Draft

Dear (Member of Congress):

As you struggle to balance the Federal budget, it is important to never lose sight of the critical role the Medicaid program plays in caring for over 35 million of our most vulnerable populations. It currently covers one-third of all births, three-fifths of Americans living in poverty, and nearly two-thirds of nursing home residents.

As providers of health care to these populations, we stand united in our support for a reformed Medicaid program that controls costs and allows states more flexibility in the design and administration of their programs. We are also unified, however, in our strong opposition to excessive reductions in funding and radical restructuring of the program that substitutes a block grant financing mechanism that would jeopardize people's access to needed care and our ability to provide it.

While savings necessary to help balance the budget are achievable, they need not and should not come at the expense of eliminating our longstanding national commitment to a Federally-enforced health care entitlement for all categories of vulnerable Americans covered under the Medicaid program. With this in mind, we would adamantly oppose any Medicaid restructuring proposal that does not adequately meet the following objectives:

-- **Preservation of the Medicaid Entitlement.** The Federally-enforced eligibility entitlement to a set of nationally-defined benefits must be maintained. Fifty states defining and enforcing eligibility to a widely-varying benefits package would break this nation's 30-year national health care safety-net commitment.

-- **Continued Federal Financial Responsibility for Medicaid.** The Federal government should continue to be a responsive financing partner with the states when they suffer through unexpected periods of recession and inflation. A block grant would eliminate the responsibility of the Federal Government and, in economic downturns, would force states to reduce coverage, slash reimbursement and/or raise taxes. In fact, according to the Center for Budget and Policy Priorities, even a one percent increase in inflation above current Congressional Budget Office projections would place a staggering $65 billion unanticipated shortfall squarely on the shoulders of states and local governments.

-- **Continued State Financial Responsibility for Medicaid.** The States' long-standing financial partnership in funding the Medicaid program should also be maintained. State matching rate changes that reduce the minimum Medicaid contribution by States (as, for example, contemplated by the Republican conference agreeement) would take as must as $290 billion out of the health care system -- $205 billion from state reductions and $85 billion from Federal cuts. Obviously a cut of this magnitude could well force States to deny coverage for millions of Americans. This would result in a significant increase in uncompensated care to a health care system already overburdened by over 40 million uninsured Americans.

Draft

--- **A Financial Environment in which Providers Can Continue To Serve Medicaid -- and private -- patients.** Although we understand the desire for additional flexibility for states, we believe that there a number of provisions being considered by the Congress and the Administration that may severely harm providers. They include the repeal of the Boren amendment, the repeal of protections against provider taxes, and the allowance for benefit copayment increases. Since many low income people will not be able to afford the copayments, such out-of-pocket increases may serve simply as back-door provider cuts. Assuring adequate provider payments enables providers to continue our commitment to serve all Americans, regardless of their sickness or wealth.

Block grant approaches, which would totally repeal the current Medicaid statute, meet none of our minimum objectives. Proposals that limit Federal spending on a per beneficiary basis and preserves the Federally-enforced entitlement meet our minimum objectives. What is more, they achieves our objectives without undermining the national commitment to a health care safety net and without going backwards in providing desperately needed coverage to millions of Americans.

As we stand at the brink of the next millennium, it is all of our responsibility to restore our nation's fiscal strength while maintaining our compassion. A viable Medicaid program will help us meet that challenge.

The White House
Office of Presidential Letters and Messages

Facsimile from Seth Masket
Voice: (202) 456-5514; FAX: (202) 456-2806

No. of Pages (including cover): 2 Date: 1/26/96

To: JEN KLEIN

Voice: 6-2599 Fax: 6-2878

Comments: THIS IS BOB POTTER'S LETTER. I HAVE NOTHING ELSE TO SHARE AT THIS TIME. THANKS!

DRAFT

Lonnie R. Bristow, M.D.
American Medical Association
515 North State Street
Chicago, IL 60610

Dear Dr. Bristow:

Thank you for your letter regarding Medicare reform, the antitrust laws, and physician networks.

As you know, I believe that physician-directed networks offer the prospect of cutting costs and allocating a higher percentage of the premium dollar to patient care. Unnecessary barriers to the formation of physician networks prevent physicians from forming networks as competitive alternatives to insurance sponsored health insurance plans. My Administration supports the removal of any such unnecessary barriers. At the same time, we also believe that the antitrust laws, when properly applied, are important to preserve competitive alternatives as well.

My Administration will continue to work to ensure that unnecessary barriers will not prevent physician-sponsored networks from forming. I will continue to give these issues, and your views, thoughtful consideration in my review of Medicare reform.

Sincerely,

Jon Klein - Fyi

THE WHITE HOUSE

WASHINGTON

November 27, 1995

INFORMATION

MEMORANDUM FOR THE PRESIDENT

FROM: Carol Rasco

SUBJECT: Academic Health Centers and Budget Strategy

I. SUMMARY

After reviewing John Young's (Co-Chair of the President's Committee of Advisors on Science and Technology) letter and suggestions on how to support academic health centers, you asked for an update of where our health/budget policy and strategy stands with regard to this issue. Chris Jennings has provided us with the following update:

By any definition, academic health centers would fare better under your balanced budget plan than they would under the Republican's budget. However, despite personal appeals by Leon and other senior White House officials, the association that represents academic health centers nationally -- the American Association of Medical Colleges (AAMC) -- has refused to be publicly critical of the Republican plan.

Out of fear that the academic health centers would play the "quality" card, the Republicans actively courted their support (or at least non-opposition). Their negotiations produced a $13.5 billion Graduate Medical Education (GME) trust fund.

The source of financing the new Republican GME fund is unclear and certainly may not be permanent. Even if one assumes the new account will be fully funded, it would not come close to offsetting the deep Republican Medicare and Medicaid cuts that will hurt academic health centers. Moreover, it would still leave these institutions in much worse shape (at least $4-5 billion over seven years) than they would find themselves under your balanced budget plan.

Despite acknowledging the above shortcomings, the leadership of the AAMC fears alienating the Congressional Republicans. (The AAMC also says they fear their silence on the budget front may harm their relationship with the Administration.) However, we do not anticipate a change in their "play both sides of the track" strategy -- at least until later in the game.

II. DISCUSSION

Not all representatives of academic health centers have remained silent about the Republican health care cuts. Those from Boston and New York have been critical, but the elite national press rarely picks them up.

Although some in the AAMC privately concede that their stay quiet strategy may well end up costing them big money, they have chosen this course for three reasons. First, unlike the Republicans, they do not believe we would ever do anything that is hostile to their concerns. Second, they successfully bargained for their significant GME trust fund. And lastly, they well understand that the Republicans will be drafting the details of any final deal and they want to have "friends on the inside" when they do.

Based on our current academic health care policy, their calculated assumption that we would take care of them is not unfounded. In fact, your proposal incorporates every recommendation made by Dr. Young. It:

- Establishes a new Commission to develop specific policies that address the long-term private and public funding challenges academic health centers face in an increasingly cost-conscious and competitive environment;

- Keeps cuts in Graduate Medical Education (GME), Disproportionate Share (DSH), and Medicaid to a minimum (about $12 billion less than what the Republicans advocate); and

- Proactively responds to the academic health centers' number one legislative priority -- the establishment of a new GME fund that is financed by a reduction in Medicare reimbursement to HMOs. (Most Medicare HMOs are not contracting out with academic health centers but are being reimbursed by Medicare as though they are; the new $5-7 billion fund would be used to create incentives for HMOs to contract out with academic health centers.)

The AAMC likes the Republicans' trust fund concept because it opens the door to the possibility of non-Medicare generated financial support. However, their first priority is the GME fund proposal included in your balanced budget plan. This is because, unlike the Republican trust fund, they know they can count on the money being there. (Not surprisingly, they would like us to support the retention of the Republican trust fund -- no matter how little the money.)

We will continue to meet with the representatives of the academic health center community to seek their support in the upcoming negotiations. They may come on board later in the process.

THE PRESIDENT HAS SEEN
11-20-95

EXECUTIVE OFFICE OF THE PRESIDENT
PRESIDENT'S COMMITTEE OF ADVISORS ON SCIENCE AND TECHNOLOGY
WASHINGTON. D.C. 20500

November 8, 1995

95 NOV 14 P12:28

President William J. Clinton
The White House
1600 Pennsylvania Avenue, N.W.
Washington, DC 20500

Dear Mr. President:

The significant accomplishments in American biomedical research and our innovations in medical care are widely respected throughout the country and, indeed, the world. These achievements have occurred primarily at our Nation's academic health centers. Since World War II, the Federal government has played a vital role in the support of academic health centers and has done so on a bipartisan basis.

Your Administration's 1994 health care reform plan acknowledged the important contribution to our quality of life made by academic health centers and provided a mechanism to mitigate the loss of significant revenue that these institutions are now experiencing. In the absence of comprehensive health care reform, academic health centers are beginning to show signs of serious stress. Although they represent only six percent of the Nation's non-Federal acute care hospitals, these institutions provide more than half of the care for the indigent and uninsured populations. The prospect of sharp reductions in Medicare, Medicaid, and Disproportionate Share (DSH) expenditures, coupled with the erosion of clinical revenues resulting from the emergence of managed care, could have a devastating impact on the Nation's capacity to support medical research and education and the system that provides medical care to its most vulnerable citizens.

Academic health centers develop the biomedical knowledge and clinical techniques needed for new and improved treatments, train the Nation's physicians and provide unique patient care resources. In the long term, biomedical research conducted in these centers offers our citizens the best potential to enhance their quality of life and control medical expenditures with cost-effective methods for disease prevention and management.

Historically, the Federal government has assumed responsibility for a majority of the support for fundamental biomedical research and graduate medical education as a public investment that contributes broadly to the health of Americans. In 1995, the Federal investment in academic health centers for biomedical research and education was about one percent of total health care expenditures. Measured by any standard, this very modest rate of investment in an area of extraordinarily rapid advancement in knowledge and technology has had a remarkable yield. In addition, the Federal government provides, through the Medicaid and DSH programs, significant support for low-income patient care delivered in academic health centers.

Clinical revenues derived from medical practice programs conducted by the faculty of academic health centers have been another very significant source of funds for these programs of research, education and indigent care. Current changes in the health care system, including Medicare and Medicaid reform, driven by Federal and State fiscal concerns and the emergence of managed care, also threaten to eliminate this critical support for biomedical research and medical education.

We recognize the need to slow the rate of growth in health care costs and endorse efforts to address this need. Both public and private elements of the health care system need to be carefully examined and restructured to enhance medical efficacy and cost-effectiveness. However, it is also essential that in this process, the crucial public benefits that are contributed uniquely by academic health centers be recognized, and that their continued strength remain an important priority in the ongoing health care debate.

A panel of your Committee of Advisors on Science and Technology (PCAST) examined these issues and reached the following conclusions:

- **Sharing the Responsibility** -- The education of competent physicians and scientists, and the production of new biomedical knowledge and technologies, represent vital public necessities. To date, only the Federal government has supported these functions explicitly through the Graduate Medical Education (GME) mechanisms of the Medicare program. With a few notable exceptions, other payers do not contribute to this support. We affirm the principle that responsibility for supporting the missions of academic health centers and their contributions to the well-being of society should be broadly shared by all who benefit.

- **Care for the Indigent and Uninsured** -- Historically, academic health centers have provided care for a disproportionate share of the indigent and uninsured populations and have received a Medicare payment adjustment for this service. It is likely that this responsibility can only increase in the developing private and public medical care marketplaces. With the trend toward managed care, others are even less likely to provide this service because of its resource-intensive nature.

- Current Debate -- A satisfactory disposition of these critically important and complex issues is unlikely to emerge from the heat of the current public debate, with its intense and narrow focus on budgetary concerns.

To support and sustain the Nation's academic health centers in the immediate future and over the longer term, PCAST therefore respectfully suggests that you consider the following recommendations:

- **Expert Commission** -- We recommend that an expert commission, credible to the President, the Congress and the public, be established to develop and recommend specific policies to address the preservation of the research and educational capacity of the Nation's academic health centers, and the supply, composition and support of the future health care work force. The commission should carefully consider the implementation of an equitable mechanism to achieve these objectives. The commission should also determine the most effective way to allocate training funds in furthering the goals of a rational workforce policy to ensure that the numbers and competencies of health care professionals are responsive to the Nation's needs. We believe that such an approach can best ensure the future vitality of our biomedical research enterprise and the highest quality of our Nation's medical care.

- **Graduate Medical Education (GME)** -- In the interim, in revising the Medicare program, the Administration should continue to resist disproportionate decreases in the GME accounts. Further, the funds for GME that are currently melded into the premiums paid to all Medicare managed care providers (the Average Adjusted Per Capita Cost formula) should be redirected to accomplish their intended objectives. This may entail developing a process that provides these payments directly to caregivers and institutions that are involved in graduate medical education.

- **Disproportionate Share** -- If academic health centers are to continue their role of disproportionately caring for the indigent and uninsured populations, then appropriate resources must be provided. This will almost certainly remain a responsibility of the government.

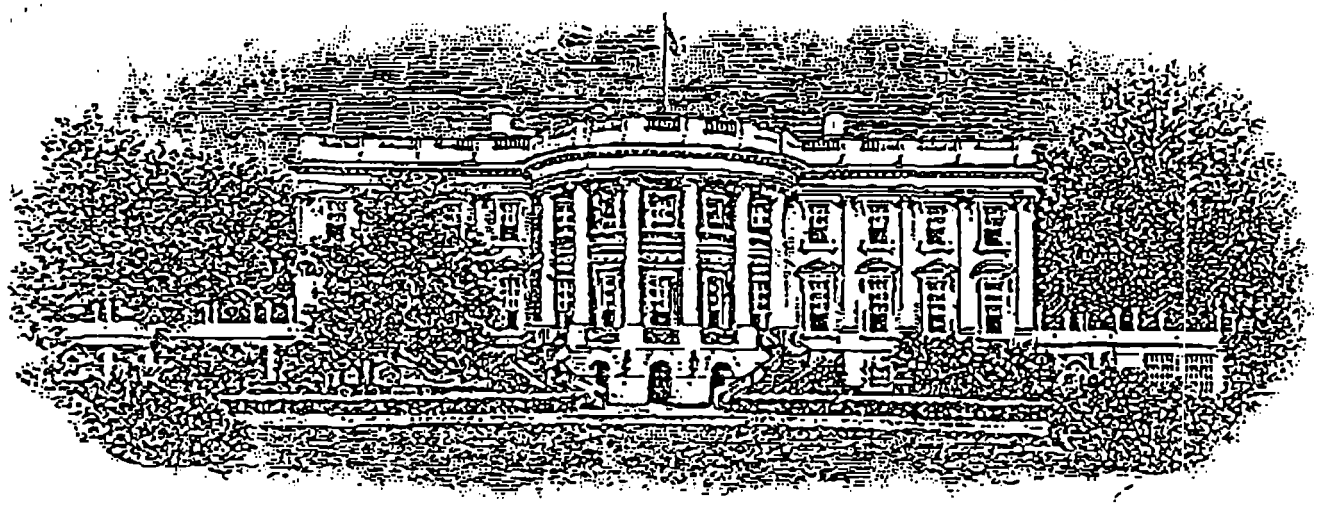
PCAST believes that the academic health centers are a national resource that, together with our research universities, must be sustained for the good of the Nation. We hope that you will find these recommendations helpful.

Sincerely,

John A. Young
Co-Chair
President's Committee of Advisors
on Science and Technology

What happened
w/ this?

The White House



DOMESTIC POLICY

FACSIMILE TRANSMISSION COVER SHEET

TO: Jen Klein

FAX NUMBER: 6-2878

TELEPHONE NUMBER:

FROM: Chris J.

TELEPHONE NUMBER:

PAGES (INCLUDING COVER): 5

COMMENTS: Most recent ASPE version

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ASSISTANT SECRETARY FOR PLANNING AND EVALUATION

For: Most recent ASPE Version

PHONE: (202)690-8794 FAX: (202)690-6518

Date: _____

From: JEANNE _____ To: CHRIS _____

Division: _____ Division: _____

City & State: _____ City & State: _____

Office Number: _____ Office Number: _____

Fax Number: _____ Fax Number: _____

Number of Pages + cover _____

REMARKS: Is this what Jon Richard Sorian wanted?

ACADEMIC HEALTH Ctrs

Draft - Please make sure that you tell Jack that you needed me to do this.

DRAFT EDITORIAL

DRAFT

When one of our family members is ill, what do we want for them? The answer is simple: the best medical care possible, provided by highly trained professionals, and backed up by state-of-the-art research. And who educates those professionals, conducts that research, and provides care and service in communities like _____? It is academic health centers and teaching hospitals [like _____]. But today, the unique mission of these institutions is at risk. Proposed Congressional cuts in Medicare and Medicaid, coupled with changes in the private market, threaten the funding that academic health centers need to continue to serve as a cornerstone of our nation's health care system.

The Congressional Budget Proposal

Let's look first at the federal budget. The Congress proposes reductions of $452 billion in Medicare and Medicaid over the next seven years -- $270 billion in Medicare, and $182 billion in Medicaid. Those are staggering numbers -- four times larger than anything ever enacted. But to understand their true impact, it is useful to look at what those cuts will mean for the growth in spending per person in each of these programs. Private health insurance spending per person will increase by about 7.1 percent annually over the next seven years, according to the Congressional Budget Office (CBO). The Congressional Medicare cuts would bring Medicare spending per beneficiary down to a growth rate of about 4.9 percent annually -- or 30 percent below the private sector growth rate for each of the next seven years. The Congressional Medicaid cuts are even worse -- bringing the Medicaid growth rate down to about 1.4 percent annually -- or 80 percent below the private sector growth rate.

DRAFT

The result? The purchasing power of these two essential health programs will lag significantly behind the private market each year for the next seven years. The beneficiaries and their families will pay more and, most likely, get less. Specifically, each beneficiary will pay about $2,825 more ($5,650 per couple) over the next seven years, assuming that 50 percent of the Medicare cut comes from beneficiaries [Replace with state-specific data for area in which provider is located. And, the federal Medicaid cut would force states to cut services, reduce provider payments, and eliminate coverage for about 8.8 million children, elderly, and disabled Americans by the year 2002. [Replace with state-specific data for provider location]

Impact on academic health centers

What does all this mean for academic health centers and teaching hospitals like _____? We will continue to take a leadership role in research and the education of professionals. [Insert local example of some innovations?] We are also striving to remain competitive as the health system changes and becomes more cost-conscious. [Insert example of cost cutting]

But the fact remains that it costs more for us to provide care <u>because</u> our education and research mission adds to our patient care costs. Medicare has historically been the most responsible payor of medical education, explicitly acknowledging its value and paying for its support. In addition, we provide a substantial amount of indigent care for individuals who do not have health insurance. [Insert local indigent care $ or #]. Medicaid has served as a payor for poor and sick populations who would otherwise strain hospitals' ability to both provide quality health care and education. While private payers have borne some of these costs, in the increasingly competitive private health market they are seeking the lowest cost services for their enrollees are not likely to pay the extra costs of facilities that also provide education and research.

DRAFT

This support of Medicare and Medicaid for the unique mission academic health centers will be dramatically reduced by the Medicare and Medicaid cuts proposed by the Republicans in Congress. The magnitude of the cuts alone means that academic health centers will face the same pressures but with less funding. But it is not just the size of the cuts: it is the specifics. In draft Medicare plans produced by the Congressional majority, payments for indirect medical education and graduate medical education would be reduced along with disproportionate share payments and high-cost medical staff payments, which go largely to academic health centers. This means that academic health centers won't be able to train, won't be able to conduct research that leads to break-throughs, and won't be able to absorb the costs of providing care to the rising number of uninsured Americans.

Will the results be dramatic -- immediate shutdowns, or quick, visible declines in the quality of care? Probably not: slow, steady disinvestment in education and research are never very visible at first. But they have lagged effects that may be even more debilitating in the long run -- because today's education and research directly affects tomorrow's care. When your family -- and your children's families -- need health care ten, twenty, or thirty years from now, do you want the health professionals then in practice to be the product of excellence in education -- or of a slowly defunded education and research system?

[provider] is committed to maintaining and enhancing the quality of our education, research, and service. That is our core mission -- and reflects the needs and aspirations of our community and our patients. Deep budgetary reductions that prevent us from meeting your needs -- now and in the future -- must be opposed.

THE WHITE HOUSE
WASHINGTON, D.C. 20500

DATE: 11/18/95

TO: LAURA TYSON
CHRIS JENNINGS
JENNIFER KLEIN

FROM: **Staff Secretary**

FYI

The attached has been forwarded to the President.

EXECUTIVE OFFICE OF THE PRESIDENT
PRESIDENT'S COMMITTEE OF ADVISORS ON SCIENCE AND TECHNOLOGY
WASHINGTON, D.C. 20500

95 NOV 14 P12 : 28

November 8, 1995

President William J. Clinton
The White House
1600 Pennsylvania Avenue, N.W.
Washington, DC 20500

Dear Mr. President:

The significant accomplishments in American biomedical research and our innovations in medical care are widely respected throughout the country and, indeed, the world. These achievements have occurred primarily at our Nation's academic health centers. Since World War II, the Federal government has played a vital role in the support of academic health centers and has done so on a bipartisan basis.

Your Administration's 1994 health care reform plan acknowledged the important contribution to our quality of life made by academic health centers and provided a mechanism to mitigate the loss of significant revenue that these institutions are now experiencing. In the absence of comprehensive health care reform, academic health centers are beginning to show signs of serious stress. Although they represent only six percent of the Nation's non-Federal acute care hospitals, these institutions provide more than half of the care for the indigent and uninsured populations. The prospect of sharp reductions in Medicare, Medicaid, and Disproportionate Share (DSH) expenditures, coupled with the erosion of clinical revenues resulting from the emergence of managed care, could have a devastating impact on the Nation's capacity to support medical research and education and the system that provides medical care to its most vulnerable citizens.

Academic health centers develop the biomedical knowledge and clinical techniques needed for new and improved treatments, train the Nation's physicians and provide unique patient care resources. In the long term, biomedical research conducted in these centers offers our citizens the best potential to enhance their quality of life and control medical expenditures with cost-effective methods for disease prevention and management.

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Clinical revenues derived from medical practice programs conducted by the faculty of academic health centers have been another very significant source of funds for these programs of research, education and indigent care. Current changes in the health care system, including Medicare and Medicaid reform, driven by Federal and State fiscal concerns and the emergence of managed care, also threaten to eliminate this critical support for biomedical research and medical education.

We recognize the need to slow the rate of growth in health care costs and endorse efforts to address this need. Both public and private elements of the health care system need to be carefully examined and restructured to enhance medical efficacy and cost-effectiveness. However, it is also essential that in this process, the crucial public benefits that are contributed uniquely by academic health centers be recognized, and that their continued strength remain an important priority in the ongoing health care debate.

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- **Care for the Indigent and Uninsured** – Historically, academic health centers have provided care for a disproportionate share of the indigent and uninsured populations and have received a Medicare payment adjustment for this service. It is likely that this responsibility can only increase in the developing private and public medical care marketplaces. With the trend toward managed care, others are even less likely to provide this service because of its resource-intensive nature.

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PCAST believes that the academic health centers are a national resource that, together with our research universities, must be sustained for the good of the Nation. We hope that you will find these recommendations helpful.

Sincerely,

John A. Young
Co-Chair
President's Committee of Advisors
on Science and Technology

TALKING POINTS FOR VISIT TO MEDICAL CENTER OF DELAWARE

- As I toured the medical center and talked with the staff, I was reminded that we have the greatest health care system in the world -- the most talented and dedicated health care professionals, and the finest institutions.

- Above all else, we must evaluate any changes to our health care system by how they affect quality. In the President's eyes, there is nothing more important, and he will not accept any proposal from the Congress that threatens the quality of care that Americans have come to expect.

- The Republicans are proposing to cut an unprecedented $270 billion from the Medicare program and a devastating $182 billion from the Medicaid program. These cuts are four times as large as anything ever enacted. And not one penny of these savings is reinvested into the health care system.

- There is simply no way to take $450 billion out of our health care system without threatening quality. Let's look at the impact of these cuts.

Medicare

- Everyone has heard about the scope and size of the Republican Medicare cuts. What you might not know is this: Republicans claim they wish to emulate the private sector. The reality is that their proposals don't match the private sector growth per person rate of 7.1 percent -- they limit it to an unrealistic 4.9%.

- At a time when the private sector managed care industry is squeezing hospitals and other health care facilities, these cuts will be even more devastating. I know that this has been of particular concern here in Wilmington. [Laura: This is referencing the articles we enclosed in your briefing book.]

- As an academic medical center, you face higher costs because your mission is research and education as well as patient care. Your patients tend to be sicker, and you make an even greater investment in technology than most other hospitals. I also know that you serve a large number of indigent patients, which for your three facilities add an additional financial burden of $45 million in uncompensated care.

- But what do these numbers mean in more understandable terms? Well, right here in New Castle County, the $270 billion in Medicare cuts translate into a $561 million dollar reduction in Medicare dollars coming into the county, a $152 million reduction in 2002 alone. Assuming that 50 percent of these cuts come from beneficiaries, people on Medicare in New Castle would pay $3,425 ($6,850 per couple) more over seven years.

- Republicans say that they need these cuts to save the Medicare Trust Fund. But they won't tell you that the Trust Fund has faced an insolvency problem of 7 years or less in 9 separate occasions. They won't tell you that the Trust Fund is in better shape than when the President came into office, due to his 1993 budget, which every Republican opposed. They won't tell you that the President's balanced budget proposal would strengthen the Trust Fund through October, 1996 -- 11 years from now. And finally, they won't tell you that you don't need $270 billion to strengthen the Trust Fund.

- In fact, many of their cuts have nothing to do with the Trust Fund. The over $100 billion in Part B beneficiary and provider cuts the Republicans are considering are not dedicated to the Part A Trust Fund. Instead they are used to help pay for their unnecessary $245 billion tax cut.

Medicaid

- And we have not even talked about Medicaid yet. You serve a large and disproportionate number of these vulnerable and expensive patients. There is no health care provider that I am aware of who has ever suggested that they were overcompensated by Medicaid.

- Republicans claim that Medicaid spending would continue to increase, albeit not as fast as it has in the past. What they aren't telling you, however, is that the Federal contribution would not keep up with enrollment growth, let alone inflation or changes in the cost of health services.

- As I mentioned before, the Republicans would constrain Medicare to an unrealistically low 4.9 percent per person growth rate; the corresponding Medicaid growth rate would be an incredible 1.4 percent.

- In response, States would be forced to reduce provider payments, services and coverage. If the cuts were divided evenly, in the year 2002 alone, already low payments to providers would be reduced by more than $11 billion across the country.

- Should the Republicans' $182 billion in Medicaid cuts become law, Delaware alone would lose $331 million in Federal Medicaid funding over seven years, and $98 million in 2002 alone -- a 30% reduction in that year. That is a cut by any definition.

- But it gets worse. In Delaware, as in all other States, the reduction in Federal Medicaid dollars will force the State to drop coverage for the most vulnerable of our citizens. 21,000 in this State will lose coverage in the year 2002 alone, according to a new Urban Institute study. You know better than anyone what this means for you. It means even more uninsured patients creating an even greater uncompensated burden for your institution.

President's Position on Health Care

- The President's position is clear: He has said that he will be forced to veto any legislation that contains this level of Medicare and Medicaid cuts.

- You simply don't need anywhere near this level of cuts. The President's balanced budget clearly shows how this is possible. With approximately one-third the cuts, we can eliminate the deficit, improve the financial health of the Medicare program and make Medicaid more efficient. But we can do all this while assuring that health care providers can continue to give quality care, preserving coverage, and protecting Medicare beneficiaries from excessive out-of-pocket increases.

- I am convinced that the President's budget reflects the values and priorities of the vast majority of the American public. The President hopes and expects that these values will be reflected in the budget that eventually comes out of the Congress.

- But this won't happen if the Congressional majority does not get the message -- loud and clear -- that their budget and tax cuts go too far, and will hurt too many Americans. We need your help to get that message out. We look forward to working with you.

DRAFT EDITORIAL

When one of our family members is ill, what do we want for them? The answer is simple: the best medical care possible, provided by highly trained professionals, and backed up by state-of-the-art research. And who educates those professionals, conducts that research, and provides care and service in communities like _____? It is academic health centers and teaching hospitals [like _____]. But today, the unique mission of these institutions is at risk. Proposed Congressional cuts in Medicare and Medicaid, coupled with changes in the private market, threaten the funding that academic health centers ~~require~~ need to continue to serve as a cornerstone of our nation's health care system.

The budget

Lets look first at the federal budget. The Congress proposes reductions of $452 billion in Medicare and Medicaid over the next seven years -- $270 billion in Medicare, and $182 billion in Medicaid. Those are staggering numbers -- four times anything ever enacted. ~~but too large for any of us to really understand.~~ But to understand their true impact, it is useful to look at what those cuts will mean for the growth in ~~translate them into something more meaningful -- growth rates in~~ spending per person each in both of these programs.

- Private health insurance spending per person will increase by about 7.1 percent annually over the next seven years, according to the Congressional Budget Office (CBO).
- The Congressional Medicare cuts would bring Medicare spending per beneficiary down to a growth rate of about 4.9 percent annually -- or 30 percent below the private sector growth rate for each of the next seven years.
- The Congressional Medicaid cuts are even worse -- bringing the Medicaid growth rate down to about 1.4 percent annually -- or 80 percent below the private sector growth rate.

Get rid of bullets

The result? The purchasing power of these two essential health programs will lag significantly behind the private market each year for the next seven years. The beneficiaries and their families will pay more and, most likely, get less. Specifically:

DRAFT

- each beneficiary will pay about $2,825 more ($5,650 per couple) over the next seven years, assuming that 50 percent of the Medicare cut comes from beneficiaries; [Replace with state-specific data for area in which provider is located]
- the federal Medicaid cut would force states to cut services, reduce provider payments, and eliminate coverage ~~-- cutting an estimated~~ 8.8 million children, elderly, and disabled ~~individuals~~ by the year 2002. [Replace with state-specific data for area in which provider is located]

Impact on academic health centers

What does all this mean for academic health centers and teaching hospitals like _____?

We are ~~striving~~ to remain competitive as the health system changes and becomes more cost-conscious ~~and we are taking~~ a leadership ~~role through~~ research and the education of professionals ~~needed for that future system~~. [Insert local example of some innovations?]

But the fact remains that it costs more for us to provide care because our education and research mission adds to our patient care costs. In addition, we provide a substantial amount of indigent care for individuals who ~~are without~~ health ~~benefits~~. [Insert local indigent care $ or #]. All these costs require funding from private payors, Medicare, and Medicaid. Medicare has been a major source of financing for graduate medical education -- and in the increasingly competitive private health market, private payors seeking the lowest cost services for their enrollees are not likely to pay the extra costs of facilities that also provide education and research.

We can pretend that academic health centers will somehow be protected despite the deep Medicare and Medicaid cuts -- that the "other guy" will be cut. But that is not real. The proposed cuts are too large -- and will yield higher beneficiary costs, lower provider payments, and more and more individuals uninsured -- requiring care that must ultimately be financed by other payors.

DRAFT

Will the results be dramatic -- immediate shutdowns, or quick, visible declines in the quality of care? Probably not: slow, steady disinvestment in education and research are never very visible at first. But they have lagged effects that may be even more debilitating in the long run -- because today's education and research directly affects tomorrow's care. When your family -- and your children's families -- need health care ten, twenty, or thirty years from now, do you want the health professionals then in practice to be the product of excellence in education -- or of a slowly defunded education and research system?

[provider] is committed to maintaining and enhancing the quality of our education, research, and service. That is our core mission -- and reflects the needs and aspirations of our community and our patients. Deep budgetary reductions that prevent us from meeting your needs -- now and in the future -- must be opposed.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
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Contact: Patricia Shea
(202) 828-0456

AAMC NEWS

PRESS ADVISORY

TEACHING HOSPITAL CEO'S TO SPEAK OUT AGAINST MEDICARE CUTS

WHAT: Six teaching hospital leaders, representing institutions from every region of the country, will address the impact that reduced Medicare support and an increasingly competitive marketplace will have on the viability of their institutions at a press conference tomorrow. The event is sponsored by the Association of American Medical Colleges.

House and Senate budget plans released last week recommend reducing Medicare spending by $250 billion over the next seven years. To achieve these savings, it is likely that Medicare's support for teaching hospitals' academic missions—care for the nation's sickest patients, medical education and clinical research—will be sharply reduced. Teaching hospital leaders contend that massive cuts in Medicare support for these activities, when coupled with private sector losses and other cuts in Medicare reimbursement, will have a very negative impact on the world-recognized excellence of these institutions. Every American's quality of life will suffer as a result.

WHERE: Longworth House Office Building
Room 1416

WHEN: Tuesday, May 16, 1995
11:30 a.m. to 12:30 p.m.

WHO: Spencer Foreman, M.D., president, Montefiore Medical Center, Bronx, NY

William Kerr, director, Medical Center at the University of California, San Francisco, Calif.

Charles Mullins, M.D., executive vice chancellor for health affairs, University of Texas System, Austin, Texas

Mitchell Rabkin, M.D., president, Beth Isreal Hospital, Boston, Mass.

William Rice, J.D., chancellor and vice president for health affairs, University of Tennessee, Memphis, Tenn.

Robert Waller, M.D., president and CEO, Mayo Foundation, Rochester, Minn.

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The Association of American Medical Colleges represents the 125 accredited U.S. medical schools; the 16 accredited Canadian medical schools; some 400 major teaching hospitals, including 74 Veterans Administration medical centers; 91 academic and professional societies representing 87,000 faculty members; and the nation's 67,000 medical students and 102,000 residents.

AAMC

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"Academic Medicine In The Emerging Price Competitive Environment"

We are here representing academic medical centers - those institutions that have the multiple missions of patient care, education, and research. Some of us are large urban centers, some are smaller and located in largely rural states. Some of us are public, some are private, some are specialty-oriented, some emphasize primary care. But regardless of our location or emphasis, our ability to fulfill our multiple missions is in jeopardy. Our missions are as follows:

- o providing regional and stand-by services such as trauma care, burn care, high risk obstetrics, and newborn care;
- o serving large groups of severely ill and disadvantaged patients including, in many instances, those who are unable to pay;
- o educating the next generation of physicians and other health providers regardless of the mix of primary care providers or specialists; and
- o maintaining the most productive research enterprise in the world.

As citizens and community leaders we support the need to address federal spending. While there is substantial support among the American people for the effort in general, the particulars are tough. However, we also know that decisions , especially tough ones, need to be informed ones. We are here in the hope that as discussions continue about the particulars of reductions in federal spending, informed and fair decisions will be made about the special Medicare payments we now receive for graduate medical education.

First, we wish to describe our efforts in the marketplace:

- o Academic medical centers are struggling to be competitive in a new world of health care delivery. Each of us is working hard to cut costs and remain competitive - we are downsizing, merging, creating networks, developing new teaching methods, identifying new ways to train primary care physicians outside hospitals. Academic medicine is taking a leadership role in a changing health care delivery system.
- o Teaching hospitals and academic medical centers, because of their unique missions, incur higher costs than do other types of hospitals. Until very

recently, both private payers, by paying higher charges, and Medicare, through the indirect medical education (IME) adjustment and the direct medical education (DME) payment, shared in supporting our mission. Increasingly, managed care plans and HMOs refuse to share in the responsibility of paying for the teaching mission. The withdrawal of the private sector from its responsibilities makes the federal role all the more important.

Due to this new competitive environment, the private sector is no longer bearing its fair share of the costs of our teaching, research, and patient care missions. In this new competitive market we are not able to command higher prices for our services.

Second, we believe every American benefits from the work performed at our academic medical centers:

- the research breakthroughs occurring at our institutions which include the first successful liver, heart, and bone marrow transplants; first identification of AIDS; and the first human gene therapy for cystic fibrosis;

- the physicians trained at our institutions, who in turn provide care in every single state;

- the treatment of complex cases and innovative protocols developed at our institutions, which are then replicated throughout the country and the world.

The federal government is the bulwark of support on which we must depend to continue in our role as the backbone and the future of American medicine:

- We have to live with the cuts in projected Medicare spending that all hospitals will have to endure;

- The direct medical education payment and the disproportionate share (DSH) payment are identified as major targets for cutting;

- The indirect medical education (IME) payment, which represents twenty-five percent of Medicare inpatient revenue for major teaching hospitals - is being targeted for a major reduction in spending.

- These (DME and DSH) and the IME proposals are not cuts in rates of increase in projected spending; they are real reductions in spending from FY1995 levels.

Massive reductions in Medicare reimbursement for activities related to graduate medical education will, when coupled with private sector losses, and other cuts in Medicare reimbursement, have a very negative impact on our continued excellence. Every American's quality of life will suffer as a result.

We believe there is a legitimate role for government to recognize and support our missions. We urge Congress to study carefully the current funding crisis in academic medicine, and to proceed with great caution and deliberation before singling out and imposing disproportionate budget cuts on teaching hospitals and academic medical centers.

Spencer Foreman, M.D.
President
Montefiore Medical Center
Bronx, New York

Mitchell T. Rabkin, M.D.
President
Beth Israel Hospital
Boston, MA

William B. Kerr
Director
Medical Center at the University of California, San Francisco
San Francisco, CA

William R. Rice, J.D.
Chancellor and Vice President for Health Affairs
The University of Tennessee, Memphis
Memphis, TN

Charles B. Mullins, M.D.
Executive Vice Chancellor for Health Affairs
The University of Texas System
Austin, TX

Robert R. Waller, M.D.
President & Chief Executive Officer
Mayo Foundation
Rochester, MN

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AAMC NEWS

For Immediate Release

BUDGET PROPOSALS WOULD DEVASTATE ACADEMIC MEDICINE

Washington, D.C., May 16, 1995–House and Senate budget proposals that could cut billions dollars in funding support to the nation's medical schools, teaching hospitals, and medical research efforts "will devastate academic medicine's ability to care for the American people and to ensure future quality through medical education and research," said Jordan J.Cohen, M.D., president of the Association of American Medical Colleges. "Funding cuts of this magnitude will push medical schools and teaching hospitals to the brink of financial ruin and put our nation's highest quality health care services in serious jeopardy."

Calling the budget committee proposals a "systematic undermining of the infrastructure of academic medical centers," Dr. Cohen warned that medical schools and teaching hospitals already are facing extraordinary challenges to their survival. "Academic medical centers are fighting for survival in a price-competitive marketplace largely unwilling to pay for the social goods these centers produce–care for the nation's sickest patients, a skilled health care workforce, access to health care for the uninsured and new medical knowledge," he said. "The additional financial pressure brought on by drastic reductions in federal support threatens the very viability of teaching hospitals and medical schools."

Budget Proposal Recommendations

- Both the House and the Senate Budget Committees have targeted Medicare for reductions in excess of $250 billion over seven years. While neither committee has made specific recommendations to achieve this level of savings, it is likely that Medicare's support for teaching hospitals' academic missions will be sharply reduced. Since its inception, Medicare has recognized the need to support the academic missions of teaching hospitals. It has done so in the form of two specific payments. The indirect medical education (IME) adjustment compensates teaching hospitals for the additional costs associated with their academic programs including care for the most severely ill

- more -

patients; the provision of unique, low volume-high cost services such as burn and neonatal intensive care units; and an environment that fosters medical research and physician training. Direct medical education (DME) payments provide support for the costs associated with training physicians (graduate medical education).

The House Budget Committee Health Task Force has forwarded to the House committees on Ways and Means and Commerce specific recommendations to cut IME and DME payments as a means to achieve the overall Medicare budget reduction target. These recommendations call for a 60 percent reduction--totaling $21.1 billion over seven years--in IME, and a reduction--totalling $6.14 billion--for DME.

- The House budget plan recommends a 5 percent reduction--totalling $4 billion over seven years--in funding for the National Institutes of Health (NIH), the world's premier biomedical and behavioral research enterprise, which support scientists in more than 1,700 institutions across the United States. The Senate identified an overall discretionary health budget reduction target and a series of assumptions that suggest that the NIH budget could be reduced between 10 percent and 25 percent in fiscal year 1996.

- The House budget plan recommends elimination of $2 billion over seven years in funding for health professions training programs which play a critical role in encouraging students to enter primary care disciplines and in supporting minority and disadvantaged students who pursue careers in medicine and other health professions.

- The House budget plan recommends elimination of the Agency for Health Care Policy and Research--at a savings of $973 million over seven years. This agency supports the development and dissemination of cost-saving medical practice guidelines and funds critically needed health services and outcomes research.

"Taken together, these cuts will cripple the viability of an invaluable and irreplaceable part of this country's health care system--the nation's medical schools and teaching hospitals," he said.

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AAMC NEWS

Contact: Patricia Shea
(202) 828-0456

For Immediate Release

MEDICARE CUTS WILL THREATEN TEACHING HOSPITAL SERVICES

Washington, D.C., May 16, 1995--With Congress considering cutting Medicare funding by more than $250 billion over the next seven years, the nation's teaching hospitals are taking a hard look at the viability of some of the services they provide.

Medicare, since its inception, has recognized that teaching hospitals are the country's venues for advanced medical care of its sickest patients, physician training and clinical research. Through a set of specific payments, Medicare provides support to these institutions so that they can successfully maintain these activities. Both the House and the Senate Budget Committees have targeted Medicare for reductions in excess of $250 billion over seven years. While neither committee has made specific recommendations to achieve this level of savings, it is likely that Medicare's support for teaching hospitals' academic missions will be sharply reduced.

"The proposed reductions in Medicare funding for teaching hospitals comes at a time when these institutions already are fighting for survival in a price-competitive marketplace that largely is unwilling to pay for the social goods they produce--care of our sickest patients, a skilled health care workforce, access to health care for the uninsured and new medical knowledge," said Jordan J. Cohen, M.D., president of the Association of American Medical Colleges. "If these payments are reduced, teaching hospitals will be faced with the options of scaling back their services, eliminating their academic missions, or, for those institutions in extremely price-competitive markets, actual closure."

If Medicare support is substantially reduced as market competition pressures continue to increase, teaching hospitals will consider:

- reducing or closing pediatric programs
- reducing or eliminating training for rescue squad personnel

- more -

Medicare Cuts--2

- reducing their support of medical schools
- reducing the size of or eliminating residency programs
- reducing support for clinical research
- reducing or closing their trauma units
- closing the psychiatric units
- reducing hospital staff--physicians and nurses
- reducing their commitment to care for the indigent
- cutting high-tech, medically beneficial but expensive services such as burn units, transplant programs, and PET scans
- closing poison control centers
- reducing or closing high-risk obstetrics programs
- reducing community services programs such as rural outreach and community clinics.

"Teaching hospitals already are under siege," said Dr. Cohen. "Medicare cuts of this magnitude will cripple health care services not only for the elderly but for entire communities across the country."

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August 15, 1995

MEDICAL CENTER OF DELAWARE MEDICARE EVENT

DATE: Wednesday, August 16
TIME: 1:45pm
LOCATION: Medical Center of Delaware at Wilmington, 501 West 14th Street
FROM: Andre Oliver
Marilyn Yager

I. PURPOSE

To highlight the impact of GOP Medicare cuts on beneficiaries and the institutions who serve them.

II. BACKGROUND

This event will include a brief tour of an acute care section of the hospital where a large number of Medicare beneficiaries would be patients. During this tour the hospital President, Alan Johnson will focus on the importance of a facility like theirs maintaining a high quality of care for senior citizens, and especially indigent seniors. They will talk about how Medicare and Medicaid cuts in the range of what the GOP is proposing will severely impact their ability to maintain all of the services they now provide, which includes rehabilitative care and home care services.

The Medical Center of Delaware (not-for-profit facility) operates three facilities in Delaware. You will be visiting the Wilmington facility which serves a large number of Medicare patients because their rehabilitation center is there, as well as an outpatient clinic. They have satellite primary care clinics in numerous neighborhoods.

As one of the largest comprehensive health care providers in Delaware, their patient population draws heavily from New Jersey, Maryland, and Pennsylvania, as well as Delaware. The Medical Center System is the third largest employer in Delaware with 5300 employees. The Wilmington Hospital has 188 beds and is known for its rehab center, cancer center, and trauma center.

The Medical Center is the state's large teaching and medical research facility. It also does more than $45 million in uncompensated care. The GOP cuts on Medicaid, Medicare medical education, and Medicare disproportionate share will have devastating impact on teaching facilities like Wilmington.

Allen Johnson, the President and CEO has an interesting background. Prior to joining the Medical Center in 1986, Mr. Johnson was the CEO of St. Vincent Medical Center in Toledo, Ohio, a Catholic facility run by the Grey Nuns System of Montreal, Canada. And before that he was the COO of Henry Ford Hospital in Detroit. These are both pretty progressive hospitals in the health care world. And finally, he currently the Chairman of the Board for the Delaware Hospital Assn.

III. PARTICIPANTS

Allen Johnson, President and CEO of the Medical Center of Delaware.
Lynn Jones, Administrator of Wilmington Hospital
Robert Bell, Director of Government and Community Relations for the Medical Center.
Wilmington Visiting Nurse Assn Representative (TBD)
Hospital Physician (TBD)

IV. SEQUENCE OF EVENTS

- Arrive in Wilmington by Train from New York at 11:30 -- you will be picked up by Bob Bell, Dir. Government Relations, Medical Ctr of Delaware.
- 11:50 am arrive at the Wilmington Newsjournal for Editorial Board.
- 1:00 pm depart newspaper for Medical Center
- 1:20 pm arrive at Medical Center -- brief down time for lunch. The hospital will provide a brief holding room with lunch for you.
- 1:45 pm begin tour of rehab and acute care patient bed areas. Allen Johnson and others will tell you about what you are seeing and how congressional Medicare and Medicaid cuts will affect these types of services.
- 2:15 pm conclude tour with brief statements to the press. First, statement by Allen Johnson, and then your statement.
- Depart.

V. PRESS

Open Press (we expect 2 local TV, 2 local radio, and Wilmington Newsjournal).

VI. TALKING POINTS

Attached.

Q: Are you aware that the President and several members of the board of a Wilmington hospital, St. Francis, have resigned over a dispute with their parent company's (Franciscan Health Care) demand that the hospital sign a contract with U.S. Healthcare? They contend that the terms of the proposed contract are so onerous that their ability to provide high quality health care would be jeopardized. Do you have a comment on that?

A. Yes, I am aware of that situation. Of course, I can't comment on a local situation without knowing all the facts, but I can tell you how the government approaches managed care. As you probably know, both Medicare and Medicaid have become increasingly involved in managed care contracts. We believe they can be a very effective way of delivering high quality health care. But let's be clear about the government's involvement with managed care. Our primary and most important interest is assuring that high quality health care is delivered to our beneficiaries.

For example, in our Medicaid demonstration projects, which the Health Care Financing Administration recently approved for Delaware, the state must ensure that high quality care is provided to Medicaid beneficiaries. As part of that effort, the state will collect data on every encounter Medicaid beneficiaries have with the health care system so that it can monitor whether adequate access is being provided. The state must assure that contracting health plans establish and implement quality assurance plans and provide assurances to the government that the rates set for managed care plans are actuarially sound. In addition, the state will measure beneficiary satisfaction with services and access to care. A corrective action plan will be implemented for any health plan with a low score.

We believe this is the right way to pursue managed health care. While we place a high priority on cost containment, our first priority must be protecting our beneficiaries and assuring that they have access to high quality health care services.

HEALTH CARE FINANCING ADMINISTRATION

ADDRESSEE:	FROM: Kathy King
Jennifer Kline	OFFICE OF THE ADMINISTRATOR 200 INDEPENDENCE AVE., S.W. ROOM 314G WASHINGTON, DC 20201
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TOTAL PAGES:	ADDRESSEE'S FAX MACHINE NUMBER:	DATE:

REMARKS: This is about Delaware's 1115 waiver

More to follow.

HHS NEWS

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

FOR IMMEDIATE RELEASE
Wednesday, May 17, 1995

Contact: HCFA Press Office
(202) 690-6145

Approval of Delaware Medicaid Demonstration

HHS Secretary Donna E. Shalala today announced approval of Delaware's statewide health care demonstration project, the Diamond State Health Plan. Delaware will expand its Medicaid program to provide comprehensive health coverage to 8,000 poor adults and children not previously covered by Medicaid and with incomes up to 100 percent of the federal poverty level. The state will finance the expansion using savings from enrollment in managed care.

Through this demonstration, Delaware seeks to improve and expand access to health care to more adults and children throughout the state, create a managed care delivery system which emphasizes primary care, and control the growth of health care expenditures for the Medicaid population.

Secretary Shalala stated, "The approval of this demonstration illustrates the administration's commitment to working with states to implement innovative ideas and to ensure that our neediest citizens have access to health care. Governor Tom Carper is to be commended for his leadership."

All AFDC, AFDC-related and SSI Medicaid recipients will be eligible for the program with the exception of those receiving long-term care in institutional or home and community-based

- More -

settings and those who are eligible for Medicare. Medicaid recipients not eligible for the Diamond State Health Plan will remain in the state's fee-for-service Medicaid program. Delaware expects approximately 63,000 individuals to be enrolled in DSHP by the end of the demonstration 8,000 of whom will be new enrollees.

The Diamond State Health Plan, which will go into effect in October 1995 and continue through the year 2000, will offer a basic benefit package including medical and mental health services. Delaware will incorporate its current managed care program, the Nemours CHILD Plan, as well as the state's case managed program for adults receiving general assistance, into the Diamond State Health Plan. Certain optional Medicaid services will continue to be reimbursed under the state's fee-for-service program for categorical eligibles.

Bruce C. Vladeck, administrator of the Health Care Financing Administration, said that "DSHP will provide comprehensive health care to Delaware's most vulnerable citizens. Our collaboration with the state should provide significant new benefits for many of its citizens."

Mental health services exceeding those provided in the basic benefit package will be delivered by the appropriate state agencies and will be reimbursed on a fee-for-service basis. By the end of the demonstration, the state intends to create a single mental health system that will provide services on a capitated basis.

Since January 1993, HHS has approved 10 comprehensive health care reform demonstration projects, and 25 targeted Medicaid demonstrations. The administration has also approved welfare reform demonstrations in 28 states.

# # #

DELAWARE DIAMOND STATE HEALTH PLAN

The Health Care Financing Administration (HCFA) has approved Delaware's section 1115 Medicaid demonstration proposal entitled the Diamond State Health Plan (DSHP), which was submitted by the Delaware Department of Health and Social Services on July 29, 1994. Using savings achieved under managed care, Delaware will expand Medicaid health coverage to approximately 8,000 additional poor adults and children in the state. The DSHP will implement a mandatory Medicaid managed care program statewide. The program is expected to start on October 1, 1995 and operate for 5 years.

Through the DSHP, the State seeks to (1) improve and expand access to health care to more adults and children throughout the State, (2) create a managed care delivery system emphasizing primary care, and (3) control the growth of health care expenditures for the Medicaid population.

ELIGIBILITY

- All Aid to Families with Dependent Children (AFDC), AFDC-related, and State Supplementary Income (SSI) Medicaid recipients will be eligible for the program with the exception of those receiving long-term care in institutional or home and community based settings and those that are eligible for Medicare. Medicaid eligibles not eligible for DSHP will remain in the state's fee-for-service Medicaid program. Adults and children with incomes up to 100 percent of the Federal poverty level will also be eligible for health coverage through the DSHP.

- Approximately 63,000 individuals are expected to be enrolled in the DSHP by the end of the demonstration (year 2000). Approximately 8,000 of the 63,000 will be new eligibles.

SERVICE DELIVERY SYSTEM

- The State will contract with managed care health plans on a county wide basis. The State will encourage plans to contract with essential community providers, including Federally Qualified Health Centers (FQHCs) and Title X providers.

- The State will incorporate into the DSHP its existing 1115 demonstration, the Nemours CHILD Plan, a partially capitated managed care program for Medicaid eligible children. The Nemours program is financed and operated by the Nemours Foundation and provides services to Medicaid eligible children (under age 19 with incomes below the Federal poverty level). Services are provided in clinics that are owned and run by the Nemours Foundation. The Nemours program will be extended for an additional three years (until 2000) and the State will develop plans for

integrating the two programs. DSHP members may choose either a Nemours clinic or a health plan based provider for their children.

- The State will also incorporate into the DSHP its case managed program for adults receiving General Assistance benefits, "GA Health First".

- The DSHP managed care plans will be required to coordinate with existing providers for children and adolescents, including with Nemours clinics and the State's school-based health clinics. DSHP members will have the option of choosing as a primary care provider for their children either a provider in their own managed care plan or a Nemours clinic.

BENEFITS

- The DSHP offers a basic benefit package including medical and mental health services. The State will continue to reimburse certain optional Medicaid services (e.g., transportation in other than emergency circumstances) under the State's fee-for-service program for the AFDC, AFDC-related and SSI Medicaid recipients. Although all enrolled children will receive all medically necessary services through the Early, Periodic, Screening, Diagnosis, and Treatment program, these optional services will not be available to the newly eligible adult group through the managed care plans.

- Mental health services exceeding those provided in the basic benefit package will be delivered by the relevant State agencies and will be reimbursed by Medicaid on a fee-for-service basis. In the later years of the demonstration, Delaware plans to create a single mental health system that provides mental health services for all DSHP members on a capitated basis.

- The State also will extend family planning benefits for two years after a woman loses eligibility.

- Pharmacy services will be provided on a fee-for-service basis for the first two years while the State implements a drug utilization review program. After the program is fully implemented, prescription drugs will be incorporated into the capitation rate.

- The State intends to impose co-payments for the expansion group of adult eligibles. These will include a $5 charge for all non-emergency use of hospital emergency rooms and a $1 charge for brand name drugs, except when medically necessary or when no generic equivalent exists.

ENROLLMENT/OUTREACH

Delaware will contract with Health Benefits Managers (HBM) to facilitate and monitor member enrollment in managed care plans. HBMs will be responsible for outreach and education of potential eligibles through marketing and promotional activities. Once deemed eligible, participants will have a month to select a plan before being assigned to a plan. All plans will offer an open enrollment period annually. At this time, participants will have their eligibility redetermined.

TALKING POINTS FOR VISIT TO MEDICAL CENTER OF DELAWARE

- As I toured the medical center and talked with the staff, I was reminded that we have the greatest health care system in the world -- the most talented and dedicated health care professionals, and the finest institutions.

- Above all else, we must evaluate any changes to our health care system by how they affect quality. In the President's eyes, there is nothing more important, and he will not accept any proposal from the Congress that threatens the quality of the system.

- The Republicans are proposing to cut an unprecedented $270 billion from the Medicare program and a devastating $182 billion from the Medicaid program. These cuts are four times as large as anything ever proposed. And not one penny of these savings is reinvested into the health care system.

- There is simply no way to take $450 billion out of our health care system without threatening quality. Let's look at the impact of these cuts.

Medicare

- Everyone has heard about the scope and size of the Republican Medicare cuts. What you might not know is this: Republicans claim they wish to emulate the private sector. The reality is that their proposals don't match the private sector growth per person rate of 7.1 percent -- they limit it to an unrealistic 4.9%.

- At a time when the private sector managed care industry is squeezing hospitals and other health care facilities, these cuts will be even more devastating. I know that this has been of particular concern here in Wilmington. [Laura: This is referencing the articles we enclosed in your briefing book.]

- As an academic medical center, you face higher costs because your mission is research and education as well as patient care. Your patients tend to be sicker, and you make an even greater investment in technology than most other hospitals. I also know that you serve a large number of indigent patients, which for your three facilities add an additional financial burden of $45 million in uncompensated care.

- But what do these numbers mean in more understandable terms? Well, right here in New Castle County, the $270 billion in Medicare cuts translate into a $561 million dollar reduction in Medicare dollars coming into the county, a $152 million reduction in 2002 alone. Assuming that 50 percent of these cuts come from beneficiaries, people on Medicare in New Castle would pay $3,425 ($6,850 per couple) more over seven years.

- Republicans say that they need these cuts to save the Medicare Trust Fund. But they won't tell you that the Trust Fund has faced an insolvency problem of 7 years or less in 9 separate occasions. They won't tell you that the Trust Fund is in better shape than when the President came into office, due to his 1993 budget, which every Republican opposed. They won't tell you that the President's balanced budget proposal would strengthen the Trust Fund through October, 1996 -- 11 years from now. And finally, they won't tell you that you don't need $270 billion to strengthen the Trust Fund.

- In fact, many of their cuts have nothing to do with the Trust Fund. The over $100 billion in Part B beneficiary and provider cuts the Republicans are considering are not dedicated to the Part A Trust Fund. Instead they are used to help pay for their unnecessary $245 billion tax cut.

Medicaid

- And we have not even talked about Medicaid yet. You serve a large and disproportionate number of these vulnerable and expensive patients. There is no health care provider that I am aware of who has ever suggested that they were overcompensated by Medicaid.

- Republicans claim that Medicaid spending would continue to increase, albeit not as fast as it has in the past. What they aren't telling you, however, is that the Federal contribution would not keep up with enrollment growth, let alone inflation or changes in the cost of health services.

- As I mentioned before, the Republicans would constrain Medicare to an unrealistically low 4.9 percent per person growth rate; the corresponding Medicaid growth rate would be an incredible 1.4 percent.

- In response, States would be forced to reduce provider payments, services and coverage. If the cuts were divided evenly, in the year 2002 alone, already low payments to providers would be reduced by more than $11 billion across the country.

- Should the Republicans' $182 billion in Medicaid cuts become law, Delaware alone would lose $331 million in Federal Medicaid funding over seven years, and $98 million in 2002 alone -- a 30% reduction in that year. That is a cut by any definition.

- But it gets worse. In Delaware, as in all other States, the reduction in Federal Medicaid dollars will force the State to drop coverage for the most vulnerable of our citizens. 21,000 in this State will lose coverage in the year 2002 alone, according to a new Urban Institute study. You know better than anyone what this means for you. It means even more uninsured patients creating an even greater uncompensated burden for your institution.

President's Position on Health Care

- The President's position is clear: He has said that he will be forced to veto any legislation that contains this level of Medicare and Medicaid cuts.

- You simply don't need anywhere near this level of cuts. The President's balanced budget shows how. With approximately one-third the cuts, we can eliminate the deficit, improve the financial health of the Medicare program and make Medicaid more efficient. But we can do all this while assuring that health care providers can continue to give quality care, preserving coverage, and protecting Medicare beneficiaries from excessive out-of-pocket increases.

- I am convinced that the President's budget reflects the values and priorities of the vast majority of the American public. The President hopes and expects that these values will be reflected in the budget that eventually comes out of the Congress.

- But this won't happen if the Congressional majority does not get the message -- loud and clear -- that their budget and tax cuts go too far, and will hurt too many Americans. We need your help to get that message out. We look forward to working with you.

Q: How will Delaware ensure that high quality health care is provided by participating managed care plans?

A: Under all statewide health reform demonstrations, States must ensure that high quality care is provided by participating managed care plans. This is accomplished through both the collection of 100 percent encounter level data (as opposed to aggregate summary level data) and implementation of quality assurance plans.

In Delaware, each participating managed care plan will collect 100 percent encounter data on the Diamond State Health Plan enrollees and the state will validate the completeness and accuracy of this data. The State will also use the data to analyze quality of care.

The State will measure beneficiary satisfaction with services and access to care in each plan. A corrective action plan must be implemented for any plan with a low score. The financial performance of each plan will also be monitored.

Q: Are you aware that the President and several members of the board of a Wilmington hospital, St. Francis, have resigned over a dispute with their parent company's (Franciscan Health Care) demand that the hospital sign a contract with U.S. Healthcare? They contend that the terms of the proposed contract are so onerous that their ability to provide high quality health care would be jeopardized. Do you have a comment on that?

A. Yes, I am aware of that situation. Of course, I can't comment on a local situation without knowing all the facts, but I can tell you how the government approaches managed care. As you probably know, both Medicare and Medicaid have become increasingly involved in managed care contracts. We believe they can be a very effective way of delivering high quality health care. But let's be clear about the government's involvement with managed care. Our primary and most important interest is assuring that high quality health care is delivered to our beneficiaries.

For example, in our Medicaid demonstration projects, which the Health Care Financing Administration recently approved for Delaware, the state must ensure that high quality care is provided to Medicaid beneficiaries. As part of that effort, the state will collect data on every encounter Medicaid beneficiaries have with the health care system so that it can monitor whether adequate access is being provided. The state must assure that contracting health plans establish and implement quality assurance plans and provide assurances to the government that the rates set for managed care plans are actuarially sound. In addition, the state will measure beneficiary satisfaction with services and access to care. A corrective action plan will be implemented for any health plan with a low score.

We believe this is the right way to pursue managed health care. While we place a high priority on cost containment, our first priority must be protecting our beneficiaries and assuring that they have access to high quality health care services.