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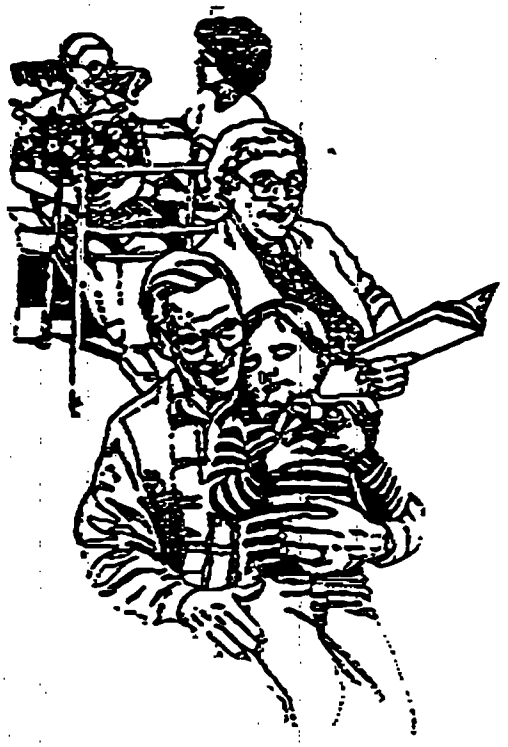
HEALTH CARE FINANCING ADMINISTRATION



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REMARKS:

Revised press fact sheet.

I did a little more word-smithing on PASARR

HHS FACT SHEET

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH CARE REGULATORY REFORM

JULY 1995

Introduction

Reforming the federal government's regulatory process is a top priority of the Clinton Administration. Consistent with this commitment, President Clinton and Vice President Gore asked Health and Human Services Secretary Donna Shalala to assist in meeting this priority by carefully examining the regulatory requirements of the Health Care Financing Administration (HCFA). As part of the reinventing government initiative, HCFA reviewed its regulations to determine which requirements can be reduced or eliminated without compromising Medicare and Medicaid beneficiaries' access to quality health care.

HCFA serves nearly 37 million Medicare beneficiaries and, in partnership with state governments, another 36 million Medicaid beneficiaries. HCFA ensures program beneficiaries are aware of the services for which they are eligible and that those services are accessible, meet quality standards, and are delivered in an efficient manner. HCFA also ensures that health care providers of services meet approved standards, and program funds are used effectively.

Regulatory Reform Initiatives

The following are the next major HCFA initiatives to evolve from HCFA's commitment to the Administration's regulatory reform process. Some of the initiatives result directly from collaborative efforts and public consultation with industry groups, beneficiary organizations, state associations, and state agencies. All of the initiatives cut unnecessary red tape and regulatory burdens and demonstrate HCFA's customer-focus and responsiveness to the changing needs of its customers and partners.

1. **Physician Attestation:** Eliminate the physician form required to certify the accuracy of all diagnosis and procedures before submission for payment by Medicare. Ending this requirement eliminates 11 million forms a year, saving almost 200,000 hours of physician time and decreasing hospital administrative costs by approximately $22,500 per hospital annually.

2. **Clinical Laboratory Improvement Amendments:** Improve the CLIA system and reduce regulatory burden by rewarding good laboratory performance, creating incentives for manufacturers to develop more reliable testing equipment, allowing private organizations meeting certain standards to accredit laboratories, and using proficiency testing as an outcome measure to

monitor laboratory performance. A flexible, targeted survey system, reduced information requirements, and streamlined inspection process have been initiated.

3. **Outcome Performance Measures:** Change focus of regulations to measures of outcomes of care rather than measures of process requirements. Eliminate unnecessary process requirements and instead develop outcome-based performance standards; collect and analyze patient care data needed for continuous quality improvement and performance evaluation; increase consistency of requirements across providers; and ask the customer to provide input on what the outcome measures should be, and to evaluate the services they receive. Changes involve:

- Home Health Agency Conditions of Participation
- Medicare Hospital Conditions of Participation
- ESRD Facility Conditions of Coverage
- Rules for ESRD Facilities - A Pilot for Good Performers
- Elimination of Personnel Requirements for Excellent ESRD Facilities

4. **The HCFA-1500 Form:** Require participating Federal Employee Health Benefit Plan (FEHBP) carriers to use the HCFA-1500 form for physicians' and other practioners' claims. The HCFA-1500 is currently used by physicians and others to submit claims for reimbursement of health care services under Medicare. This change will mean that physicians and other practioners will be able to use a single form to submit claims for many patients -- both Medicare beneficiaries and patients enrolled in the FEHBP.

5. **Annual Preadmission Screening and Annual Resident Review (PASARR):** Currently, two federal requirements call for the assessment of nursing home patients. This change eliminates the requirement under PASARR that mentally ill and mentally retarded nursing home residents are assessed annually by states. Resident assessments and reassessments conducted by states under the general nursing home requirements ensure that residents' continuing needs are properly evaluated and met. The preadmission screening for these residents under PASARR is retained.

6. **Nurse Aide Training and Competency Evaluations:** Permit states to approve nurse aide training and competency evaluation programs offered in nursing homes. This flexibility will safeguard the availability of nursing homes which might otherwise stop participation in the Medicare and Medicaid programs, especially in rural areas. It will also make it easier for nurse aides to obtain the training they need to provide quality services to our beneficiaries.

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Vice President Gore's Remarks
ReGo 2 — HCFA Regulatory Reform
July 11, 1995

Thank you, Steve, and thank you Mrs. Clinton.

Steve, your description of the attestation **(a-tess-TA-shun)** form reminds me of the Henny Youngman joke about the man who goes to his doctor and says, "Doc, it hurts when I do this."

(Lift your arm above your head.)

The doctor says to him, "Don't do that."

(If you hold the pose, you might get a laugh — Henny would be proud.)

Now, that's common sense at work.

(NOTE: There is a banner behind you that reads *"Common Sense At Work")*

So, when you tell me that signing the "Physician Attestation Form" wastes time and money and makes you mad, I tell you ***"don't do that"*** — that's the common sense cure: don't sign it any more. We're canceling that regulation.

Last year, HCFA canceled the regulation saying that doctors had to sign a similarly irritating form every year — it acknowledged the penalties for cheating on Medicare. Now it's time to get rid of the so-called "attestation form" for each Medicare patient who is being discharged from a hospital.

The doctor is supposed to certify that none of his diagnoses or charges are fraudulent before the hospital can send in the claim. Now, is that crazy, or what?

Do we really think that if the doctor ***were*** a crook, he would — having been confronted by that intimidating Physician Attestation Form — Ah! The very name makes a charlatan shudder — did we think he would suddenly have a change of heart, and come clean?

More to the point, is it the official opinion of the U.S. Government that the vast majority of doctors and hospitals in this country ***are*** crooks?

The correct answer is, "None of the above." So, we are relegating the "Physician Attestation Form" to the trash heap of yesterday's government. From now on, we will start with ***trust*** instead of mistrust. We'll start from the assumption that the vast majority of America's doctors and hospitals are honest people and reputable institutions — not dens of thieves.

By the way — each year, America's doctors had to sign 11 million of those forms. Even if each one only took a minute to look over and sign, that's 200,000 hours of doctor time that can now be devoted to patients instead of paperwork.

And hospitals will save time and money too. They used to have messengers driving around town with the forms tracking down signatures. One hospital I heard about held an occasional "***physician amnesty day***" and enticed the doctors with free brownies to come in and sign the forms.

Sorry if our common sense regulatory reform is messing up a good thing there.

(Laughter)

A few weeks ago, President Clinton announced the progress we've made with regulatory reform — 16,000 pages of federal regulations are being cancelled outright, and another TK pages are being infused with a new spirit of partnership and common sense.

That kind of regulatory ***reform*** is the right way to change government. Regulatory ***ruination*** is the wrong way.

Public opinion poll after poll shows that most Americans do want less government interference — they do want a smaller government — ***yes***. And we are making it less intrusive and smaller — the smallest it's been since the Kennedy Administration.

But, most Americans don't want to ***give up completely*** on government. Most Americans believe as President Clinton and I believe — that government is the way a free people work together to solve their biggest national problems.

But if government does not work well — if it never seems to solve the problems it sets out to solve — problems like crime or poverty, disease or ignorance, threats to our security or to our economy — then Americans loose faith in government. And when we do that, we are loosing confidence in our own ability to work together as a free people.

That is a crisis of confidence we face today. Thirty years ago, when asked if government could be trusted to do the right thing, 75% of Americans said yes. Today, it's less than 20%. Confidence has been lost by Democrats as well as Republicans — by the old and by the young — among all races and creeds — the loss has been across the board.

We have to restore America's faith in government. We have to restore our faith in ourselves. That's why we have to make government work better — not just cost less. That's why President Clinton and I have been reinventing government.

You know, just listening to the First Lady and Dr. Gleason describe what is wrong with health care regulation is like a trip down reinvention memory lane for me. Two years ago, when President Clinton gave me the reinvention job, I found the very same things wrong all over the government: lots of attention to *red tape*, but little interest in *results* — lots of *mistrust* and confrontation, but very little *partnership* and teamwork — long on *rules*, but short on common sense.

And just as the First Lady learned about the real problems, and how to fix them, from physicians like Dr. Gleason and his colleagues who were kind enough to join us today, I've found that the best ideas about how to make government work better and cost less always come from the people on the front lines — people who do the real work day in and day out.

We listened to those people about reinventing the rest of government. And we are listening to you doctors and other medical professionals about how to fix government's role in health care.

The parallels are really striking. Take on-the-job worker safety for example: Government regulation has helped make the American workplace safer over the years. But, our new approach is making big improvements for workers, with fewer costly hassles for business owners. It was started by some front-line workers in Maine, and now, President Clinton has ordered OSHA to take the new approach nation-wide. It is based on partnership among labor, management, and government with a common goal of healthy workers in a growing economy.

The same kind of results-oriented partnerships are changing things so that the government can protect the environment without using up a forest-worth of paperwork — so that government can ensure the safety and effectiveness of drugs without being such a pain — and the government can enforce trade regulations without holding up shippers or shanghaiing travelers. The list of reforms goes on and on.

- And HCFA has come up with better ways to ensure that Medicare patients get top notch care — ways focused on results rather than red tape. Instead of holding frequent inspections to make sure all the proper procedures are being followed, and all the workers have the specified experience and college degrees, and all the paperwork is neat and tidy — we will start checking to see how the ***patients are doing***. And, we will let everyone know which facilities produce excellent results. That way, government can help consumers make informed choices.

- And for nursing homes that care for the mentally ill, we are cutting out the duplicate requirements for initial and annual patient assessments. One regulation requires the assessments if funding comes from Medicare or Medicaid — another regulation requires states to do a second set of assessments just because the patient is in a nursing home. We want states to spend their health care money on ***first class care*** — not on ***federal second guessing.***

- And to make life simpler for doctors and their administrative assistants, we will have all insurance companies that cover federal workers use the standard Medicare claim form. You won't need to learn a different set of paperwork rules for each different company.

These are some of the changes we're making. But, this is not the end of it. We will keep listening — and keep changing — and keep restoring faith in government. As the First Lady pointed out, when it comes to reinventing government, health care is no different from any other national problem: We need faith that we can solve our problems together through government. And to regain that faith, we need to make government work better and cost less.

That's what Clinton and Gore are all about — making government work better ***and*** cost less. That is — and always will be — the right way.

Reinventing

HEALTH CARE

Regulation

PRESIDENT BILL CLINTON
VICE PRESIDENT AL GORE

JULY 1995

"I believe we can bring back common sense and reduce hassle without stripping away safeguards for our children, our workers, our families."

President Bill Clinton – February 21, 1995

OVERVIEW

Introduction

The Clinton Administration has made reforming the Federal government's regulatory process a top priority. Consistent with this commitment, President Clinton and Vice President Gore asked Health and Human Services Secretary Donna Shalala to assist in meeting this priority by carefully examining the regulatory requirements of the Health Care Financing Administration (HCFA).

HCFA has taken the President's and Vice President's commitment to reinventing government and government regulations seriously and is meeting the challenge. HCFA has a new customer service focus: we are working in partnership with the rest of the health care community to institute better, more common sense ways of operating. HCFA has reviewed its regulations to determine which requirements could be reduced or eliminated while assuring that we continually improve the quality of services to some of America's most vulnerable populations -- Medicare and Medicaid beneficiaries. This report contains the initiatives that have resulted to date from the review of HCFA's regulations.

Agency Overview

The Health Care Financing Administration's primary mission is to assure health care security for nearly 37 million Medicare beneficiaries and, in partnership with State governments, another 36 million Medicaid beneficiaries. HCFA ensures that program beneficiaries are aware of the services for which they are eligible and that those services are accessible, meet quality standards, and are delivered in an efficient manner. HCFA also ensures that health care providers of services meet approved standards and that program funds are used efficiently.

Regulatory Reform Principles

Regulatory reform means regulating only when necessary and no more than needed. When regulations are issued, they must be the most cost effective, least intrusive, and most flexible types of regulations that achieve the stated objectives. This common sense way of regulating is accomplished by working with our partners, including industry groups and States, and by keeping in touch with the needs of our customers. For HCFA, this means knowing what our beneficiaries want and need, and then working with our partners to fulfill and even exceed these expectations.

To guide the regulatory review process, HCFA relied on three basic principles that help define the Agency's new and improved approach to regulations and customer service.

- Communicate not dictate -- The number one tenet of this principle is to communicate through listening and consulting, thereby increasing our understanding of what our customers need, what they like and dislike about our programs, and how we can serve them better overall. This principle says that HCFA will consult with our partners and beneficiaries about how our programs and policies should improve, instead of dictating such changes to them as has been done too often in the past. When changes are a result of legislative initiatives, HCFA will consult with partners and stakeholders on the full range of implementation issues that needs to be addressed.

- Educate rather than inundate -- Top-rate customer service also means making sure that customers understand our programs and policies. Providing reams and reams of information is not enough and probably not effective. The "new" HCFA is committed to educating instead of inundating. This principle ensures that HCFA will educate our customers by developing effective educational techniques and disseminating information about how our programs operate rather than inundating them with information that is difficult to understand and doesn't speak to their needs.

- Innovate more than regulate -- HCFA's regulatory reform and improved customer service initiatives are driven more by innovation than regulation. This means that HCFA is relying upon innovation in program operations and administration more than regulation to foster improved customer service capabilities. For example, by streamlining Medicare claims processing and information exchange, the Medicare Transaction System will make electronic interaction with Medicare easier for providers and beneficiaries and will enable Medicare contractors to devote more time to customer service activities.

Accomplishments

During the Clinton Administration, HCFA has improved its regulatory process to focus on results, not red tape.

- In March 1994, HCFA published a regulation that replaced the requirement for physicians to provide hospitals annually with a signed acknowledgment concerning penalties for misrepresenting certain information with a one-time signing requirement at the time a physician is initially granted hospital admitting privileges. Almost 24,000 hours of physician time will be saved. One major medical association characterized this change as one that will alleviate the "hassle factor" for physicians and an important step toward restoring mutual trust between the Federal Government and the medical profession.

- HCFA is totally redesigning its system to pay claims for Medicare services. Currently, providers must cope with 9 different claims processing systems operated by 72 insurance companies at 57 sites. The development of the Medicare Transaction System (MTS) will increase control of program expenditures, simplify administrative operations, and improve services to beneficiaries and providers. This integrated, national system will replace the diverse existing systems and significantly simplify administrative operations for beneficiaries, providers, and the Medicare program. Final contracts for the analysis, design, development, testing, and implementation of the MTS were awarded in January and March 1994.

- HCFA has re-invented its evaluation of Medicare contractors. The newly restructured Medicare contractor performance evaluation establishes Medicare beneficiaries and medical care providers as integral partners in the evaluation process. This new evaluation process, which began October 1, 1994, allows for greater flexibility in evaluating Medicare contractor operations and performance.

- The process for btaining Medicaid home and community-based services waivers was simplified and now enables States to offer a wide variety of home and community-based services as cost-effective alternatives to more expensive institutional care. Without this regulatory change, published July 25, 1994, joint State and Federal efforts to expand opportunities to provide cost-effective alternatives to institutional care would have been frustrated. The regulatory provisions were worked out in collaboration with the States (through the National Governor's Association).

Regulatory Reform Initiatives

The following proposals are the next major HCFA initiatives to evolve from our commitment to the regulatory reform process.

*1. **Physician Attestation:*** Eliminate the physician form required to certify the accuracy of all diagnosis and procedures before submission for payment by Medicare.

*2. **Clinical Laboratory Improvement Amendments:*** Reduce burden and improve the CLIA system by rewarding good performance by laboratories, creating incentives for manufacturers to develop more reliable testing equipment, allowing private organizations that meet certain standards to accredit laboratories, and using proficiency testing as an outcome measure to monitor laboratory performance.

*3. **Outcome Performance Measures:*** Change current regulations that focus solely on requirements for measuring processes, rather than outcomes of care. Changes affect:

- Home Health Agency Conditions of Participation
- Medicare Hospital Conditions of Participation
- ESRD Facility Conditions of Coverage
- Rules for ESRD Facilities - A Pilot for Good Performers
- Elimination of Personnel Requirements for Excellent ESRD Facilities

*4. **The HCFA-1500 Form:*** Require participating Federal Employee Health Benefit Plan (FEHBP) carriers to use the HCFA-1500 form for physicians' and other practitioners' claims. The HCFA-1500 is currently used by physicians and others to submit claims for reimbursement of health care services under Medicare. This change will mean that physicians and other practitioners will be able to use a single form to submit claims for many patients – both Medicare beneficiaries and patients enrolled in the FEHBP.

*5. **Annual Preadmission Screening and Annual Resident Review:*** Eliminate the requirement that mentally ill and mentally retarded nursing home residents are assessed annually. Resident assessments and reassessments required under the general nursing home requirements are entirely adequate to assure that residents' continuing needs are properly assessed and met. The preadmission screening for these residents is retained.

*6. **Nurse Aide Training and Competency Evaluations:*** Permit States to approve nurse aide training and competency evaluation programs offered in nursing homes.

HCFA INITIATIVES

1. Physician Attestation

Background: Since the Medicare hospital inpatient prospective payment system (PPS) was implemented by HCFA in 1984, HCFA regulations have required physicians to sign an "attestation form" for each Medicare patient discharged from a hospital. The form certifies the accuracy of the diagnoses and procedures for each patient. This information is used to ensure that the correct coding is on the claim, the correct diagnosis-related group (DRG) can be assigned, and the proper Medicare payment can be made.

Feedback from physicians, hospitals, and intermediaries has told us that obtaining the physician's signature is burdensome and results in billing delays that hurt hospital cash flow and hinder service to the beneficiary. Peer Review Organization (PRO) review of attestations has resulted in less than a 0.01 percent denial rate of sampled claims. In addition, the improvement in hospital record keeping and coding sophistication make the hospitals the appropriate focus for combating fraud and abuse.

Proposal: Eliminate the form requirement and instead hold hospitals responsible for the accuracy of their diagnoses and procedures. With improved technology and software coding capabilities, hospitals are more equipped than ever to combat billing fraud and abuse, the form's original purpose.

Impact:

- Reduces paperwork burden and "hassle" on physicians and hospitals.
- Decreases administrative costs for hospitals.
- 11 million forms will be eliminated.
- Almost 200,000 hours of physician time will be saved.
- Hospitals will have improved cash flow and reduced labor costs by approximately $22,500 per hospital per year.

Implementation and Timeline: HCFA will publish this final regulation by September 1, 1995.

2. Clinical Laboratory Improvement Amendments

Background: The Clinical Laboratories Improvement Amendments (CLIA) of 1988 established baseline quality standards that ensure the accuracy, reliability, and timeliness of laboratory testing. These requirements are based on the complexity of the test performed, rather than where the test is performed. Compliance with the standards is determined through on-site inspection.

HCFA and the Centers for Disease Control and Prevention, which share responsibility for the CLIA program, continually review ways to reduce the burden and improve the entire CLIA system. A flexible survey system that employs data analysis to target good performers and allow for self-attestation and off-site review has already been initiated for certain laboratories. HCFA has reduced information requirements and eliminated unnecessary paperwork and has taken steps to reduce personnel requirements. HCFA also revised and streamlined the inspection process. Additional burden reductions are being undertaken that will virtually eliminate oversight for certain laboratories, establish performance standards in place of process requirements, and use information and education as a substitute for sanctions.

Proposal:

1. Waive the routine 2-year survey of users of "black box" technology, conducting surveys only if there are indications of problems or complaints. ("Black box" technology refers to simple and easy to use test systems that have demonstrated accuracy and precision through scientific studies.) We will develop and implement criteria for accurate and precise "black box" technology that will be followed to determine if the technology qualifies for waiver of the routine 2-year survey. A small number of surveys will be conducted to validate the criteria for determining "black box" technology and to assure quality.

   Impact:

   - Creates incentives for manufacturers to develop more reliable testing equipment by stimulating demand for accurate and precise technological testing systems.
   - Reduces paperwork and costs for providers, especially for physician office laboratories, as well as reducing costs of program management.

   Implementation and Timeline: Proposed rules will be published in September 1995.

2. Clarify and expand the waiver criteria and streamline the waiver process so that CLIA regulations can be waived for more tests. CLIA requirements will be waived for tests approved for home use by the Food and Drug Administration -- that is, tests that do not require trained personnel.

   Impact:

   - Decreases burden, especially for physician office laboratories because of less regulatory oversight.
   - Increases access to greater variety of tests. Physician office laboratories may expand the range of tests they perform without an increase in costs/burden.
   - Creates incentives for manufacturers to develop more test systems that meet the clarified waiver criteria and criteria for approval for home use.
   - Eliminates inspection fees for many of the 60,000 physician offices and other small laboratories not now waived that decide to perform only tests from the expanded waiver category.
   - Many additional laboratories will face lower inspection fees because, while they will continue to perform non-waived tests, many more tests will fall into the expanded waiver category.

   Implementation and Timeline: Proposed regulations will be published in September 1995.

3. Use performance standards and require less frequent on-site inspections (surveys) of excellent performers. Private accrediting organizations may be approved for Federal accrediting status ("deemed status") when their accreditation standards are as stringent as CLIA. Exempt laboratories from CLIA requirements when the State in which they are located has requirements equal to or more stringent than CLIA's.

   Impact:

   - Reduces inspection burdens.
   - Rewards good performers with fewer inspections. This is a positive incentive to improve performance.
   - Offers laboratories oversight by peers by approving private accrediting organizations

for Federal accrediting status.

- States with strong licensure programs are being approved for exemption from CLIA.

Implementation and Timeline: To date, notices to approve four accrediting organizations (College of American Pathologists, Joint Commission on Accreditation of Healthcare Organizations, Commission on Office Laboratory Accreditation, and the American Society of Histocompatibility and Immunogenetics) and the State of Washington have been published. Notices for two additional accrediting organizations and one additional State are pending. Final rules to eliminate redundancies or unnecessary requirements for Federal review and approval will be published in March 1996.

4. Use proficiency testing (PT) "failures" for education and as an outcome indicator in laboratory quality. (PT is testing samples of known values to assess the accuracy of a laboratory's results.) Sanctions (for example, loss of Medicare payment or loss of approval to do testing) are imposed only in cases of immediate jeopardy or when the laboratory has refused to correct the problem or has had repeated failures on proficiency testing.

Impact:

- Less intrusive than traditional regulation and oversight.

- Allows use of proficiency testing as an outcome measure to monitor laboratory performance, provides laboratories with feedback on test quality, and as an incentive to improve performance.

- Minimizes the fear of sanctions in 60,000 non-waived laboratories.

Implementation and Timeline: A proposed rule will be published in March 1996.

3. Outcome Performance Measures

Background: Medicare, as a purchaser of health care, requires hospitals, home health agencies (HHAs), and End-Stage Renal Disease (ESRD) facilities to meet health and safety requirements to participate in the Medicare program. Historically, these requirements measure "process" (procedural and administrative systems as proxies for quality health care) rather than "outcomes" (evaluations of actual patient care) and the adequacy of quality management programs.

HCFA is committed to changing current regulations that focus solely on requirements for measuring processes. The Agency realizes that not focusing on outcome measures results in several inherent problems. First, regulatory requirements vary by type of facility and provider even when the services provided in each facility are the same, creating inequities and inappropriate incentives. Second, without outcome measures, there is very little information available for consumers on the quality of care at a given facility. Third, by law, HHAs must be surveyed yearly--even though historical data show that this frequency is excessive for many HHAs and does not improve care.

HCFA is revising regulations for hospitals, home health agencies, and End-Stage Renal Disease facilities to address these issues, eliminate unnecessary process requirements, and focus on the outcomes of care.

Proposal: Eliminate unnecessary process requirements and instead develop outcomes-based performance standards; collect and analyze patient care data needed for continuous quality improvement and performance evaluation; increase consistency of requirements across providers; and ask the customer to provide input on what the outcome measures should be, and to evaluate the services they received. We are seeking legislation to give us flexible survey cycles.

Impact:

- Eliminating unnecessary process requirements for compliance will reduce compliance and survey burdens and make it possible to focus on actual patient care.
- Educating the consumer will produce a strong, non-regulatory force to improve quality of care.
- Powerful data will be available to regulators and providers.
- Produces savings because providers are free to achieve high quality outcomes in the most cost-effective manner.

Outcomes Performance Measures Initiatives

HCFA is currently involved in the following new initiatives that focus on the concept of "Outcomes Performance Measures" and the consensual approach to developing regulations.

Home Health Agency Conditions of Participation:

HCFA is developing revisions to the Medicare Home Health Agency (HHA) conditions of participation. The purpose of the revision is to place greater emphasis on patient outcomes while reducing the current emphasis on process requirements (e.g., elaborate professional qualifications and other "paperwork" requirements) and enhancing an HHA's flexibility in meeting patient needs. The Agency has actively involved home health beneficiaries, providers, physicians, professional organizations (American Association of Retired Persons, National Association for Home Care, American Federation of Home Health Agencies, American Medical Association, Visiting Nurses Association of America, American Academy of Home Care Physicians), States (State Survey and Medicaid Agencies), and intermediaries in order to receive input on developing revisions to the conditions of participation. A work group of HCFA staff and representatives of Medicare beneficiaries, home health providers, physicians, and State Survey Agencies will develop a Standard Core Assessment Instrument for use in home health care. The use of this tool is central to HCFA's efforts to place the emphasis of survey and enforcement on patient outcomes.

Implementation and Timeline: HCFA will publish a proposed rule in September 1996.

Hospital Conditions of Participation:

HCFA is revising the current hospital conditions of participation to center on the patient, support a cross-functional approach to patient care, and focus on quality. In developing these revisions, HCFA has worked closely with organizations representing hospitals, practitioners, patients, and States and has already distributed informal pre-regulatory drafts to approximately 70 outside groups for comment.

Implementation and Timeline: HCFA will publish a proposed rule in January 1996.

End Stage Renal Disease (ESRD) Conditions of Coverage:

HCFA's ESRD Conditions of Coverage (COC) have not been comprehensively revised since their original implementation in the late 1970's. The current COC are primarily focused on process-oriented requirements, and do not provide adequate support for a modern

survey system based on an outcome-oriented approach. Under the current regulation, facilities have a substantial paperwork burden. As a result, revised regulations must be issued to increase facility flexibility and to bring the ESRD COC up to current standards of practice in the ESRD community. The revised COC will address the outcome-oriented, patient-centered standards process where appropriate, reflect innovations in the dialysis and transplant community, and address new issues such as adequacy of dialysis to ensure that the Medicare beneficiary is receiving the most progressive quality of care possible. Thus, HCFA's emphasis will be on the total patient experience with dialysis, including patient functional well-being and continuous quality improvement. The revised regulations will include development of performance expectations for the facility that result in quality, comprehensive care for the dialysis patient.

Implementation and Timeline: HCFA will publish a proposed rule in March 1996.

Rules for ESRD Facilities - A Pilot for Good Performers:

HCFA is conducting a pilot project to apply a different, less prescriptive set of rules to excellent ESRD facilities. Under the pilot project, an ESRD facility's performance will be measured using only three key patient care outcome indicators. The pilot differs from the current system in three important ways. First, these indicators will be used in place of the current certification standards and surveys will be waived. Second, the pilot project will focus on helping facility staff use outcome measures in an ongoing way to improve the care provided to dialysis patients. Third, facilities that document sustained achievement in the outcome indicators over six consecutive months will be awarded a HCFA certificate of excellence.

The indicators measure the quality of hemodialysis in three areas critical to the health of the patient: adequate dialysis, control of anemia, and adequate water supply. They will be used by the facilities to monitor the condition of each dialysis patient and to achieve improvement in the patient's health status. For the pilot project, excellence will be identified through a process focused on the quality indicators. The process will look at whether facilities have an internal quality monitoring system, whether the results of such monitoring are documented, and whether results are sustained. The facilities that qualify in this pilot will have established certain internal quality control mechanisms in order to participate. Routine surveys of these facilities will be waived and HCFA will examine other appropriate means of providing regulatory relief for good performers. Surveys will be conducted in response to complaints about the quality of care or if the data indicate a potential serious problem.

Information about project results will be packaged in brochures and newsletters so that ESRD patients and non-participating ESRD facilities will be aware of the results. In this competitive industry, a successful project will stimulate many other providers to seek

recognition as "EXCELLENT" facilities.

ESRD facilities will be notified of their eligibility to participate and participation will be voluntary. The pilot will be limited to facilities in the States of Colorado, Idaho, Montana, and Washington.

Implementation and Timeline: Planning for this pilot is underway. Regulations to permit this pilot will be published in November 1995.

Elimination of Personnel Requirements:

HCFA is conducting a pilot project that will evaluate the impact of the elimination of Medicare personnel requirements for ESRD facilities. Currently, the Medicare conditions for coverage for ESRD facilities include fairly detailed specifications for several types of personnel employed in furnishing ESRD services to Medicare beneficiaries. For example, the medical director of the facility must be a physician, board eligible in internal medicine; the nurse in charge must have 12 months of clinical experience, with 6 months experience with ESRD patients; the social worker must be master level educated, etc. Over the years, HCFA has received comments from the industry both in favor of elimination of the personnel requirements and in favor of strengthening them. Those in favor of relaxing the requirements commonly cite the difficulty rural facilities can face in recruitment of personnel with the requisite experience. They believe that the job does not require the level of experience and education prescribed in order to perform adequately. Those in favor of maintaining personnel requirements cite the medical condition of ESRD patients as justification for the skills level requirements. They express concern that if the personnel requirements are weakened or eliminated, ESRD facilities, most of which are proprietary entities, would hire less experienced and more inexpensive personnel to provide care that is of inferior quality.

The pilot project would be conducted in concert with another proposed project establishing new rules for historically good ESRD performers (see above). HCFA will collect information regarding the skills level of all personnel employed by those facilities participating in the project. Facilities would be informed that as part of the project, Medicare would not apply any of the personnel requirements contained in the conditions for coverage. At the end of the two-year project period, HCFA will re-collect information regarding the education and experience level of all the facility's staff and evaluate the impact of the changes on predetermined measures of quality of care.

Implementation and Timeline: Planning for this pilot is underway. Regulations to permit this pilot will be published in November 1995.

4. The HCFA-1500 Form

Background: The HCFA-1500 form is currently used by physicians, other practitioners, and durable medical equipment suppliers to submit claims for Medicare reimbursement of health care services. The HCFA-1500 is also used by many other insurers for claims submission. Although many Federal programs require the use of the HCFA-1500, use of the form is not required by the Federal Health Benefit Plan (FEHBP). Currently, more than a dozen different forms are used by fee-for-service carriers participating in FEHBP. In addition, instructions for the forms vary across programs.

Proposal: After a phase-in period, the Office of Personnel Management (OPM) will require participating FEHBP carriers to use the HCFA-1500 form for physicians' and other practitioners' claims.

Impact: Physicians will be able to use one form to submit claims for services provided to many patients. The number of claims forms that are used will drop from more than a dozen to one and instructions will be standardized.

Implementation and Timeline: OPM phase-in of the HCFA-1500 will begin in January 1996 and will be completed in September 1996. By the year 2000, the majority of provider claims will be submitted electronically.

5. Preadmission Screening and Annual Resident Review (PASARR) of Mentally Ill and Mentally Retarded Residents

Background: Nursing homes under Medicare and Medicaid are currently required by law to conduct an initial assessment of each resident within 14 days of admission, with a reassessment whenever a significant change in condition occurs but in any event at least once a year. In addition, there is a statutory requirement that for persons with serious mental illness or mental retardation entering a nursing home, the State is required to conduct: (1) a preadmission screening to assure that the individual is being appropriately placed in a nursing home, and (2) an annual reassessment to assure that the patient continues to be appropriately diagnosed and treated.

Proposed Solution: Legislation would be proposed to eliminate the duplicate annual assessment. Resident assessments and reassessments required under the general nursing home requirements are entirely adequate to assure that residents' continuing needs are properly assessed and met. Preadmission screening, which deters inappropriate admissions, would continue.

Impact: By eliminating the redundant annual PASARR reassessment, costly duplication of effort by States would be reduced and nursing facilities would be relieved of intrusive annual inspections.

Implementation and Timeline: Legislation will be proposed.

6. Nurse Aide Training and Competency Evaluations

Background: To assure quality of care in nursing homes, current law prohibits nursing homes from using nurse aides that have not successfully completed a training or competency evaluation program. The statute requires the Secretary to establish requirements for the approval of nurse aide training and competency programs. The law further forces States to prohibit, for a period of two years, nurse aide training and competency evaluation programs operated by or in nursing homes that were subject to an extended survey or partial extended survey or certain other sanctions. (Extended or partial extended surveys are conducted as more intensive follow-up investigations after a routine survey has demonstrated that a facility is furnishing substandard care.)

When a facility's program has been disapproved, the facility may not even be the site of an aide program conducted by others during the time that the two-year penalty is imposed. The prohibition on approval of nurse aide training and competency evaluation programs causes a special problem for rural nursing homes where a community college or other training facility may be inaccessible to nurse aides. Rural facilities can face a serious shortage of trained and competent staff due to the expense and inconvenience of sending prospective aides to remote locations. Alternative training programs may not be available.

Proposed Solution: Specify that a State could choose to approve a nurse aide training and competency evaluation program offered in (but not by) a nursing home subject to an extended or partial extended survey or certain other sanctions if the State determines that there is no other nurse aide training and competency evaluation program offered within a viable distance. States would be required to provide ongoing oversight of these programs in the interest of patient health and safety.

Impact: This proposal would safeguard the availability of nursing homes which might otherwise stop participation in the Medicare and Medicaid programs as a result of losing a training programs' approval. It would also make it easier for nurse aides to obtain the training they need to provide quality services to our beneficiaries.

Implementation and Timeline: Legislation will be proposed.

Conclusion

Under President Clinton's leadership, HCFA has made communication, cooperation, and partnership the guiding principles of the regulatory process, replacing the adversarial environment that often existed in the past. At a time when the American health care system is undergoing dramatic changes, HCFA is committed to putting the federal government's customers -- the American people -- first. We are pleased to report that the initiatives described in this report represent just the beginning phases of HCFA's ongoing work on regulatory relief.

FAX COVER SHEET

Dr. Steve Gleason
1601 N.W. 114th Street, Suite 130
Des Moines, Iowa 50325

Phone: (515)222-7252
Fax: (515-222-7257

Staff Contact: Nicki

****

DATE: 7-7-95

TO: Jennifer Klein

COMPANY: _____

FAX NO. 202-456-2878 *PHONE NO.* _____

****

DELIVERY INSTRUCTIONS: ____ *URGENT* ____ *ROUTINE*

THIS IS PAGE 1 OF ____ PAGES (INCLUDING THIS PAGE).

COMMENTS: Jennifer - Dr. wants you to fax changes to his home this weekend. Call first @ 515-277-1771. Fax is same as phone #. Thanks.

CONFIDENTIALITY STATEMENT

DRAFT

DRAFT

Reducing Bureaucracy in Health Delivery

Comments by Dr Steve Gleason

The White House

July 11, 1995

Thank you, Mrs. Clinton, for a most gracious introduction, but it should be me and all Americans, in fact, thanking you for your courage in tackling important health issues. You have been a champion for paperwork reduction, for preserving Medicare, for patient choice, and, of course, for the uninsured. In reminding us that we are, indeed, our brother's keeper, you have provided moral balance to the health debate. And I believe bureaucracy reduction is, indeed, a moral as well as a fiscal issue.

Highlighting that point was the herald event that transformed me into a political activist.

Frustrated by the many conflicting rules and regulations that seemed to be coming from all different directions, I, like many other physicians, tended to address this problem in 1986 by arguing with colleagues in the doctors' lounge—an exercise that was supposed to effect change. But, in reality, it just reinforced our anger and our political ineptitude.

But when my father went to the Emergency Room, saying that he was sicker than he had ever been, I found I needed to find better ways to effect change. This was in the days when pre-admission paperwork approval was in vogue and the Emergency Room staff was struggling with the fact that his chest x-ray, EKG,

DRAFT

laboratory data, and vital signs were all normal. In spite of complaints of pain from my normally stoic father, he appeared, on paper, to be perfectly healthy. It took many hours before we were able to gain the approval to proceed with surgery for what ended up being a ruptured bowel and subsequent septicemia. Following surgery, he went into respiratory arrest and was on a ventilator the better part of three months before he died. During a short period when he was off of the ventilator, I stayed with my father almost night and day, discussing with him life in general. But one particular night his curiosity led us to a pressing question. Why was it that physicians who are charged with the health of a Nation couldn't affect and streamline the process by which patients are admitted to the hospital. It was one of his last clearly spoken thoughts.

That's why this initiative is so critical to me. Unnecessary bureaucracy diverts time and money away from patient care and, at times, delays important procedures. Reducing paperwork in health care is, I believe, a moral as well as a fiscal issue.

The number of regulations and rules concerning health care are similar, in some respect, to Winston Churchill's definition of history. "History", Mr. Churchill said, "is just one damn thing after another." And the regulations which have been promulgated on consumers and providers of health care over the past two decades have often been confusing, and, certainly, at times, conflicting in their purpose.

It has seemed that some Republicans and Democrats have been out of touch with this Country's founding ideals. Thomas Jefferson, (the first Democrat) fought against government oppression and eloquently defended individual liberty and

DRAFT

tolerance. Burdensome regulations can have a fearsome oppressive effect on the quality, creativity, and fiscal good sense necessary for great medical care. By creating a myriad of regulations and forms, each one designed to protect the very few, government has, at times, created a tremendous burden for the vast majority. It is, therefore, notable and refreshing that this Administration is willing to tackle the issue of reinventing government and regulatory relief.

I'm pleased to be here today to participate in this announcement as part of the Administration's ongoing effort. I have the job of highlighting just one small piece from the array of recommendations which the Vice President will soon review.

And I should add, Mr. Vice President, we all appreciate very much your efforts to move us into the next millennium. Your work on our behalf to reduce unnecessary bureaucracy and develop new technologies is appreciated more than you know.

The pile you see before you represents physician attestation statements. For those of you unfamiliar with this form, it was a form designed during some previous Administration to do several things.

- It was designed as an additional summary sheet of the diagnoses in a medical case. This form, of course, is in addition to a fully complete discharge summary that already had such information.
- It was designed to legally bind the physician by requiring an "attestation or "truth oath" concerning the accuracy of the dictated discharge summary.

Under Medicare law some thought this form made it easier to put pressure on

physicians to dictate accurate medical records. We later found out, of course, that the regular discharge summary suffices fully for that activity. In the end, the only result was that it added more work to the physician's day, more costs in the Medical Records Department, and effectively delayed hospital payments by an additional thirty days. This pile of paper represents the number of attestation statements signed in a single year by a single, middle sized community hospital in Iowa.

This particular pile of attestation statements represents 11,127 discharges representing one full year for one hospital:

- Nine medical records staff spent 6,100 hours in one year to prepare the forms.
- The forms required an additional 927 hours of physician time.
- Total hospital and physician costs per year for this effort was $158,000.

When extrapolated to the entire Nation, this form creates 369 (136.8) million dollars in unnecessary expense and 16.8 (6.1) million hours in unnecessary paperwork, not to mention the over 9 billion dollars in delayed Medicare payments per year to the Nation's hospitals.

Eliminating this form is a very important step on our road to recovery from bureaucracy. It helps return physicians to the bedside and cuts bureaucracy-related costs. And this represents only one of over a thousand different kinds of forms which consume 20 to 30 percent of our healthcare professionals' workday throughout the Nation.

DRAFT

I cannot leave today without offering two important thank yous. The first to Bruce Vladek and HCFA for the monumental effort involved in making HCFA a customer-friendly organization.

I also want to thank those of you in the audience, many of whom have been instrumental in bringing this important work to fruition.

Thank you very much, Mrs. Clinton, for allowing me to share in part of this historic announcement. I look forward to working with the Administration in the months to come to further implement these initiatives.

DRAFT

THE PRESIDENT'S ECONOMIC PLAN:
A BALANCED BUDGET THAT PUTS PEOPLE FIRST

I. FRAMEWORK TO BALANCE THE BUDGET: Building on his 1993 plan that reduces the deficit by $1 trillion over seven years, the President today is releasing his economic framework for balancing the budget by the year 2005 while still investing in education and training; taking serious steps toward health reform while strengthening the Medicare Trust Fund and protecting beneficiaries; and targeting tax cuts only to working families. The President's plan builds on the savings and investments in his FY1996 budget and calls for real cuts in most areas of government spending other than Social Security.

II. THREE FUNDAMENTAL DIFFERENCES: While the President shares the goal of reaching a balanced budget with the Republican Congress, there are three fundamental differences in what the President will call for to make this a balanced budget that puts working families first.

1. FIRST STEPS TOWARD HEALTH CARE REFORM WHILE STRENGTHENING THE MEDICARE TRUST FUND:

Republican Plan: The Republican plans call for deep Medicare savings that would require a senior couple to pay $1500-$2000 a year more by the year 2002 -- only to pay for unjustifiable tax cuts.

President's Plan: The President's plan calls for half the Medicare savings of the Republican plans ($124 billion), no new Medicare beneficiary cuts, and takes the first steps toward serious health reform. The President calls for one-third the level of Medicaid savings ($55 billion) of the Republican plans, gives states additional flexibility, and protects Medicaid coverage by including a per person cap. Elements of the health reform plan include:

- **Protecting the Medicare Trust Fund to 2005**
- **Health Security for Working Families After a Job Loss: (6 months of health coverage for families who lose insurance when they lose a job)**
- **More Options for Medicare Managed Care that Protects choice**
- **Prevention: No Co-payments for Medicare Mammography Screening**
- **Alzheimer Respite Benefit**
- **Downpayment on Home and Community-based Long-term care**
- **Insurance Reforms including Portability and Limits on Exclusions for Pre-existing Conditions**
- **Give Small Businesses Pooling Options, including Participation in FEHBP**
- **Self-Employed Tax Deduction Increased to 50%**

2. PROTECTING INVESTMENT IN EDUCATION AND TRAINING:

Republican Plans: The Republican plans cut investments in education by $43 billion over seven years, cutting Head Start and seeking to eliminate or dramatically cut GOALS 2000, Safe and Drug-Free Schools, AmeriCorps, student aid, and job training at all levels.

President's Plan: The President's plan puts people first by preserving investments in education and training, with significant increases in Head Start, Goals 2000, AmeriCorps, student aid, a new GI Bill of Rights for Workers that increases training through Skill Grants, and a $10,000 education tax deduction.

3. A TAX CUT THAT IS TARGETED ONLY TO WORKING FAMILIES:

Republican Plans: The Republican House plan calls for a $630 billion tax cut over ten years that would give a $20,000 tax cut to the top 1% of taxpayers, and the Senate budget calls for increasing taxes on 14 million working families.

President's Plan: The President's plan keeps his full Middle Class Bill of Rights tax cuts: a $500 tax credit for children under 13; a $10,000 education deduction, and an expanded IRA that allows more working families not only to save for retirement but also to use the savings for education, a first home, or long-term care for a sick relative.

III. COMPONENTS OF SAVINGS FOR BALANCING THE BUDGET: The President's plan does not change the basic budget for FY1996, but it extends the savings pattern in domestic discretionary spending through 2005 while calling for serious, but reasonable entitlement savings.

- Medicare savings are $124 billion over seven years, less than half of the Republican plans, while protecting beneficiaries, securing the Medicare Trust Fund through 2005 and taking the first steps toward health reform.

- Medicaid savings are $55 billion in over 7 years -- one-third the size of the Republican proposals -- and include a per person cap to protect coverage, rather than an aggregate block grant.

- Welfare reform has savings of $35 billion which is less than half of the Republican proposals and essentially consistent with major Democratic alternatives.

- Corporate contribution of $25 billion over seven years through a bipartisan effort to close corporate loopholes, special interest tax breaks, and unwarranted corporate subsidies.

• Other than education, research and selected investments in the environment and other areas, domestic discretionary spending is cut by over 20% in real terms near the end of the plan.

• Defense outlays in the President's plan are above both the House and Senate levels in FY2002, yet savings are achieved by keeping budget authority constant from FY2002-2005.

IV. A MORE BALANCED APPROACH TO BALANCING THE BUDGET:

Republican Plan: The Republican plan calls for deep Medicare cuts and education cuts in order to pay for a tax cut going largely to the most well-off. A top national forecaster, WEFA, (formerly Wharton Econometrics) has projected that this seven-year path would slow growth, increase unemployment to over 8.5%, and delay their deficit projections by at least two years.

President's Plan: By limiting a tax cut to working families and by calling for a moderately longer time path to balance the budget, the President's plan avoids the necessity of cutting education or calling for new Medicare beneficiary cuts. This 10-year plan has the benefits of a solid balanced budget path with less of the downside, contractionary risks of the Republican seven-year proposals.

DRAFT HRC INSERT FOR DOCS SPEECH:

- Everyone in this room is well aware that the health care challenges we all worked to address in the last Congress remain with us. As health care professionals, you don't just read about it, you live it. You see it every day and every night.

- The fear of losing health insurance when you leave one job for another still remains. The inability of small businesspersons to find and keep affordable health insurance for themselves and their employees is no less a problem. The numbers of the uninsured, and therefore uncompensated care, continue to increase at an alarming pace of about one million Americans a year. The upcoming aging of the baby boom population and their accompanying and currently unmet long-term care needs is looming just over the horizon.

- The concerns about how pressures to contain public and private health care spending effect quality and choice are even greater than they were last year. Our academic health centers and other centers of excellence for research and training are growing increasingly concerned about the impact of tightening payment rates from managed care entities and Medicare and Medicaid. Our rural and inner city hospitals feel equally threatened.

- All of this is to say that we must stay engaged in addressing these and many more present and future health care challenges. There is no better group of individuals than those in this room to help craft the responses. We must defend against approaches that would take our system backwards and move forward, in a bipartisan basis, to craft constructive steps forward.

- You are the professionals who are best positioned to help bridge the differences and political gaps between the parties and competing approaches. The President and I look forward to working with you in this regard.

OUTLINE OF FIRST LADY'S MEETINGS ON TUESDAY, JULY 11

11:30 AM - 12:00 NOON

POLITICAL MEETING WITH SUPPORTIVE DOCTORS:
Indian Treaty Room
This meeting is with the 60 physicians who have come to Washington as a part of the Steve Gleason's group (the National Health Policy Council). Doug Sosnik plans to give a quick update of the reelect; First Lady will comment on why it is so important for health care providers to be involved in the political process; Steve Gleason and Irwin Redlener will give a personal pitch about how these physicians can stay involved.

12:15 pm - 12:45 pm (they will be ready at 12:00 noon)

PRIVATE PRE-BRIEF WITH THE HEADS OF THE NATIONAL PHYSICIAN ORGANIZATIONS:
Room 472, OEOB
The purpose of this meeting is to pre-brief the heads of the national physician organizations in a discussion setting, so that they fully understand our reg. reform recommendations, and will be more prepared to make supportive statements following the official event.

DEPARTMENT OF HEALTH & HUMAN SERVICES

A fax message from:

Melissa T. Skolfield
Deputy Assistant Secretary for Public Affairs
Phone: (202) 690-6853 Fax (202) 690-5673

To: Jennifer Klein
TDPC

Fax: 456-2878 Phone: 456-2599

Date: 7/10 Total number of pages sent: 2

Comments:

Here's the media advisory, which your press office has cleared. Victor Zonana (690-6343) will cc: you when he sends the fact sheet & press release to Mike Russell.

M.

HHS NEWS

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

July 10, 1995

A D V I S O R Y

For Tuesday, July 11

Medicare Regulatory Reforms:
Presentation, Media Briefing

1 p.m. -- PRESENTATION -- Vice President Gore, First Lady Hillary Rodham Clinton and HHS Secretary Donna E. Shalala will unveil Medicare regulatory reforms that reduce paperwork for doctors and other health care providers. Also participating will be Dr. Steve Gleason of Des Moines, Iowa, chair of the National Health Policy Council. (Presentation and photo opportunity only: no q and a.)

WHERE: Room 450 Old Executive Office Building.

3 p.m. -- MEDIA BRIEFING -- A briefing regarding the reforms will be given by Bruce Vladeck, administrator of the Health Care Financing Administration.

WHERE: Humphrey Building Auditorium
200 Independence Ave. SW

CONTACT: HCFA Press Office
(202) 690-6145

July 10, 1995

MEMORANDUM TO JENNIFER KLEIN

FROM: MARILYN YAGER
OFFICE OF PUBLIC LIAISON

WHAT: BUDGET AND PRE-BRIEFING FOR PHYSICIANS ATTENDING HCFA REGULATORY REFORM EVENT.

DATE/TIME: Tuesday, July 11
9:30am - 11:00am

LOCATION: Room 450

PURPOSE: To provide a detailed briefing on the regulatory reform proposals and the current congressional situation for the supportive physicians who traveled to Washington for our HCFA Reg. Reform event.

BACKGROUND:

Several weeks ago we asked Dr. Steve Gleason to extend an invitation to members of the National Health Policy Council (NHPC) to join us for an update on Phase I of our health care regulatory reform recommendations. In response 60 of their members will comprise the majority of the audience for the 1:00pm REGO event. Although most of NHPC are physicians, some are nurses, teaching hospital administrators, and other health professionals.

As you will recall, the NHPC actively supported the Health Security Act with many of their members official surrogate speakers for the health care war room here at the White House. There has been little opportunity since the last Congress adjourned, to tell these folks how much we appreciated their support and to let them know that we still welcome their input. By providing additional briefings for those attending the REGO event, we hope to send the message that they have not been forgotten.

We also wanted to provide a detailed briefing of our REGO recommendations, because many of these individuals will be doing local media after the 1:00 event.

FORMAT:

Welcome	Harold Ickes
Budget Overview	Alice Rivlin
Details of GOP budget and Clinton Proposal	Nancy-Ann Min Chris Jennings
Health Cared Regulatory Reform Recommendations	Bruce Vladeck Jennifer Klein
Q & A	

PARTICIPANTS:

List attached.

July 10, 1995

POLITICAL MEETING WITH GLEASON GROUP

DATE: Tuesday, July 11
TIME: 11:30 am
LOCATION: Room 474, OEOB
FROM: Marilyn Yager

I. PURPOSE

To personally thank these supportive physicians and other providers for their time and commitment to health care reform in general, and specifically their advocacy on behalf of the Health Security Act. To urge them, as health care professionals, to stay involved in the political process during the months ahead.

II. BACKGROUND

As stated in the purpose, this is an opportunity to let these supportive health care providers know that we have not forgotten all the time and dedication they gave to the health care reform debate. Many of these physicians are not only discouraged with the results of the health care reform debate, but also with the resulting void left to interact with the Administration.

The ongoing regulatory reform process demonstrates that their input continues to have results, especially since Steve Gleason (on behalf of the National Health Policy Council) helped to drive the process which resulted in today's recommendations.

This private meeting with these folks provides an opportunity for you to remind them how important it is that health care professionals stay active in the political process and that they can make (and have made) a difference.

III. PARTICIPANTS

Approximately 60 members of the National Health Policy Council. List attached.

IV. SEQUENCE OF EVENTS

- HRC arrives in Room 474
- HRC briefly works the crowd (providing photo opportunities)
- Steve Gleason and Irwin Redlener make brief remarks.
- Steve Gleason introduces HRC.
- HRC makes brief remarks.
- HRC departs (Doug Sosnik will remain to take questions about the political process during the months ahead).

V. PRESS

Closed.

VI. REMARKS

Talking points attached.

July 10, 1995

PRE-BRIEF MEETING WITH THE LEADERSHIP OF THE NATIONAL PHYSICIAN GROUPS

DATE: Tuesday, July 11
TIME: 12:15 pm
LOCATION: Room 474, OEOB
FROM: Marilyn Yager

I. PURPOSE

To privately brief the heads of the national physician organizations on the recommendations to be released. More specifically to help them place in perspective the regulatory reform recommendations to be announced, and to assist them in providing a positive reaction to our recommendations.

II. BACKGROUND

Knowing that most health care providers receive their federal information through their professional organizations, we felt it was critical to have a private meeting with the heads of national organizations. In addition, it is important that they are clear about our recommendations and intentions so that they feel informed should reporters contact them for comment.

In this meeting we hope to clarify that although they may have hoped our recommendations would go further or be more significant, we hope they will place in context <u>all</u> of the changes we have made to date and recognize that we have truly instituted a process by which we are constantly seeking ways to reduce or eliminate burdensome requirements on provider. If possible, we should make it clear that supportive comments of the steps the Department of Health and Human Services has taken so far will make it that much more easier for us to continue on this path.

It should be noted that several of the associations represented in this meeting differed greatly in their support for the Health Security Act (HSA), although the majority of the groups represented were active supporters. As you will recall, groups like the American College of Physicians, the American Association for Family Physicians, and the American Academy of Pediatrics were active supporters. Other physician groups like the American Medical Association and the American Society for Internal Medicine, while supporting the five principles, took strong exception to many parts of the HSA.

III. PARTICIPANTS

List attached.

IV. SEQUENCE OF EVENTS

- HRC arrives in Room 472.
- HRC makes brief remarks.
- Secretary Donna Shalala and Administrator Bruce Vladeck will provide more detailed description of the recommendations.
- Discussion.
- HRC departs.

V. PRESS

Closed.

VI. REMARKS

Talking Points attached.

TENTATIVE SCHEDULE FOR PHYSICIANS

Tuesday, July 11

NOTE: You should come to the Pennsylvania Avenue entrance to the Old Executive Office Building at the corner of Pennsylvania and 17th Street (this building is right next to the White House). Please try to arrive by 9:00 am to allow for your security clearance.

9:30am - 10:45am	Budget/Issues Briefing Room 450, Old Executive Office Building (This will include a substantive briefing on Medicare and Medicaid)
~~11:00am - 11:45am~~ 11:30 - 12:00 30 ~~11:45~~am - 12:30pm	~~Special Event~~ Pol The White House Indian Treaty Rm. Lunch (on your own)(many local sandwich shops near the Old Executive Office Building)
12:45pm - 2:00pm	Healthcare Regulatory Reform Event with the Vice President and First Lady Room 450, Old Executive Office Building
2:00pm - 3:30 pm	Potential press interviews for individual physicians (for those who are able to stay during this time period, we will try to arrange press interviews with your home state press).

ADDITIONAL NOTE: We apologize for changes in the schedule which have moved the length of the meetings into the afternoon. We hope this will not inconvenience anyone's scheduled travel plans.

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. list	While House health care briefing invitees [Personally Identifiable Information] (35 pages)	07/07/1995	b(6)

COLLECTION:
Clinton Presidential Records
First Lady's Office
Jennifer Klein
OA/Box Number: 9147

FOLDER TITLE:
Regulatory Review - Event [2]

2014-0536-S
kc1610

RESTRICTION CODES

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

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

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

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

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

TO: Melanne Verveer
FROM: Jennifer Klein
Marilyn Yager
DATE: 4/27/95
RE: Health Care Regulatory Relief Event

Here is a summary of our proposal for the Health Care Regulatory Relief Event.

DATE:

As you know, Steve Gleason was unable to organize the doctors in time for an April 27 event. He needs at least three weeks to notify the doctors so that they can change their patient schedules and get plane tickets.

Patti has suggested May 22. However, we were subsequently told that the Vice President also wants to participate and is unavailable on that day. Maggie and Jennifer (who both spoke with Elaine Kamarck) agreed that it will be difficult not to include him if he wants to be part of the event. He is available on May 24 and 25.

PARTICIPANTS:

Remarks: The First Lady
The Vice President
Secretary Shalala or Bruce Vladeck

Audience: Dr. Gleason's doctors
Other supportive physician and hospital groups
HHS Regional Directors

EVENT PROPOSAL:

9:30 a.m. Gleason's group gets briefing on health care reform from Carol Rasco and/or Laura Tyson and details of regulatory relief proposals from Bruce Vladeck or Helen Smits and Jennifer.

10:00 a.m. HRC holds private meeting with representatives from Dr. Gleason's group and the presidents of the physician and hospital associations.

11:00 a.m. Event in East Room. HRC announces new regulatory relief proposals as well as progress on other initiatives that the Administration has already undertaken and plans for ongoing efforts to reduce regulatory burdens. The Vice President highlights the importance of these efforts as part of our overall effort to reduce burdens and make our progams more customer-service oriented. Secretary Shalala or Bruce Vladeck provide more detail on the initiatives.

12:00 p.m. Participants from key states do radio and print interviews highlighting the impact of these changes.

cc: Patti Solis

E X E C U T I V E O F F I C E O F T H E P R E S I D E N T

17-Feb-1995 04:19pm

TO: Jennifer L. Klein

FROM: Barbara D. Woolley
Public Liaison

SUBJECT: Format for Regulatory Releast

Regulatory Release Format

Location: Hospital in one of the key states

Press: Both, National and regional

Format:
Audience: Approximately 100 made of those folks that benefit from regulatory release: Physicians and Hospitals folks from our supportive hospital, physician, other groups that benefit from the regulatory relief. Also have 30 or so folks from location.

Panel: 14 people on panel. The First Lady, 2 Hospital Administrators, 2 Physicians, 1 or 2 HHS rep (Donna Shalala and Bruce V.) 6 consumers with personal nightmare highlighting regulatory issues. 1 insurer. 1 employer. 1 service provider. 1 expert outside the government, maybe from one of the groups who provide expertise on issue.

Full List for One O'Clock Event

Attendees for the ~~9:30~~ 1:00 Meeting, "The Steve Gleason Group"

Raymond Adleman, MD
Norfolk, Virginia

Stephen Michael Ahner
Washington, DC

Gloria Jackson Bacon, MD
Chicago, Illinois

Alan Baskin, MD
Dumont, New Jersey

Robert Berenson, MD
Bethesda, Maryland

Allah Bhatti, MD
Milwaukee, Wisconsin

Richard Boxer, MD
Milwaukee, Wisconsin

John (Jack) Bresch
Catholic Health Assoc.
Washington, D.C.

E. Richard Brown, PhD
Los Angeles, California

Karen Burke, MD
Kaiser Permanente
Raleigh, North Carolina

David Cawley
1st Hospital Co.
Financial Systems
Reston, Virginia

Jerome Connally, PT
Billings, Montana

Lynn Cutler
The Kamber Group
Washington, D.C.

Carol Daniels
Texas Dept. of Health
Austin, Texas

Gerben DeJong, PhD
Bethesda, Maryland

L.C. Dorsey, DSW, LCSW
Mt. Bayou, Mississippi

Charles Dougherty, PhD
Omaha, Nebraska

Gail Douglas, RN, MPH
Boston, Massachusetts

Beth Doaoretz, MD
Norfolk, Virginia

Ron Dozoretz, MD
1st Hospital Co.
Norfolk, Virginia

Jack Michael Dutzar, MD
Spokane, Washington

Kevin Fickensher, MD
Milwaukee, Wisconsin

Pat Ford-Roegner
HHS-Regional Director
Atlanta, Georgia

Howard Freed, MD
Slingerlands, New York

James Harold French, Jr. MD
Fairfax, Virginia

Ms. Terry Gaffney
American Nurses Assn
Washington, DC

David Gencarelli
Washington, DC

Timothy Gleason
Des Moines, Iowa

Steve Gleason
Natl Health Policy
Council
Des Moines, Iowa

Herb Gleason
Boston, Massachusetts

Steve Gorin
Canterbury, New Hampshire

Robert Grayson, MD
Surfside, Florida

Mary Hansen, RN, PhD
Des Moines, Iowa

Mary Hayes, DDS
Chicago, Illinois

Richard Hollis, MD
Amory, Mississippi

John Holloman, MD
New York, New York

Allen Hyman, MD
New York, New York

Kenneth Ingber, DMD
Washington, DC

David Jackson, MD, PhD
Columbus, Ohio

Lawerence Jindra, MD
Garden City, New Jersey

Charles Johnson
Des Moines, Iowa

Gloria Johnson-Powell, MD
Boston, Maryland

Harry Jonas, MD
Chicago, Illinois

Florence July, RN, BSN
Okemah, Oklahoma

Mi Ja Kim, RN, PhD
Chicago, Illinois

Richard Knapp, PhD
Washington, DC

Carol Kuhle
Des Moines, Iowa

Judy Kline Leavitt, RN
Ithaca, New York

William Licamele, MD
Washington, DC

Irving Loh, MD
Thousand Oaks, California

Gordon MacLeod, MD
Pittsburgh, Pennsylvania

Tammy Mann, PhD
Washington, DC

Robert Millman, MD
New York, New York

Mary Mundinger, RN, DrPh
New York, New York

Janet O'Keefe
Washington, D.C.

George Rapier, MD
San Antonio, Texas

Irwin Redlener
New York, New York

Neil Redlener, MD
Boston, Massachusetts

Susan Reynolds, MD
Malibu, California

Elena Rios, MD
Washington, DC

Alan Rosenfield, MD
New York, New York

Barbara Ross-Lee, MD
Athens, Ohio

Robert Ruben, MD
Bronx, New York

Karen Walsh Rutledge
Washington, DC

Vin Sahney, PhD
Detroit, Michigan

Elizabeth Shannahan
Des Moines, Iowa

Aaron Shirely, MD
Jackson, Mississippi

Suzanne Smith
Cleveland, Ohio
Particia Starck, RN
Houston, Texas

David Swicskowski, MD
Des Moines, Iowa

William Terry, MD
Boston, Massachusetts

Jorge Valle, MD
Northbrook, Illinois

Victor Vela, MD
San Antonio, Texas

Robert Waters, Esq.
Washington, DC

Sterling Williams, MD
New York, New York

Kathy Wood Dobbins
Nashville, Tennessee

Marilyn's Doctor's Groups at 1pm Briefing

The American Academy of of Pediatrics
- Elizabeth Noyes
- Rachel Schaffer
- Deborah Ringel
- Adam Ellis
- Anne Webster Green

American Osteopathic Association
- Elizabeth Beckwith
- Stacy Bohlem
- Michael Conrad

American Group Practice Association
- Donald Fisher
- Susan Whitaker
- M. Kathleen Kenyon
- Rebecca Gray
- R. Brian Lewis

American Society of Internal Medicine
- Alan Nelson
- John Philip DuMoulin
- Kristin Louisa Miller

Physicians Advisory Council
- Kenneth Viste, Jr., MD

American College of Emergency Physicians
- Richard Aghababian, MD
- John Scott
- Lee Robert Godown
- Roslyne Debbie Weiner Schulman

American College of OB/GYNs
- Kathy Bryant
- Carol Vargo

American Academy of Family Physicians
- Charles Huntington, III

American College of Preventive Medicine
- Hazel Keimowitz
- Donna Grossman
- Barbara Anne Clark
- Tracey Lynne Ialeggio
- Marcus Randall Eng

American Medical Women's Association
Eileen McGrath
Diane Helentjaris, MD
Omega Cecile Logan Silva, MD
Willa Marlene Brown, MD
Deborah MArtina Smith, MD

American Medical Association
Randolph Smoak
Rich Deem
John Emery
Mary Jo Malone
Margaret Garikes

American College of Physicians
Howard Shapiro, PhD

American Association of Homes and Services for the Aging
Edgar Rivas
Michael Rodgers
Maureen Sullivan
Heidi Young

American Association of Physicians of Indian Origin
Bhimsen Rao, MD
Madhu Mohan, MD

Protestant Heatlh Alliance
Sherry Hayes

Office of Personal Management
Lorraine Green
William Flynn
Lucretia Myers
Abby Block

American Health Care Association
Bruce Yarwood
Richard Miller
Jack MacDonald
Blaine Hendrickson
Steve Chies

THE WHITE HOUSE

WASHINGTON

SCHEDULE AT THE WHITE HOUSE

NATIONAL HEALTH POLICY COUNCIL MEMBERS

Tuesday, July 11

9:30 am - 11:00 Room 450, OEOB	Briefing on the Medicare/Medicaid Budget and Pre-Briefing on the Regulatory Reform Recommendations.
11:00 am - 12:30 pm Room 474, OEOB	Private Meeting with First Lady and Buffet Lunch
12:45 pm - 2:00 pm Room 450, OEOB	Health Care Regulatory Reform Event with the Vice President and First Lady
2:00 pm to 3:00 pm Room 450, OEOB	Regional Press Interviews for Individuals from outside of Washington, DC.

THE WHITE HOUSE

WASHINGTON

June 28, 1995

Dear Mr. Speaker:

We share the goal of balancing the federal budget, and I look forward to working with you on this important matter.

But as we work together to reach our shared goal, we must ensure that we do so the right way -- the way that will raise the standards of living for average Americans.

My plan to balance the budget over 10 years will help raise average living standards by cutting unnecessary spending while investing in education and training, targeting tax relief to middle-income Americans, and taking incremental but serious steps toward health care reform. By contrast, the conference agreement cuts too deeply into Medicare and Medicaid and cuts education and training both to pay for a tax cut that is too large for too many who don't need it, and to meet the 7 year time frame.

Though I am determined to work with you to balance the budget, I cannot accept legislation that will threaten the living standards of American families.

I hope we can work together and avoid a situation in which I would have no choice but to use my veto authority broadly. The American people want us to work together to balance the budget and to do it the right way. I am ready to do that.

Sincerely,

Bill Clinton

The Honorable Newt Gingrich
Speaker of the
House of Representatives
Washington, D.C. 20515

THE WHITE HOUSE

WASHINGTON

June 28, 1995

Dear Mr. Leader:

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But as we work together to reach our shared goal, we must ensure that we do so the right way -- the way that will raise the standards of living for average Americans.

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Sincerely,

Bill Clinton

The Honorable Bob Dole
Majority Leader
United States Senate
Washington, D.C. 20510

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

THE DIRECTOR

June 28, 1995

The Honorable Pete V. Domenici
Chairman
Committee on the Budget
U.S. Senate
Washington, D.C. 20510

Dear Mr. Chairman:

I am writing to transmit the Administration's views on the conference report on H. Con. Res. 67, the concurrent resolution on the budget for fiscal years 1996-2002.

We stand at an important moment in the nation's history. For the first time in recent memory, the President and leaders in Congress have agreed that we must put in place a plan to balance the federal budget. We want to work with Congress on this important goal.

The key question is: How? With this conference report, the American people now have before them two profoundly different approaches -- the President's 10-year plan and the conferees' 7-year plan.

As the Administration has indicated to Congress on many occasions, we have very serious concerns about the approach taken in this conference report. The conferees would balance the budget too quickly and, at the same time, provide a huge tax cut whose benefits would flow disproportionately to the wealthy. To do so, the conferees would cut deeply into Medicare and Medicaid and cut discretionary spending so much that funds for education and training, science and technology, and other priorities that would help raise the living standards of average Americans would be seriously depleted.

If reconciliation and appropriations legislation implementing these policies were presented to the President, I would strongly recommend that he use his veto authority.

The President's plan to balance the budget over a reasonable period of time would protect Medicare and Medicaid, invest in education and training and other priorities, and provide for a targeted tax cut to help middle-income Americans raise their children, save for the future, and pay for postsecondary education.

To reach balance, the President would eliminate wasteful spending, streamline programs, and end unneeded subsidies; take the first, serious steps toward health care reform; reform welfare to reward work; cut non-defense discretionary spending,

aside from the President's investments, 22 percent in real terms in 2002; and target tax relief to middle-income Americans.

From our early analysis of the conference report, we continue to have the same concerns that we expressed about both the House and Senate budget resolutions.

Specifically, I want to express the Administration's deep reservations about the following elements of the conference agreement:

Time frame to a balanced budget. Last fall, Congressional Republicans set an arbitrary goal of balancing the budget over 7 years while providing a huge tax cut whose benefits would flow disproportionately to the wealthy. Then, they had to find the spending cuts needed to reach balance in 2002. That is the wrong approach.

By contrast, the President chose his policies first and let the date to reach balance flow from them. As a result, he was able to cut wasteful spending while protecting vital services.

Tax cuts. The conferees have settled on a $245 billion tax cut, whose details will be crafted by the congressional tax-writing committees. Such a tax cut is too expensive; it will force unnecessarily deep cuts in Medicare as well as education and other priorities. And, based on the House-passed tax proposal, we remain concerned that the benefits will flow mostly to those who do not need them -- the very individuals who have moved ahead over the last two decades as others stayed in place or fell behind.

The President has proposed a less expensive, targeted tax cut to help middle-income Americans raise their young children, pay for postsecondary education, and save for the future. That is a much better way to help raise average living standards.

Health care. The conferees propose to cut Medicare by $270 billion by slowing the annual growth rate to an average of 6.4 percent over 1995 to 2002. They propose to reduce Medicaid by $182 billion, by converting it into a block grant and slowing the annual growth rate to 4 percent by 1998. Such proposals would threaten Medicare beneficiaries, cut Medicaid coverage for millions of children and elderly Americans, and endanger many hospitals, including academic health centers. Assuming a 50/50 beneficiary/provider split, these steps would raise out-of-pocket costs for couples on Medicare by $5,650 between 1996 and 2002. These severe out-of-pocket increases would not be necessary if the conferees opted for the President's tax cut proposal.

As the President has often said, the key to long-term deficit reduction is controlling health care costs through health care reform. He proposes a serious first step toward reform that would strengthen the Medicare Hospital Insurance

(HI) Trust Fund, ensuring Medicare solvency until at least 2005; expand benefits to families; make insurance more affordable for small business; and reform the insurance market. At the same time, he proposes less than half the Medicare savings and a third of the Medicaid savings as Congress, and would impose no new cost increases on Medicare beneficiaries.

Education and other investments. In attempting to balance the budget over 7 years and finance a huge tax cut, Congress would have to cut virtually everything else, including the very programs that would help raise average living standards. Compared to the 1995 level, the resolution would cut discretionary spending for education and training by $26 billion over seven years. In addition, the conference report proposes saving $10 billion in the student loan program, apparently by raising costs to middle- and low-income students.

By contrast, the President proposes to increase discretionary funding for education and training by $41 billion over the next 7 years. In addition, the President would save money in the student loan program not by cutting in-school interest subsidies and forcing middle- and low-income students to pay more; rather, he would phase in Federal Direct Student Loans quicker, cutting subsidies to wealthy banks, secondary markets, and other intermediaries. That would assist 6 million people a year -- and save money for the government, schools, and students.

In addition, the Administration remains concerned about the size of the proposed welfare cuts; they would cut benefits to poor families, thus punishing children in the process. Congress would increase the tax burden on low-income families by rolling back scheduled increases in the Earned Income Tax Credit, which is designed to reward work by lifting working families out of poverty.

Overall, while the Administration and Congress share the goal of a balanced budget, we have grave concerns about the approach set forth in this conference report. We hope to work with you, as the process moves forward, to find an approach that is acceptable to both the President and Congress.

Sincerely,

Alice M. Rivlin
Director

Identical letter sent to Honorable J. James Exon, Honorable John R. Kasich, Honorable Martin Olav Sabo