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FI004

THE WHITE HOUSE

THE PRESIDENT HAS SEEN
10-20-99

WASHINGTON

October 20, 1999

MR. PRESIDENT:

On your behalf, we executed the attached letter on Medicare to Members of Congress.

FYI

Sean Maloney

THE WHITE HOUSE

WASHINGTON

October 19, 1999

Copied
Jennings
Podesta

The Honorable William V. Roth, Jr.
Chairman
Committee on Finance
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

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

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

Preparing and strengthening Medicare for the next century is and will continue to be a top priority for my Administration. For this reason, I proposed a plan that makes the program more competitive and efficient, modernizes its benefits to include the provision of a long-overdue prescription drug benefit, and dedicates a portion of the surplus to help secure program solvency for at least another 10 years. However, I also share your belief that we need to take prompt action -- whether in the context of broader or more limited reforms -- to moderate the excessive provider payment reductions in the BBA of 1997. I believe that legislative modifications in this regard should be paid for and should not undermine the solvency of the Medicare trust fund.

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

Attached is a summary of the over 25 administrative actions that my Administration is currently implementing or will take to address Medicare provider payment issues. The Department of Health and Human Services is taking virtually all the administrative actions possible under the law that have a policy justification, which will accrue to the benefit of hospitals, nursing homes, home health agencies, and other providers.

We are finishing our review of our administrative authority to address the 5.7 percent reduction in hospital outpatient department payments. We believe that the Congressional intent was to not impose an additional reduction in aggregate payments for hospitals and I favor a policy that achieves this goal. The enactment of clarifying language on this subject would be useful in making clear Congressional intent with regard to this issue. I have attached a letter from Office of Management and Budget Director Jack Lew, which was sent at the request of Congressman Bill Thomas, detailing how such language would be scored by OMB.

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

On the issue of skilled nursing facilities, we agree that nursing home payments for the sickest Medicare beneficiaries are not adequate. I intend to take all actions possible to address this. Administratively, we can and will use the results of a study that is about to be completed to adjust payments as soon as possible. While we believe that these adjustments must be budget neutral, we are continuing to review whether we have additional administrative authority in this area.

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

We believe that our administrative actions can complement legislative modifications to refine BBA payment policies. These legislative modifications should be targeted to address unintended consequences of the BBA that can expect to adversely affect beneficiary access to quality care.

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

Sincerely,

Bill Clinton

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

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

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

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

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

**Under review.

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

HOSPITALS: GENERAL

Capping hospital transfer policy at 10 DRGs for 2 years, through 2002. We will postpone for two years the extension of the hospital transfer policy to additional diagnoses beyond the current set of 10 Diagnosis Related Group (DRG) categories. We also will consider whether further postponement of extension to additional diagnoses is warranted.

Stop administrative recoupment of DSH payments based on unclear guidance. We have recently determined that certain hospitals received additional disproportionate share hospital (DSH) payments because guidance on how to claim these funds was insufficiently clear. We will therefore hold harmless hospitals that have received these additional payments. We also will soon clarify guidance to hospitals and our claims processing contractors on how to claim these funds. And we will provide further clarification to State Medicaid agencies because they are the primary source of data critical to the DSH calculations. We will apply the clarified policy and hold hospitals responsible for being in compliance as of January 1, 2000.

HOSPITAL OUTPATIENT PAYMENTS

We are finishing our review of our administrative authority to address the 5.7 percent reduction in hospital outpatient department payments. We believe that the Congressional intent was for this policy to be implemented in a way that is budget neutral for hospitals and the Administration favors a policy that achieves this goal. Unfortunately, a technical drafting change has produced some confusion over the outpatient payment formula. The enactment of clarifying language on the subject would be most useful in eliminating the confusion caused by the technical drafting of the current law. In addition, there are a number of changes that we believe are necessary to address specific policy concerns and moderate the payment reductions in the Medicare prospective payment system (PPS) for outpatient departments. Although we are prohibited by law from committing to changes before the final rule is published, we can outline the approaches we believe are consistent with Administration policy and expect to take in the outpatient department rule. These include:

Delay implementation of the volume control mechanism for 2 years, which would reduce payment reductions. We expect to delay implementing the proposed "volume control mechanism." The statute requires the agency to develop a volume control mechanism. In the proposed rule, we suggested use of a mechanism that might lead to a downward adjustment in the payment rates as early as 2002 (to reflect volume increases in 2000). Delaying this mechanism would provide time for providers to adjust to the new system.

Moderate payment reductions for rural, cancer and other hospitals experiencing large changes, in budget-neutral manner, in transition to prospective payment system (PPS). We expect to include a 3-year transition to the new PPS by making budget-neutral adjustments that will increase payments to hospitals that would otherwise incur large payment reductions. These hospitals would include certain rural, inner city, cancer, and teaching hospitals. Some hospitals, like cancer hospitals, are projected to experience a reduction in excess of 30 percent. This transition policy would ensure that payments do not drop below a specified threshold to protect against such reductions.

Delay implementation of prospective payment system for cancer hospitals until additional data are collected. The lack of reliable data from cancer centers makes developing a prospective payment system for them difficult. Consequently, we now expect to delay full implementation of the PPS system for the cancer hospitals and to use an interim payment system for at least 18 months from the initiation date of PPS for other hospitals. We would not end this interim system until we are ready to implement a prospective system for cancer hospitals based on full information.

Make technical refinements to the Ambulatory Payment Classification (APC) system. We plan to make changes to address the many technical comments received regarding the proposed Ambulatory Payment Classification (APC) system as part of the final rule, including the detailed comments from MedPAC. We also plan to address the many other comments, including those related to the appropriateness of the system for categories of providers, in the final rule. And we have hired another independent, outside contractor, Kathpal, to provide additional private-sector expertise as we address problems with the data we have on the cost of chemotherapeutic agents. This contractor is examining a random sample of patients who need chemotherapy and other high-cost drug costs to advise us on possible methods and data for assuring adequate payment for these drugs. We believe that further outside reviews would delay the implementation of the system and the planned reductions in beneficiary out-of-pocket expenses.

Allow for temporary cost-based APCs for certain new technologies. Concerns have been raised about the adequacy of payments in APCs for medical technologies that are new (and hence are not reflected in the data bases on which we do our estimates) and where the cost of the item is very large relative to the payment for the APC. In some instances it may be possible to accommodate new, high-cost technology items within the APCs. In others, we expect to specify in advance and use a set of cost-related APCs for some period of time while better data about actual costs are collected.

Create additional APCs for certain high-cost drugs (e.g., chemotherapy drugs). Packaging payments for certain covered drugs with the procedure or visit with which they are furnished could underpay hospitals and slow the introduction of new drugs into the system. Thus, we anticipate creating additional APCs to pay for certain drugs, particularly high-cost drugs. Where appropriate, we would permit billing for multiple APCs depending on dosages actually used. With respect to chemotherapy, we expect to substantially increase the number of APCs for chemotherapy agents to minimize the variability within groups and assure beneficiary access is not compromised. We would also create APCs for supportive and adjunctive therapies.

Create separate APCs to pay for blood and blood products. Under the proposed rule, we would pay for blood and blood products as part of the payment for a surgical procedure or blood transfusion service. As a result of concerns raised in comments, we have reconsidered our proposal and now expect to implement separate APCs to pay for blood, other blood products and anti-hemophilic factors.

Pay, at least temporarily, for corneal tissue at acquisition costs rather than as part of the payment for overall corneal transplant surgery. Under the proposed rule, we would pay for corneal tissue acquisition costs as part of the payment for corneal transplant surgery. Given the variable rates at which hospitals acquire the tissue from eye banks, we are likely to accept the recommendation to decouple payment for tissue acquisition from that for the surgical procedure and to pay for it, at least until further experience is gained, based on acquisition cost.

Eliminate use of diagnostic codes in payments for medical visits and reassess use in future. The proposed rule based payments for medical visits to clinics and emergency departments on codes for both medical procedures and diagnosis. Because diagnostic codes are not used in payment for all other services, we now expect to revise our medical groups by eliminating the use of diagnostic codes in computing payment amounts for the present.

SKILLED NURSING FACILITIES (SNF) PAYMENTS

Increase payment for high acuity patients. We will use administrative flexibility to increase relative weights for the Resource Utilization Groups for high acuity patients under the Skilled Nursing Facility Prospective Payment System (SNF PPS). We expect to have research findings on advisable refinements completed by the end of this year and to include them in a proposed rule next Spring, for implementation in October 2000. We believe these changes should be budget neutral. However, we are continuing to review whether we have additional administrative authority.

Exclude certain types of services furnished in hospital outpatient departments from SNF PPS: CT scans, MRIs, cardiac catheterizations, emergency services, major ambulatory surgical procedures, and radiation therapy. Using the limited administrative discretion afforded by the statute, we have excluded these types of services performed in hospital outpatient departments from the SNF PPS bundle. We have done so because such services are exceptionally intensive and well beyond the scope of SNF care plans. We received a significant number of comments, both in response to last year's interim final rule, and at a national Town Hall meeting we held to solicit comments on SNF PPS. We are examining whether any additional hospital outpatient services (e.g., chemotherapy) could be carved out within the scope of our present administrative authorities, but believe that legislation is necessary to exclude these or other services (e.g., prostheses) categorically.

HOME HEALTH PAYMENTS

Delay tracking patients and pro-rating payments. Although fiscal intermediaries are responsible for tracking and pro-rating payments, we were unable to make the necessary systems changes to accomplish this due to our efforts related to Year 2000 computer systems requirements. Therefore, we are delaying implementation of the requirement until the implementation of the prospective payment system. We have developed a way to implement this proposal under the prospective payment system that will allow fiscal intermediaries and HCFA to more directly track beneficiaries. We also want to clarify that the law does not make home health agencies responsible for tracking utilization for purposes of pro-rating payments.

Provide for extended interim payment system repayment schedules for agencies. As part of our Medicare reform plan, we are allowing agencies an automatic 36 months to repay excess interim payment system (IPS) overpayments. The first year is interest-free.

Postponing the requirement for surety bonds until October 1, 2000. We are postponing the requirement for surety bonds until October 1, 2000, when we will implement the new home health prospective payment system. This will help ensure that overpayments related to the interim payment system will not be an obstacle to agencies obtaining surety bonds.

Change surety bond requirement to $50,000, not 15 percent of annual agency Medicare revenues. We are also following the recommendation of the General Accounting Office by requiring all agencies to obtain bonds of only $50,000, not 15 percent of annual agency Medicare revenues as was proposed earlier.

Eliminate the sequential billing rule. As of July 1, 1999, we eliminated the sequential billing rule. Many home health agencies had expressed concern about the impact of the implementation of this requirement on their cash flows and this measure should alleviate these problems to a large degree.

Phase in reporting of services in 15-minute increments. We are phasing in our instructions implementing the requirement that home health agencies report their services in 15-minute increments in response to concerns that the demands of Y2K compliance were competing with agency efforts to implement this BBA provision. By allowing this degree of flexibility for a temporary period, we will prevent any agency cash flow problems or returned claims.

PHYSICIAN PAYMENTS

Improve annual updates in payments for physicians' services to correct for erroneous projections through administrative actions. As we indicated in the *Federal Register* on October 1, 1999, at this time, we do not believe we have the ability under current law to make adjustments to revise the Sustainable Growth Rate (SGR) based on later data. We agree that there is a problem and thus have submitted, as part of the FY 2000 budget, a budget-neutral legislative proposal to require that revisions be made to correct estimation errors in calculation of the SGR and to fix other technical aspects of the SGR. However, we are continuing to review whether we have any ability administratively to address this issue.

RURAL PROVIDER PAYMENTS

Change the average wage threshold percentages so more rural hospitals can reclassify. We are implementing policies making it easier for rural hospitals, whose payments now are based on lower, rural area average wages, to be reclassified and receive payments based on higher average wages in nearby urban areas and thus get higher reimbursement. Right now, facilities can get such reclassifications if the wages they pay their employees are at least 108 percent of average wages in their rural area, and at least 84 percent of average wages in a nearby urban area. We are planning to change those average wage threshold percentages in the FY 2001 hospital regulation so more hospitals can be reclassified.

Use same wage index for inpatient and outpatient PPS. In the proposed rule, we expect to help rural hospitals by using the same wage index for calculating rates that is used to calculate inpatient prospective payment rates. This index would take into account the effect of hospital reclassifications and redesignations.

Modify Health Professional Shortage Area designations. We are also working to address other concerns of rural providers, where we can, through administrative actions. The Health Care Financing Administration has formed a high-level working group on rural health to work with providers to identify both administrative and legislative issues and resolve those that we have the authority to address under current law. For example, we are working with the Health Services and Resources Administration to modify the Health Professional Shortage Area designations. We are also considering changes to policies related to Critical Access Hospitals, Graduate Medical Education payments for rural providers, and wage indices for rural providers.

AMBULATORY SURGICAL CENTER (ASC) PAYMENTS

Postpone implementation based on 1999 survey. We plan to publish the final rule on payment policy changes for ASCs next spring and implement the new system in July 2000. The current ASC rates have been in place since 1990 and are based on 1986 survey data. We appreciate the desire to incorporate more current data. However, the process of sending out and having the ASCs complete the surveys, auditing the surveys, analyzing the data, writing a proposed rule, commenting on a proposed rule, and issuing a final rule is lengthy. If we were to delay implementing payment changes until the 1999 survey data are incorporated, we would have to delay the payment policy changes planned for July 2000 for an additional three years.

MEDICARE +CHOICE PAYMENTS

Phase in risk adjustment over a 5-year period. In March, we announced a five-year transition to comprehensive risk adjustment for Medicare+Choice plans to minimize the disruption to plans. We plan to begin the transition in 2000 with a 90/10 blend of demographically and risk adjusted rates. This blend will be gradually increased over five years so that in 2004, rates will be fully risk adjusted using a comprehensive adjustment system that takes into account all care settings.

We believe that this five-year transition strikes the appropriate balance between concern for plans and our obligation to be fiscally responsible and ensure that plans are paid fairly and appropriately for the care they provide, especially to the sickest beneficiaries. Our actuaries estimate that this transition schedule will cost the Medicare Trust Funds $4.5 billion more than full implementation of risk adjustment in 2000. Our current phase-in schedule prevents plans from experiencing more than a five to ten percent shift in rates in the first few years. For example, based on our impact analyses using 1997 and 1998 plan data, no plan would face more than a 1.85 percent reduction in 2000 and plans on average would face only a 0.7 percent reduction in 2000. Significant differences in later years would indicate that a plan's enrollees are substantially healthier than average, in which case it is appropriate to pay more to other plans that are caring for less healthy enrollees. A number of experts, including the Medicare Payment Advisory Commission, support this approach. We would like to work with Congress and other interested parties to further review technical modifications to improve Medicare+Choice risk adjustment.

Extending EverCare frail elderly demonstration through 12/31/01 and exempt from risk adjustment during this extension. For EverCare managed care plans that provide specialized services to the frail elderly, we are extending this demonstration project for an additional year through December 31, 2001. We also will continue the exemption from risk adjustment during this extension. This will provide additional time to complete our evaluation of this project. It also will allow EverCare to submit additional data on the special population it serves, which we can analyze for possible use in refinement of our risk adjustment methodology.

Improve beneficiary protections and access to administration. We also published refinements to Medicare+Choice regulation that improve beneficiary protections and access to information. For example, we clarified that any beneficiary who is enrolled in a Medicare+Choice plan that withdraws from the program is entitled to immediate enrollment in any other remaining Medicare+Choice plan serving the enrollee's area.

Ease provider participation rules. We have taken additional steps to assist plans and encourage their participation in Medicare+Choice. We worked with Congress to give plans two more months to file the information used to approve benefit and premium structures so plans are able to use more current experience when designing benefit packages and setting cost sharing levels. We also eased provider participation rules and increased flexibility for plans in coordinating care for enrollees with serious or complex conditions and in conducting initial health assessments for new enrollees.

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

October 18, 1999

THE DIRECTOR

Honorable William M. Thomas
Chairman, Subcommittee on Health
Committee on Ways and Means
United States House of Representatives
Washington, D. C.

Dear Mr. Chairman:

I am writing to respond to your request regarding how the Administration would score the attached language clarifying Congressional intent on the outpatient prospective payment system (PPS) enacted in the Balanced Budget Act (BBA).

As you know, the outpatient PPS was intended to rationalize outpatient payment policy. The intent of that legislation was to correct a flaw in outpatient payments, and included multi-year savings of $7.2 billion from lower rates of cost growth under the new system. The law was not intended to impose an additional reduction in aggregate payments to hospital outpatient departments. No such reduction was contemplated when the BBA was negotiated, and we continue to believe that such a reduction would be unwise. The Medicare program needs to continue to encourage outpatient care, not discourage it by failing to pay its full costs.

Unfortunately, however, a technical drafting change has produced some confusion over the outpatient payment formula. The enactment of clarifying language on the subject would be most useful in eliminating the confusion caused by the technical drafting of the current law. The attached draft language would clarify the law and assist in carrying out the intent of Congress.

The Administration would not score the draft language, which would not modify the statutory provision, since it would only clarify the intent of Congress. Under the Budget Enforcement Act, legislative action is scored only when it changes current law. Findings or clarifications by Congress do not change the law and do not result in scoring. We are not aware of any cases since enactment of the Budget Enforcement Act in 1990 where findings or clarifications by Congress were scored. Therefore, the attached language, if enacted, would not be scored by the Office of Management and Budget.

Sincerely,

Jacob J. Lew
Director

SEC.___.INTENTION REGARDING BASE AMOUNTS IN APPLYING THE HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM.–With respect to determining the amount of copayments described in paragraph (3)(A)(ii) of subsection 1833(t) of the Social Security Act, as added by section 4523(a) of Balanced Budget Act of 1997, Congress finds that such amount should be determined without regard to such subsection and clarifies that the Secretary of Health and Human Services has the authority to determine such amount without regard to such subsection, and that the base amounts to be calculated under paragraph (3)(A) not reflect any reductions in aggregate payments to hospitals for covered OPD services.

Okay for Signature by
Staff Secretary
Date 10/19/99

October 19, 1999

The Honorable William M. Thomas
Chairman
Committee on House Administration
House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

I am writing to respond to your request about administrative actions that my Administration can take to moderate the impact of the Balanced Budget Act (BBA) of 1997 on Medicare providers.

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

Preparing and strengthening Medicare for the next century is and will continue to be a top priority for my Administration. For this reason, I proposed a plan that makes the program more competitive and efficient, modernizes its benefits to include the provision of a long-overdue prescription drug benefit, and dedicates a portion of the surplus to help secure program solvency for at least another 10 years. However, I also share your belief that we need to take prompt action -- whether in the context of broader or more limited reforms -- to moderate the excessive provider payment reductions in the BBA of 1997. I believe that legislative modifications in this regard should be paid for and should not undermine the solvency of the Medicare trust fund.

You have requested a summary of the administrative actions that I plan to take to moderate the impact of the BBA. In particular, questions have been raised about four specific issues related to payment for hospital outpatient departments, managed care, skilled nursing facilities, and disproportionate share hospitals.

Attached is a summary of the over 25 administrative actions that my Administration is currently implementing or will take to address Medicare provider payment issues. The Department of Health and Human Services is taking virtually all the administrative actions possible under the law that have a policy justification, which will accrue to the benefit of hospitals, nursing homes, home health agencies, and other providers.

We are finishing our review of our administrative authority to address the 5.7 percent reduction in hospital outpatient department payments. We believe that the Congressional intent was to not impose an additional reduction in aggregate payments for hospitals and I favor a policy that achieves this goal. The enactment of clarifying language on this subject would be useful in making clear Congressional intent with regard to this issue. I have attached a letter from Office of Management and Budget Director Jack Lew, which was sent at your request, detailing how such language would be scored by OMB.

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

On the issue of skilled nursing facilities, we agree that nursing home payments for the sickest Medicare beneficiaries are not adequate. I intend to take all actions possible to address this. Administratively, we can and will use the results of a study that is about to be completed to adjust payments as soon as possible. While we believe that these adjustments must be budget neutral, we are continuing to review whether we have additional administrative authority in this area.

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

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

Sincerely,

BILL CLINTON

BC/SPM/efr (10PGRP)
(thomas.ltr)

Xeroxed copy of signed original to NH thru Sean Maloney

CLEAR THRU SEAN MALONEY

PRESIDENT TO SIGN

All returned to Leg. Aff 10-19-99

October 19, 1999

The Honorable William V. Roth, Jr.
Chairman
Committee on Finance
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

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

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

Preparing and strengthening Medicare for the next century is and will continue to be a top priority for my Administration. For this reason, I proposed a plan that makes the program more competitive and efficient, modernizes its benefits to include the provision of a long-overdue prescription drug benefit, and dedicates a portion of the surplus to help secure program solvency for at least another 10 years. However, I also share your belief that we need to take prompt action -- whether in the context of broader or more limited reforms -- to moderate the excessive provider payment reductions in the BBA of 1997. I believe that legislative modifications in this regard should be paid for and should not undermine the solvency of the Medicare trust fund.

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

Attached is a summary of the over 25 administrative actions that my Administration is currently implementing or will take to address Medicare provider payment issues. The Department of Health and Human Services is taking virtually all the administrative actions possible under the law that have a policy justification, which will accrue to the benefit of hospitals, nursing homes, home health agencies, and other providers.

We are finishing our review of our administrative authority to address the 5.7 percent reduction in hospital outpatient department payments. We believe that the Congressional intent was to not impose an additional reduction in aggregate payments for hospitals and I favor a policy that achieves this goal. The enactment of clarifying language on this subject would be useful in making clear Congressional intent with regard to this issue. I have attached a letter from Office of Management and Budget Director Jack Lew, which was sent at the request of Congressman Bill Thomas, detailing how such language would be scored by OMB.

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

On the issue of skilled nursing facilities, we agree that nursing home payments for the sickest Medicare beneficiaries are not adequate. I intend to take all actions possible to address this. Administratively, we can and will use the results of a study that is about to be completed to adjust payments as soon as possible. While we believe that these adjustments must be budget neutral, we are continuing to review whether we have additional administrative authority in this area.

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

We believe that our administrative actions can complement legislative modifications to refine BBA payment policies. These legislative modifications should be targeted to address unintended consequences of the BBA that can expect to adversely affect beneficiary access to quality care.

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

Sincerely,

BILL CLINTON

BC/SPM/ws (10PRES)
(roth.ltr)

Xeroxed copy of signed original to NH thru Sean Maloney

CLEAR THRU SEAN MALONEY

PRESIDENT TO SIGN

October 19, 1999

The Honorable Daniel Patrick Moynihan
Ranking Member
Committee on Finance
United States Senate
Washington, D.C. 20510

Dear Senator Moynihan:

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

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

Preparing and strengthening Medicare for the next century is and will continue to be a top priority for my Administration. For this reason, I proposed a plan that makes the program more competitive and efficient, modernizes its benefits to include the provision of a long-overdue prescription drug benefit, and dedicates a portion of the surplus to help secure program solvency for at least another 10 years. However, I also share your belief that we need to take prompt action -- whether in the context of broader or more limited reforms -- to moderate the excessive provider payment reductions in the BBA of 1997. I believe that legislative modifications in this regard should be paid for and should not undermine the solvency of the Medicare trust fund.

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Sincerely,

BILL CLINTON

BC/SPM/ws (10PRES)
(moynihan.ltr)

Xeroxed copy of signed original to NH thru Sean Maloney

CLEAR THRU SEAN MALONEY

PRESIDENT TO SIGN

For files

Dear Representative Stark:
The Honorable Fortney Pete Stark
House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:
The Honorable Tom Bliley
Chairman
Committee on Commerce
House of Representatives
Washington, D.C. 20515

Dear Representative Dingell:
The Honorable John D. Dingell
House of Representatives
Washington, D.C. 20515

Dear Representative Rangel:
The Honorable Charles B. Rangel
House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:
The Honorable Bill Archer
Committee on Ways and Means
House of Representatives
Washington, D.C. 20515

Dear Representative Bilirakis:
The Honorable Michael Bilirakis
House of Representatives
Washington, D.C. 20515

Dear Representative Brown:
The Honorable Sherrod Brown
House of Representatives
Washington, D.C. 20515

Dear Senator Rockefeller:
The Honorable John D. Rockefeller IV
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:
The Honorable Phil Gramm
Committee on Banking, Housing
and Urban Affairs
United States Senate
Washington, D.C. 20510

Separate letter

Dear Mr. Chairman:
The Honorable William M. Thomas
Chairman
Committee on House Administration
House of Representatives
Washington, D.C. 20515

Dear Representative Stark:
The Honorable Fortney Pete Stark
House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:
The Honorable Tom Bliley
Chairman
Committee on Commerce
House of Representatives
Washington, D.C. 20515

Dear Representative Dingell:
The Honorable John D. Dingell
House of Representatives
Washington, D.C. 20515

Leg affairs May want to add Congressmen:
- Rangell
- Archer
- Bilirakis
- Brown
- Rockefeller Senate
- ~~Gramm~~ Gramm Senate

Sherrod

Moynihan
United States Senate

Roth
US Senate

October 19, 1999

MEMORANDUM FOR THE RECORD

Presidential letters to certain Senators and Congressmen re Medicare

Today, the President sent an identical letter to all of the individuals whose names are typed on the attached list. The attached letter to Congressman William Thomas is a sample.

The President also sent letters to Senators Roth and Moynihan which were identical to the others except for the opening two paragraphs. Copies of these two letters are also attached.

JWGoodling

Copy of Roth letter
sent to POTUS on 10-20-99