-$7,231,400	48.98%	18.59%	67.57%	49.81%
103	STANISLAUS MEDICAL CENTER	CA	-$964,393	-$951,856	20.52%	53.93%	74.45%	79.02%
104	SUMMIT MEDICAL CENTER	CA	-$12,404,016	-$14,741,757	46.41%	29.28%	75.70%	44.84%
105	SURBURBAN MEDICAL CENTER	CA	-$1,396,693	-$1,489,738	19.78%	45.22%	65.01%	78.41%
106	SUTTER MERCED MEDICAL CENTER	CA	-$1,683,283	-$1,979,876	31.04%	43.16%	74.20%	52.68%
107	SUTTER SOLANO MEDICAL CENTER	CA	-$2,116,288	-$2,557,338	39.00%	30.01%	69.00%	47.66%
108	TULARE DISTRICT HOSPITAL	CA	-$1,802,060	-$2,308,652	52.13%	27.05%	79.18%	42.99%
109	UNIV OF CALIFORNIA DAVIS MED CENTER	CA	-$14,214,584	-$17,517,612	23.76%	45.00%	68.76%	62.71%
110	UNIVERSITY MEDICAL CENTER	CA	-$3,186,589	-$3,715,178	16.18%	56.66%	72.84%	93.41%
111	VALLEY PRESBYTERIAN HOSPITAL	CA	-$3,626,777	-$4,291,547	32.43%	38.73%	71.16%	45.27%
112	VENTURA COUNTY MEDICAL CENTER	CA	-$1,058,196	-$1,254,365	13.19%	55.22%	68.41%	89.84%
113	VILLA VIEW COMMUNITY HOSPITAL	CA	-$673,398	-$789,486	38.66%	47.26%	85.91%	55.21%
114	WATSONVILLE COMMUNITY HOSPITAL	CA	-$2,118,444	-$2,319,867	31.47%	34.70%	66.17%	41.99%
115	WHITE MEMORIAL MEDICAL CENTER	CA	-$5,957,860	-$7,303,088	21.28%	52.92%	74.20%	92.25%
116	***HUERFANO COUNTY MEDICAL CENTER***	CO	-$215,850	-$254,957	48.68%	28.03%	76.71%	40.43%
117	***SAN LUIS VALLEY REGIONAL MEDICAL CTR***	CO	-$685,413	-$750,480	41.10%	25.42%	66.52%	44.27%
118	***SOUTHEAST COLORADO HOSPITAL***	CO	-$163,597	-$198,362	52.32%	36.52%	88.84%	48.60%
119	GREATER SOUTHEAST HOSPITAL	DC	-$4,552,357	-$5,580,497	43.32%	36.85%	80.17%	54.55%
120	HOWARD UNIVERSITY HOSPITAL	DC	-$6,852,198	-$8,758,200	35.01%	38.35%	73.36%	57.62%
121	***CAMPBELLTON-GRACEVILLE***	FL	-$146,479	-$147,239	64.08%	9.30%	73.38%	41.96%
122	CORAL GABLES HOSPITAL	FL	-$3,763,302	-$4,537,491	63.63%	15.34%	78.97%	76.95%
123	***DOCTORS MEMORIAL HOSPITAL***	FL	-$332,594	-$429,330	76.08%	14.27%	90.35%	41.56%
124	***MADISON COUNTY MEMORIAL HOSPITAL***	FL	-$124,908	-$144,271	80.10%	4.88%	84.98%	41.67%
125	PALM SPRINGS GENERAL HOSPITAL	FL	-$3,286,361	-$4,245,025	64.96%	13.51%	78.47%	75.87%
126	PAN AMERICAN HOSPITAL	FL	-$3,610,634	-$4,627,287	64.29%	9.35%	73.64%	70.27%
127	SOUTH SHORE HOSPITAL & MEDICAL CENTER	FL	-$2,422,618	-$2,876,274	65.29%	19.55%	84.85%	51.88%
128	WESTCHESTER GENERAL HOSPITAL	FL	-$1,410,928	-$1,858,305	52.99%	18.48%	71.47%	75.53%
129	BACON COUNTY HOSPITAL	GA	-$372,854	-$466,949	60.82%	14.48%	75.30%	44.13%
130	BANKS-JACKSON-COMMERCE HOSPITAL	GA	-$518,221	-$613,963	59.77%	16.42%	76.18%	41.75%
131	BAPTIST HOSP WORTH CO	GA	-$136,216	-$158,944	48.59%	28.97%	77.56%	49.80%
132	BLECKLEY MEMORIAL HOSPITAL	GA	-$188,348	-$230,809	70.54%	9.23%	79.77%	40.88%
133	BULLOCH MEMORIAL HOSPITAL	GA	-$1,815,245	-$2,523,224	45.93%	27.67%	73.60%	49.85%
134	BURKE COUNTY HOSPITAL	GA	-$463,520	-$594,366	49.84%	35.35%	85.20%	73.35%
135	CALHOUN MEMORIAL HOSPITAL	GA	-$63,014	-$46,695	68.94%	11.69%	80.63%	42.78%
136	CANDLER COUNTY HOSPITAL	GA	-$520,741	-$629,492	67.85%	14.57%	82.42%	47.32%
137	CLINCH MEMORIAL HOSPITAL	GA	-$128,075	-$126,912	58.27%	18.39%	76.66%	47.81%
138	COFFEE REGIONAL MEDICAL CENTER	GA	-$1,608,190	-$2,059,625	39.27%	29.64%	68.91%	56.52%
139	***COLQUITT REGIONAL MEDICAL CENTER***	GA	-$1,471,505	-$2,181,436	49.96%	24.28%	74.24%	44.89%
140	COLUMBIA FAIRVIEW PARK HOSPITAL	GA	-$1,951,445	-$2,319,453	42.57%	28.88%	71.45%	48.83%
141	CRISP REGIONAL HOSPITAL	GA	-$1,232,917	-$1,529,341	54.60%	23.54%	78.14%	47.03%
142	DODGE COUNTY HOSPITAL	GA	-$749,192	-$940,235	61.11%	16.60%	77.72%	44.83%
143	DONALSONVILLE HOSPITAL INC	GA	-$503,566	-$661,355	46.08%	23.61%	69.69%	53.97%
144	***DOOLY MEDICAL CENTER***	GA	-$245,128	-$319,573	65.43%	10.98%	76.41%	41.98%
145	DORMINY MEDICAL CENTER	GA	-$787,748	-$958,726	63.83%	23.25%	87.08%	44.49%
146	EARLY MEMORIAL HOSPITAL	GA	-$140,729	-$183,829	67.81%	12.26%	80.07%	52.07%
147	EMANUEL COUNTY HOSPITAL	GA	-$576,046	-$735,736	59.25%	20.87%	80.12%	52.20%
148	EVANS MEMORIAL HOSPITAL	GA	-$315,497	-$416,260	61.35%	20.86%	82.21%	47.42%
149	GRADY GENERAL HOSPITAL	GA	-$383,594	-$469,015	56.45%	17.63%	74.08%	49.19%
150	HANCOCK MEMORIAL HOSPITAL	GA	-$576,958	-$696,759	53.09%	17.14%	70.23%	59.87%
151	IRWIN COUNTY HOSPITAL	GA	-$155,939	-$173,433	47.88%	29.39%	77.28%	63.89%
152	JEFF DAVIS HOSPITAL	GA	-$330,538	-$507,526	60.25%	22.31%	82.56%	41.91%

Hospitals in bold italics are eligible for relief under the Roth-Moynihan bill.

High Need Hospitals (>65% inpatient days from Medicare + Medicaid; DSH %>40)

	Hospital	State	Year 2000 BBA Cut	Year 2002 BBA Cut	% of Medicare Days	% of Medicaid Days	% of MR/MA Days	DSH %
153	JENKINS COUNTY HOSPITAL	GA	-$221,277	-$288,881	58.08%	17.43%	75.51%	46.64%
154	LIBERTY MEMORIAL HOSPITAL	GA	-$306,483	-$377,406	37 74%	33.33%	71.07%	55.26%
155	LOUIS SMITH MEMORIAL HOSPITAL	GA	-$155,036	-$204,522	60 68%	18.34%	79.02%	46.05%
156	MEADOWS REGIONAL MEDICAL CENTER INC	GA	-$964,911	-$1,113,059	55.26%	24.07%	79.33%	46.64%
157	MEMORIAL HOSPITAL	GA	-$621,230	-$809,847	52.80%	23.45%	76.25%	44 22%
158	MEMORIAL HOSPITAL OF ADEL INC	GA	-$359,984	-$413,003	42.40%	32 57%	74.96%	58 87%
159	MILLER COUNTY HOSPITAL	GA	-$95,627	-$124,067	58.88%	24.04%	82.92%	51.61%
160	MINNIE G BOSWELL MEMORIAL HOSPITAL	GA	-$296,866	-$391,534	54.33%	19.25%	73.58%	52.54%
161	PARKWAY MEDICAL CENTER	GA	-$1,308,391	-$1,687,052	35 50%	33.33%	68.83%	50.12%
162	PEACH COUNTY HOSPITAL	GA	-$238,928	-$341,879	52.17%	16.65%	68.82%	45.76%
163	PHOEBE PUTNEY MEMORIAL HOSPITAL	GA	-$6,717,266	-$8,379,820	40.41%	31.44%	71.85%	49.65%
164	SOUTHWEST GEORGIA REGIONAL MEDICAL CTR	GA	-$162,596	-$194,115	62.82%	19.02%	81 84%	44.36%
165	SOUTHWEST HOSPITAL AND MEDICAL CENTER	GA	-$647,949	-$803,597	36.96%	31 65%	68.61%	52.64%
166	***STEWART WEBSTER***	GA	-$167,029	-$268,224	75.49%	15.06%	90.54%	53 38%
167	SUMTER REGIONAL HOSPITAL	GA	-$1,510,347	-$1,916,483	46.45%	28.53%	74.98%	46.46%
168	TATTNALL MEMORIAL HOSPITAL	GA	-$108,081	-$93,338	50 79%	28.05%	78.84%	48.56%
169	TAYLOR REGIONAL HOSPITAL	GA	-$924,091	-$1,221,859	41.93%	26.90%	68.83%	47.79%
170	TAYLOR TELFAIR REGIONAL HOSPITAL INC	GA	-$223,045	-$264,120	72.73%	12.75%	85.48%	44.45%
171	***WAYNE MEMORIAL HOSPITAL***	GA	-$1,330,025	-$1,738,578	55.85%	17.18%	73.03%	40.26%
172	WHEELER COUNTY HOSPITAL	GA	-$436,567	-$558,718	65.92%	20 22%	86.14%	59 58%
173	HALE HO'OLA HAMAKUA	HI	-$15,840	-$16,994	66 67%	2 47%	69.14%	76.10%
174	***MOLOKAI GENERAL HOSPITAL***	HI	-$36,842	-$57,332	71.90%	8.48%	80.38%	56.07%
175	ST FRANCIS MEDICAL CENTER	HI	-$4,680,212	-$5,726,502	46 11%	20.01%	66.12%	40.90%
176	ST FRANCIS MEDICAL CENTER-WEST	HI	-$1,788,603	-$2,390,986	41.88%	30.06%	71.94%	47.61%
177	***RINGGOLD COUNTY HOSPITAL***	IA	-$86,852	-$47,932	53.00%	12.37%	65.37%	41.40%
178	BETHANY HOSPITAL	IL	-$966,426	-$1,190,732	26.84%	58 27%	85.10%	81.58%
179	DOCTORS HOSP HYDE PK	IL	-$3,929,757	-$5,136,622	51.92%	37.95%	89.87%	56.61%
180	GRANT HOSPITAL OF CHICAGO	IL	-$3,310,457	-$4,125,388	47.75%	29.73%	77.48%	44 58%
181	LORETTO HOSPITAL	IL	-$1,645,030	-$2,124,003	54.08%	32.76%	86.85%	49 83%
182	MT SINAI HOSPITAL MEDICAL CENTER	IL	-$3,197,811	-$3,756,288	18.61%	56.47%	75.08%	65 55%
183	NORWEGIAN-AMERICAN HOSPITAL	IL	-$940,344	-$1,033,558	13.94%	58.55%	72.49%	89.26%
184	ROSELAND COMMUNITY HOSPITAL	IL	-$1,148,240	-$1,431,902	33 84%	46.08%	79.92%	51.58%
185	SACRED HEART HOSPITAL	IL	-$1,307,108	-$1,759,486	61.76%	25.95%	87.70%	52.30%
186	SOUTH SHORE HOSPITAL	IL	-$1,362,191	-$1,614,091	50.36%	32 40%	82.76%	48 04%
187	ST ANTHONYS HOSPITAL	IL	-$2,417,388	-$3,190,645	37.66%	45 79%	83.46%	58.69%
188	ST BERNARD HOSPITAL	IL	-$1,615,628	-$2,126,325	34.15%	58.43%	92.58%	75.43%
189	ST ELIZABETH HOSPITAL OF CHICAGO INC	IL	-$4,006,590	-$4,782,486	38.73%	38.21%	76.94%	56.32%
190	ST MARY OF NAZARETH HOSPITAL CENTER	IL	-$4,147,991	-$5,177,791	38.37%	38.03%	76.39%	55.22%
191	ST MARYS HOSPITAL OF EAST ST LOUIS	IL	-$2,076,824	-$2,860,453	40.38%	50.07%	90.44%	81.31%
192	THOREK HOSPITAL AND MEDICAL CENTER	IL	-$1,685,433	-$1,990,143	43.87%	23 60%	67.47%	43 34%
193	TOUCHETTE REGIONAL HOSPITAL INC	IL	-$392,929	-$488,041	19.13%	60.65%	79.78%	75.68%
194	WOOD RIVER TOWNSHIP HOSPITAL	IL	-$833,976	-$1,056,684	41.05%	43 76%	84.81%	58.74%
195	METHODIST HOSPITALS, INC NLAKE CAM,THE	IN	-$4,204,250	-$5,311,931	44.26%	35.75%	80.01%	49.32%
196	WILLIAM N WISHARD MEMORIAL HOSPITAL	IN	-$5,555,499	-$6,927,760	25.64%	40.14%	65.78%	56.65%
197	ARH REGIONAL MEDICAL CENTER	KY	-$3,111,000	-$3,680,895	54.50%	18.90%	73.40%	40.94%
198	BEREA HOSP	KY	-$607,229	-$760,222	64.23%	13.80%	78.03%	40.45%
199	BOURBON COMMUNITY HOSPITAL	KY	-$533,893	-$684,584	52.53%	16.94%	69 48%	46.60%
200	CAVERNA MEMORIAL HOSP	KY	-$137,123	-$155,502	63.05%	23.51%	86 56%	62 58%
201	***CLINTON COUNTY HOSPITAL***	KY	-$372,248	-$450,628	58.59%	21.54%	80.13%	58.74%
202	***CUMBERLAND COUNTY HOSPITAL***	KY	-$252,261	-$261,341	59 06%	22.15%	81.21%	59 36%
203	FORT LOGAN HOSP	KY	-$303,490	-$337,486	64 58%	18.40%	82.98%	45 35%
204	GEORGETOWN COMMUNITY HOSPITAL	KY	-$494,177	-$631,212	41 60%	24.76%	66.35%	40 26%
205	HARLAN APPALACHIAN REGIONAL HOSP	KY	-$1,201,878	-$1,441,711	50.93%	29.32%	80.25%	41.36%
206	HARRISON MEMORIAL HOSP	KY	-$508,384	-$806,398	43.49%	29.40%	72.89%	45.53%
207	HIGHLANDS REGIONAL MEDICAL CENTER	KY	-$1,770,676	-$1,891,107	47.72%	20.42%	68.14%	40.62%
208	JANE TODD CRAWFORD MEMORIAL HOSP	KY	-$165,414	-$214,466	59.82%	18.16%	77.99%	49.78%
209	JENKINS COMMUNITY HOSP	KY	-$151,452	-$175,077	46.48%	30.97%	77.45%	47.05%
210	***KENTUCKY RIVER MEDICAL CENTER***	KY	-$970,704	-$1,022,973	51.95%	31.31%	83.26%	56.67%
211	KNOX CO HOSP	KY	-$251,639	-$167,586	55.64%	22.03%	77.67%	48.43%
212	***LAKE CUMBERLAND REGIONAL HOSPITAL***	KY	-$1,937,373	-$2,209,633	50.78%	35.75%	86.53%	54.29%
213	***MARCUM & WALLACE MEMORIAL HOSPITAL***	KY	-$93,390	-$71,535	74.69%	13.71%	88.40%	40.29%
214	***MARY BRECKINRIDGE HOSPITAL***	KY	-$263,696	-$278,451	44.81%	30.01%	74.81%	75.80%
215	MARY CHILES HOSP	KY	-$462,819	-$288,451	58.90%	21.78%	80.68%	45.82%
216	MARYMOUNT HOSPITAL	KY	-$1,122,603	-$1,369,165	53.14%	25.62%	78.76%	44 18%
217	MEMORIAL HOSP INC	KY	-$429,969	-$583,634	43.17%	37.15%	80.31%	74.68%
218	MIDDLESBORO APPALACHIAN REGIONAL HOSP	KY	-$1,033,539	-$1,239,238	54.38%	20.28%	74.67%	45.24%
219	MONROE CO MEDICAL CENTER	KY	-$506,648	-$630,518	62.01%	22.08%	84.10%	59.09%
220	MORGAN CO APPALACHIAN REG HOSP	KY	-$259,754	-$313,728	65.42%	17.36%	82.79%	54.62%
221	OUR LADY OF THE WAY HOSP	KY	-$373,488	-$527,404	44.90%	36.22%	81.12%	47.53%
222	PAUL B HALL REGIONAL MEDICAL CENTER	KY	-$935,300	-$1,164,195	53.14%	29.50%	82.64%	51.10%
223	PINEVILLE COMMUNITY HOSP	KY	-$943,863	-$1,187,017	59.80%	21.72%	81.52%	42 32%
224	RUSSELL CO HOSP	KY	-$279,267	-$321,817	33.16%	50.48%	83.65%	41 13%
225	ST CLAIRE MEDICAL CENTER	KY	-$1,923,810	-$2,492,759	56.76%	21.68%	78.44%	53 57%
226	WAYNE CO HOSP INC	KY	-$216,933	-$231,670	65.00%	19.34%	84.34%	55.15%
227	***WESTLAKE REGIONAL HOSPITAL***	KY	-$729,847	-$911,437	46 32%	25.42%	71.74%	56.71%
228	ABBEVILLE GENERAL HOSPITAL	LA	-$882,168	-$1,127,929	55.64%	24.38%	80.02%	41.36%

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High Need Hospitals (>65% inpatient days from Medicare + Medicaid; DSH %>40)

	Hospital	State	Year 2000 BBA Cut	Year 2002 BBA Cut	% of Medicare Days	% of Medicaid Days	% of MR/MA Days	DSH %
229	AMERICAN LEGION HOSPITAL	LA	-$908,819	-$1,122,009	53.35%	30.96%	84.31%	45.79%
230	AVOYELLES HOSPITAL	LA	-$824,020	-$1,028,034	78.54%	12.24%	90.78%	44.89%
231	BEAUREGARD MEMORIAL HOSPITAL	LA	-$638,365	-$807,443	43.56%	31.41%	74.97%	46.70%
232	***BUNKIE GENERAL HOSPITAL***	LA	-$179,363	-$227,424	85.70%	12.14%	97.84%	46.54%
233	CALDWELL MEMORIAL HOSPITAL	LA	-$133,586	-$169,679	44.07%	44.70%	88.77%	92.36%
234	CONCORD HOSPITAL (ACADIA)	LA	-$78,224	-$96,800	65.18%	31.68%	96.86%	45.12%
235	DOCTORS HOSPITAL OF OPELOUSAS	LA	-$1,479,117	-$1,839,589	52.50%	20.18%	72.69%	52.04%
236	EAST CARROLL PARISH HOSPITAL	LA	-$79,634	-$91,375	55.06%	32.32%	87.38%	62.89%
237	FRANKLIN FOUNDATION HOSPITAL	LA	-$743,091	-$1,011,786	66.00%	27.20%	93.20%	40.76%
238	***FRANKLIN MEDICAL CENTER***	LA	-$1,017,930	-$1,180,817	71.84%	18.71%	90.55%	41.46%
239	HOMER MEMORIAL HOSPITAL	LA	-$605,926	-$806,131	61.10%	23.03%	84.13%	42.62%
240	***HOOD MEMORIAL***	LA	-$286,406	-$602,987	66.07%	22.56%	88.63%	52.89%
241	JO ELLEN SMITH MEMORIAL HOSPITAL	LA	-$1,492,779	-$1,767,912	64.72%	27.94%	92.66%	43.69%
242	L S HUCKABAY MEMORIAL HOSPITAL	LA	-$356,948	-$514,015	57.24%	26.56%	83.81%	58.69%
243	LAKE CHARLES MEMORIAL HOSPITAL	LA	-$4,044,993	-$4,987,730	48.26%	25.84%	74.11%	42.76%
244	LAKELAND MEDICAL CENTER	LA	-$2,224,878	-$2,670,489	58.83%	26.78%	85.61%	43.43%
245	***MADISON PARISH HOSPITAL***	LA	-$243,437	-$297,413	64.73%	22.91%	87.64%	58.90%
246	MEADOWCREST HOSPITAL	LA	-$2,904,467	-$3,452,466	35.31%	33.89%	69.20%	51.97%
247	MINDEN MEDICAL CENTER INC	LA	-$2,529,063	-$2,765,318	45.89%	31.03%	76.92%	44.07%
248	***NATCHITOCHES PARISH HOSPITAL***	LA	-$1,878,099	-$2,094,542	41.50%	34.75%	76.25%	54.03%
249	NORTH OAKS MEDICAL CENTER	LA	-$5,701,941	-$6,791,627	47.76%	21.31%	69.07%	49.92%
250	OPELOUSAS GENERAL HOSPITAL	LA	-$1,920,545	-$2,342,682	51.07%	24.70%	75.78%	54.63%
251	***POINTE COUPEE GENERAL HOSPITAL***	LA	-$312,976	-$396,575	68.45%	0.00%	68.45%	40.92%
252	***RICHARDSON MEDICAL CENTER***	LA	-$597,669	-$833,823	71.60%	16.18%	87.78%	44.46%
253	***RICHLAND PARISH HOSPITAL NO. 1A***	LA	-$397,310	-$590,064	72.64%	15.84%	88.48%	44.80%
254	RIVER WEST MEDICAL CENTER	LA	-$1,038,110	-$1,679,660	30.17%	46.60%	76.76%	73.42%
255	RIVERLAND MEDICAL CENTER	LA	-$486,159	-$568,071	60.19%	29.85%	90.04%	50.06%
256	SAVOY MEDICAL CENTER	LA	-$1,953,323	-$2,944,456	50.58%	35.74%	86.32%	62.45%
257	ST CHARLES GENERAL HOSPITAL	LA	-$1,462,023	-$1,904,662	50.49%	24.92%	75.41%	50.50%
258	ST CLAUDE MEDICAL CENTER	LA	-$314,576	-$434,614	31.63%	68.14%	99.76%	108.20%
259	TULANE UNIVERSITY HOSPITAL	LA	-$6,302,889	-$7,488,527	33.38%	36.98%	70.36%	64.19%
260	WEST CARROLL MEMORIAL HOSPITAL	LA	-$432,747	-$633,997	65.54%	21.74%	87.28%	54.21%
261	WEST FELICIANA PARISH HOSPITAL	LA	-$94,765	-$133,199	56.05%	12.11%	68.16%	47.16%
262	WINN PARISH MEDICAL CENTER	LA	-$1,079,801	-$1,361,890	70.62%	17.58%	88.20%	42.31%
263	LIBERTY MED CENTER	MD	-$1,679,120	-$2,097,722	47.21%	23.07%	70.29%	48.77%
264	ST MARYS REGIONAL MEDICAL CENTER	ME	-$3,203,202	-$4,197,668	48.76%	31.89%	80.65%	43.92%
265	DETROIT REC HOSP & UNIV HLTH CENTER	MI	-$7,154,435	-$9,227,097	33.79%	35.64%	69.43%	60.40%
266	DETROIT RIVERVIEW HOSPITAL	MI	-$4,621,465	-$6,139,793	45.66%	35.71%	81.37%	55.58%
267	GRACE HOSPITAL NORTHWESTERN UNIT	MI	-$10,431,163	-$12,951,771	40.70%	31.87%	72.57%	47.87%
268	HURLEY MEDICAL CENTER	MI	-$6,598,556	-$8,466,276	30.34%	38.44%	68.78%	51.72%
269	HUTZEL HOSPITAL	MI	-$2,402,604	-$3,016,291	9.37%	65.63%	75.00%	83.36%
270	MERCY HOSPITAL	MI	-$3,519,131	-$3,774,946	51.81%	29.49%	81.29%	42.75%
271	MICHIGAN HOSPITAL AND MEDICAL CENTER	MI	-$1,911,343	-$2,251,496	37.00%	35.57%	72.57%	49.26%
272	HENNEPIN COUNTY MEDICAL CENTER	MN	-$9,846,859	-$12,673,397	29.62%	36.79%	66.41%	57.83%
273	REGIONS HOSPITAL (ST PAUL-RAMSEY MED CTR)	MN	-$7,921,934	-$9,727,718	28.53%	36.52%	65.05%	44.98%
274	COX WALNUT LAWN	MO	-$1,621,680	-$2,143,916	36.55%	39.94%	76.49%	64.21%
275	LUCY LEE HOSPITAL	MO	-$1,837,794	-$1,864,735	53.74%	24.82%	78.57%	43.90%
276	LUTHERAN MEDICAL CENTER	MO	-$2,266,536	-$2,698,678	50.05%	36.93%	86.99%	47.33%
277	***REYNOLDS COUNTY GENERAL MEM HOSPITAL***	MO	-$91,965	-$138,727	59.21%	19.97%	79.17%	50.54%
278	TRUMAN MEDICAL CENTER	MO	-$2,997,066	-$3,566,593	27.26%	51.83%	79.09%	78.18%
279	TRUMAN MEDICAL CENTER EAST	MO	-$794,659	-$998,160	24.16%	48.62%	72.78%	56.35%
280	TWIN RIVERS REGIONAL MEDICAL CENTER	MO	-$858,249	-$1,097,470	49.66%	28.66%	78.32%	78.84%
281	BAPTIST MEM HOSP/GOLDEN TRIANGLE INC	MS	-$2,048,636	-$2,227,259	46.35%	21.33%	67.68%	41.72%
282	BAPTIST MEMORIAL HOSPITAL UNION COUNTY	MS	-$810,034	-$1,044,445	40.02%	29.88%	69.89%	57.05%
283	BOLIVAR MEDICAL CENTER	MS	-$792,771	-$878,597	43.22%	34.27%	77.48%	68.27%
284	CHOCTAW COUNTY HOSPITAL	MS	-$60,693	-$77,046	25.17%	59.70%	84.87%	90.81%
285	CLAIBORNE COUNTY HOSPITAL	MS	-$134,157	-$169,787	49.87%	26.47%	76.34%	69.93%
286	CLAY COUNTY MEDICAL CENTER	MS	-$637,446	-$896,122	57.42%	21.03%	78.45%	49.71%
287	COVINGTON COUNTY HOSPITAL	MS	-$147,585	-$139,249	61.02%	24.66%	85.68%	69.86%
288	DELTA REGIONAL MEDICAL CENTER	MS	-$1,901,841	-$2,323,930	51.00%	29.37%	80.36%	59.77%
289	***FIELD MEMORIAL HOSPITAL***	MS	-$338,340	-$475,546	62.35%	18.16%	80.51%	52.01%
290	FORREST GENERAL HOSPITAL	MS	-$6,055,853	-$7,858,995	46.92%	22.77%	69.69%	43.23%
291	FRANKLIN COUNTY MEMORIAL HOSPITAL	MS	-$1,549,683	-$1,775,646	54.29%	23.62%	77.90%	75.62%
292	GREENWOOD LEFLORE HOSPITAL	MS	-$2,234,180	-$2,511,527	51.32%	24.75%	76.07%	54.77%
293	***GRENADA LAKE MEDICAL CENTER***	MS	-$873,505	-$1,036,567	54.31%	28.70%	83.02%	54.63%
294	HARDY WILSON MEMORIAL HOSPITAL	MS	-$367,084	-$474,033	64.45%	18.63%	83.07%	53.67%
295	***HUMPHREYS COUNTY MEMORIAL HOSPITAL***	MS	-$150,152	-$164,872	68.09%	23.15%	91.23%	68.87%
296	JEFFERSON COUNTY HOSPITAL	MS	-$93,305	-$120,626	50.26%	49.74%	100.00%	104.64%
297	***KILMICHAEL HOSPITAL***	MS	-$122,023	-$148,434	82.32%	6.48%	88.80%	47.79%
298	KINGS DAUGHTERS HOSPITAL	MS	-$728,140	-$1,002,983	44.19%	27.97%	72.16%	49.93%
299	LAIRD HOSPITAL	MS	-$433,290	-$568,939	74.30%	10.75%	85.05%	43.69%
300	LUCIUS OLEN CROSBY MEMORIAL HOSPITAL	MS	-$446,818	-$426,401	55.06%	26.71%	81.77%	44.99%
301	MADISON COUNTY MEDICAL CENTER	MS	-$291,812	-$323,744	54.76%	25.77%	80.53%	70.00%
302	METHODIST HEALTHCARE-MIDDLE MS HOSP	MS	-$444,467	-$546,270	58.88%	21.57%	80.45%	78.22%
303	METHODIST MEDICAL CENTER, INC	MS	-$3,869,445	-$4,971,417	48.21%	18.63%	66.84%	40.20%

Hospitals in bold italics are eligible for relief under the Roth-Moynihan bill.

High Need Hospitals (>65% inpatient days from Medicare +-Medicaid; DSH %>40)

	Hospital	State	Year 2000 BBA Cut	Year 2002 BBA Cut	% of Medicare Days	% of Medicaid Days	% of MR/MA Days	DSH %
304	***MONTFORT JONES MEMORIAL HOSP***	MS	-$358,959	-$459,450	72.73%	12.62%	85.35%	49.83%
305	NATCHEZ COMMUNITY HOSPITAL/SWING BED	MS	-$1,016,780	-$1,241,668	51.96%	25.79%	77.76%	48.60%
306	NATCHEZ REGIONAL MEDICAL CENTER	MS	-$1,624,419	-$2,264,320	59.32%	24.72%	84.04%	46.07%
307	NESHOBA COUNTY GENERAL HOSPITAL	MS	-$347,356	-$432,583	58.52%	16.62%	75.13%	55.23%
308	NEWTON REGIONAL HOSPITAL	MS	-$275,628	-$338,188	58.11%	19.89%	78.00%	51.63%
309	NORTH SUNFLOWER COUNTY HOSPITAL	MS	-$260,937	-$452,883	56.35%	22.35%	78.70%	61.12%
310	NOXUBEE GENERAL HOSPITAL	MS	-$178,124	-$250,387	80.47%	10.09%	90.57%	53.36%
311	OKTIBBEHA COUNTY HOSPITAL	MS	-$917,846	-$1,218,883	38.82%	34.13%	72.96%	57.59%
312	PARKVIEW REGIONAL MEDICAL CENTER	MS	-$1,253,004	-$1,310,981	31.77%	37.44%	69.21%	64.65%
313	QUITMAN COUNTY HOSPITAL & NH	MS	-$169,949	-$186,743	71.79%	18.03%	89.82%	72.60%
314	SCOTT REGIONAL HOSPITAL	MS	-$333,299	-$426,660	46.01%	23.94%	69.96%	58 02%
315	SENATOBIA COMMUNITY HOSPITAL	MS	-$275,383	-$382,857	50.60%	25.17%	75.78%	64.11%
316	***SHARKEY-ISSAQUENA COMMUNITY HSPTL.***	MS	-$118,059	-$208,966	73.47%	12.90%	86.36%	47 57%
317	SIMPSON GENERAL HOSPITAL	MS	-$295,161	-$378,347	67.08%	13.85%	80 93%	43.73%
318	SMITH COUNTY HOSPITAL AND SWING BED	MS	-$133,009	-$167,433	48.70%	28.70%	77.39%	65 67%
319	***SOUTH CENTRAL REGIONAL MEDICAL CENTR***	MS	-$2,408,759	-$3,322,954	53.24%	21.72%	74.95%	42.10%
320	SOUTH PANOLA COMMUNITY HOSPITAL	MS	-$360,064	-$441,269	74.38%	6 70%	81.08%	50.42%
321	***SOUTH SUNFLOWER COUNTY HOSPITAL***	MS	-$243,222	-$8,812	44.83%	45.19%	90.02%	76.07%
322	SW MISSISSIPPI GENERAL HOSPITAL	MS	-$2,196,890	-$3,413,144	49.82%	20.07%	69.89%	41.03%
323	TALLAHATCHIE GENERAL HOSPITAL	MS	-$110,765	-$127,426	69 66%	9.22%	78.88%	46.31%
324	TRACE REGIONAL HOSP AND SWING BED	MS	-$882,368	-$1,194,586	59 29%	26.33%	85.63%	73.82%
325	TYLER HOLMES MEMORIAL HOSPITAL	MS	-$293,196	-$373,008	69.09%	16.21%	85 30%	53.91%
326	UNIVERSITY HOSPITAL - DURANT,THE	MS	-$199,178	-$243,489	69.50%	8.61%	78.11%	40.27%
327	UNIVERSITY OF MISSISSIPPI MED CENTER	MS	-$6,971,972	-$8,505,404	17.84%	49.20%	67.04%	84.42%
328	VICKSBURG MEDICAL CENTER	MS	-$2,166,963	-$2,537,314	56.08%	19.64%	75.71%	40.84%
329	***WAYNE GENERAL HOSPITAL***	MS	-$785,710	-$882,267	58.52%	16.02%	74.54%	50 50%
330	***ASHE MEMORIAL HOSPITAL***	NC	-$659,844	-$819,589	75.09%	10.28%	85.37%	40.04%
331	BERTIE MEMORIAL HOSPITAL	NC	-$307,120	-$379,991	12.14%	80.03%	92.17%	42.20%
332	BETSY JOHNSON MEMORIAL HOSPITAL	NC	-$1,196,030	-$1,381,343	52.08%	25.54%	77.61%	49.63%
333	BLADEN COUNTY HOSPITAL	NC	-$512,814	-$593,536	54 73%	33 38%	88.11%	61.86%
334	BRUNSWICK COMMUNITY HOSPITAL	NC	-$729,483	-$876,849	53 73%	19 89%	73.62%	59.44%
335	CAPE FEAR VALLEY MEDICAL CENTER	NC	-$5,838,133	-$7,385,156	44 89%	29.26%	74.15%	49.22%
336	CAROLINAS MEDICAL CENTER/BEHAV HEALTH	NC	-$16,656,225	-$21,486,860	33.65%	32.02%	65.67%	43 16%
337	CHOWAN HOSPITAL	NC	-$700,895	-$923,650	53.32%	25.60%	78.92%	48.73%
338	COLUMBUS COUNTY HOSPITAL INC	NC	-$2,268,586	-$2,823,581	66.32%	20.40%	86.72%	47 38%
339	DUPLIN GENERAL HOSPITAL	NC	-$718,880	-$875,197	46.16%	34.99%	81.15%	64 08%
340	GOOD HOPE HOSPITAL	NC	-$745,517	-$837,059	59.46%	20.94%	80.40%	51.45%
341	GRANVILLE MEDICAL CENTER	NC	-$514,725	-$609,452	54.93%	21.12%	76.05%	42.39%
342	***HALIFAX MEMORIAL HOSPITAL***	NC	-$2,456,828	-$3,088,670	61.90%	21.73%	83.63%	43.13%
343	HERITAGE HOSPITAL	NC	-$1,686,444	-$1,940,289	45.19%	29 57%	74.76%	56.16%
344	JOHNSTON MEMORIAL HOSPITAL	NC	-$1,401,502	-$1,552,143	61.60%	19.41%	81.00%	41.71%
345	MARIA PARHAM HOSPITAL	NC	-$1,775,893	-$2,301,657	53 39%	22.39%	75.78%	46 25%
346	MARTIN GENERAL HOSPITAL	NC	-$405,471	-$416,264	52.71%	20.40%	73.12%	54.29%
347	NASH GENERAL HOSPITAL	NC	-$3,959,510	-$4,495,988	56.15%	22.33%	78.49%	44.75%
348	PITT COUNTY MEMORIAL HOSPITAL	NC	-$16,053,424	-$21,060,173	43.91%	26.29%	70 20%	44.41%
349	***PUNGO DISTRICT HOSPITAL CORPORATTION***	NC	-$548,619	-$666,055	41.36%	41.62%	82.98%	43.07%
350	RICHMOND MEMORIAL HOSPITAL	NC	-$932,882	-$1,227,769	45.14%	27.89%	73.04%	40.30%
351	ROANOKE CHOWAN HOSPITAL	NC	-$1,395,249	-$1,673,202	56.79%	21.14%	77.92%	48.14%
352	SAMPSON REGIONAL MEDICAL CENTER	NC	-$1,340,664	-$1,647,677	55 99%	25.10%	81.09%	49.89%
353	SCOTLAND MEMORIAL HOSPITAL	NC	-$1,372,574	-$1,543,035	35.06%	30.45%	65.50%	58.16%
354	***SOUTHEASTERN REG MEDICAL CENTER***	NC	-$3,400,017	-$3,547,469	46.24%	29.47%	75.71%	60.21%
355	TRANSYLVANIA COMMUNITY HOSPITAL INC	NC	-$717,382	-$1,018,062	39.56%	41.02%	80.57%	61.39%
356	UNION REGIONAL MEDICAL CENTER	NC	-$1,539,347	-$1,910,280	51.75%	26.37%	78.12%	42.99%
357	UNIVERSITY OF NORTH CAROLINA HOSPITAL	NC	-$16,726,875	-$20,185,243	34.22%	32.50%	66.72%	48.82%
358	WILSON MEMORIAL HOSPITAL	NC	-$3,979,487	-$6,416,222	61.70%	19.00%	80.70%	40.03%
359	***PRESENTATION MEDICAL CENTER***	ND	-$146,002	-$202,637	52 16%	27.45%	79.62%	54.71%
360	EAST ORANGE GENERAL HOSPITAL	NJ	-$3,502,928	-$4,449,842	55.29%	19.46%	74.75%	40 49%
361	ST JAMES HOSPITAL	NJ	-$1,302,603	-$1,598,182	46.18%	29.39%	75.57%	45.89%
362	ST MICHAELS MEDICAL CENTER	NJ	-$6,596,149	-$8,636,567	50.31%	27.51%	77 82%	41.41%
363	UNITED HOSPITALS OF NEWARK	NJ	-$2,662,461	-$3,806,486	33 80%	36.14%	69.94%	55.39%
364	***CIBOLA GENERAL HOSPITAL***	NM	-$235,071	-$287,358	33.45%	32.22%	65.67%	44.03%
365	***DEBACA GENERAL HOSPITAL***	NM	-$30,531	-$40,188	34.00%	62.49%	96.49%	42.43%
366	***HOLY CROSS HOSPITAL***	NM	-$543,005	-$661,443	49.04%	17.69%	66.72%	43.38%
367	***NORTHEAST REGIONAL HOSPITAL***	NM	-$724,718	-$915,509	46 33%	20.36%	66.70%	44.69%
368	***PLAINS REGIONAL MED CTR-PORTALES***	NM	-$216,971	-$224,445	50.54%	23.91%	74.45%	40.91%
369	***SOCORRO GENERAL HOSPITAL***	NM	-$153,518	-$206,832	37.18%	34.22%	71.39%	53.51%
370	***BATTLE MOUNTAIN GENERAL HOSPITAL***	NV	-$32,094	-$47,442	4.78%	90.13%	94.91%	96.28%
371	BAYLEY SETON HOSPITAL	NY	-$2,890,541	-$4,147,280	31.07%	45.52%	76.60%	57.96%
372	BETH ISRAEL MEDICAL CENTER	NY	-$31,058,963	-$39,055,977	40.13%	34.75%	74.88%	45.18%
373	BRONX-LEBANON HOSPITAL CENTER	NY	-$6,505,403	-$8,394,803	18.70%	73.78%	92.48%	100.93%
374	BROOKDALE HOSPITAL MEDICAL CENTER	NY	-$8,698,262	-$11,308,225	27.31%	49.43%	76.73%	65.44%
375	BROOKLYN - CALEDONIAN HOSP	NY	-$11,385,976	-$15,066,782	33.51%	44.84%	78.36%	59.50%
376	CABRINI MEDICAL CENTER	NY	-$7,891,327	-$10,746,610	50.01%	27.81%	77.82%	42.08%
377	CLIFTON SPRINGS HOSPITAL	NY	-$1,224,555	-$1,643,805	42.23%	33.92%	76.15%	40 69%
378	EASTERN LONG ISLAND HOSPITAL	NY	-$1,213,205	-$1,534,033	47.97%	40.60%	88.58%	44.90%

High Need Hospitals (>65% inpatient days from Medicare + Medicaid; DSH %>40)

	Hospital	State	Year 2000 BBA Cut	Year 2002 BBA Cut	% of Medicare Days	% of Medicaid Days	% of MR/MA Days	DSH %
379	ERIE COUNTY MEDICAL CENTER	NY	-$6,656,006	-$9,095,295	37.71%	32.63%	70.35%	46.22%
380	INTERFAITH MEDICAL CENTER	NY	-$5,035,164	-$6,822,947	20.27%	68.47%	88.74%	92.70%
381	JAMAICA HOSPITAL	NY	-$8,666,160	-$11,106,917	34.36%	41.03%	75.39%	52.08%
382	LONG ISLAND COLLEGE HOSPITAL	NY	-$12,025,394	-$15,298,583	34.99%	34.17%	69.16%	42.97%
383	LUTHERAN MEDICAL CENTER	NY	-$8,990,200	-$12,282,514	42.81%	38.36%	81.18%	47.43%
384	NASSAU COUNTY MEDICAL CENTER	NY	-$6,777,562	-$9,260,598	26.41%	51.47%	77.87%	60.69%
385	NEW YORK INFIRMARY BEEKMAN DOWNTOWN	NY	-$3,713,042	-$5,060,590	34.56%	37.06%	71.62%	57.91%
386	NORTH GENERAL HOSPITAL	NY	-$2,637,237	-$3,720,994	35.41%	59.06%	94.46%	85.87%
387	OUR LADY OF MERCY MED CTR FLOR D'URSO	NY	-$8,687,115	-$11,289,250	45.10%	32.04%	77.15%	43.15%
388	PRESBYTERIAN HOSPITAL	NY	-$34,414,243	-$44,766,366	33.68%	34.61%	68.30%	46.49%
389	SHEEHAN MEMORIAL HOSPITAL	NY	-$660,497	-$902,791	24.20%	66.21%	90.41%	93.51%
390	ST BARNABAS HOSPITAL	NY	-$7,913,421	-$10,975,759	33.14%	48.19%	81.33%	72.93%
391	ST FRANCIS HOSPITAL	NY	-$3,253,854	-$4,337,054	41.69%	39.06%	80.74%	44.60%
392	ST LUKES - ROOSEVELT HOSPITAL	NY	-$21,039,991	-$27,924,598	33.06%	38.63%	71.69%	54.58%
393	ST VINCENTS HOSPITAL MEDICAL CENTER	NY	-$15,364,273	-$20,304,047	37.69%	33.56%	71.24%	43.83%
394	STATEN ISLAND UNIVERSITY HOSPITAL-NORT	NY	-$19,596,692	-$25,837,643	40.97%	33.37%	74.34%	41.55%
395	TRI-COUNTY MEMORIAL HOSPITAL	NY	-$448,330	-$595,184	35.65%	42.37%	78.02%	50.81%
396	UNION HOSPITAL	NY	-$237,201	-$336,829	3.96%	84.06%	88.03%	126.08%
397	UNIVERSITY HOSPITAL OF BROOKLYN	NY	-$7,240,306	-$9,890,570	30.36%	40.77%	71.14%	59.24%
398	WYCKOFF HEIGHTS HOSPITAL	NY	-$6,136,145	-$7,981,504	37.22%	41.98%	79.20%	61.75%
399	YONKERS GENERAL HOSPITAL	NY	-$1,282,917	-$1,735,319	25.21%	59.89%	85.10%	75.07%
400	SAINT LUKE'S MEDICAL-CENTER	OH	-$5,433,813	-$6,886,585	46.01%	35.07%	81.08%	47.89%
401	CHOCTAW MEMORIAL HOSPITAL	OK	-$238,932	-$284,462	74.38%	12.69%	87.08%	56.59%
402	DOCTORS HOSPITAL	OK	-$2,081,516	-$2,724,857	47.96%	29.47%	77.43%	41.72%
403	***EASTERN OKLAHOMA MEDICAL CENTER***	OK	-$790,945	-$978,067	59.64%	18.31%	77.95%	50.95%
404	HILLCREST HEALTH CENTER, INC	OK	-$2,105,334	-$2,357,722	21.70%	55.75%	77.45%	48.94%
405	***MCCURTAIN MEMORIAL HOSPITAL***	OK	-$1,197,039	-$1,415,335	52.63%	26.41%	79.04%	52.62%
406	MEDICAL CTR OF SOUTHEASTERN OKLAHOMA	OK	-$1,201,767	-$1,411,929	54.10%	23.57%	77.67%	40.66%
407	***MEMORIAL HOSPITAL (ADAIR CO. HEALTH CTR)***	OK	-$284,963	-$340,015	61.17%	15.38%	76.55%	57.36%
408	WAGONER COMMUNITY HOSPITAL	OK	-$686,626	-$930,223	36.35%	31.59%	67.94%	54.64%
409	WOODLAND PARK HOSPITAL	OR	-$904,355	-$1,134,958	42.13%	40.15%	82.28%	59.07%
410	ALBERT EINSTEIN MEDICAL CENTER	PA	-$15,788,045	-$18,627,008	41.72%	25.74%	67.46%	40.80%
411	ALLEGHENY UNIV HOSPITALS CITY AVE (PARKVIEW)	PA	-$5,180,769	-$6,298,835	39.66%	33.19%	72.86%	45.59%
412	ALLEGHENY UNIV HOSPITALS MT SINAI	PA	-$1,930,957	-$2,242,487	4.96%	79.70%	84.66%	63.28%
413	EAGLEVILLE HOSPITAL	PA	-$259,181	-$337,409	22.94%	67.26%	90.20%	115.58%
414	EPISCOPAL HOSPITAL	PA	-$4,596,862	-$5,840,722	33.77%	53.74%	87.51%	82.36%
415	GERMANTOWN HOSPITAL & COMM HLTH SVCS	PA	-$3,614,105	-$4,330,131	41.98%	24.79%	66.77%	41.03%
416	KENSINGTON HOSPITAL	PA	-$96,751	-$142,250	6.97%	83.09%	90.07%	126.14%
417	MERCY PROVIDENCE HOSPITAL, INC	PA	-$1,856,645	-$2,330,335	59.67%	27.70%	87.37%	46.98%
418	MONSOUR MEDICAL CENTER	PA	-$827,600	-$1,087,198	46.57%	37.88%	84.45%	47.53%
419	PRESBYTERIAN-U OF PA MEDICAL CENTER	PA	-$8,501,296	-$10,053,526	46.48%	30.11%	76.58%	46.31%
420	ST AGNES MEDICAL CENTER	PA	-$3,935,092	-$4,625,603	57.26%	16.09%	73.35%	47.01%
421	ST JOSEPH HOSPITAL	PA	-$2,291,155	-$2,914,404	19.77%	72.98%	92.75%	91.36%
422	TEMPLE EAST INC	PA	-$985,815	-$1,143,900	47.52%	37.92%	85.44%	69.91%
423	BAMBERG COUNTY MEMORIAL HOSPITAL	SC	-$476,284	-$343,930	50.22%	19.74%	69.96%	47.25%
424	CAROLINA PINES REGL MED CTR (BYERLY)	SC	-$916,981	-$1,185,072	49.74%	23.73%	73.47%	47.14%
425	CAROLINAS HOSP SYS KINGSTREE	SC	-$214,756	-$307,757	37.83%	29.16%	66.99%	56.92%
426	CHESTERFIELD GENERAL HOSPITAL	SC	-$718,610	-$911,420	49.83%	35.14%	84.97%	48.88%
427	CLARENDON MEMORIAL HOSPITAL	SC	-$404,945	-$520,961	49.52%	22.93%	72.45%	61.96%
428	***COLLETON REGIONAL HOSPITAL***	SC	-$1,324,095	-$1,640,185	52.99%	22.40%	75.39%	43.76%
429	HAMPTON REGIONAL MEDICAL CENTER	SC	-$200,573	-$210,794	55.23%	21.54%	76.78%	42.03%
430	LAKE CITY COMMUNITY HOSPITAL	SC	-$372,896	-$513,437	31.97%	39.34%	71.30%	42.93%
431	LORIS COMMUNITY HOSPITAL	SC	-$1,140,108	-$1,603,267	54.21%	26.68%	80.89%	47.62%
432	LOW COUNTRY GENERAL HOSPITAL	SC	-$129,749	-$144,927	60.89%	21.50%	82.40%	53.57%
433	MARION COUNTY MEDICAL CENTER	SC	-$641,940	-$845,928	41.35%	28.36%	69.71%	54.92%
434	MARLBORO PARK HOSPITAL	SC	-$726,973	-$957,747	53.71%	25.08%	78.79%	49.31%
435	MULLINS HOSPITAL	SC	-$1,075,990	-$1,327,796	58.30%	17.05%	75.35%	41.98%
436	ROPER HOSPITAL NORTH INC	SC	-$973,254	-$1,515,176	46.47%	32.29%	78.75%	51.58%
437	ST EUGENE MEDICAL CENTER	SC	-$960,350	-$1,293,329	43.86%	24.89%	68.75%	56.29%
438	TRMC OF ORANGEBURG & CALHOUN	SC	-$3,166,141	-$4,058,999	52.36%	20.91%	73.27%	44.74%
439	TUOMEY	SC	-$3,192,383	-$4,156,783	50.04%	24.54%	74.59%	41.43%
440	***BENNETT COUNTY HOSPITAL***	SD	-$49,849	-$60,679	52.17%	34.32%	86.49%	58.53%
441	***WINNER REGIONAL HEALTHCARE CENTER***	SD	-$306,969	-$440,844	53.79%	22.28%	76.07%	44.08%
442	***BAPTIST MEMORIAL HOSPITAL LAUDERDALE***	TN	-$502,387	-$456,536	71.95%	17.72%	89.67%	43.04%
443	***BOLIVAR GENERAL HOSPITAL***	TN	-$314,743	-$385,615	72.09%	21.47%	93.57%	68.45%
444	COLUMBIA RIVER PARK HOSPITAL	TN	-$1,591,856	-$1,788,271	61.01%	15.63%	76.65%	41.94%
445	COLUMBIA STONES RIVER HOSPITAL	TN	-$532,501	-$629,522	69.48%	16.49%	85.97%	41.56%
446	CUMBERLAND RIVER HOSPITAL	TN	-$603,981	-$722,353	73.27%	15.90%	89.17%	51.75%
447	***FENTRESS COUNTY GENERAL HOSPITAL***	TN	-$883,266	-$1,001,982	47.16%	37.94%	85.10%	70.31%
448	GRANDVIEW MEDICAL CENTER (COLUMBIA SOUTH PITTS)	TN	-$1,051,161	-$1,255,389	51.93%	33.15%	85.08%	52.50%
449	***HARDIN COUNTY GENERAL HOSPITAL***	TN	-$596,884	-$709,141	62.60%	22.88%	85.48%	44.75%
450	HAWKINS COUNTY MEMORIAL HOSPITAL	TN	-$528,438	-$618,837	69.59%	17.19%	86.77%	42.58%
451	HUMBOLDT GENERAL HOSPITAL INC	TN	-$261,017	-$291,773	46.10%	34.82%	80.92%	45.18%
452	***JELLICO COMMUNITY HOSPITAL***	TN	-$758,009	-$892,289	48.41%	34.70%	83.11%	64.42%
453	JOHN W HARTON REGIONAL MED CENTER	TN	-$1,531,875	-$1,716,929	52.25%	32.66%	84.91%	46.67%
454	JOHNSON COUNTY HOSPITAL INC	TN	-$248,765	-$243,286	70.68%	12.17%	82.85%	47.54%

Hospitals in bold italics are eligible for relief under the Roth-Moynihan bill.

High Need Hospitals (>65% inpatient days from Medicare + Medicaid; DSH %>40)

	Hospital	State	Year 2000 BBA Cut	Year 2002 BBA Cut	% of Medicare Days	% of Medicaid Days	% of MR/MA Days	DSH %
455	LINCOLN REGIONAL HOSPITAL	TN	-$489,514	-$505,218	55.28%	21.52%	76.80%	41.41%
456	LIVINGSTON REGIONAL HOSPITAL	TN	-$1,165,392	-$1,360,365	65.57%	15.75%	81.32%	46.29%
457	MEDICAL CENTER OF MANCHESTER	TN	-$505,535	-$618,754	51.51%	28.73%	80 24%	51.80%
458	METHODIST HAYWOOD PARK HOSPITAL INC	TN	-$315,295	-$404,909	59 02%	27.13%	86.15%	61.47%
459	METHODIST HEALTHCARE FAYETTE HOSPITAL	TN	-$363,157	-$420,751	64.74%	20.90%	85.64%	62.62%
460	METHODIST HEALTHCARE-MCNAIRY HOSPITAL	TN	-$457,093	-$556,585	66.81%	22.11%	88.92%	42.47%
461	METHODIST HOSPITAL OF MCKENZIE	TN	-$195,998	-$226,347	44.78%	37.60%	82.38%	53.23%
462	MORRISTOWN HAMBLEN HOSPITAL ASSOC	TN	-$1,674,766	-$1,965,423	54.08%	21.39%	75.47%	40 66%
463	***SCOTT COUNTY HOSPITAL***	TN	-$1,028,129	-$1,205,744	59.68%	19.12%	78.79%	47.39%
464	SMITH COUNTY MEMORIAL HOSPITAL	TN	-$618,129	-$713,585	70.89%	15.40%	86.29%	47.82%
465	ST JOSEPH HOSPITAL	TN	-$4,271,068	-$4,959,339	66.90%	25.63%	92.52%	48.01%
466	TAKOMA ADVENTIST HOSPITAL	TN	-$1,141,442	-$1,342,576	54.36%	24.48%	78.84%	43.01%
467	TENNESSEE CHRISTIAN MEDICAL CENTER	TN	-$2,803,226	-$3,620,772	39.17%	35.70%	74 87%	52.69%
468	UNIVERSITY OF TN MEMORIAL HOSPITAL	TN	-$10,069,245	-$11,302,468	36.63%	28.38%	65.00%	45.06%
469	***WAYNE MEDICAL CENTER***	TN	-$321,987	-$356,915	70.63%	15.76%	86 38%	41.33%
470	***WHITE COUNTY COMMUNITY HOSPITAL***	TN	-$816,512	-$994,712	55.17%	22.63%	77.80%	48.76%
471	***ALICE REGIONAL HOSPITAL***	TX	-$1,409,297	-$1,504,678	43.31%	35.51%	78.82%	70.36%
472	BAYCOAST MEDICAL CENTER	TX	-$1,250,793	-$1,448,432	43.15%	22.83%	65.98%	40.06%
473	BAYOU CITY MEDICAL CENTER	TX	-$797,766	-$1,111,713	14.16%	65.02%	79.18%	103.79%
474	BEAUMONT MEDICAL AND SURGICAL CENTER	TX	-$2,669,649	-$3,302,208	37 43%	53 22%	90.66%	65.64%
475	BELLAIRE MEDICAL CENTER	TX	-$2,198,434	-$2,838,494	34.41%	41.93%	76.34%	59.44%
476	***BROWNFIELD REGIONAL MEDICAL CENTER***	TX	-$274,331	-$341,933	52 10%	20.74%	72.84%	44.73%
477	BROWNSVILLE MEDICAL CENTER	TX	-$2,848,987	-$3,720,660	48.20%	33.24%	81.44%	73.76%
478	CHRISTUS JASPER MEMORIAL HOSPITAL	TX	-$494,453	-$547,293	54.78%	33.00%	87.78%	49.47%
479	CHRISTUS SANTA ROSA HOSPITAL	TX	-$4,551,157	-$6,068,657	41.30%	27.97%	69.27%	61.10%
480	***CHRISTUS SPOHN HOSPITAL BEEVILLE***	TX	-$559,465	-$799,594	44.64%	21.86%	66.50%	42.60%
481	***CHRISTUS SPOHN HOSPITAL KLEBERG***	TX	-$1,543,392	-$1,901,598	43.19%	30 72%	73.90%	57.51%
482	CLEVELAND REGIONAL MEDICAL CTR	TX	-$1,715,540	-$1,931,154	55.59%	27.78%	83 37%	45.86%
483	DALLAS SOUTHWEST MEDICAL CENTER	TX	-$1,336,905	-$1,607,623	56.10%	22.56%	78.65%	57.66%
484	DALLAS/FORT WORTH MEDICAL CENTER	TX	-$2,130,547	-$2,486,636	44.68%	30.27%	74.95%	43.75%
485	***DIMMIT MEMORIAL HOSPITAL***	TX	-$251,561	-$371,738	64.72%	25.54%	90 25%	67.37%
486	DOCTORS HOSPITAL OF LAREDO	TX	-$1,111,250	-$1,409,586	39.64%	40.59%	80 23%	80.96%
487	DOCTORS MEMORIAL HOSPITAL	TX	-$368,617	-$418,245	65 12%	24.40%	89.51%	41.36%
488	DOLLY VINSANT MEMORIAL HOSPITAL	TX	-$608,355	-$862,186	60.35%	15.45%	75.80%	55 97%
489	EDINBURG REGIONAL MEDICAL CENTER	TX	-$1,589,417	-$2,110,802	36.61%	40.77%	77.37%	82.53%
490	***FALLS COMMUNITY HOSPITAL AND CLINIC***	TX	-$342,608	-$416,732	78.49%	10 44%	88.93%	41.46%
491	***FORT DUNCAN MEDICAL CENTER***	TX	-$957,014	-$1,099,211	50 09%	38.04%	88.12%	107 97%
492	***FRIO HOSPITAL***	TX	-$246,113	-$341,826	48.83%	38.22%	87.04%	78.84%
493	HEREFORD REGIONAL MEDICAL CENTER	TX	-$236,651	-$263,872	48.64%	26.34%	74.98%	47.27%
494	HIGHLAND MEDICAL CENTER	TX	-$836,621	-$1,237,020	42.04%	33.12%	75 16%	70.46%
495	KNAPP MEDICAL CENTER	TX	-$3,015,259	-$3,884,070	44.30%	29.62%	73 92%	80.73%
496	MCALLEN MEDICAL CENTER	TX	-$9,566,397	-$13,536,405	35.84%	47.68%	83.52%	85.65%
497	MEMORIAL HOSPITAL	TX	-$278,397	-$330,427	62.26%	31.78%	94.04%	42.51%
498	MEMORIAL HOSPITAL PADADENA	TX	-$1,805,591	-$2,258,976	38.55%	40.05%	78.60%	58 22%
499	MERCY REGIONAL MEDICAL CENTER	TX	-$4,477,478	-$5,687,537	34.73%	37.17%	71.89%	75.41%
500	MISSION HOSPITAL INC	TX	-$1,457,566	-$1,973,474	40.49%	43.36%	83.85%	82.71%
501	NORTH HOUSTON MEDICAL CENTER	TX	-$4,228,561	-$4,615,899	39.58%	39.19%	78.77%	60.21%
502	NORTHSIDE GENERAL HOSPITAL	TX	-$79,665	-$96,312	15.94%	67.52%	83.46%	90.57%
503	***PECOS COUNTY MEMORIAL HOSPITAL***	TX	-$262,578	-$351,930	39 31%	29.54%	68 85%	40.91%
504	PLAINS MEMORIAL HOSPITAL	TX	-$104,542	-$163,932	53.94%	25.05%	78.99%	53.22%
505	***REEVES COUNTY HOSPITAL***	TX	-$233,613	-$311,139	56.77%	26.65%	83 43%	48 30%
506	RIO GRANDE REGIONAL HOSPITAL	TX	-$3,471,637	-$4,447,727	56.14%	15.44%	71.58%	44.92%
507	SOUTHWEST GENERAL HOSPITAL	TX	-$2,519,440	-$3,189,682	50.23%	38.12%	88 36%	78.67%
508	SOUTHWESTERN GEN HOSP	TX	-$465,564	-$509,787	37.66%	48.03%	85.69%	86.95%
509	***STARR COUNTY MEMORIAL HOSPITAL***	TX	-$150,350	-$52,220	26.73%	61.30%	88.03%	127.57%
510	TITUS COUNTY MEMORIAL HOSPITAL	TX	-$1,903,072	-$2,424,377	47.71%	31.07%	78.78%	44.69%
511	***TRI-CITY COMMUNITY HOSPITAL***	TX	-$387,797	-$407,492	55.56%	9.57%	65.13%	41.24%
512	TRI CITY HEALTH CENTRE INC	TX	-$1,743,300	-$2,182,726	43.41%	36.58%	79.98%	63.00%
513	***UVALDE MEMORIAL HOSPITAL AUTHORITY***	TX	-$734,353	-$816,595	47.26%	31.32%	78.58%	51.72%
514	***VAL VERDE MEMORIAL HOSPITAL***	TX	-$551,151	-$100,775	43.43%	22.50%	65.92%	49.08%
515	VALLEY BAPTIST MEDICAL CENTER	TX	-$7,317,070	-$8,733,050	47.36%	31.09%	78.45%	54.69%
516	VALLEY REGIONAL MEDICAL CENTER	TX	-$2,000,412	-$2,443,581	26.20%	51.19%	77.38%	97.81%
517	CAPITOL MEDICAL CENTER	VA	-$1,391,710	-$1,863,644	65.87%	29.27%	95.14%	60.57%
518	***LEE COUNTY COMMUNITY HOSPITAL***	VA	-$1,181,716	-$1,414,431	64.31%	15.28%	79.59%	40.28%
519	NORTON COMMUNITY HOSPITAL	VA	-$1,029,817	-$1,073,902	52.45%	30 01%	82.46%	42.37%
520	RICHMOND COMMUNITY HOSPITAL	VA	-$796,657	-$984,902	64.61%	25 79%	90.40%	59.89%
521	RUSSELL CNTY MED CNTR	VA	-$1,361,870	-$1,625,462	64.48%	30.09%	94 57%	50.01%
522	***OTHELLO COMMUNITY HOSPITAL***	WA	-$129,978	-$168,859	22.73%	52.85%	75.58%	78.80%
523	PROSSER MEMORIAL HOSPITAL	WA	-$106,051	-$121,934	22.39%	51.06%	73.46%	68.85%
524	PROVIDENCE TOPPENSIH HOSPITAL	WA	-$264,191	-$319,089	23.14%	58.38%	81.53%	71.46%
525	PUGET SOUND HOSPITAL	WA	-$1,059,254	-$1,235,512	32.43%	41.50%	73.93%	64 86%
526	SKYLINE HOSPITAL	WA	-$190,893	-$268,557	50.51%	30.17%	80.68%	47.50%
527	SUNNYSIDE COMMUNITY HOSPITAL	WA	-$539,530	-$642,091	39.77%	34.56%	74.33%	47.17%
528	NORTHWEST GENERAL HOSPITAL	WI	-$293,170	-$256,959	32.24%	48.82%	81.06%	89 90%

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High Need Hospitals (>65% inpatient days from Medicare + Medicaid; DSH %>40)

	Hospital	State	Year 2000 BBA Cut	Year 2002 BBA Cut	% of Medicare Days	% of Medicaid Days	% of MR/MA Days	DSH %
529	SINAI SAMARITAN MEDICAL CENTER	WI	-$7,602,458	-$9,373,159	31.96%	46.13%	78.09%	60.06%
530	***PRESTON MEMORIAL HOSPITAL***	WV	-$368,077	-$487,564	44.20%	30.27%	74.47%	51.37%
531	***STONEWALL JACKSON MEMORIAL HOSPITAL***	WV	-$756,424	-$956,774	65.02%	3.62%	68.64%	43.78%
532	***WELCH EMERGENCY HOSPITAL***	WV	-$440,760	-$584,497	55.46%	26.21%	81.66%	40.10%
533	***LANDER VALLEY MEDICAL CENTER***	WY	-$592,348	-$753,909	38.57%	32.19%	70.75%	41.53%
			-$1,102,813,277	**-$1,377,336,349**				

Notes:

Payer mix, DSH percentages, and estimated BBA cuts based on 1997 Medicare Cost Report data.

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