QUESTIONS ON COMPETITIVE DEFINED BENEFIT

Given that a major concern of health plans is lack on competition with the traditional fee-for-service program – why do you propose keeping fee-for-service from competing? How will this encourage plan participation?

It is important to realize that our proposal does have the traditional program compete with health plans. Our competitive plan gives beneficiaries financial incentives to choose lower cost health plans. The out-of-pocket premium costs of beneficiaries are reduced when they select a health plan that is less expensive than the traditional program. Beneficiaries get 75% of the savings and the government gets 25%. Managed care plans "compete" with the traditional program, on price, for beneficiaries.

The traditional program will compete with managed health care – for the best innovations, the highest quality care, the most efficient operations. Our success as an agency will be in having a wide array of affordable health plan options available to beneficiaries across the country.

What our plan doesn't do is charge beneficiaries more than they would pay today if they choose to remain in traditional Medicare. They have a financial incentive to choose less expensive plans but they are not penalized if they believe the traditional program is best for them. We want the traditional program to remain a steady, reliable program for our seniors to come back to – even while we hope that won't be necessary. It must remain affordable. Our plan does that. By including a prescription drug benefit for all beneficiaries, with shared financing from the government and beneficiaries premiums, beneficiaries will be able to feel secure that their drug needs are covered and be able to choose between the traditional program and managed care based on price and quality, not benefits.

Further, managed care has a promise to keep. It has always held itself out as promoting high quality coordinated care for less money than traditional fee-for-service. Including fee-for-service in the competition and thereby upwardly skewing payment rates to MCOs, would not let MCOs make good on that promise.

This isn't real competition because fee-for-service is not included. Doesn't this show you aren't really interested in competition?

Our proposal, where managed care plans vie for Medicare market share based on price and quality against fee-for-service, is nothing other than competition. It is true we do not propose to raise premiums for beneficiaries who remain in the traditional program, but this does not mean that there is no competition.

It is important to remember, managed care promised to be the financing and service delivery system that delivered high quality care for less than fee-for-service. There is no reason to further raise fee-for-service premiums in order to promote competition based on price.

Doesn't your proposal continue the "fairness gap" because you arbitrarily pay plans less than fee-for-service?

The 'fairness gap' is an interesting argument. Yes, health plans get paid less than fee-for-service under the current program, and our proposal, because health plans have always told us they can provide higher quality care, with better outcomes, for less cost, than traditional fee-for-service. That is why employers choose MCOs for their health plans, and why people enroll in these organizations.

Under current rules, Medicare MCOs use excess funds from statutorily defined government pricing to provide benefits beyond the basic Medicare package (prescriptions, eyeglasses, dental care for example). We are proposing to base MCO competition on price -- price for a defined, guaranteed benefit package. Because our plan includes a new prescription drug benefit, financed by government contributors and beneficiary premiums, plans will not have to finance these benefits within their basic payment rate. The MCOs have an opportunity to shine -- to provide the standard benefit package for less than the traditional program

Under our proposal, the fairness gap argument has no place. Plans will compete against the traditional program for market share, and to do so, they will need effective pricing -- equal to or lower than fee-for-service -- which is what they have always needed, and relied upon, to gain enrollees in any market. Our plan offers beneficiaries reduced premiums if they choose a MCO that can deliver high quality care for less – an improvement on the current system.

QUESTIONS ON PRIVATE SECTOR PURCHASER TOOLS FOR TRADITIONAL MEDICARE

Why is Administration proposing changes in Medicare that Congress has expressly rejected for the past several years?

The Administration has been, and remains, keenly interested in making Medicare a high quality, accountable and efficient program of health care financing for the Nation's senior citizens who deserve the very best. Our proposals represent the best way to reach those goals. Some of our proposals have been presented to Congress before by the Administration. We are currently conducting demonstrations of some of the proposals. We stand by both the soundness of the proposals, like contractor reform and competitive bidding, and the need for their enactment in order to modernize and strengthen the program. I believe that, thanks to the efforts of the Bipartisan Commission on the Future of Medicare, Congress has a greater knowledge of, and appreciation for, the need to modernize the traditional program and give us the tools we need to make Medicare more efficient, accountable and quality-oriented.

BACKGROUND:

Proposals that have been previously proposed:

- Competitive Pricing for managed care
- Competitive Bidding for Part B fee-for-service
- Changes to Medigap to protect people who lose MCO coverage
- Centers of Excellence
- Contracting Reform

Would HCFA become too powerful in the marketplace if it had these tools?

It is not a question of becoming too powerful but rather a question of whether we will give HCFA the tools it needs to operate like efficient, accountable private sector purchasers of high quality health care. Undeniably, Medicare has a significant presence in the market, but that presence should be used to the advantage of the beneficiary and the taxpayer to purchase quality cost-effective, health care. Our market leverage is not used today. Expects like the National Academy of Social Insurance and the Bipartisan Commission on the Future of Medicare agree that these tools are needed appropriate. I might also add that the tools we are requesting would allow us to recognize and reward providers of high quality health care -- something Medicare does not currently do. Nothing less will do to bring Medicare into the 21st Century.

Do you intend to limit choice for beneficiaries?

Beneficiaries will not have their choices limited by these proposals. These proposals provide beneficiaries with a greater number of choices in how they obtain health care services (for example, the primary care case management proposal) and what their costs will be for particular services (e.g., the PPO proposal). If anything, these proposals will enhance beneficiaries' ability to make choices because they will know that certain providers have been selected for participation in particular programs on the basis of meeting quality standards, and they will know that they can expect to have cost savings if they use particular providers.

Only in the case of certain suppliers under the competitive bidding proposal will beneficiaries be required to use particular suppliers. However, competitive bidding will only be used in situations where adequate access can be ensured, and we will also monitor the quality of supplies provided. In addition, the competitive bidding only will be used for the purchasing of supplies—not for physician services, for example. In the case of supplies, the nature of the items that will be purchased in this way are often identical supplies offered by different entities (they are "fungible" goods).

What will HCFA do to make price competition more acceptable to providers and suppliers?

Our experience so far with price competition in fee-for-service, through the Centers of Excellence demonstration, indicates that providers welcome the opportunity to participate in

these kinds of programs. The price competition proposals offer providers certain advantages, such as increased volume or designation as a higher quality provider, which may also have a " spillover" effect beyond the provider's Medicare patients.
While these proposals expand on the successful demonstration and build upon the experience of private sector purchasers to bring about new opportunities for price competition, it is also true that the traditional provider participation and payment rules will continue to apply and be available to providers.

How will HCFA be fair in choosing geographic areas to implement policies?

We would choose geographic areas where we would expect these innovative programs to be successful—that is, the programs would provide more choices to beneficiaries and providers, they would improve the quality of care, and they would result in program savings. These circumstances are likely to exist in areas where there is excess capacity or unusual patterns of care. They are also likely to be the areas where the private sector has used similar purchasing tools and are prevalent in the particular marketplace.

What administrative incentives are you talking about in your competitive pricing program?

The administrative arrangements could include such incentives as simplifying claims processing for providers, reducing billing payment cycle time, and alternative claims and cost settlement processing.

Won't these proposals cause a lot of upheaval in care of the elderly?

In the case of physician care and hospital care, any beneficiary may continue to receive care in the same way they do today. What these proposals provide are new choices that enable beneficiaries to obtain higher quality care or better-coordinated care, often with lower out-of-pocket costs.

Aren't you concerned about creating Medicare monopolies? How will you prevent this?

Medicare has always had to be sensitive to the issue of its extensive market power as a large purchaser representing a vulnerable population. More so than other payers, Medicare has a social responsibility in its payment policies, and Congress has recognized this in a number of ways through special payment rules that will continue to be in place.

What these proposals do is give more providers the choice of electing payment mechanisms that are different from the traditional administered pricing mechanism. Providers are not obligated to enter into these arrangements, but there are many advantages for them if they do.

If anything, we believe these proposals will enhance competition and improve efficiency rather than leading to market distortions such as monopolies.

How does your price competition in Medicare managed care proposal differ from the Kansas City and Phoenix competitive pricing demonstrations?

The underlying motivation for each is the same, which is that market forces should be used to establish an appropriate price for Medicare+Choice plans. Our competitive pricing proposal sets up a system that makes the competition among plans more clearly based on price. In our proposal, beneficiaries who choose the most efficient plans are likely to see their Part B premiums reduced, in some cases down to zero. Our proposal also makes it easier for national plans (i.e., plans covering more than one market area) to participate in the bidding process.

Aren't you running into lots of technical problems and local area political opposition in both the competitive price and competitive bidding demos? Please tell us the problems.

The Kansas City and Phoenix competitive pricing demonstrations have not been successful and have not engendered plan support. Why do you think this proposal would be any different?

The principal obstacle to successful implementation of the competitive pricing and bidding demonstrations has been the "not in my backyard" syndrome: people favor the principle of greater competition, but are concerned when it is affecting just them and not others.

This type of concern is less likely to arise because these proposals aim to make the various competitive approaches more widespread, and, hopefully, the norm rather than the exception in many areas of the country.

What if there is no Center of Excellence near a beneficiary? They are penalized and have to pay "full price." Is this fair?

Beneficiaries who do not have reasonable access to a Center of Excellence would not be " penalized." They would see no change from today. However, it is already the case that beneficiaries often do travel to particular sites of care, even in the absence of any incentives to do so, to use particular providers. As is true with the Centers of Excellence demonstration, under this proposal Centers will be able to provide incentives such as payment of travel and lodging costs that will enable more beneficiaries to have reasonable access to participating facilities.

Wouldn't the PPO limit beneficiaries choice? Would there be enough PPO participants in rural areas to ensure choice and give rural beneficiaries the opportunity to limit out of pocket costs?

The PPO would not limit choice. Beneficiaries can continue to use non-PPO providers with no penalty. If they have PPO providers available, beneficiaries may choose them and receive lower cost-sharing.

It is true that some areas may be less likely to have PPO providers, particularly rural areas, but that is more likely a function of provider availability in those areas. The lack of commercial HMOs in some rural areas does not argue for purchasers not offering HMOs in those areas where they are viable.

How will you determine high quality for physician, supplier or inpatient services? How will you know a cost-conscious provider is simply not cutting corners and providing low quality care? What system do you have in place to tell the difference?

The area of measuring quality and appropriate utilization continues to be a developing area, and given the changes in health care technology and delivery is likely to always be evolving. We are actively working with private sector groups such as the Foundation for Accountability (FAcct) and our colleagues at the Agency for Health Care Policy Research (AHCPR) on the development of evidence based guidelines and measuring health care performance and outcomes. The health care industry is gaining increasing experience with such measures as avoidable hospitalizations, and condition and procedure-specific mortality rates. Procedure-specific mortality rates were one of the factors considered in the Centers of Excellence demonstration. Our experience with the competitive demonstration on durable medical equipment indicates that we are able to distinguish between high quality and poor suppliers.

Could group practices participate in the PPO? How is the PPO proposal different from the integrated delivery arrangement? Could a doctor participate in the PPO and integrated delivery program too?

A doctor can participate in both programs, and all individual physicians within a group practice could participate as PPO providers.

There are many differences between these two programs (one of which, the integrated delivery arrangement, is initially a demonstration). Currently, although physicians direct most care beneficiaries receive -- in hospitals, in home health agencies, etc. -- they have no financial benefit or consequences for over-prescribing. Under the integrated delivery arrangement proposal, physician group practices will receive bonuses for achieving certain targets for the overall utilization of the beneficiaries under their care. Quality of care would be closely monitored. The PPO arrangement is not all-encompassing in this way. PPO providers are only responsible for the care they themselves provide under the PPO payment arrangement and quality standards.

Didn't your modernization proposals rely on data we don't have, analysis we don't know how to do, and standards that no one has developed because there's no agreement on what is good quality care?

Our modernization proposals rely on the experience gained from demonstrations and the experience of other purchasers. For example, in the Centers of Excellence demonstration, data on procedure-specific mortality rates was one of the factors considered in evaluating applicants.

Our experience with the competitive demonstration on durable medical equipment indicates that we are able to use a variety of information and data to distinguish between high quality and poor suppliers.

How is the PCCM proposal different from the PPO – don't they have the same goal at the provider level – care coordination for better outcomes and lower costs? How does all this work together?

All of our proposals have the same general aims: to improve the quality of care and reduce program expenditures where appropriate. The PCCM proposal and the PPO proposal accomplish these goals in very different ways. The PCCM proposal provides assistance to beneficiaries who are clear candidates for improved coordination of care.

Why is contractor reform so important?

I would start by noting that the system is not exactly structured the way it was at the beginning of the Medicare program. We started with well over 130 Medicare contractors and are now down to 60. We started off with nearly all providers and beneficiaries submitting nearly all of their Medicare claims on paper, often not on standard claim forms, whereas today health care providers (including physicians and suppliers) submit nearly all of their Medicare claims electronically. Today, a significant majority of Medicare claims are processed by the contractors with no manual involvement whatsoever.

We see these and other trends continuing into the future. We take it as a given that the Medicare system will continue to evolve and respond to new technological and performance imperatives. We believe we need additional flexibility in contracting to manage this evolution. This need is the basic reason we seek changes in our contracting legislation.

The current statute constrains who we may contract with for fiscal intermediary functions to entities nominated by hospitals and skilled nursing facilities. The statute also constrains what types of business entities may perform carrier functions. Medicare law provides the contractors with special rights in regard to contract terminations that are not in alignment with general government contracting law. And, current law limits our bargaining leverage with the contractors by establishing cost-reimbursement contracts as the default arrangement for Medicare contracting.

These types of provisions have made it increasingly difficult to manage the contractor network as the number of contractors has diminished. In a number of instances, we have had a very small pool of contractors available to consider for new work to when a company has left the program. Statutory constraints are not the only issue here, and changing these constraints will not be a " magic bullet,: but we believe this contracting environment needs to be opened up. I also want to stress that we see this proposal as leading to an evolutionary process: contracting reform does not mean that we intend to replace nearly all, or even most, of our current contractors in the near future. Our proposal will allow us to both continue doing business with our current contractors,

but would position us to make changes in contracting configuration as needed.

HCFA can't maintain its current workload. How can you take on more?

Despite the Year 2000 workload, HCFA is on track with implementing the vast majority of the 335 BBA provisions that affect HCFA programs. New preventive benefits, skilled nursing facility payment reforms, the Medicare+Choice program, and many other provisions have been implemented on time.

Also, while we first believed we would have to delay the FY and CY 2000 provider updates because of Y2K, we now believe we can implement these updates on time.

Of the 335 provisions requiring HCFA implementation, we have completed implementation of 188 and made substantial progress toward implementing many of the remaining 147.

Other BBA provisions that likely will still be delayed include hospital outpatient prospective payment, SNF consolidated billing and others.

Part A provider payment updates will be made this fall and the physician and other Part B updates will be made in January. We will implement delayed provisions as soon after April 1, 2000 as possible. Provisions requiring complex systems changes, such as home health prospective payment and outpatient hospital prospective payment, are first in the programming cue.

How could you keep qualified facilities out of Centers of Excellence when there would be no basis? Won't it destroy some facilities to be outside the Medicare program?

This proposal would create a Centers of Excellence program as a permanent part of Medicare by authorizing the Secretary to competitively pay selected facilities a single bundled rate for all services, potentially including post-acute services, associated with a surgical procedure or hospital admission related to a medical condition.

As with the CABG demonstration, selected facilities would have to meet special quality standards and would be required to implement a quality improvement plan. The single rate paid to a Center for a particular procedure or admission would result in savings to the program while assuring that beneficiaries who choose to obtain their care in these Centers receive high quality services. Also, as under the demonstration, Centers would be allowed to provide additional services (such as private room) to attract beneficiaries and could waive a portion of beneficiary cost-sharing. Medicare achieved an average of 12% savings for CABG procedures performed through the demonstration.

One of the factors that led HCFA to demonstrate the centers of excellence concept is that studies show that facilities that do a high volume of a specific procedure usually have better patient outcomes, i.e., faster and more complete recoveries and lower mortality rates.

The proposal does not destroy facilities that are not centers of excellence. Beneficiaries would be free, as they are today, to obtain services from the hospitals and physicians they choose. We expect that many beneficiaries will choose to receive care from physicians and facilities that are not designated as centers of excellence.

Give Backs

It is outrageous that the Administration refuses to identify the BBA payment policies that need modification. Why do you continue to refuse to be helpful in this process of figuring out what needs to be done?

We will work with you to continue to assess the situation and make revisions to ensure that beneficiaries have access to needed care. The President's plan recognizes that there may be a need to adjust and gradually phase-in some of the change made in the BBA while building on the fiscal discipline imposed by it. The plan includes set-aside funding for this purpose and take administrative actions to smooth out the transition.

The set-aside, totaling $7.5 billion for FY 2000-09, is funded in the context of the reform plan, but its uses are not specified. The Administration wants to work with Congress, Congressional advisory commissions, and provider and beneficiary groups to determine what policies to monitor and how to address problems in a fiscally responsible way. The Administration will only support targeted changes to resolve specific problems with beneficiary access to quality care and will oppose legislation that significantly opens up the BBA.

Background:

HCFA is proactively monitoring the impact of the BBA to ensure that beneficiary access to covered services is not compromised by systematically gathering data from media reports, beneficiary advocacy groups, providers, Area Agencies on Aging, State Health Insurance Assistance Programs, claims processing contractors, State health officials, and other sources to look for objective information and evidence of the impact of BBA changes on access to quality care. They are also examining information available from the Securities and Exchange Commission, Wall Street analysts, Census Bureau data, and Bureau of Labor statistics to better understand the impact of Medicare on the health marketplace.

In addition, the HHS Inspector General's office is performing a number of related studies to assist HCFA in monitoring the BBA changes.

How much should therapy caps be increased?

We continue to be concerned about these limits and are troubled by anecdotal reports about the adverse impact of these limits. Limits on these services of $1500 may not be

sufficient to cover necessary care for all beneficiaries. Because of our concern, our HHS Inspector General colleagues have agreed to study the impact of the BBA's $1500 limit on outpatient rehabilitation therapy to help us judge whether and how any adjustments to the cap should be made. We would be happy to work with the Congress to assess the situation and make revisions to ensure beneficiaries have access to needed care.

What can we do to provide relief for costs of care of high acuity patients in SNFs? Why don't you have any administrative relief in this proposal?

We know that there are concerns that the PPS does not fully reflect the costs of non-therapy ancillaries such as drugs for high acuity patients. We share these concerns and are conducting research that will serve as the basis for refinements to the Resource Utilizations Groups (or "RUGs") that we expect to implement next year. We know, too, that we will need to periodically evaluate the system to ensure that it appropriately reflects changes in care practices and in the Medicare population. HCFA has also asked the HHS Inspector General to interview hospital discharge planners about whether they are having difficulty placing beneficiaries in nursing facilities or home health.

The statute for the SNF PPS is very restrictive. The law requires use of 1995 as a base year, and implementation by July 1, 1998 with a three year transition. It did not allow for exceptions to the transition, carving out of any service, or creation of an outlier policy. We are carefully reviewing the possibility of making administrative changes to the PPS, but we believe we have little discretion.

We are using the limited discretion afforded by the statute to administratively excluded certain types of exceptionally intensive outpatient hospital services from the SNF PPS bundle, such as CT scans, MRIs, cardiac catheterizations, emergency services, major ambulatory surgical procedures, and radiation therapy. We are also considering the possibility of excluding certain additional outpatient hospital services -- such as chemotherapy and large-limb prosthetic devices.

Outpatient PPS - Will low volume urban & rural hospitals be treated the same as academic health centers? If not, how will the adjustment be different?

We are doing everything we can to mitigate the impact of the outpatient department prospective payment system on low volume urban, rural and teaching hospitals and our adjustments are essentially the same for each type of hospital.

Our plan spells out a number of time-limited actions that HCFA is taking to smooth the implementation of some of the provisions of the Balanced Budget Act that are within our administrative authority under the statute. These changes will help ensure beneficiary access to care while maintaining BBA discipline that is essential for protecting Medicare's future.

During the three-year transition to this new system, budget-neutral adjustments will be made to increase payments to hospitals these types of hospitals. Without these budget-neutral

adjustments, these hospitals would experience sudden reductions in payment under the outpatient prospective payment system.

To help all hospitals with the transition to outpatient prospective payment, what is known as a " volume control mechanism" will not be implemented in the first few years of the new payment system. The law requires Medicare to develop such a mechanism because prospective payment includes incentives that can lead to unnecessary increases in the volume of covered services. The proposed prospective payment rule presented a variety of options for controlling volume and solicited comments on these options. Delaying their implementation will provide an adjustment period for providers as they become accustomed to the new system.

Also to help hospitals with the transition to prospective payment, Medicare will use the same wage index for calculating rates that is used to calculate inpatient prospective payment rates. This takes into account the effect of hospital reclassifications and redesignations.

Outpatient PPS - How much money are you talking about moving around in your budget neutral proposal? Aren't you just financially threatening a new set of hospitals with your proposal?

$0.8 billion over fiscal years 2001-2010.

The statutory authority allows us to make adjustments to hospitals that are most adversely impacted during a transition period of three years. Our data suggests that teaching, rural and cancer hospitals will face the most severe reductions in outpatient payments under the new prospective payment system.

How many rural hospitals will be helped by your proposal? Will rural and urban be defined by the same standard of low volume?

In the short term, we believe that the combination of adjustments in the President's plan will help all rural hospitals either through our proposed changes, through our steps to provide administrative relief, or a combination of both.

The administrative changes include:

* Delaying expansion of hospital transfer policy
* Transition to outpatient department prospective payment system
* Delay implementation of outpatient department "volume control mechanism"
* Making it easier for rural hospitals to reclassify as "urban" for payments

For both the short and long,terms, we propose set-aside funding, $7.4 billion over 10 years, to be used to make appropriate and justified modifications to BBA policies. We want to work with Congress, Congressional advisory commissions, provider and beneficiary groups to assess what

policies would be most focused to address problems in a fiscally responsible way.

Home Health – What is your authority to delay the surety bond requirement? Why can't you take similar broad interpretations of statute to provide even more relief for industry–like SNFs or hospitals?

In January, 1998, we issued a home health surety bond regulation to comply with the statutory implementation date. There were significant problems with the regulation, however. After discussions with key members of Congress, we agreed to delay the implementation date of the surety bond requirement.

Where we have the authority, we have done what we could to address other provider concerns and provide relief where we can.

* We are eliminating the sequential billing rule as of July 1, 1999. Many HHAs expressed concern about the impact of the implementation of the sequential billing requirement on their cash flows. This should alleviate the cash flow problems experienced by some agencies.

* To ease the financial hardship on home health agencies stemming from IPS overpayments, we are permitting extended repayment schedules for up to 12 months without interest. HHAs may receive extended payment schedules beyond the 12 months if they meet the financial need and ability to repay criteria.

* We have decided to exclude the costs of teaching physicians, interns and residents, and Certified Registered Nurse Anesthetists in the calculation of the FY 1999 wage index in response to concern within the hospital industry. These changes were proposed in our May 7, 1999, proposed rule.

* To address industry concerns, we have administratively excluded certain types of exceptionally intensive outpatient hospital services from the SNF PPS bundle, such as CT scans, MRIs, cardiac catheterizations, emergency services, major ambulatory surgical procedures, and radiation therapy.

You are now estimating that the new outpatient department (OPD) prospective payment system (PPS) will result in reducing hospital revenues by 5.7 percent. There has been a legal analysis done suggesting that HCFA has the administrative authority to implement the system in a way that does not result in this reduction. What is your opinion of this analysis? Do you still plan to take this reduction?

Our Office of General Counsel has analyzed the legal opinion submitted by the American Hospital Association very closely and has determined that we do not have the authority to calculate payments in the manner suggested in this opinion.

We are aware that the 5.7 percent reduction under this new payment system is sizeable. However, OGC believes that the language of the law is very clear in specifying how payments are to be calculated.

-- OGC believes that the plain language of the Balanced Budget Act directs the Secretary to estimate the total amount of copayments to be paid "under this subsection." This calculation is used to determine aggregate base payments to hospitals in the first year. Since copayments under the subsection are based on median charges, and median charges are substantially lower than average charges, this results in a reduction in total base payments.

-- The interpretation advanced by the AHA, under which the Secretary would estimate the total amount of copayments that would have been paid under the old system is inconsistent with the plain language of the statute. By referring to copayments "under this subsection," the statute unambiguously directs HCFA to estimate copayments under the new PPS, not copayments that would have been made under the old system.

-- The legal analysis also makes an argument based on legislative history. This, however, is unavailing. Legislative history may be helpful in construing ambiguous statutory language, but legislative history cannot override plain statutory language.

Do you believe you have any flexibility to reduce the magnitude of the 5.7 percent reduction in OPD spending under the prospective payment system(PPS)? It is our understanding that you may have the ability to reduce the 5.7% reduction to 4.4%.

The difference between 4.4% and 5.7% is due to the methodology used to calculate copayments for multiple procedures. When an individual has more than one surgical procedure done on the same day, the proposed policy is to pay the full fee schedule amount on the first procedure but only half the fee schedule amount on the additional procedures. This is consistent with the policy we currently use in ambulatory surgical centers and physician offices.

In our initial calculations under the OPD proposed rule, we had erroneously omitted the copayment reduction for the multiple procedures. When we recalculated the rates based on refined data last month, we included this copayment reduction. If we were to require beneficiaries to pay the full copayment amount on multiple procedures, the overall reduction in revenue to hospitals would be only 4.4% rather than 5.7%.

We have not yet made a decision about what our policy will be with respect to beneficiary copayments on multiple procedures. We are continuing to examine this policy.

Extenders

How can you propose to extend BBA payment reduction policies even as Congress is about to begin debating BBA give backs – indeed your own proposal includes give backs?

The plan includes proposals to build on the fiscal discipline that the BBA brought to Medicare. As stewards of the Medicare program, we are obliged to recommend changes to payment rates to maintain incentives for certain providers and suppliers to operate efficiently. Rather than allowing for full updates once BBA cost savings policies expire, we believe these providers and suppliers should continue to make a modest contribution to preserving and protecting Medicare for the future and to extending the life of the Part A Trust Fund. The plan includes reductions to certain provider payment updates for 2003 through 2009.

How can you forecast the effect of BBA and fraud & abuse curtailment on providers with enough accuracy to propose payment reduction policies that would only commence in 2003? How could you know if this is appropriate, correct or necessary?

We believe actuarial estimates were essentially correct regarding the impact of the BBA provisions. What the actuaries were unable to forecast was the success of our fraud and abuse and certain delays in payments that occurred for a number of reasons.

We remain convinced that the policies the BBA put in place were sound ones and our proposal makes only appropriate and justifiable changes.

As stewards of the Medicare program, we are obliged to recommend changes to payment rates to maintain incentives for certain providers and suppliers to operate efficiently. We believe providers and suppliers should continue to make a modest contribution to preserving and protecting Medicare for the future and to extend the Part A Trust Fund.

MEDICARE ROLL OUT

Groups:

- American Hospital Association
- American Association of Medical Colleges
- American Health Care Association
- American Medical Association
- National Association of Home Care
- Drug Manufacturers: PhRMA and BIO
- AARP?

Congress:

- Democratic Leadership
- Republican Leadership and/or potential friendly Members
- Committee Ranking Members
- Key Base Democrats: e.g. Kennedy, Rockefeller, etc.
- Key Swing Democrats: Conrad, Graham, etc.
- Hearing strategy: Next week or not?

Validators:

- Reischauer
- Aaron
- Feder
- Moon
- Reinhardt
- Tyson
- Altman
- Thorpe

Media:

- Millius
- Tang
- USA Today/Susan Page
- Weinstein
- Roll-out for press strategy

FAX COVER SHEET

OFFICE OF LEGISLATION

Number of Pages: 6+14 Date: 6-23

To: CHRIS JENNINGS	From: BONNIE WASHINGTON
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Phone:	Phone:

REMARKS: REVISED PER YOUR REQUEST

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MEDICARE REFORM PLAN: IMPLICATIONS FOR PHYSICIANS

SURPLUS

Surplus for Medicare: Extending the life of the Medicare trust fund helps providers because it lessens the need for radical payment reductions that would otherwise be required. To extend the life of the trust fund without the surplus financing, Medicare provider payments in Part A would have to be reduced by almost $200 billion over 10 years – and hundreds of billions more in the outyears.

Legislative

Set-aside funding for modifications of BBA (legislative; $7.5 billion over 10 years). The plan would create a set-aside stream of funding to be used to make appropriate and justified modifications to BBA policies. This set-aside, totaling $7.5 billion over 10 years, is funded in the context of the reform plan, but its uses are not specified. We want to work with Congress, Congressional advisory commissions, provider and beneficiary groups to assess what policies would be most focused to address problems in a fiscally responsible way.

Improvements to the physician sustainable growth rate (legislative; no cost). The President's FY 2000 budget/legislative program, which was submitted in February 1999, contains a legislative proposal for a budget-neutral technical amendment to fix a number of problems with the physician sustainable growth rate (SGR). The SGR is a target rate of growth for Medicare physicians' services which was legislated in BBA.

The problems and solution are highly technical. As a result of some design flaws, Medicare updates for physicians' services are expected to oscillate between large increases and large decreases. In addition, the SGR cannot be revised to correct for estimation errors.

The physician community has argued strongly that they believe we have the existing authority to correct for estimation errors in the SGR. They believe that the 1999 and 2000 updates were lower than what they would have been by at least 1 percent in each year if we corrected for projection error. The HHS General Counsel has indicated that we cannot fix this problem under current law. Thus, we have submitted a legislative proposal to fix all the SGR problems in a budget-neutral manner.

OUT-YEAR CHANGES

There are no provider payment reductions for physicians in the plan.

MEDICARE REFORM PLAN: IMPLICATIONS FOR HOME HEALTH AGENCIES

SURPLUS

Surplus for Medicare: Extending the life of the Medicare trust fund helps providers because it lessens the need for radical payment reductions that would otherwise be required. To extend the life of the trust fund without the surplus financing, Medicare provider payments in Part A would have to be reduced by almost $200 billion over 10 years – and hundreds of billions more in the outyears.

EARLY-YEAR CHANGES

Administrative

Extending time for repayment of overpayments (administrative; no cost). The President's plan increases the time for repayment of overpayments related to the interim payment system from one year to three years, with interest. Currently, home health agencies are provided with one year of interest-free extended repayment schedules. This will alleviate cash flow problems some home health agencies are facing as a result of the interim payment system.

Modifying the requirements for surety bonds (administrative; no cost). In addition, the plan postpones the requirement for surety bonds until October 1, 2000, when the new home health prospective payment system will be implemented. This will help ensure that overpayments related to the interim payment system will not be an obstacle to agencies obtaining surety bonds. Also, agencies will be required to obtain bonds of only $50,000, not 15 percent of annual agency Medicare revenues as was proposed earlier.

Legislative

Set-aside funding for modifications of BBA (legislative; $7.5 billion over 10 years). The plan would create a set-aside stream of funding to be used to make appropriate and justified modifications to BBA policies. This set-aside, totaling $7.5 billion over 10 years, is funded in the context of the reform plan, but its uses are not specified. We want to work with Congress, Congressional advisory commissions, provider and beneficiary groups to assess what policies would be most focused to address problems in a fiscally responsible way.

OUT-YEAR CHANGES

There are no provider payment reductions for home health agencies in the Plan.

MEDICARE REFORM PLAN: IMPLICATIONS FOR SKILLED NURSING FACILITIES

SURPLUS

Surplus for Medicare: Extending the life of the Medicare trust fund helps providers because it lessens the need for radical payment reductions that would otherwise be required. To extend the life of the trust fund without the surplus financing, Medicare provider payments in Part A would have to be reduced by almost $200 billion over 10 years – and hundreds of billions more in the outyears.

EARLY-YEAR CHANGES

Administrative

Refining resource utilization groups (administrative; no cost). We know that there are concerns that the PPS does not fully reflect the costs of non-therapy ancillaries such as drugs for high acuity patients. We share these concerns and are conducting research that will serve as the basis for refinements to the Resource Utilizations Groups (or "RUGs") that we expect to implement next year. We know, too, that we will need to periodically evaluate the system to ensure that it appropriately reflects changes in care practices and in the Medicare population. HCFA has also asked the HHS Inspector General to interview hospital discharge planners about whether they are having difficulty placing beneficiaries in nursing facilities or home health.

The statute for the SNF PPS is very restrictive. The law requires use of 1995 as a base year, and implementation by July 1, 1998 with a three year transition. It did not allow for exceptions to the transition, carving out of any service, or creation of an outlier policy. We are carefully reviewing the possibility of making administrative changes to the PPS, but we believe we have little discretion.

Some have advocated for changing the index HCFA uses to update SNF payments from the market basket to the Producer Price Index (PPI). The PPI is a relatively new measure and is volatile. While the PPI was higher than the market basket last year, it is likely to fall below the market basket in the coming years. The PPI measures for hospitals and home health are already lower than these providers' respective market baskets.

Legislative

Set-aside funding for modifications of BBA (legislative; $7.5 billion over 10 years). The plan would create a set-aside stream of funding to be used to make appropriate and justified modifications to BBA policies. This set-aside, totaling $7.5 billion over 10 years, is funded in the context of the reform plan, but its uses are not specified. We want to work with

Congress, Congressional advisory commissions, provider and beneficiary groups to assess what policies would be most focused to address problems in a fiscally responsible way.

OUT-YEAR CHANGES

There are no provider payment reductions for skilled nursing facilities in the Plan.

MEDICARE REFORM PLAN: IMPLICATIONS FOR HOSPITALS

SURPLUS

Surplus for Medicare: Extending the life of the Medicare trust fund helps providers because it lessens the need for radical payment reductions that would otherwise be required. To extend the life of the trust fund without the surplus financing, Medicare provider payments in Part A would have to be reduced by almost $200 billion over 10 years – and hundreds of billions more in the outyears.

EARLY-YEAR CHANGES

Administrative

Delaying expansion of hospital transfer policy (administrative; $1.6 billion over 10 years). The BBA reduced payments to hospitals that transfer patients to another hospital or unit, skilled nursing facilities (SNF), or home health agency after a shorter than average length of stay. This policy has been implemented for the 10 Diagnostic Related Groups (DRGs) with the highest rates of discharge. This action would delay the implementation of this transfer policy in all DRGs for 2 years.

Transition to outpatient department prospective payment system (administrative; no cost). Under the BBA, a new prospective payment system (PPS) would be implemented for outpatient departments in 2001. HCFA estimates that certain hospitals could have a large loss in payments (e.g., a rural hospital reduction of 15 percent; teaching hospital reduction of 10 percent; cancer hospital reduction of 30 percent). The Administration is proposing to limit these losses through a 3-year, budget-neutral transition.

Delay implementation of outpatient department "volume control mechanism" (administrative; no cost). The new prospective payment system for hospital outpatient departments required Medicare to develop a mechanism to ensure that the PPS does not lead to unnecessary increases in volume that offset the savings from the PPS. The Administration will delay the implementation of this volume control mechanism to provide an adjustment period for providers as they become accustomed to the system.

Making it easier for rural hospitals to reclassify as "urban" for payments (administrative; no cost). Right now, facilities can obtain reclassification if the wages they pay their employees are at least 108 percent of the average wages in their rural area, and at least 84 percent of average wages in a nearby urban area. We are planning to change these percentages to ease the restrictions on reclassifications. Additionally, rural hospitals could use the inpatient wage index under outpatient prospective payment system and the Bureau of Labor Statistics would conduct a study of the indexes affecting rural hospital payments (in Daschle's rural hospital bill).

Legislative

Set-aside funding for modifications of BBA (legislative; $7.5 billion over 10 years). The plan would create a set-aside stream of funding to be used to make appropriate and justified modifications to BBA policies. This set-aside, totaling $7.5 billion over 10 years, is funded in the context of the reform plan, but its uses are not specified. We want to work with Congress, Congressional advisory commissions, provider and beneficiary groups to assess what policies would be most focused to address problems in a fiscally responsible way.

Removing disproportionate share hospital (DSH) payments from managed care (legislative; no cost). The plan would include a policy to remove DSH payments from managed care payments and pay the hospitals directly. Supported by the Administration in 1997, this assures that hospitals receive the payments intended by the law.

OUT-YEAR CHANGES

No payment changes until 2003: The plan does not include any extension of BBA savings from providers until 2003, when the Balanced Budget Act (BBA) of 1997 expires.

Higher updates than BBA: Beginning in 2003, policies would be implemented that increase hospital payments in most cases more than the BBA effects in 2002. There would be no DSH cut, as in the BBA. The hospital market basket would be reduced by 1.0 rather than 1.1 (2001 reduction in BBA), and rural hospitals would get an even higher update (-0.5). The PPS hospital capital reduction would be halved.

MEDICARE REFORM PLAN: IMPLICATIONS FOR RURAL HOSPITALS

SURPLUS

Surplus for Medicare: Extending the life of the Medicare trust fund helps providers because it lessens the need for radical payment reductions that would otherwise be required. To extend the life of the trust fund without the surplus financing, Medicare provider payments in Part A would have to be reduced by almost $200 billion over 10 years – and hundreds of billions more in the outyears.

EARLY-YEAR CHANGES

Administrative

Delaying expansion of hospital transfer policy (administrative; $1.6 billion over 10 years). The BBA reduced payments to hospitals that transfer patients to another hospital or unit, skilled nursing facilities (SNF), or home health agency after a shorter than average length of stay. This policy has been implemented for the 10 Diagnostic Related Groups (DRGs) with the highest rates of discharge. This action would delay the implementation of this transfer policy in all DRGs for 2 years.

Delaying expansion of hospital transfer policy (administrative; $1.6 billion over 10 years). The BBA reduced payments to hospitals that transfer patients to another hospital or unit, skilled nursing facilities (SNF), or home health agency after a shorter than average length of stay. This policy has been implemented for the 10 Diagnostic Related Groups (DRGs) with the highest rates of discharge. This action would delay the implementation of this transfer policy in all DRGs for 2 years.

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Higher updates than BBA: Beginning in 2003, policies would be implemented that increase hospital payments in most cases more than the BBA effects in 2002. There would be no DSH cut, as in the BBA. The hospital market basket would be reduced by 1.0 rather than 1.1 (2001 reduction in BBA), and rural hospitals would get an even higher update (-0.5). The PPS hospital capital reduction would be halved.

MEDICARE REFORM PLAN: IMPLICATIONS FOR TEACHING HOSPITALS

SURPLUS

Surplus for Medicare: Extending the life of the Medicare trust fund helps providers because it lessens the need for radical payment reductions that would otherwise be required. To extend the life of the trust fund without the surplus financing, Medicare provider payments in Part A would have to be reduced by almost $200 billion over 10 years – and hundreds of billions more in the outyears.

EARLY-YEAR CHANGES

Administrative

Delaying expansion of hospital transfer policy (administrative; $1.6 billion over 10 years). The BBA reduced payments to hospitals that transfer patients to another hospital or unit, skilled nursing facilities (SNF), or home health agency after a shorter than average length of stay. This policy has been implemented for the 10 Diagnostic Related Groups (DRGs) with the highest rates of discharge. This action would delay the implementation of this transfer policy in all DRGs for 2 years.

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MEDICARE REFORM PLAN: IMPLICATIONS FOR MANAGED CARE PLANS

The President's Medicare plan is designed to increase competition within the Medicare program by:

Giving HCFA additional private sector purchasing tools that will allow it to become a more prudent purchaser of health care, and

Introducing price competition into the Medicare+Choice program so that both beneficiaries and Medicare can reduce the amount they pay for benefits provided by Medicare+Choice plans.

These changes will help ensure beneficiary access to quality care while maintaining the discipline of the BBA that is essential to protecting Medicare's future.

Under the President's plan, Medicare+Choice plans would annually submit premium bids for the cost of providing Medicare services. Medicare would pay each plan based on the plan's bid relative to Medicare fee-for-service costs:

For plans that bid at the Medicare fee-for-service level, Medicare would pay 85 percent of the plan's premium and the beneficiary would pay the remainder.

For plans that bid lower than the Medicare fee-for-service level, beneficiaries would get 75 percent of the savings from the lower bid and Medicare would get 25 percent of the savings. This arrangement gives beneficiaries financial incentives to choose more efficient plans.

For plans that bid above the Medicare fee-for-service level, Medicare would pay 85 percent of the Medicare fee-for-service cost in the area toward the plan's premium and the beneficiary would pay the remainder.

The President's new payment structure for the Medicare+ Choice program will be fairer to beneficiaries, Medicare+Choice plans and Medicare.

Beneficiaries will be able to reduce their Part B premiums by choosing more efficient health plans. Efficient Medicare+Choice plans will be able to provide the guaranteed Medicare benefits plus lower cost sharing for a premium below the current Part B premium. Beneficiaries who today are receiving additional benefits from their Medicare+Choice plans can continue to do so, by using some of their Part B savings to purchase supplemental benefits from their Medicare+Choice plan.

The new payment plan also addresses many of the concerns raised by Medicare+Choice plans about the current payment arrangement. The new arrangement:

Relies on competitive bidding rather than administered pricing. Plans will be able to bid whatever premium they feel is appropriate for the Medicare benefits, capped at 97 percent of Medicare fee-for-service costs. This "cap" is higher than the effective payment level for Medicare+Choice plans today. Under this new system, efficient plans will be able to offer more choices of savings and additional benefits to beneficiaries than they do today.

Restores full geographic adjustment in higher cost areas while retaining enhanced payment rates in lower-cost areas. Under the current system, payment rates in historically higher cost areas have been reduced so that rates in lower-cost areas can be enhanced. These "blended" rates have reduced the amounts available in urban and other higher-cost areas, with rates often increasing at only 2 percent per year.

Adds a prescription drug benefit to the defined Medicare package for all beneficiaries, including beneficiaries in Medicare+Choice plans. Including drugs as a Medicare benefit will mean that plans will receive a higher payment from Medicare for providing drug coverage. Due to rising drug costs, plans recently have expressed concern that they may not be able to continue to provide drug coverage under the current Medicare+Choice payment arrangement. The payment arrangement will assure that plans will be able to continue to provide a basic drug benefit. Plans also will be able to offer to supplement the Medicare defined drug benefit if they wish to do so.

Bases the level of payment to Medicare+Choice plans on the fee-for-service costs in each area. This assures that the payments available to Medicare+Choice plans will increase as fast as Medicare fee-for-service (many areas are now seeing payments increasing at only 2 percent per year).

MEDICARE REFORM PLAN: IMPLICATIONS FOR PHARMACY BENEFIT MANAGERS

The President's Medicare plan is designed to strengthen and protect Medicare for the future. It will ensure adequate financing of the program and extend the life of the Trust Fund, include a new prescription drug benefit, and give Medicare the ability to use private sector purchasing tools to better manage the program.

Prescription drugs have become an essential part of health care today. The correct use of prescription drugs can reduce hospitalizations, prevent and manage disease, and dramatically improve the quality of life.

The new prescription drug benefit included in the President's Medicare plan uses private sector competition to offer choice, encourage innovation, negotiate the best prices and ensure access to drugs for Medicare beneficiaries.

Specifically, the benefit relies on the experience and purchasing power of pharmacy benefit managers that have simplified administration and contained drug costs.

The prescription drug benefit will be privately run through a set of pharmacy benefit managers. The contracted PBM will be paid a fee for managing the benefit, with some incentives to control cost and utilization. In general, however, the government would retain the risk for the cost and utilization of services under the benefit.

The benefit will include minimal direction from the federal government and would allow the PBMs to use various cost containment tools in administering the program. The plan will include no government mandates beyond a basic minimum package.

This plan will increase the number of lives covered by PBMs while not restricting the PBMs' ability to negotiate with drug manufacturers and will allow PBMs to continue to gain savings by educating physicians and patients to select appropriate, affordable, and safe and effective drugs.

The prescription drug benefit will vastly improve the quality of care that Medicare provides to its beneficiaries by not requiring them to choose between drugs and other necessities. Also, the drug benefit, if properly administered by a PBM or other entity, will decrease drug-drug interactions and hospitalizations.

MEDICARE REFORM PLAN: IMPLICATIONS FOR DRUG MANUFACTURERS

The President's Medicare plan is designed to strengthen and protect Medicare for the future. It will ensure adequate financing of the program and extend the life of the Trust Fund, include a new prescription drug benefit, and give Medicare the ability to use private sector purchasing tools to better manage the program.

Prescription drugs have become an essential part of health care today. The correct use of prescription drugs can reduce hospitalizations, prevent and manage disease, and dramatically improve the quality of life.

The new prescription drug benefit included in the President's Medicare plan uses private sector competition to offer choice, encourage innovation, and ensure access to drugs for Medicare beneficiaries.

Specifically, the benefit creates access to prescriptions drugs for all Medicare beneficiaries, including the approximately 14 million that do not currently have any type of prescription drug coverage. The benefit relies on pharmacy benefit managers to continue to negotiate fair prices with drug manufacturers rather than on price controls.

Medicare beneficiaries are large consumers of prescription drugs. However, with numerous employers and insurers dropping their drug coverage, many beneficiaries have decreased their drug consumption due to the lack of insurance. This benefit will ensure that beneficiaries have access to prescription drugs and that drug manufacturers do not lose their current volume.

The benefit will include minimal direction from the federal government and will allow drug manufacturers to negotiate with pharmacy benefit managers much as they do today, without any additional price controls.

This benefit will allow drug manufacturers to continue to conduct their research and develop the latest technology while ensuring that Medicare beneficiaries have access to that technology.

The prescription drug benefit will vastly improve the quality of care that Medicare provides to its beneficiaries by not requiring them to choose between drugs and other necessities. Also, the drug benefit, if properly administered by a PBM or other entity, will decrease drug-drug interactions and hospitalizations.

National Journal

FAX COVER SHEET

DATE: 6/23/99

TO: Chris Jennings, Theresa

ORGANIZATION:

FAX: 456-5557

FROM: Marilyn Werber Serafini

Number of Pages (including Cover): 3

Comments:

Marilyn has a Friday deadline (6/25)

1501 M Street, N.W. • Suite 300 • Washington, D.C. 20005 • (202)739-8400 • Fax (202)833-8069
www.nationaljournal.com

Hi Chris.
Thanks for the time last week. May I attribute the following quotes to you or to an administration official? -Marilyn (202)739-8415

CONCERNING HEALTH MARTS, ASSOCIATION HEALTH PLANS
"We're concerned that some proposals would create more problems than they're addressing, because they segment the healthy populations from the sicker populations, and they also bypass important protections under state laws. Our hope is that we can work with members who are interested in helping small businesses purchase health care, but we want to make sure it's done in a way that doesn't undermine the market place as we know it."

"[Boehner's] introduction of a bill within a patient's bill of rights creates some concerns, too. We don't want to weigh down a bill that has growing bipartisan support in the House, and we feel very, very strongly that there i a strong mandate for a patient bill of rights. To load it down with potentially controversial provisions is concerning.

CONCERNING THE TAX CREDIT PROPOSALS
"I don't think there has yet to be a consensus on whether to move in this area, and, if so, how and what?" There are lots of questions that must be answered.

"The President's appraoch about any approach in health care is that if anyone wants to put resources on the table and talk about other ways to increase access to affordable coverage, he's open to talking about it. We learned over the years that you've got to build consensus for the best way to dedicate resources for coverage expansion."

"How much should tax credits or incentives be? If you don't set the credit at a high enough amount, you'll have a very small take up rate of currently uninsured, and a very high take up rate of the insured. You're talking over 8 percent of the premium or people don't voluntarily take it up. The problem is that if you go that high, and provide that tax inducement, you also are spending a lot of money on people who are currently insured as well as those who are uninsured, and the cost is very expensive.

CONCERNING EQUITY:
"You can make an argument for tax equity, and some do, and I think that's compelling. But the question is whether or not that's the first place you wan to put your dollars."

CONCERNING CROWD OUT
"Under any scenario I think we would say that you don't want to undermine the employer market place right now.

MARKET REFORMS:
"We need insurance reforms as well. We need to ensure that there is access to affordable coverage, that there is not discriminatory underlying practices. I you're going to put the money in, you should use that carrot to get long overdue insurance reforms."

ABOUT OTHER OPTIONS:
"The tax credit approach really should be viewed as a different way to get subsidies into the market place, for people to have more affordable ways to purchase health care. You may want to think about that option. You also may want to think about subsidy options that are akin to CHIP. You may want to think of a combination, and I think that all of those should be on the table for serious consideration."

"Tax credits are a concept that has some appeal because it's a different way to provide subsidies to people. But I've learned that concepts are very popular at the beginning, and then when you get to learning the implications, and you get the scoring, and you get the ratio of how many insured you're picking up as opposed to the uninsured, people will say, 'Is that the best wa to go?' In the end it will become less appealing unless it's more carefully thought through."

CONCERNING WHERE THE ADMINISTRATION IS:
"Both Democrats and Republicans are interested in tax credit proposals, and w are too. We have a process under way where we're reviewing options."

"There's growing interest in the growing uninsured in the country. There's no one who would be more interested in it than the president, the vice president and the First Lady. But we want to make sure that as we proceed, we proceed i a way that doesn't break the bank. One of the hallmarks of this administratio is its commitment to thoughtful to policy that's carefully evaluated.

"We need consensus. If people think that only one side is pushing it, then it's unacceptable. If we can help to forge that environment for a bipartisan consensus, then we should attempt to do so."

HCFA
MEDICARE • MEDICAID
Health Care Financing Administration

FAX COVER SHEET

OFFICE OF LEGISLATION

Number of Pages: _____ Date: _____

To: Chris Jennings / Jeanne Lambrew	From: Bonnie Washington
Fax: _____	Fax: 202-690-8168 or 205-5157
Phone: _____	Phone: _____

REMARKS: Provider one-pagers
Does not include the 2 that are
coming from OMB on drugs

HEALTH CARE FINANCING ADMINISTRATION
200 Independence Ave., SW
Room 341-H, Humphrey Building
Washington, DC 20201

Provider Group: Physicians

- The President's Medicare plan is designed to strengthen and protect Medicare for the future. It will ensure adequate financing of the program and extend the life of the Trust Fund, include a new prescription drug benefit, and give Medicare the ability to use private sector purchasing tools to better manage the program.

- The plan achieves these goals without imposing new provider cuts during the time where the BBA cuts are currently in effect. The plan does not include savings from provider payment updates until 2003.

- In addition to the drug benefit and other important program reforms, the President's plan includes a number of time-limited administrative actions we will take to smooth the implementation of some of the more severe provisions of the BBA.

- These changes will help ensure beneficiary access to quality care while maintaining the discipline of the BBA that is essential to protecting Medicare's future.

- The President's plan would create a set-aside stream of funding to be used to make appropriate and justified modifications to BBA policies. This set-aside, totaling $x billion over ten years, is funded in the context of the entire reform plan, but its uses are not specified. We want to work with Congress, Congressional advisory commissions, provider and beneficiary groups to determine what policies would best address specific problems in a fiscally responsible way.

- The plan does build on the BBA, by including moderated provider payment reduction policies beginning in 2003 through 2009. These policies will help preserve and protect Medicare for the future and extend the life of the trust fund. There are no provider payment reductions for physicians in the plan.

- The President's FY 2000 budget/legislative program, which was submitted in February 1999, contains a legislative proposal for a budget-neutral technical amendment to fix a number of problems with the physician sustainable growth rate (SGR). The SGR is a target rate of growth for Medicare physicians' services which was legislated in BBA.

- The problems and solution are highly technical. As a result of some design flaws, Medicare updates for physicians' services are expected to oscillate between large increases and large decreases. In addition, the SGR cannot be revised to correct for estimation errors.

- The physician community has argued strongly that they believe we have the existing authority to correct for estimation errors in the SGR. They believe that the 1999 and 2000 updates were lower than what they would have been by at least 1 percent in each year if we corrected for projection error. The HHS General Counsel has indicated that we cannot fix this problem under current law. Thus, we have submitted a legislative proposal to fix all the SGR problems in a budget-neutral manner.

- In addition to payment reforms, the President's plan includes a strategy for modernizing management of the Medicare program by bringing private sector expertise to the Health Care Financing Administration.

- The plan includes a strategy to assess HCFA's personnel needs and plans to submit legislation to waive some Federal personnel rules to ensure the proper expertise, if warranted.

- The plan also includes a number of public/private advisory bodies to make the decision-making process more open and to allow HCFA to benefit from private sector expertise in the important areas of overall management, Medicare coverage policy, and the Medicare beneficiary education campaign.

- Finally, the plan includes a strategy to re-engineer the relationship between HCFA's central and regional offices to ensure improved communication and consistent application of policies nationwide.

Provider Group: Home Health Agencies

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- Specifically, the President's plan increases the time for repayment of overpayments related to the interim payment system from one year to three years, with interest. Currently, home health agencies are provided with one year of interest-free extended repayment schedules. This will alleviate cash flow problems some home health agencies are facing as a result of the interim payment system.

- In addition, the plan postpones the requirement for surety bonds until October 1, 2000, when the new home health prospective payment system will be implemented. This will help ensure that overpayments related to the interim payment system will not be an obstacle to agencies obtaining surety bonds. Also, agencies will be required to obtain bonds of only $50,000, not 15 percent of annual agency Medicare revenues as was proposed earlier.

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- Finally, the plan includes a strategy to re-engineer the relationship between HCFA's central and regional offices to ensure improved communication and consistent application of policies nationwide.

Provider Group: Hospitals

- The President's Medicare plan is designed to strengthen and protect Medicare for the future. It will ensure adequate financing of the program and extend the life of the Trust Fund, include a new prescription drug benefit, and give Medicare the ability to use private sector purchasing tools to better manage the program.

- The plan achieves these goals without imposing new provider cuts during the time where the BBA cuts are currently in effect. The plan does not include savings from provider payment updates until 2003.

- In addition to the drug benefit and other important program reforms, the President's plan includes a number of time-limited administrative actions we will take to smooth the implementation of some of the more severe provisions of the BBA.

- These changes will help ensure beneficiary access to quality care while maintaining the discipline of the BBA that is essential to protecting Medicare's future. We are making a number of changes to lessen the impact of the BBA on hospitals. For example:

  - The transfer policy requires Medicare to reduce payments for certain diagnoses to hospitals that transfer patients to another hospital or unit, skilled nursing facilities (SNF), or home health agency after a shorter than average length of stay. The BBA gave the Secretary of HHS the authority to extend the transfer policy to additional diagnoses after October 1, 2000. We are proposing to postpone the extension of the transfer policy to additional diagnoses to give hospitals more time to adjust to the initial policy which is now in effect for the 10 Diagnostic Related Groups (DRGs) with the highest rates of discharge.

  - The BBA requires HCFA to implement a prospective payment system (PPS) for hospital outpatient departments. HCFA has published a proposed rule outlining the new system and has solicited comments. HCFA estimates that under the proposed hospital outpatient PPS, certain hospitals will experience a relatively large loss in payments. As an example, rural hospitals are estimated to lose more than 15 percent, teaching hospitals with more than 100 residents are estimated to lose approximately 10 percent, and cancer hospitals are anticipated to lose over 30 percent. These impacts are illustrative and are overstated due to coding issues.

  - We are evaluating the many comments we received on the rule and in response, we are planning to provide a limit on losses relative to a each hospital's current payment and cost experience with outpatient services. This transition policy will be implemented for 3 years, with the limit gradually declining each year. Since HCFA does not have the statutory authority to use new money for this purpose under current law, this policy will be funded on a budget neutral basis across all hospitals.

- In addition, with respect to the outpatient hospital PPS, we are not planning to implement the "volume control mechanism" in the first few years of the new system. The law required Medicare to develop such a mechanism because prospective payment includes incentives that can lead to unnecessary increases in volume. However, we believe that delaying the implementation will provide an adjustment period for providers as they become accustomed to the new system.

- We are also proposing to use our administrative authority to make it easier for rural hospitals to reclassify to urban areas. Right now, facilities can obtain reclassification if the wages they pay their employees are at least 108 percent of average wages in their rural are, and least 84 percent of average wages in a nearby urban area. We are planning to change these percentages to ease the restrictions on reclassification.

- The President's plan would create a set-aside stream of funding to be used to make appropriate and justified modifications to BBA policies. This set-aside, totaling $x billion over ten years, is funded in the context of the entire reform plan, but its uses are not specified. We want to work with Congress, Congressional advisory commissions, provider and beneficiary groups to determine what policies would best address specific problems in a fiscally responsible way.

- In addition to working with Congress to identify possible legislative changes, the plan includes a specific legislative proposal to carve out Disproportionate Share Hospital (DSH) payments to managed care and have Medicare make DSH payments directly to hospitals on behalf of managed care enrollees.

- The plan does build on the BBA, by including moderated provider payment reduction policies beginning in 2003 through 2009. These policies will help preserve and protect Medicare for the future and extend the life of the trust fund.

- The President's plan does not include further reductions to DSH or graduate medical education payments to hospitals.

- The BBA includes a 2.1 percent reduction in reimbursement for PPS hospital capital costs in FY 2002. We are proposing to include a 1 percent reduction in reimbursement for PPS hospital capital costs from FY 2003 through FY 2009.

- The plan extends and modifies the BBA reductions to the PPS hospital updates. We are proposing a different hospital update for rural hospitals than urban hospitals. Specifically our proposal includes payment updates for inpatient rural hospitals of market basket minus 0.5 percentage points in FY 2003, and would increase the percentage point reduction by an additional 0.6 percentage points each year until the same update applies for rural and urban hospitals.

- The plan extends a two BBA provisions affecting PPS-exempt hospitals. It extends from fiscal year 2003 through fiscal year 2009 the reduction in rate increases based on the relationship between a hospital's operating cost and its target amount. The plan also extends for the same time period the 15 percent reduction in reimbursement for PPS-exempt hospital capital costs.

- In addition to payment reforms, the President's plan includes a strategy for modernizing management of the Medicare program by bringing private sector expertise to the Health Care Financing Administration.

- The plan includes a strategy to assess HCFA's personnel needs and plans to submit legislation to waive some Federal personnel rules to ensure the proper expertise, if warranted.

- The plan also includes a number of public/private advisory bodies to make the decision-making process more open and to allow HCFA to benefit from private sector expertise in the important areas of overall management, Medicare coverage policy, and the Medicare beneficiary education campaign.

- Finally, the plan includes a strategy to re-engineer the relationship between HCFA's central and regional offices to ensure improved communication and consistent application of policies nationwide.

Provider Group: Rural Hospitals

- The President's Medicare plan is designed to strengthen and protect Medicare for the future. It will ensure adequate financing of the program and extend the life of the Trust Fund, include a new prescription drug benefit, and give Medicare the ability to use private sector purchasing tools to better manage the program.

- The plan achieves these goals without imposing new provider cuts during the time where the BBA cuts are currently in effect. The plan does not include savings from provider payment updates until 2003.

- In addition to the drug benefit and other important program reforms, the President's plan includes a number of time-limited administrative actions we will take to smooth the implementation of some of the more severe provisions of the BBA.

- These changes will help ensure beneficiary access to quality care while maintaining the discipline of the BBA that is essential to protecting Medicare's future. We are making a number of changes to lessen the impact of the BBA on hospitals. For example:

  - We are proposing to make it easier for rural hospitals to reclassify to urban areas. Right now, facilities can obtain reclassification if the wages they pay their employees are at least 108 percent of average wages in their rural are, and least 84 percent of average wages in a nearby urban area. We would like to change these percentages to ease the restrictions on reclassification.

  - The BBA gave the Secretary of HHS the authority to extend the transfer policy to additional diagnoses after October 1, 2000. We are proposing to postpone the extension of the transfer policy to additional diagnoses.

  - HCFA estimates that under the proposed hospital outpatient PPS, low volume rural hospitals will experience a loss in payments for outpatient services of approximately 17.4 percent. However, we believe that this impact analysis is overstated due to coding issues.

  - Nevertheless, we are planning to provide a limit on losses relative to a each hospital's current payment and cost experience with outpatient services. This policy will be implemented for 3 years, with the limit gradually declining each year. Although we are still working out the technical details of this proposal, we anticipate that this policy should help low-volume rural hospitals. Since there is no authority to use new money for this purpose, this policy will be funded on a budget neutral basis across all hospitals.

- In addition, with respect to the outpatient hospital PPS, we are not planning to implement the "volume control mechanism" in the first few years of the new system. The law required Medicare to develop such a mechanism because prospective payment includes incentives that can lead to unnecessary increases in volume. However, we believe that delaying the implementation will provide an adjustment period for providers as they become accustomed to the new system.

- The President's plan would create a set-aside stream of funding to be used to make appropriate and justified modifications to BBA policies. This set-aside, totaling $x billion over ten years, is funded in the context of the entire reform plan, but its uses are not specified. We want to work with Congress, Congressional advisory commissions, provider and beneficiary groups to determine what policies would best address specific problems in a fiscally responsible way.

- The President's plan also includes a proposal to carve out DSH payments to managed care and have Medicare make DSH payments directly to hospitals on behalf of managed care enrollees.

- The plan does build on the BBA, by including moderated provider payment reduction policies beginning in 2003 through 2009. These policies will help preserve and protect Medicare for the future and extend the life of the trust fund.

- We are proposing a different hospital update for rural hospitals than urban hospitals. Specifically our proposal includes payment updates for inpatient rural hospitals of market basket minus 0.5 percentage points in FY 2003, and would increase the percentage point reduction by an additional 0.6 percentage points each year until the same update applies for rural and urban hospitals.

- The BBA includes a 2.1 percent reduction in reimbursement for PPS hospital capital costs in FY 2002. We are proposing to include a 1 percent reduction in reimbursement for PPS hospital capital costs from FY 2003 through FY 2009.

- In addition to payment reforms, the President's plan includes a strategy for modernizing management of the Medicare program by bringing private sector expertise to the Health Care Financing Administration.

- The plan includes a strategy to assess HCFA's personnel needs and plans to submit legislation to waive some Federal personnel rules to ensure the proper expertise, if warranted.

- The plan also includes a number of public/private advisory bodies to make the decision-making process more open and to allow HCFA to benefit from private sector expertise in the important areas of overall management, Medicare coverage policy, and the Medicare beneficiary education campaign.

- Finally, the plan includes a strategy to re-engineer the relationship between HCFA's central and regional offices to ensure improved communication and consistent application of policies nationwide.

Provider Group: Teaching Hospitals

- The President's Medicare plan is designed to strengthen and protect Medicare for the future. It will ensure adequate financing of the program and extend the life of the Trust Fund, include a new prescription drug benefit, and give Medicare the ability to use private sector purchasing tools to better manage the program.

- The plan achieves these goals without imposing new provider cuts during the time where the BBA cuts are currently in effect. The plan does not include savings from provider payment updates until 2003.

- In addition to the drug benefit and other important program reforms, the President's plan includes a number of time-limited administrative actions we will take to smooth the implementation of some of the more severe provisions of the BBA.

- These changes will help ensure beneficiary access to quality care while maintaining the discipline of the BBA that is essential to protecting Medicare's future.

- The President's plan also includes a proposal to carve out DSH payments to managed care and have Medicare make DSH payments directly to hospitals on behalf of managed care enrollees.

- The BBA gave the Secretary of HHS the authority to extend the transfer policy to additional diagnoses after October 1, 2000. We are proposing to postpone the extension of the transfer policy to additional diagnoses.

- HCFA estimates that under the proposed hospital outpatient PPS, teaching hospitals with more than 100 residents will experience a loss in payments for outpatient services of approximately 10.6 percent. However, we believe that this impact analysis is overstated due to coding issues.

  Nevertheless, we are planning to provide a limit on losses relative to a each hospital's current payment and cost experience with outpatient services. This policy will be implemented for 3 years, with the limit gradually declining each year. Although we are still working out the technical details of this proposal, we anticipate that this policy will help teaching hospitals. Since there is no authority to use new money for this purpose, this policy will be funded on a budget neutral basis across all hospitals.

- In addition, with respect to the outpatient hospital PPS, we are not planning to implement the "volume control mechanism" in the first few years of the new system. The law required Medicare to develop such a mechanism because prospective payment includes incentives that can lead to unnecessary increases in volume. However, we believe that delaying the implementation will provide an adjustment period for providers as they become accustomed to the new system.

- The President's plan would create a set-aside stream of funding to be used to make appropriate and justified modifications to BBA policies. This set-aside, totaling $x billion over ten years, is funded in the context of the entire reform plan, but its uses are not specified. We want to work with Congress, Congressional advisory commissions, provider and beneficiary groups to determine what policies would best address specific problems in a fiscally responsible way.

- The plan does build on the BBA, by including moderated provider payment reduction policies beginning in 2003 through 2009. These policies will help preserve and protect Medicare for the future and extend the life of the trust fund.

- The BBA includes a 2.1 percent reduction in reimbursement for PPS hospital capital costs in FY 2002. We are proposing to include a 1 percent reduction in reimbursement for PPS hospital capital costs from FY 2003 through FY 2009.

- In addition to payment reforms, the President's plan includes a strategy for modernizing management of the Medicare program by bringing private sector expertise to the Health Care Financing Administration.

- The plan includes a strategy to assess HCFA's personnel needs and plans to submit legislation to waive some Federal personnel rules to ensure the proper expertise, if warranted.

- The plan also includes a number of public/private advisory bodies to make the decision-making process more open and to allow HCFA to benefit from private sector expertise in the important areas of overall management, Medicare coverage policy, and the Medicare beneficiary education campaign.

- Finally, the plan includes a strategy to re-engineer the relationship between HCFA's central and regional offices to ensure improved communication and consistent application of policies nationwide.

Provider Group: Managed Care Plans

The President's Medicare plan is designed to increase competition within the Medicare program by:

Giving HCFA additional private sector purchasing tools that will allow it to become a more prudent purchaser of health care, and

Introducing price competition into the Medicare+Choice program so that both beneficiaries and Medicare can reduce the amount they pay for benefits provided by Medicare+Choice plans.

These changes will help ensure beneficiary access to quality care while maintaining the discipline of the BBA that is essential to protecting Medicare's future.

Under the President's plan, Medicare+Choice plans would annually submit premium bids for the cost of providing Medicare services. Medicare would pay each plan based on the plan's bid relative to Medicare fee-for-service costs:

For plans that bid at the Medicare fee-for-service level, Medicare would pay 85 percent of the plan's premium and the beneficiary would pay the remainder.

For plans that bid lower than the Medicare fee-for-service level, beneficiaries would get 75 percent of the savings from the lower bid and Medicare would get 25 percent of the savings. This arrangement gives beneficiaries financial incentives to choose more efficient plans.

For plans that bid above the Medicare fee-for-service level, Medicare would pay 85 percent of the Medicare fee-for-service cost in the area toward the plan's premium and the beneficiary would pay the remainder.

The President's new payment structure for the Medicare+ Choice program will be fairer to beneficiaries, Medicare+Choice plans and Medicare.

Beneficiaries will be able to reduce their Part B premiums by choosing more efficient health plans. Efficient Medicare+Choice plans will be able to provide the guaranteed Medicare benefits plus lower cost sharing for a premium below the current Part B premium. Beneficiaries who today are receiving additional benefits from their Medicare+Choice plans can continue to do so, by using some of their Part B savings to purchase supplemental benefits from their Medicare+Choice plan.

The new payment plan also addresses many of the concerns raised by Medicare+Choice plans about the current payment arrangement. The new arrangement:

Relies on competitive bidding rather than administered pricing. Plans will be able to bid whatever premium they feel is appropriate for the Medicare benefits, capped at 97 percent of Medicare fee-for-service costs. This "cap" is higher than the effective payment level for Medicare+Choice plans today. Under this new system, efficient plans will be able to offer more choices of savings and additional benefits to beneficiaries than they do today.

Restores full geographic adjustment in higher cost areas while retaining enhanced payment rates in lower-cost areas. Under the current system, payment rates in historically higher cost areas have been reduced so that rates in lower-cost areas can be enhanced. These "blended" rates have reduced the amounts available in urban and other higher-cost areas, with rates often increasing at only 2 percent per year.

Adds a prescription drug benefit to the defined Medicare package for all beneficiaries, including beneficiaries in Medicare+Choice plans. Including drugs as a Medicare benefit will mean that plans will receive a higher payment from Medicare for providing drug coverage. Due to rising drug costs, plans recently have expressed concern that they may not be able to continue to provide drug coverage under the current Medicare+Choice payment arrangement. The payment arrangement will assure that plans will be able to continue to provide a basic drug benefit. Plans also will be able to offer to supplement the Medicare defined drug benefit if they wish to do so.

Bases the level of payment to Medicare+Choice plans on the fee-for-service costs in each area. This assures that the payments available to Medicare+Choice plans will incease as fast as Medicare fee-for-service (many areas are now seeing payments increasing at only 2 percent per year).

In addition to payment reforms, the President's plan includes a strategy for modernizing management of the Medicare program by bringing private sector expertise to the Health Care Financing Administration.

The plan includes a strategy to assess HCFA's personnel needs and plans to submit legislation to waive some Federal personnel rules to ensure the proper expertise, if warranted.

The plan also includes a number of public/private advisory bodies to make the decision-making process more open and to allow HCFA to benefit from private sector expertise in the important areas of overall management, Medicare coverage policy, and the Medicare beneficiary education campaign.

Finally, the plan includes a strategy to re-engineer the relationship between HCFA's central and regional offices to ensure improved communication and consistent application of policies nationwide.

Tricia Smith
202 434
3770
#ARD

DRAFT: June 24, 1999

Medicare Reform Rollout

CHRONOLOGICAL ORDER BY DATE

Tuesday, June 22, 1999

5:00 pm	**Labor – Retirement Benefit Meeting**	**Chris Jennings**
Room 476	Gerry Shea, AFL/CIO	Gene Sperling (drop by)
	David Blitztein, UFCW	Jean Lambrew
	Jeff Gibson, 1199 New York	Karen Tramontano (drop by)
	David Hirschland, UAW	Gary Claxton
	Steve Sleigh, Machinists	Mark McClellan,Treas. (?)
	Carol Regan, SEIU	Barbara Woolley
	John Abraham, AFT-	
	Marie Monrad, AFSCME	
	Louise Novotny, CWA	
	Jim Ray, Buildings and Const Trades Dept.	

Wednesday, June 23, 1999

12:00 pm	**American Hospital Association**	**John Podesta**
	Dick Davidson, President and CEO	Gene Sperling (if available)
	Rick Pollack, Vice President	Mary Beth Cahill/B. Woolley
	Tom Nichols, Vice President	Jack Lew/Dan Mendelson
	Disability Groups	**Gene Sperling**
	4:30 Roosevelt Room	Jonathan Young

Thursday, June 24, 1999 Proposed Meetings

11:00am	**Catholic Health Assn.**	**John Podesta**
Johns Office	Rev. Michael Place, CEO	Chris Jennings
	Jack Bresch, Vice Presi, Gov. Relations	Mary Beth Cahill
	Fish Brown, Vice Presi for Policy	Barbara Woolley
	Michael Conley, Chair, OH	

2:30 pm **Room 211**	**Pharmacists** National Community Pharm Assn, John Rector Nat Assn. Of Chain Drug Stores, Larry Calcott	**Chris Jennings** Dan Mendelson Gary Claxton Jean Lambrew Bonnie Washington Barbara Woolley
12:00 PM **Room 216**	**National Assn For Public Hospitals** **Larry Gage** **Lynn Fagnini**	**Chris Jennings** Barbara Woolley **Dan Mendelson**
Thur 2:30	**Women's Groups** Older Women's League Alzheimer's Assn. AAUW	**Gene Sperling** Jenny Luray Barbara Woolley

Friday, June 25, 1999 **Proposed Meetings**

6:00pm **Rm 180**	**American Health Care Association** (Nursing Homes) David Seckman, President Bruce Yarwood Dan Mosca Steve Guillard Vic Fazio	**Steve Ricchitti** Chris Jennings Mary Beth Cahill/B. Woolley Dan. M.
3:30 pm **Room 180**	**American Association of Medical Colleges** (Teaching Hospitals) Jordan Cohen, President Ralph Muller, Chicago, Chair Dick Knapp Tom Glynn, CEO, Partners Health Care System Michael Collins David B Skinner (NY) Jerry Klepner (Black, Kelly, Scruggs & Healey)	**Steve Ricchitti** Mary Beth Cahill/B. Woolley Chris Jennings Dan Mendelson Neera Tanden
5 PM BIOTECH **Rm. 180**	Bruce Carroll Jr, Govt. Relations Carl Feldbaum, Pres of BIO David Holveck, CEO, Centocor Inc. Walter Moore, VP Gove. Relations, Genentech	**John Podesta** Dan Mendelson Chris Jennings David Beier

Nancy Myers, Fed. Govt Relations, BIO
Rita Norton, Dir. Of Govt. Relations, AMGEN
Lisa Raines, VP Govt. Relations, Genzyme
Mark Skaltesky, Pres and CEO, GelTex Pharmaceuticals

1:30 pm **Rm 180**	**National Association for Home Care** Val Halamandaris, President Theresa Forester Jeff Kincheloe	**Steve Ricchetti** Chris Jennings Dan M. Barbara Woolley
9☺0 Conf Call 456-6755 ext. 5237	**Corporates** Larry Atkins, Nat. Health Care Lobbyist Rep. Corporate Org.	**Chris Jennings** Mary Beth Cahill Dan M. Jay Dunn Mark McClellan Gary Claxton

Monday, June 28, 1999 **Proposed Meetings**

10 AM	**PhRMA** Amgen, Chair of PhRMA Merck **SmithKline** PhRMA Staff	**Dan M.** **David Beier** **Chris Jennings**
11 AM	**American Medical Association**	**Chris Jennings** Barbara Woolley Dan Mendelson
	AFL/CIO (	**John Podesta** **Gene Sperling** Mary Beth Cahill Chris Jennings Karen Tramontano
	Pharmacists [if committed to strong support] National Community Pharm Assn, John Rector	Chris Jennings Dan Mendelson

Nat Assn. Of Chain Drug Stores, Larry Calcott	Jean Lambrew Bonnie Washington Barbara Woolley
American Assn for Health Plans Karen Ignangi, President	**Gene Sperling?** Dan M. Chris Jennings Gary Claxton
HIAAA Chip Kahn, CEO	**Gene Sperling?** Jack Lew? /Dan M. Chris Jennings Gary Claxton

CALLS TO VALIDATORS MONDAY EVENING

AARP– Horace Deets, John Rother, Kevin Donnellen	**Gene Sperling** Chris Jennings Mary Beth Cahill
Leadership Council on Aging **Disability Groups** **Women's Groups**	Chris Jennings/B. Woolley Chris Jennings/J. Young Gene Sperling/J. Luray/B. Woolley

MIDSESSION REVIEW AND MEDICARE ROLLOUT

Midsession Review

Sunday Evening

- Gene, Jack and Larry to brief House and Senate Budget Committee Staff (Tom Kahn, Sue Nelson, Bruce King) and Leadership Staff on a conference call.
- Gene, Jack and Larry to brief Daschle and Gephardt.
- Gene, Jack and Larry to call Lautenberg, Obey, Spratt.

Monday

- 8:30 am – Gene, Jack and Larry to brief the House Budget Committee and Ways and Means on a conference call. (Should these be separate or together)
- 9:00 am – Gene, Jack and Larry to brief the Senate Budget Committee and selected Members of the Senate Finance Committee on a conference call. (Should these be separate or together)
- Jack and Larry to call Conrad and Domenici (separately).
- Gene and Larry to call Pomeroy.

Please note – Gene suggested that we have a story embargoed w/ the AP until the end of the briefings. (Based on this proposal, I guess 9:00am or 9:30am)

Based on the POTUS' schedule, at this time it appears as if the midsession announcement may be at 8:30am. Larry thinks that this is untenable and suspects that the time will change.

Medicare Rollout

Sunday

- Conference call w/ Andi King (Gephardt) and Jane Lowenson (Daschle).
- Joel to talk to Elmendorf

Monday

- Conference call to Democratic Health Staff

- Calls to be divided among:

Podesta, Ricchetti, Rubin, Shalala, Sperling, Lew, Stein, Jennings

Rangel
Dingell
Stark
Waxman
Cardin
Sherrod Brown
Tanner
Stenholm
Spratt
Allen
DeLauro
Frost
Pomeroy

Moynihan
Kerrey
Graham
Breaux
Kennedy
Rockefeller
Conrad

Tuesday

POTUS event scheduled from 2:15pm – 3:30pm.

Calls to R's after the announcement, including:

First Tier
Chafee
Domenici (Lew or Stein)

Roth (Rubin)
Hastert (Podesta)
Bilirakus
Thomas

Second Tier
Grassley
Jeffords
Snowe
Collins

Wednesday

Bipartisan Staff mtg on House and Senate sides

DRAFT

President Clinton's Plan To Modernize and Strengthen Medicare:
Communications Rollout Plan:
June 23, 1999

The purpose of this document is to spell out our Medicare rollout strategy and the key tasks that must be completed before, during and after the announcement of the President's Medicare proposal on Tuesday, June 29th.

Goals:

- Establish the President's proposal to reform and strengthen Medicare as a credible and substantive plan with lawmakers, reporters, opinion makers and elites.
- Communicate directly to the American people that the President's proposal benefits them through non-national media, including: daytime television, regional newspapers, radio, constituency groups/publications and the internet.
- Mobilize key constituency groups in support of meaningful reform to communicate their support for the proposal and affect its adoption.

Administration Briefers:

It has been suggested that each briefing be conducted by a team of three people, to be composed of one person from the Economic Team, one person from the Health Care Team and one Senior White House staff person. These teams can be drawn from the following people:

Senior White House Staff: Podesta; Ricchetti; Stein; Johnson
Economic Team: Rubin; Sperling; Lew; Mathews
Health Care Team: Shalala; Thurm; Jennings; DeParle

Administration Officials to Book for Interviews:

John Podesta, Bob Rubin, Gene Sperling, Donna Shalala, Ann Lewis

Friday, June 25th

Late Afternoon/Evening Hill Briefing – Daschle/Gephardt Health Staffers:

Jennings goes to Hill Friday to brief top health care staffer for Sen. Daschle and Minority Leader Gephardt. (No paper.)

Sunday Shows (?):

Based on early coverage, decide whether to book Administration officials on Sunday shows to do curtain raiser on Medicare.

Monday, June 28th

POTUS – Mid-Session Review Event:

Announcement of Mid-Session Review and new surplus numbers.

Constituency Calls:

Sperling:
Max Richmond and Martha McSteen, Natl. Cmte. to Preserve Soc. Security and Medicare
Horace Deets, AARP

Sperling or Thurm:
Conference calls with seniors, disabled and women's groups.

Evening Hill Briefing – Key Committee Staff:

Jennings goes to Hill to brief key staffers on Ways & Means, Commerce, Finance & Health committees.

Tuesday, June 29th

Television:

Morning TV: Book Shalala, Sperling and other Administration officials on network morning shows, and early cable news segments
Daytime Cable News: Reach John King and others to shape early news stories. Book Rubin, Shalala, Podesta, Sperling, Lewis and others on key daytime cable news programs/segments. (depends on early coverage…)
Network Anchor Calls: Podesta (?) calls the three network anchors to shape Tues. evening news and Wed. morning news.
Financial News Shows: Book Secretary Rubin on Financial news programs.
Evening/PM TV: Book Administration officials on network news; the Newshour; and cable news programs (Larry King; other?).

Radio:

Morning Radio: Someone from WH does 2 minutes with NPR early am
Actualities: Rubin for financial programs (?); Shalala
Roundtable Give radio networks chance to get better sound at separate briefing in Roosevelt Room between 10:30 and 11:00?

Internet:

Have full plan and paper on the White House web site to be available as the 2:30 event begins.

White House Briefings:

6:00am **Conference or Individual Calls to Major Health Care Reporters**

Jennings (and Sperling?) do either a conference call or individual calls to major health care reporters. EMBARGOED UNTIL 10:00 A.M.

Reporters:Laurie McGinley, WSJ; Alissa Rubin, LAT; Laura Meckler, AP; Susan Page, USA Today; Amy Goldstein, Wash. Post; Robert Pear, NYT

7:00am-11:00am **Individual Calls To Key Validators**

Sperling/Lew/Jennings divide up a list of key economic/budget/health care experts to call.

Validators:	Karen Davis	Robert Reischauer
	Diane Rowland	Uwe Reinhardt
	Ken Thorpe	Marilyn Moon
	Laura Tyson	Judy Feder
	Stuart Altman	Bruce Vladek

[NOTE: Should Secretary Rubin call 3-5 financial/Wall Street type validators?]

9:00am-11:00am **Calls to Key 15-20 Senators and Members of Congress (Chief of Staff's Office)**

Podesta and Stein, along with someone from both the economic and health care team make calls to key 15-20 Senators and Members of Congress – or calls are slit up among different sub-teams.

10:00 a.m. **Briefing in White House briefing room conducted by Jennings and Sperling to explain proposal to White House reporters.**
ON THE RECORD, NOT FOR BROADCAST

10:00am-10:20am **Communications Talkers Conference Call (Loretta's Office)**

Loretta hosts conference call with regular, weekly in-town Democratic friends with someone from below the first tier from the Health or Economic Team.

11:00am **One Large Briefing for Key Constituency Groups**

(Room 450)

Jennings/Thurm/Matthews brief key groups invited by OPL in Room 450 briefing.

12:30 p.m. **Roosevelt Room briefing for Pundits.**
Conducted by a team consisting of a Senior White House staff person, someone from the Economic Team and someone from the Health Care Team.

2:30pm **Rose Garden POTUS Event**

TBD AFTER Event **Regular White House Briefing –**
Tier One Team Briefs White House Press Corps

Briefing by Podesta/Rubin/Shalala/Sperling

After Event **Editorial Board Calls**

Rubin calls Weinstein (NYT)
Sperling calls Milius (Washington Post)
Shalala calls LA Times and USA Today

After Event **Political/Intergovernmental Calls (?)**

Wednesday, June 30

- **Possible POTUS interview on way to Chicago.**
- **Prescription Drug Event in Chicago**
- **Daytime T.V.:** Book Shalala on daytime television to communicate to America how the President's Medicare proposal will help them (i.e. Rosie O'Donnell?).
- **Reach Magazine Writers and Columnists:** Calls to key magazine reporters and columnists by Podesta, Sperling and others.

  Magazines: Time, Newsweek, U.S. News, Business Week

  Columnists: Gerry Seib, Robert Samuelson, Bob Herbert, E.J. Dionne, Maureen Dowd

- **Radio**

HHS to book national and regional talk shows.

Shalala/DeParle to do syndicated shows: NPR's Diane Rehm, Dr. Dean Edell; The Joan Hamburg Show, and the Dr. Terry Mason Show. Regional radio to include: the Michael Jackson Show in LA; the Paul W. Smith Show in Detroit; WINZ-AM in Miami; WISN and WTMJ in Milwaukee and WTDY-AM in Madison.

- **Specialty Press**

  Conference calls/mailings with seniors, women's and minority press. (Beverly Barnes to coordinate).

  Target publications with high seniors readership, i.e. Modern Maturity.

- **Satellite Feeds:** Set up satellite interviews for Shalala into targeted markets for next two days.

- **Roundtable with Key Constituency Groups:**

- **Regional Editorial Boards:** Calls and mailings to the major regional editorial boards, including markets with high seniors population. (Beverly Barnes)

  HHS: conference calls into the following sta tes: New York, Florida, Connecticut, Michigan, Maine, Los Angeles, North Dakota, Iowa, Nevada, Indiana, New Jersey, Wisconsin, Ohio, Tennessee and Idaho.

- **Op-eds:** Coordinate Op-eds from validators in national papers, and seniors publications, through end of week and regional press during week of July 5.

- **Online-Interviews:** Set up 2-3 Internet interviews with Jennings/Sperling on CNN/MSNBC websites.

Thursday, July 1

- **Sperling at Sperling Breakfast** to explain plan and set up Sunday shows.

- **Continue Satellite Feeds:** Satellite interviews for Shalala into targeted markets.

Friday, July 2

- **USA Today Interview with Admin Rep TBD** perhaps on Rx drugs.
  This will be the 4th of July weekend edition, one of the most read editions.

of the year.

Possible interview with Shalala and her mother for "real person" view of how the President's proposal helps Americans.

Sunday, July 3

- **Medicare Team back on Sunday shows.**

June 19, 1999

TO: Gene
FROM: Jeanne and Chris
RE: **PAPER FOR MEDICARE ROLL-OUT**

On this page, we have outlined the full list of document that we are intending on produce (with luck and little sleep) by mid-week. We are thinking that we probably need to give principals paper / begin briefing them by the end of the week, so we have a lot of work to do.

The rest of this document is what we are calling the master document. It is a detailed description of all the policies in the plan. We are still working on the hard ones – competition, drugs, provider savings policies – but will have drafts by Sunday night. We also are hoping to get to you the press paper sooner than later, since it frames the other documents.

PAPER

- Press paper
- Walk-through document
- Master document/Detailed policy descriptions
- Improvements for beneficiaries
- Competition paper
- Trust Fund / surplus paper
- Drug benefit paper
- Comparison to Breaux-Thomas (one-page table)
- Rural paper
- Women
- Provider group paper (internal)

CJ + LB

I have read entire document. I have many questions and need 10th of brief -- but one severe point is that we will need good explan on Traditional fee-for-ser reforms with billing format.

1) Good health policy + savings
2) Private sector does it + saves ____ and helps Beyond
3) Medicare can't ... now it can ...

6/20/99

- Q and a (internal)

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I. MAKING MEDICARE MORE COMPETITIVE AND EFFICIENT

1. Managed Care Reform: Competitive Defined Benefit [in progress]

2. Private Sector Purchasing Tools for Traditional Medicare

[note: disease management, quality section being added]

Overview. As a result of aggressive policies to make Medicare more efficient and reduce fraud, Medicare spending growth per beneficiary is now at or below that of the private sector. In the past decade, however, private health care purchasers have developed a variety of techniques that appear to be successful at maximizing value by controlling costs and increasing quality of care. These newer *tools* include competitive pricing, negotiation, selective contracting, and utilization management. Additionally, private payers have developed new *applications* of existing practices, such as preferred provider arrangements, targeted prior authorization, disease management, and various forms of bundled payments. Flexibility to customize an approach and choose among these tools and applications would maximize Medicare's ability to achieve high value under the traditional program.

In contrast to other public and private purchasers of health care, Medicare lacks the necessary flexibility to adopt these practices. External groups, including the National Academy for Social Insurance, have called for HCFA to be given greater flexibility to use these tools and applications in Medicare. Similarly, the Bipartisan Commission on the Future of Medicare considered various strategies for modernizing traditional Medicare. In addition, HCFA, through demonstrations and in some legislative proposals, has been exploring for several years the possibility of greater flexibility in how Medicare might pay providers and health plans.

A common theme in the policies included in this plan is "targeting" both beneficiaries and providers who can benefit from these new tools and applications. Targeting high-cost beneficiaries with appropriate interventions will lead to better quality of care, as well as yield savings. Targeting efficient, high-quality providers to encourage and reward preferred behaviors can have similar effects. Some of the proposals also involve targeting specific areas of the country where certain approaches are most appropriate (e.g., choosing one aspect of the modernization program but not another), or where there is the greatest likelihood of an immediate impact in terms of potential savings and improved quality of care. Implementation of these proposals is also likely to be staged by geographic area, with implementation beginning in areas in which there have historically been unexplained higher health care costs than other areas.

All of the policies listed below would be effective on January 1, 2001, and would save a combined total of $XX billion over 10 years.

a. Competitive and negotiated pricing authority [note: check w/ HCFA – not best price, right?]

Policy: This proposal would authorize use of either competitive bidding or price negotiations to set payment rates for Part B items and services (except for physicians' services). DHHS would have the authority to select both the items and services and the geographic areas to be included in a bidding or

negotiation process based on the availability of providers and the potential for achieving savings. Bids would be accepted only if the providers met specified quality standards. DHHS also would have the authority to selectively contract only with providers who accept negotiated or bid prices and other contract terms.

Under this proposal, DHHS also would be given the authority to negotiate alternative flexible purchasing administrative arrangements with providers and suppliers who either: (1) agree to provide price discounts to Medicare, or (2) should be recognized for better performance. The administrative arrangements could include such incentives as alternative claims processing, administrative and related procedures. The use of the special administrative arrangements could be targeted to those areas where market competition in the area makes other arrangements common. In general, before an alternative arrangement went into place, DHHS would have to certify that the arrangement would achieve program savings either as a result of the discounts, or as a result of encouraging beneficiaries to utilize provider and suppliers that have been identified as meriting special administrative treatment because of their demonstrated appropriate utilization practices.

Background/rationale: Under current law, payment for items and services is based on statutorily prescribed payment amounts or fee schedules. Any provider or practitioner that meets Medicare's conditions of participation is eligible to receive payment for items and services provided to Medicare beneficiaries. Other purchasers of health care have successfully used competitive processes and negotiation to establish payment rates and assure high quality of items and services. HCFA, under provisions of the Balanced Budget Act, is currently in the process of testing competitive bidding processes for durable medical equipment and is planning to also test a competitive process for procuring laboratory services.

In addition, DHHS currently has no authority to modify administrative procedures for selected individual providers or suppliers. Private sector payers can negotiate various discount arrangements with specific entities in exchange for providing administrative incentives or can use administrative incentive to reward for better performance.

b. Innovative pricing for certain procedures, conditions, services or sites

Policy: This proposal would authorize DHHS to provide a single, global payment to combinations of selected practitioners, providers and suppliers for all care delivered at:

- Specific site of service (e.g., all physicians' and hospital services delivered in the hospital setting, or all professional and facility services delivered in partial hospitalization programs; or for
- Specific conditions or needs of an individual (e.g., diabetes, congestive heart failure, frail elderly, cognitively or functionally impaired, need for DME).

Practitioners, providers, and suppliers would be selected based on their ability to provide services more efficiently, to improve coordination of care (e.g., disease management, case management), or to offer additional benefits to beneficiaries (e.g., respite care, nutritional counseling, adaptive and assistive equipment, transportation). In any area where suppliers or providers are selected to be paid on a global basis, Medicare could limit the number of entities paid through the global payment arrangement, even if

other entities would otherwise be eligible for the global payment arrangement. Within the global payment, providers would have flexibility both in how services are provided and in financing additional, non-covered benefits through the global payment. Global payment arrangements would be entered into only if overall program savings are anticipated, when compared to what program payments would have been in the circumstances (e.g., for the episode of care, for the beneficiaries in question) in the absence of global payments.

In the case of global payments made for services delivered in a specific site, the payment would cover the episode of care at the site of service. For global payments made on the basis of beneficiary conditions, beneficiaries would voluntarily elect to participate in such arrangements for a defined period.

This proposal would also provide the authority to conduct demonstration projects to evaluate disease management for high-cost, chronic diseases. The Secretary would have the authority to determine appropriate accreditation standards for disease management vendors, who would provide (or subcontract to provide) services including patient screening and assessment, review of medications, patient education, telephone consultations, physician interaction, home nursing visits, and surveillance and reporting. To minimize fragmentation of care, HCFA would have the authority to require single vendors to provide disease management for related comorbidities (e.g., congestive heart failure, hypertension, coronary artery disease, and diabetes). Prospective vendors would bid competitively for contracts. Patients would enroll voluntarily and would have the right to disenroll at any time. HCFA would have the authority to require vendors to be at risk for savings of 5 to 10 percent in total medical spending (after correcting for risk selection and accounting for management fees) for the given diagnoses and to structure the payment provisions accordingly. HCFA would also have the authority to require vendors to guarantee certain patient satisfaction and quality of care outcomes. The demonstration projects would serve to evaluate the impact of disease management on quality, patient satisfaction, and costs, as well as to establish payment benchmarks for future projects.

Background/rationale: DHHS currently has no authority to modify FFS payment arrangements to reflect the combinations of services that are provided to beneficiaries in certain care settings or for certain conditions. This lack of flexibility is in sharp contrast to the ability that other payers have to negotiate various arrangements with specific entities, and the recent developments in the private sector to target certain high cost health conditions for special coordinated care delivery and structure payment accordingly. Private-sector disease management vendors indicate they are achieving savings of 20 to 50 percent (before fees) for selected high-cost, chronic diseases, and have begun to guarantee improvement in patient satisfaction and clinical outcomes, as well as cost savings.

c. Single payment for procedures or medical conditions

Policy: This proposal would create a Centers of Excellence program as a permanent part of Medicare. It would authorize the Secretary to pay competitively selected facilities a single bundled rate for all services, potentially including post-acute services, associated with a surgical procedure or hospital admission related to a medical condition. Beginning in 2001, the Secretary would establish Centers of Excellence throughout the Nation for coronary artery bypass grafts (CABG) and other heart procedures, knee replacement surgery and hip replacement surgery. The Secretary would also specify other appropriate procedures and conditions in which Centers of Excellence would be sought. As with the CABG demonstration, selected facilities would have to meet special quality standards and would be

required to implement a quality improvement plan. The single rate paid to a Center for a particular procedure or admission can not exceed the aggregate amount that would otherwise be made in order to produce overall savings to the Medicare program.

Medicare would not be required to contract with an entity, even if it otherwise met program standards, if there were already enough Centers of Excellence in that geographic area to meet projected demand. Facilities would retain the Center of Excellence designation for a three-year period as long as they continued to meet quality standards. Experience with the demonstration indicates that the designation as a Center has a "spill-over" benefit for the participant's non-Medicare business. Beneficiaries would not be required to receive services at Centers, but Centers would be allowed to provide additional services (such as a private room) or reduce/waive cost sharing to attract beneficiaries. Any beneficiary incentives would have to be approved by the Secretary. It is estimated that about 20 percent of beneficiaries would use Centers of Excellence under this plan.

Background/rationale: From 1991-1998, HCFA conducted a demonstration through which certain facilities, referred to as Centers of Excellence, were paid a single fee to provide all of the facility, diagnostic and physicians' services associated with coronary artery bypass graft (CABG) surgery. The facilities were selected on the basis of their outstanding experience, outcomes, and efficiency in performing these procedures. Medicare achieved an average of 12 percent savings for CABG procedures performed through the demonstration. This technique is widely used by private sector health benefits managers [check].

d. Medicare preferred provider option (PPO)

Policy: This plan would establish a PPO for Medicare. From the beneficiary point of view, the Medicare PPO would resemble a preferred provider arrangement or point-of-service (POS) plan operated by an insurer in the private market. Beneficiaries would be guaranteed a lower level of cost sharing by using preferred providers. This level of cost sharing would be equal to that offered in the new Medigap Plan K or, if a beneficiary is enrolled in Plan K, waive cost sharing. The quality standards of the PPO would provide beneficiaries with a straightforward way of determining that they are using higher-quality health care providers.

Physicians, other practitioners, suppliers, and institutional providers could be PPO participants. Only "participating" physicians/suppliers already enrolled in the current Medicare "par program" would be eligible. The Secretary would pre-screen, or "credential," practitioners and providers applying to be preferred provider participants based on their claims history and any quality information to determine whether they are cost-conscious, high-quality health care providers. Only those applicants with a demonstrated history of cost-effective medical practice patterns would be selected as preferred providers. PPO participants would agree to meet quality standards and utilization management requirements as established by the Secretary. The Secretary would "profile" practitioners and providers on a continual basis and would provide feedback on performance. The preferred provider designation could be removed if the participant falls below quality and utilization standards expected of PPO providers.

The program would pay PPO practitioners and providers at discounted fees. However, PPO participants would be given administrative advantages, such as faster claims payment and alternative administrative and related procedures. If expenditure targets are met, or program savings are otherwise documented,

they could be eligible for bonus payments for achieving specified performance outcomes (e.g., more health-conscious behavior by patients, improved accessibility, or demonstrated higher quality care). PPO participants may also see a "spillover" benefit in their non-Medicare business by having the quality designation of being a Medicare PPO participant.

Background/rationale: In the private sector, preferred provider organizations (PPOs) and point-of-service (POS) plans have become the predominant form of managed care. These plans make distinctions between participating and non-participating providers (physicians as well as other providers). Enrollees of these kinds of plans face differential cost sharing, and may have other advantages in using participating physicians or other providers, such as freedom from prior authorization requirements (e.g., hospital care in the Federal Employees' Blue Cross PPO), or coverage of otherwise non-covered services if preferred providers are used. Providers that agree to the contract terms of the sponsoring plan can often expect an increase in volume of patients, resulting in greater total revenue despite the discounted payment rate. Sponsoring organizations typically use certain criteria to pre-screen providers wishing to participate as preferred providers (a process generally referred to as "credentialing"), and/or continually monitor the performance of a provider in relation to its peers or expected levels of quality standards and levels of expenditures and utilization. Providers can be "de-selected" from networks (i.e., the contract is terminated) if the norms are not met.

The Medicare program also makes a distinction between participating physicians and suppliers (excluding institutional providers), and non-participating physicians and suppliers, but for a different purpose. In exchange for an agreement to abide by certain payment rules that are advantageous to beneficiaries, the participating physicians and suppliers have been given payment and administrative advantages (such as electronic media claims submission). Non-participating physicians/suppliers that do not submit a claim on an assigned basis are permitted to "balance bill" a beneficiary beyond Medicare-allowed amounts, up to a limit. As part of the participation agreement, a "par" physician/supplier agrees to submit all claims on an assigned basis, accepting the Medicare payment (plus any beneficiary allowed cost sharing) as payment in full for covered services. Medicare, through its carriers, publicizes the availability of participating physicians/suppliers. In the sense that participating physicians/suppliers agree to always accept Medicare rates, Medicare beneficiaries choosing between participating and non-participating physicians/suppliers can face differential cost sharing if a non-participating physician/supplier chooses to submit a bill on other than an assigned basis.

c. Incentive payments for qualified integrated delivery arrangements (group practices)

Policy: This proposal would create a demonstration -- which would become nationwide if proven successful -- to give qualified integrated delivery arrangements bonus payments if they can reduce total volume and intensity of all types of Medicare covered services provided to beneficiaries during the year.

A "qualified integrated delivery arrangement" is a large physician group practice that would be required to: meet or exceed certain size and scope criteria, submit acceptable clinical and administrative management plans, participate in acceptable quality improvement plans, distribute at least a portion of the bonus payments based on quality performance, and submit required performance data. HCFA would provide performance profiles to support the organization's strategic planning for successful clinical management. The Secretary would have the authority to determine the terms of the selective contract, such as its duration, the financing arrangement, and conditions for renewal.

Qualifying organizations would be given an annual per capita target based on the organization's own historic experience: average total Part A and Part B expenditures for the Medicare FFS beneficiaries seen by the organization in a base year. After each performance year, the target would be adjusted for actual age, reason for entitlement and other relevant factors. The target would need to be updated annually and possibly rebased every 3 to 5 years. A bonus could be paid to the organization when actual total per capita expenditures in the performance year are lower than the target. The bonus amount could be limited to a portion of the Medicare savings generated, and also adjusted for the portion of total Part A and Part B services that were actually provided by the qualified organization's physicians and other providers. To further encourage quality improvement, a portion of Medicare savings -- separate from the bonus payment -- could be set aside each year and paid to qualifying organizations based on process and outcome improvements.

Beneficiaries would not enroll in these organizations. They would be notified of their physician's participation, but could obtain care from any provider as they currently do. Participating organizations would monitor patient satisfaction.

Background/rationale: The physician community is largely responsible for directing health care -- providing services and making referrals. Beneficiaries and the Medicare program could benefit if the physician community, through integrated delivery arrangements, better coordinated care across sites of service, and invested in administrative structures and processes to assure efficient service delivery. Currently, the Standard Growth Rate (SGR) is the incentive under which physicians operate in FFS. It is designed to control annual growth in expenditures, and pertains only to services covered under the Medicare Physician Fee Schedule. Under SGR, individual physicians are subject to blanket penalties or rewards regardless of their relative efficiency, and SGR has no effect on the behavior of physicians as it concerns referrals for most non-physician services.

While the majority of physicians are not organized in large groups, the majority of Medicare's physician services are provided by doctors who are organized in large groups. These large groups are often associated with integrated delivery arrangements. Extrapolating this finding to the other types of Medicare services that these doctors direct (e.g., hospitalizations, SNF admissions, durable medical equipment), a target budget derived for qualified organizations in local markets that volunteer to participate could result in lower costs and better outcomes for a large segment of the traditional Medicare program.

f. Primary care case management

Policy: This proposal would allow HCFA to provide incentives to both beneficiaries and providers to voluntarily participate in care coordination arrangements for high cost / high risk beneficiaries. To encourage these beneficiaries to voluntarily enroll with a primary care case manager (PCCM), Medicare would educate targeted beneficiaries about the option and could offer additional benefits or lower cost-sharing. The average additional costs of lower cost sharing or extra benefits would be offset by an average reduction in costly services such as avoidable hospitalizations. Beneficiaries who meet the criteria for a PCCM would volunteer to remain with a PCCM for a period of time, and would receive all their needed health care either directly from or through referral by their primary care case manager.

PCCM

The Secretary would have authority to selectively contract with physicians for PCCM services. Primary care physicians would have an incentive to become a PCCM, since the designation as a PCCM would be exclusively for physicians who meet certain performance standards and other criteria. Further, the PCCMs would be marketed so that beneficiary enrollment would guarantee patient volume. Physicians would be paid fee-for-service. They would receive case management fees that could incorporate physician education and training.

Background/rationale: Today, a small fraction of beneficiaries (5%) account for 45 percent of Medicare spending. These high-cost Medicare beneficiaries could benefit from assistance with coordinating their health care. Primary care case managers (PCCMs) have been used by Medicaid and private health plans to achieve savings and improve health care outcomes. For example, a study of Medicaid in Kentucky and Maryland found that PCCMs can reduce use of ancillary services and increase use of preventive services and primary care. This care management can be especially important for older and sicker beneficiaries, who have diminished capacity to navigate the health care system.

g. Stronger prior authorization and utilization review

Policy: This proposal would give the Secretary clear authority to: (1) use prior authorization review for specific targeted services and procedures of any supplier or provider in any setting of care; and (2) also contract with other entities (e.g., carriers, fiscal intermediaries) to make prior-authorization determinations.

Outlier practice patterns of providers and practitioners (particularly for high-cost, high-volume services and procedures) would be identified using profiles that measure performance against clinical benchmarks established from evidence-based guidelines. Outlier providers and practitioners would be required to seek prior authorization for the targeted services and procedures (e.g., certain admissions, invasive procedures and radiology services).

This proposal broadens the existing prior-authorization authority of the statute to include a wider range of Medicare covered services and it gives DHHS increased flexibility to use a variety of contractors to assure that Medicare pays for services that are reasonable and necessary. Given the role of the carriers and fiscal intermediaries in making payment decisions and preventing program abuse, it is appropriate to also have the flexibility to use these contractors for utilization management activities, including prior authorization. This flexibility allows for Medicare to operate an efficient prior-authorization program through a number of organizations. The Medicare contractors have experience with utilization management activities with their private lines of business.

Background/rationale: Prior-authorization that targets specific physicians or practitioners, types of service, or geographic areas with evidence of outlier patterns or utilization problems is now a common strategy that is used by private sector purchasers. Current law gives the Secretary authority to contract with Peer Review Organizations to perform various functions, including reviewing some or all of the professional activities of physicians, other health care practitioners and institutional and noninstitutional providers. The purpose of this function is, in part, to determine whether services and items are reasonable and medically necessary and whether services and items proposed to be provided on an inpatient basis can be effectively provided more economically on an outpatient basis or in an inpatient facility of a different type. However, this prior authorization authority is limited to proposed inpatient

services and items. The current authority applies only to contracts with PROs.

h. Contracting reform

Policy: This proposal would permit the Secretary to enter into a contract with any entity qualified to perform Medicare functions notwithstanding the fiscal intermediary and carrier provisions in the Social Security Act. The Secretary could contract for the performance of Medicare fiscal intermediary functions without regard to the provider nomination provisions in Section 1816. The Secretary could award Medicare contracts on a competitive basis under the Federal Acquisition Regulation (FAR), but would also retain her current flexibility to retain current contractors who are performing well and supplement the existing pool of contractors with new entrants as she deems in the best interests of the Medicare program. Further, the Secretary could award any type of contract permitted by the FAR. The Secretary could execute combined Medicare Part A and Part B contracts. The Secretary could terminate a contract without regard to procedural requirements that are unique to the Medicare program, and the conditions under which a fiscal intermediary or carrier contract could be terminated would be subject to the FAR. Finally, the Secretary could consult with providers, health plans, and contractors regarding performance evaluation standards.

Background/rationale: This proposal is a necessary first step in updating the tools HCFA needs to engage in effective oversight of the Medicare contractors. It brings the Medicare contracting authority into closer alignment with the general government contracting rules contained in the Federal Acquisition Regulation (FAR), while preserving certain essential flexibility in the awarding and renewal of contracts currently available to the Secretary under Medicare law. These changes will improve the cost effectiveness of Medicare contractor operations. Further, it may be a necessary pre-condition for HCFA being able to successfully pursue other proposals to modernize Medicare.

3. Provider Payment Policies

Overview. This plan builds on the fiscal discipline that the Balanced Budget Act (BBA) of 1997 brought to Medicare for 1998 through 2002 by including moderated policies beginning in 2003 through 2009 (the end of the budget window). These policies will help preserve and protect Medicare for the future and extend the life of the Part A Trust Fund. The plan also, however, recognizes that there may be a need to adjust and gradually phase-in of some of the BBA policies. As such, it includes set-aside funding for this purpose, and takes administrative actions to smooth out the transition.

a. Set-aside for Balanced Budget Act (BBA) adjustment

Policy: The Medicare reform plan would create a set-aside stream of funding to be used to make appropriate and justified modifications to BBA policies. This set-aside, totaling $x billion for FY 2000-09, is funded in the context of the reform plan, but its uses are not specified. The Administration wants to work with Congress, Congressional advisory commissions, provider and beneficiary groups to determine what policies would be most focused to address problems in a fiscally responsible way.

Background/rationale: The Balanced Budget Act implemented some of the most important changes to

Medicare in its history. It contributed to the unprecedented reduction in Medicare growth and extension of the life of the Trust Fund. More than x Medicare policies were added or changed, and Medicare spending reductions that resulted accounted for 40 percent of the BBA's contribution toward balancing the budget. Given the large number and magnitude of the changes, however, some issues have inevitably arisen. This appears especially to be the case for therapy caps, payments for acute cases in nursing homes, the new outpatient prospective payment system and rural and academic hospitals.

Although some adjustments are inevitably needed, the Administration wants to carefully evaluate evidence of problems and proposed policy solutions with the Congress, advisory groups like the Medicare Payment Advisory Commission, the General Accounting Office and the Congressional Budget Office, and provider and beneficiary groups. It also intends to proceed with caution – the BBA represents an important, sound piece of legislation that should only be moderated slightly, not re-visited or repealed. The Administration will only support targeted, justifiable changes and will oppose legislation that significantly opens up the BBA.

b. Administrative actions to smooth implementation of the BBA

Policy: The Administration will take a number of time-limited actions to smooth the implementation of the more radical provisions of the Balanced Budget Act. These changes will help ensure beneficiary access to care in hospitals, home health agencies, skilled nursing facilities, and other settings while maintaining BBA discipline that is essential for protecting Medicare's future. These changes have no to small costs that will be offset by other administrative changes in Medicare [check].
Background/rationale: The Balanced Budget Act implemented many of its changes on a rapid schedule, without fully taking into account Y2K and other implementation issues. Because of the magnitude of some of the changes, certain providers may need additional time to prepare or adjust to them. These administrative actions are taken to ensure that the implementation of the BBA changes is done in a way that simultaneously assures savings and accessible, high-quality health care.

[note: the rest of this section is BBA extender-type policies. We know the policies but are still working on the rationale].

4. Improving Medicare Management: Private Advisory Boards

[done/being edited]

II. MODERNIZING MEDICARE BENEFITS

1. Improving Preventive Benefits and Eliminating Cost Sharing

Overview. Older Americans are the fastest growing age group in the United States, with an increasing number of older Americans surviving to age 85 and older. They carry the greatest proportion of chronic disease burden and disability, much of it preventable. For example, 88 percent of those over the age of 65 have at least one chronic health condition, and large numbers of older adults suffer from impaired functioning and well-being. Early detection and health screening programs and appropriate follow-up care can result in a significant reduction in morbidity and possibly prevent or postpone functional

disability.

a. Eliminating all preventive services cost sharing

Policy: This proposal would waive the Part B deductible and 20 percent coinsurance rate for all preventive services not already waived under current law. The deductible would be waived for hepatitis B vaccinations, colorectal cancer screening, bone mass measurements, prostate cancer (digital rectal exams only) and diabetes self-management benefits. Coinsurance would be waived for screening mammography, pelvic exams, hepatitis B vaccinations, colorectal screening, bone mass measurements, prostate cancer (digital rectal exams only) and diabetes self-management benefits.

Background/rationale: Cost sharing can decrease use for preventive services. According to recent studies, Medicare preventive services, many of which were added in the Balanced Budget Act of 1997, are underutilized. For example, the 1999 Dartmouth Atlas of Health Care found that only one out of eight elderly people get recommended tests for colon cancer, one in four women in their sixties are tested as recommended for breast cancer, and fewer than half the older Americans with diabetes receive regular exams that can avert serious complications of the disease. In the first two years that Medicare covered screening mammographies, only 14 percent of eligible women without supplemental insurance received a mammogram. [do we have any other data on utilization of new benefits?]

b. Launching information campaign on prevention

Policy: HHS would launch a two year, $10 million nationwide education campaign beginning in 2001 to promote the use of preventive health services by older Americans and people with disabilities. The campaign would have three parts:

- **Educating all Americans over age 50 and people with disability about the importance of preventive health care.** The Department of Health and Human Services, the Social Security Administration, and private sector partners would combine PSAs and a print media campaign to raise awareness of the value of prevention. HHS would distribute brochures and other information on health promotion and disease prevention activities through the State Health Insurance Associations and the Area Agencies on Aging. HHS would also place brochures in the Social Security Administration's 1,300 field offices. SSA would include information on the importance of preventive health care on the Cost Of Living Adjustment notice, which is sent to the approximately 6 million people with disabilities who receive SSA or SSI benefits. Information on the importance of preventive health care will also be included on the Personal Earnings and Benefit Estimate Statement and in currently produced brochures on retirement and survivors benefits. Finally, SSA would expand the section in its Medicare brochure to include a fuller discussion of the importance of health promotion activities and the benefits offered under the Medicare program.

- **Encouraging Medicare beneficiaries to use its preventive benefits.** This campaign would provide Medicare beneficiaries about the importance of regularly receiving preventive health care benefits, such as vaccinations and mammograms, and would encourage individuals to access these benefits under Medicare. This would be done is several ways:

- *Distribute comprehensive information on preventive benefits to all 39 million Medicare beneficiaries.* HHS would (1) expand the section on preventive benefits in the *Medicare and You* handbook to include information on the importance of receiving mammograms, diabetes monitoring, colorectal cancer screening, bone mass measurements, and regular vaccinations; (2) instruct insurance carriers to include preventive benefits messages on the Medicare Summary Notice statement and the Explanation of Medicare Benefits; (3) include prevention messages regularly on the Medicare Part B benefits statement; and (4) work with the private sector, including senior centers, the Cooperative State Research Education and Extension Service, the Meals on Wheels programs, and religious organizations, to deliver information to Medicare beneficiaries about the importance of preventive benefits and which ones are covered under the Medicare program.

- *Development of health status assessment tool for Medicare beneficiaries.* HCFA, together with CDC and AHCPR, will develop a health status assessment tool for beneficiaries. This self assessment tool will help the beneficiary identify important health information or significant symptoms that should be discussed with their health care provider. HHS will train the State Health Insurance Assistance Program staff to assist Medicare beneficiaries with the completion of the self assessment form so that they can raise the health issues identified by the form to their health care provider.

- **Launching an education and awareness campaign to prevent falls in the elderly.** DHHS would launch a nationwide campaign to educate older Americans about the best way to modify their home environment in order to avoid potentially harmful and debilitating falls. The campaign would utilize radio advertisements and print media, and would emphasize the following messages: use anchor rugs; minimize clutter on floors; use nonskid mats; install handrails in bathrooms, halls, and along stairways; light hallways, stairwells, and entrances; and wear sturdy shoes.

Background/rationale: Loss of function can begin to become evident as early as the fifth decade of life, arguing for preventive approaches begun in the middle years, as well as earlier, as a means of promoting health and limiting disability in the later years of life.

Increasing the venues through which Medicare beneficiaries and older Americans will be educated about the importance of preventive benefits and how to access them under the Medicare program will increase the likelihood that beneficiaries will use these services. A recent study indicates that Medicare beneficiaries do not understand that Medicare covers preventive benefits; almost 70 percent of beneficiaries who stated that they knew about the range of Medicare services were unable to answer questions about Medicare's coverage of preventive benefits correctly. However, studies indicate that repeated short, simple, print media messages enhance the target population's recall and retention of health promotion messages. These messages have also been shown to have a greater impact on individuals at higher risk.

In addition to educating beneficiaries about the importance and availability of preventive services, this proposal would address one of the major public health problems faxing the elderly: the high incidence of falls. In 1995, more than 7,700 people over the age of 65 died as a result of a fall. For people aged 65 to 84, falls are the second leading cause of injury-related death; for those aged 85 or older, falls are the leading cause of injury-related death. Falls are the most common cause of injuries and hospital admissions for trauma among the elderly, accounting for 87 percent of all fractures among people aged

65 years or older and are the second leading cause of spinal cord and brain injury. For people aged 65 years or older, 60 percent of fatal falls occur in the home. This education campaign aims to reduce the risk of falls, aiming to improve the quality of life and reduce Medicare costs.

c. Charging the U.S. Preventive Services Task Force to identify new preventive services for older Americans

Policy: The Secretary would direct the U.S. Preventive Services Task Force to conduct a series of new studies to identify preventive interventions that can be delivered in the primary care setting that are most valuable to older Americans. In addition, promoting the health of older Americans would become part of the mission statement of the Task Force.

Background/rationale: Despite the potential for preventive services to improve the quality of life for older Americans, few clinical guidelines focus on preventive care for older Americans.

The U.S. Preventive Services Task Force, an independent panel of preventive health experts, together with the Centers for Disease Control, is charged with evaluating the scientific evidence for the effectiveness of a range of clinical preventive services, including common screening tests, immunizations, and counseling for health behavior change and to produce age-and risk-factor-specific recommendations for these services. The task force focuses primarily on preventive interventions that can be delivered in the primary care setting, are widely available, and for which scientific evidence exists to assess efficacy and effectiveness.

d. Conducting a demonstration of smoking cessation drugs and counseling

Policy: HCFA would launch a demonstration project to evaluate the most successful and cost-effective means of providing smoking cessation services to Medicare beneficiaries, including testing incentive systems for both providers and beneficiaries to optimize "quit" rates. The demonstration would be based on the latest scientific evidence regarding smoking cessation strategies and guidelines developed by the Agency for Health Care Policy and Research. These guidelines suggest that the most effective smoking cessation strategies include an initial patient assessment, counseling services, and nicotine replacement therapy. Non-Medicare providers could participate in the demonstration since part of its purpose will be to determine the most cost-effective providers for delivering smoking cessation services. Medicare rules would be waived to the extent necessary to allow such providers to bill for these services. Providers would be reimbursed for the lesser of 100 percent of the cost of the service or the amount determined by a fee schedule established by the Secretary. Acupuncture and hypnosis for the purposes of encouraging smoking cessation will not be reimbursable.

Background/rationale: The four leasing causes of death – heart disease, cancer, cerebrovascular disease, and chronic obstructive pulmonary disease – are strongly related to smoking. The risk of death due to coronary heart disease in smokers is two to four times greater than in non-smokers; the risk of stroke is 1.5 times greater in smokers than in non-smokers; and mortality and serious morbidity related to COPD occurs almost exclusively in smokers. Studies from the last three decades have shown that when people stop smoking, their risk of tobacco-related morbidity and mortality decreases significantly. For example, the risk of myocardial infarction diminishes by almost one third after the first year of smoking

cessation and reaches the level of people who have never smoked by the third or fourth year of quitting.

In addition to its health benefits, smoking cessation may reduce costs. A recent study by the Mayo Clinic indicates that the estimated cost of smoking cessation treatment is $6,828 per net year of life gained (this estimate takes into account relapse rates expected for patients not undergoing intervention). This is inexpensive relative to the cost-effectiveness of other medical services (e.g., breast cancer screening costs up to $26,800 per year of life gained). However, a demonstration is needed to evaluate what type of method and reimbursement structure is most cost effective.

2. Rationalizing Cost Sharing and Medigap

[add overview paragraph on importance]

a. Adding 20 percent coinsurance on clinical laboratory services

Policy: Medicare currently pays 100 percent of the approved fee for clinical laboratory services provided to beneficiaries. For most other Part B services, beneficiaries are subject to both a deductible and the 20 percent coinsurance rate. This policy would apply 20 percent cost-sharing requirements to all clinical laboratory services and count lab services toward the deductible. Note that this cost-sharing requirement would not apply to lab services which are also preventive services (e.g., pap smears and fecal occult blood lab tests for colorectal cancer screening).

Background/rationale: Clinical laboratory services is a fast-growing Medicare service (check – any stats on historical or projected annual growth?). About 24 million beneficiaries used diagnostic lab service in 1997, at a rate of about 14 services and an annual cost of $200 per user. Some of this cost growth may result from unnecessary utilization or fraudulent providers. In 1997 alone, several clinical lab companies settled suits alleging kickbacks, billing for tests not performed, and fabrication of diagnostic codes for a total of about half a billion dollars. The HHS Office of the Inspector General estimated that, in 1996, Medicare paid about $12 billion to independent labs that could not be located.

Making beneficiaries contribute towards their lab services would help reduce over-use and cut down on fraud. As such, it is recommended by the Medicare Payment Advisory Commission among other experts. It also contributes toward the goal of making cost-sharing requirements under Part B more uniform and easier to understand. Most private health insurance plans also have some cost sharing associated with lab servcies.

b. Indexing the Part B deductible [note: placeholder/likely dropped]

Policy: Medicare's Part B deductible of $100 would be indexed annually to inflation. Indexing at inflation would ensure that the deductible grew at roughly the same rate as beneficiaries' Social Security benefit cost of living adjustment (COLA) increases.

Background/rationale: The Part B deductible (i.e., the amount that enrollees must pay for services each year before the government shares financial liability) is set at $100 a year. It is less than most private

indemnity insurance plans. The deductible has been increased only three times since Medicare began in 1966, when it was set at $50. In relation to average annual per capita charges under the SMI program, the deductible has fallen from 45 percent in 1967 to about 3 percent (projected) for 1999, according to CBO.

This policy does not really increase the deductible, but instead links it to inflation, maintaining its current value of $100 in future years. As such, it would rise by about $3 per beneficiary per year. Relative to other cost sharing proposals, it is the most evenly spread change since virtually all Medicare beneficiaries meet their Part B deductible in a year. It has been supported by organizations like MedPAC/PPRC (check) and the Congressional Budget Office.

c. Add a new Medigap plan option that allows for nominal (rather than no) cost sharing

Policy: This policy would create a new Medigap plan option that has more rational cost sharing than the current standardized plans. The design of the cost sharing would be to protect beneficiaries against catastrophic costs while maintaining nominal cost sharing to discourage unnecessary use of health care services. The Secretary would work with NAIC to design this option. It would not cover the Part B deductible.

All Medigap carriers would offer this policy, which would likely be less expensive than other plan options because of its nominal cost sharing.

Background/rationale: Medigap plans typically eliminate all cost sharing for most Medicare services. As a consquence, beneficiaries have no immediate financial cost of using health care services. One study found that Medicare spending for beneficiaries with Medgiap coverage was 29 percent higher than that of beneficiaries with no coverage, and 11 percent higher than that of beneficiaries with retiree health coverage (which typically has some cost sharing). Additionally, the premiums for Medigap have been rising rapidly – over 10 percent per year according to some sources. A policy with limited cost sharing could be less expensive than the current plan options.

d. Allow access to Medigap for beneficiaries whose managed care plan withdraws from Medicare

Policy: The President's budget included several policies that would improve access to Medigap for beneficiaries whose private plans have withdrawn from Medicare. They include:

- **Initial Open Enrollment for Medigap for Disabled and ESRD.** Under current Federal law, only aged beneficiaries have an initial open enrollment period for Medigap. Eighteen States mandate an initial open enrollment period for beneficiaries under 65 (although one of these states does not include individuals with ESRD). This proposal would expand the initial 6-month open enrollment period to new disabled and ESRD beneficiaries. It would mandate that insurers who write policies for new aged beneficiaries offer these same policies to new disabled and ESRD beneficiaries. Enactment of this proposal would assure Medigap access in all states for disabled and ESRD beneficiaries both upon initial eligibility for Medicare and also in the case of Medicare+Choice plan termination. This proposal would be effective upon enactment.

- **Special Medigap Open Enrollment Period for Certain Beneficiaries.** The BBA provided that

beneficiaries in plans that terminated their Medicare contract or reduced their service area have a 63 day open enrollment period for Medigap. The provision was triggered for the first time by plan terminations and service area reductions effective January 1, 1999. Unfortunately, given the newness of this provision, some insurance carriers were not properly prepared to answer inquiries regarding this new right. This proposal would provide a one-time additional special Medigap open enrollment period for individuals who were enrolled in a plan and who had no Medicare+Choice option after the plan terminated its contract or reduced its service area effective January 1, 1999. The special enrollment period would begin upon enactment and would last for 90 days.

- **Expand Choice of Medigap Plans During Special Enrollment Periods.** The BBA provided special enrollment opportunities for Medigap under certain situations (e.g., for an enrollee of a Medicare+Choice plan whose plan terminates its contract or reduces its service area). Under current law, however, beneficiaries in these situations only have access to plans "A","B","C" and "F", none of which include coverage of prescription drugs. This proposal would expand the BBA special open enrollment opportunities to include access to all Medigap options offered to new enrollees. This proposal would be effective upon enactment.

- **Increase Civil Monetary Penalties for Violation of Medigap Open Enrollment Requirement.** Issuers who violate the open enrollment requirement are subject to a civil monetary penalty (CMP) of $5,000 for each violation. This proposal would increase the CMP for failure to $50,000 for each violation plus $5,000 per day per violation and would be effective upon enactment.

Background/rationale: [do we have some standard language about plan pull-outs / risks to beneficiaries?]

e. Direct the Secretary of Health and Human Services and the National Association of Insurance Commissioners to update benefits in all Medigap plans

Policy: This proposal would authorize the Secretary, in consultation with the National Association of Insurance Commissioners (NAIC), to review the standard Medigap packages on a periodic basis to determine whether any changes should be made to the content or number of the packages. It would also conform Medigap benefits to the changes in this reform plan.

Background/rationale: The 10 standard Medigap packages were created as a result of OBRA 90. There is no authority in the statute to periodically reexamine these packages.

f. Direct the Secretary of Health and Human Services to report to Congress on the feasibility and advisability of adding catastrophic coverage to Medicare.

3. Medicare Buy-In for Certain People Ages 55-65

Overview. Americans ages 55 to 65 are one of the most difficult to insure populations: they have less access to and a greater risk of losing employer-based health insurance; and they are twice as likely to have health problems. Some lose their employer-based health insurance when their spouse (frequently the husband) becomes eligible for Medicare. Many lose their coverage because they lose their jobs due to

Policy: This proposal would authorize a demonstration program to test care coordination models for Medicare beneficiaries who are also eligible for Medicaid and who remain in fee-for-service Medicare. Dual eligible beneficiaries who participate would receive a one-time special clinical assessment, developed by geriatricians, of their acute and long-term care needs. Those with significant health care needs would qualify for a care coordination benefit that would include primary care services and advice from a team of providers. Care coordination services for the treatment group would be delivered by a team that includes a geriatrician, a social worker and nurse who would provide general primary care services and would advise the beneficiary about Medicare and Medicaid care options. For example, the team would suggest the best type of specialty acute care, (paid for by Medicare) review prescription drug use (paid for by Medicaid and Medicare) and make suggestions about when nursing home care and home health are necessary (paid for by Medicare and Medicaid). Other models of care coordination could also be tested. Up to 25,000 beneficiaries would be eligible for this demonstration.

Provider groups would apply for the demonstration. Providers under the demonstration could include grass-roots organizations as well as larger health care organizations. However, HCFA would be carefully screening provider applicants and monitoring the demonstration to ensure that the providers were not using the demonstration as a way to maximize Medicare payments. The demonstration would require that providers have an agreement with their state for full cooperation. Providers should have a good understanding of their state's Medicaid system.

Background/Rationale. About six million Medicare beneficiaries also receive some benefits from Medicaid. About 2/3 of these beneficiaries are eligible to receive full Medicaid coverage which includes long-term care and prescription drug benefits. On average, dual eligibles are sicker, older and poorer (by definition) than other Medicare beneficiaries and may have difficulty negotiating two separate public insurance programs for acute and long-term care coverage. In addition, providers for one program may be unaware of the actions of providers for another program --- unintentionally duplicating or contradicting each other. Some demonstration programs have tested using managed care to improve care coordination for this vulnerable population. Yet, the majority of dually eligible beneficiaries choose to remain in fee-for-service. This new demonstration effort will test models for improving care coordination for beneficiaries who choose to remain in fee-for-service.

III. MEDICARE PRESCRIPTION DRUG BENEFIT

1. Base Benefit

[draft of policy completed/being edited Saturday night; still working on rationale]

2. Catastrophic Benefit Financed by Tobacco Lawsuit.

IV. DEDICATED FINANCING FOR MEDICARE

1. Dedicating Part of the Surplus to Medicare

Policy: [draft/placeholder] The President's framework would reserve 15 percent of the projected surpluses -- $650-$700 billion -- over the next 15 years for the Medicare Trust Fund. These funds would

be prohibited from being used for any other purpose, ensuring that the money will go to help the health care needs of older and disabled Americans. Even in the absence of broader reforms, the President's framework would guarantee that Medicare can continue to provide its critical health services until 20xx -- doubling the life of the Medicare Trust Fund and providing the strongest outlook in the last 25 years.

Background/rationale: Like Social Security, Medicare enrollment will double between 1999 (39 million) and 2032 (78 million) as the baby boom generation retires. Not only will there be more elderly in the future, but the elderly will live up to 6 years longer on average by the middle of the next century. Compounding the demographic challenges are the unique factors that affect health spending -- changing disease patterns, technological advances, and a high value placed on health. For example, the improved ability to prevent and cure diseases, while making tremendous improvements in the nation's health, has also driven up costs. As a result, health spending growth has historically exceeded that of general inflation. These trends are expected to continue into the next century. Private health spending growth per person is projected to be 7.3 percent between 1999 and 2007 -- more than twice as high as general inflation.

In 1993 when President Clinton took office, the Medicare Hospital Insurance (HI) Trust Fund was projected to be exhausted in 1999. Today, it is projected to be solvent for the next ten years. This is due to the historic changes in the Balanced Budget Act of 1997, aggressive efforts to reduce Medicare fraud and the general health of the economy. Despite these improvements, Medicare is spending more than its annual income from payroll taxes and other sources. As such, it has begun to use up its assets -- as the baby boom generation begins to retire, these assets will be gone. Although Medicare's prognosis in the Trustees' 1999 report will almost inevitably be better due to strong revenues and continued low spending, the fact remains: current income sources will not be able to finance health care services for the baby boom generation.

2. Income-Related Premium (Beginning at $100/120,000)

Policy: Under this proposal, all Medicare beneficiaries would continue to receive a significant subsidy for Medicare Part B (Supplemental Medical Insurance) premium, but high-income beneficiaries would bear a greater share of its cost. This policy would:

- **Target truly high-income beneficiaries:** The income-related premium would begin at a high enough income level to exclude middle-class beneficiaries, who may have more difficulty affording the premium. Beneficiaries whose income (AGI plus tax-exempt interest) is above $100,000 (single) or $120,000 (joint) would pay an extra $10 premium per month for every $100 in additional income up to a limit. Additionally, the income thresholds for beginning the income-related premium would be indexed to inflation to prevent an ever-increasing proportion of elderly from paying the higher premium.

- **Limit the amount that beneficiaries pay:** No beneficiary would pay more than 50 percent of the premium. This prevents most high-income beneficiaries -- who typically have good health -- from opting for less expensive, private alternatives. The result of healthy beneficiaries leaving Medicare would be an increase in the average Federal spending per beneficiary.

- **Administered by Treasury.** Only the Treasury Department already collects the income information