91st Congress
2d Session } CONFIDENTIAL COMMITTEE PRINT

STAFF DATA WITH RESPECT TO H.R. 17550 SOCIAL SECURITY AMENDMENTS OF 1970

PREPARED BY THE STAFF

OF THE

COMMITTEE ON FINANCE UNITED STATES SENATE

PART 4

MEDICARE-MEDICAID

SEPTEMBER 30, 1970

Printed for the use of the Committee on Finance

U.S. GOVERNMENT PRINTING OFFICE

50-619 WASHINGTON : 1970

COMMITTEE ON FINANCE

RUSSELL B. LONG, Louisiana, *Chairman*

CLINTON P. ANDERSON, New Mexico
ALBERT GORE, Tennessee
HERMAN E. TALMADGE, Georgia
EUGENE J. McCARTHY, Minnesota
VANCE HARTKE, Indiana
J. W. FULBRIGHT, Arkansas
ABRAHAM RIBICOFF, Connecticut
FRED R. HARRIS, Oklahoma
HARRY F. BYRD, JR., Virginia

JOHN J. WILLIAMS, Delaware
WALLACE F. BENNETT, Utah
CARL T. CURTIS, Nebraska
JACK MILLER, Iowa
LEN B. JORDAN, Idaho
PAUL J. FANNIN, Arizona
CLIFFORD P. HANSEN, Wyoming

TOM VAIL, *Chief Counsel*
EVELYN R. THOMPSON, *Assistant Chie, Clerk*

CONTENTS

I. COMMITTEE STAFF RECOMMENDATIONS

Provide For Proficiency Evaluation of Otherwise Disqualified Health Care Personnel

Present Law

To qualify for participation in the program, Medicare and Medicaid facilities must meet certain staffing requirements. These requirements often call for personnel in specific categories such as registered nurses, licensed practical nurses, etc.

Problem

There is a shortage of manpower in the health care field, and many faclities have difficulty hiring sufficient qualified personnel.

At the same time there are persons available who do not meet full licensing or Medicare educational requirements, but who have had years of experience and have been granted "waivered" status (such as many waivered licensed practical nurses).

Proposal

The staff recommends a statutory provision requiring development and application of procedures by HEW to determine proficiency (including testing) to allow "waivered" or otherwise excluded or restricted personnel to demonstrate levels of competence. Personnel who demonstrated competence would be considered acceptable for Medicare staffing requirements. Since such people will have thus formally established their professional capabilities there would be no lowering of Medicare standards.

This suggestion is identical to the recommendation made by the Finance Committee in its report on the Social Security Amendments of 1967. HEW has failed to implement the Committee mandate in the interim.

Authorize Secretary of HEW To Establish Priorities for Medicaid Requirement That States Provide Health Screening Programs for Children

Present Law

Section 1905(a)(4)(B) requires all States to provide health screening programs for children under Medicaid.

Problem

HEW has delayed issuance of implementing regulations because of the great cost which full implementation and application of the screening requirement would entail for both the Federal and State governments.

Proposal

The staff suggests that the statutory provision be amended so as to authorize the Secretary to establish orderly priorities for implementa-

tion of Section 1905(a)(4)(B). Report language would indicate that initial priority should be given to health screening of pre-school-age children.

Section 225–Modify Reduction in Federal Matching for Long-stay Medicaid Patients

Effective January 1, 1971, in order to discourage and prevent overutilization of institutional care, the bill provides for a one-third reduction in Federal matching for patient stays which exceed: (a) 60 days in a general or TB hospital; (b) 90 days in a skilled nursing home; and (c) 90 days in a mental hospital. Furthermore there would be no Federal matching after an additional 275 days of care in a mental hospital during an individual's lifetime.

Additionally, to encourage greater use of outpatient services as an alternative to inpatient care the House bill provides that Federal matching for such costs would be increased by 25 percent.

Problem

The approach in the House bill is based upon the fact that throughout the country, there is substantial overutilization of institutional care and that many States have not complied with utilization review and medical audit requirements. However, the provision fails to differentiate between those States which are adequately controlling utilization and those which are not; thereby unjustifyably penalizing some States.

Proposal

The staff suggests that the House provision be modified to exempt from reductions in Federal matching, States which provide satisfactory evidence to the Secretary that they perform adequate medical audit and utilization review until such time as Professional Standards Review Organization can assume such responsibility. Thereafter, continued exemption would be contingent upon effective review by the Professional Standards Review Organization. This exemption from the one-third cutback could either be applicable to all institutional services provided in the State under Medicaid, or the exemption could be applicable only to those institutional services (i.e. care in a mental hospital or skilled nursing home) for which the State could demonstrate adequate utilization controls.

In addition, the staff suggests that the 25 percent bonus for outpatient care be deleted as an unnecessary incentive which might simply constitute increased Federal matching for the existing level of such service. The States presently have a financial incentive to maximize use of less costly outpatient services to reduce more costly inpatient care costs.

The Department favors the House provision and would recommend no change.

Provide for the Establishment of the Office of Inspector-General for Health Care Administration in H.E.W.

Present Law

No provision.

Problem

There is a need for an independent reviewing mechanism charged with specific responsibility for ongoing and continuing review of Medicare and Medicaid in terms of the efficiency and effectiveness of program operations and compliance with Congressional intent. While HEW's Audit Agency and GAO have done some helpful work, there is a need for vigorous day-to-day monitoring conducted at a level which can promptly call the attention of the Secretary and the Congress to important problems and which has authority to remedy some of those problems in timely, effective and responsible fashion.

Proposal

The staff suggests that the committee provide for the establishment of the office of Inspector General for Health Care Administration in HEW substantially as proposed in Amendment 714 sponsored by Senators Williams and Ribicoff.

Under a provision of the amendment, the Inspector General could suspend any regulation, practice, or procedure he determines to be inconsistent with efficiency or economy, or which is contrary to or does not carry out the objectives and purposes of applicable provisions of law, except that the Secretary may terminate the suspension after 30 days. The staff suggests that the amendment be modified so that the Secretary could immediately revoke a suspension order with respect to an existing regulation, practice, or procedure.

Increase Maximum Amount of Federal Medicaid Matching Funds Available to Puerto Rico

Present Law

Under the 1967 amendments, Puerto Rico receives 50% Federal matching for its Medicaid program to a maximum of $20 million in Federal funds.

Problem

There have been substantial increases in the unit costs of hospital and physicians' care over the past several years which are expected to continue. There has also been an increase in the number of Medicaid eligibles in Puerto Rico since 1967. Puerto Rico is making a substantial effort—well in excess of the $20 million it uses to match Federal funds to improve and better meet health needs of its residents.

Proposal

The staff suggests that the $20 million ceiling on Federal matching for Medicaid be increased to $30 million. There would be no change in the 50–50 matching requirement.

Allow Reduction of State Medicaid Expenditures in Fiscal Emergency

Present Law

Pursuant to sec. 1902(d) a State cannot reduce its expenditures for the State share of Medicaid from one year to the next. Failure to comply with this requirement means ineligibility for Federal medical matching.

Problem

In Missouri, the Governor's tax program was defeated by referendum. The Governor called a special session of the legislature to submit an austerity budget, which did *not* include a reduction in Medicaid funds. In the final days of the session, the State Senate cut the Medicaid appropriation, and the clock ran out on the session. The Governor had no choice but to sign the reduced appropriation bill, which put the State out of compliance with section 1902(d).

Proposal

The staff suggests that a provision be added to section 1902(d) which would authorize the Secretary to approve a temporary modification of a State plan to permit a reduction in State Medicaid spending, if such reduction were certified by the Governor to be the result of a fiscal emergency. The modification could be authorized for no more than one year.

Clarification and Expression of Congressional Intent With Respect to Intermediate Care Facilities

Present Law

A new category of facilities—intermediate care—was established under title XI of the Social Security Act in 1967. Such facilities were intended to be institutions providing more than room and board but less than skilled nursing home care. Persons receiving or eligible for cash welfare, placed in such facilities were to be those whose physical or mental condition was such as to require institutional care.

Problem

Intermediate care was intended where appropriate as a less-costly alternative to skilled nursing home and mental hospital care for those persons who would otherwise remain or be placed in skilled nursing homes or mental institutions. The independent professional audit intended to assure proper patient placement of each patient in an ICF and the independent medical audit of each patient in a skilled nursing home, required by law, are not being carried out. In a number of States substandard nursing homes have been reclassified as ICFs with wholesale paper transfer of patients. The original HEW regulations required that such institutions have at least one full-time Licensed Practical Nurse on their staffs. Present regulations have removed that requirement and the ICF program is being construed by HEW as covering persons in need of residential care but who do not necessarily have a health-related condition requiring institutional care. Additionally, while the Intermediate Care benefit is closely related to effective and economical use of skilled nursing home and mental hospital care, the program is being administered at HEW by the cash assistance personnel instead of the medical assistance personnel.

Proposal

The staff suggests that the Committee:

1. Specify in the Statute that intermediate care is health-related for persons who, in the absence of such care, would require placement in a skilled nursing home or mental institution, with a direction in the committee report that HEW amend

its regulations accordingly, including a requirement that such institutions have at least one full-time L.P.N.; and

2. indicate in the report, the expectation that intermediate care will be overseen by the agency having responsibility for Medicaid.

II. HEW AND COMMITTEE STAFF RECOMMENDATIONS

Reduce Costs of Consultants for Extended Care Facilities

Present Law

Medicare conditions of participation require extended care facilities to retain consultants in specialty areas such as medical records, dietary and social services. Reimbursement is made to each facility only for that portion of the costs of these services that represents services provided to Medicare patients.

Problem

In many parts of the country these consultants are in short supply. Consequently, the demand for their services is high and their services on a per diem basis are expensive. Many facilities have considerable difficulty in obtaining these experts and even more difficulty in paying for their services. This is particularly true where a large number of a facility's patients are on Medicaid and the facility receives a fixed per diem payment from the State for their care. Often, the State has provided similar consultative services for these Medicaid patients and no additional allowance is made for the outside consultants employed to meet the Medicare conditions of participation.

Proposal

The staff and the Department suggest that those State agencies desiring to and capable of providing these specialized consultative services to extended care facilities which request them, should be authorized to do so, subject to approval by the Secretary. Payment by Medicare would be made directly to the State for the costs incurred. The State agencies could limit the availability of such services consistent with resources and needs. This option is intended to be available only where it would further the interests of Medicare beneficiaries and would result in overall economies and simplified administration.

Terminate Nursing Home Administrators' Advisory Council December 31, 1970

Present Law

The 1967 Amendments required State licensure of nursing home administrators. An Advisory Council was established under the Statute to assemble and distribute information to the States concerning nursing home administration which would be helpful to them in establishing programs of licensure. That Council is scheduled to terminate December 31, 1971.

Problem

The Advisory Council has essentially completed its work and has passed a resolution to that effect.

Proposal

The staff and the Department suggest the Statute be amended to provide for termination of the Advisory Council as of December 31, 1970. Report language would indicate an expectation that the existing Medical Assistance Advisory Council assume responsibility for any continuing need for advice and assistance with respect to licensing of nursing home administrators.

Provide That Services of Optometrists in Furnishing of Prosthetic Lenses Not Require a Physician's Order

Present Law

Medicare will pay for prosthetic lenses furnished by an optometrist, provided that the medical necessity for such lenses has been determined by a physician.

Problem

Optometrists contend that to require their patients to obtain a physician's order for prosthetic lenses is unfair to both the patient and the optometrist. Moreover, because the physician who furnishes the order is generally an ophthalmologist, the requirement may serve to encourage patients to use an ophthalmologist in preference to an optometrist.

Proposal

The staff and the Department suggest that, for the purposes of the medicare program, an optometrist be recognized as a "physician" under section 1861(r) of the Act, but only with respect to establishing the medical necessity of prosthetic lenses for medicare beneficiaries. An optometrist would not be recognized as a "physician" for any other purposes under medicare and no additional services performed by optometrists would be covered by the proposal. This proposal is substantially the same as an amendment adopted by the Committee and the Senate in the Social Security Amendments of 1967.

Limit Reimbursement of Physical Therapists and Occupational and Speech Therapists, etc.

Present Law

The various therapies are covered under Medicare on a fee-for-service or costs basis when provided in a hospital or extended care facility or through a qualified clinic or agency.

Problem

The House bill sought to deal with the extensive abuse and uncontrolled provision of physical therapy through limiting reimbursement to not more than a salary-equivalent basis rather than fee-for-service. Difficulties have also occurred with other types of therapy services. The salary-equivalent approach does not take into account costs of maintaining an office, travel time, etc. where an independent physical therapist provides the services to an institution.

The House bill also authorizes reimbursement on an outpatient basis of up to $100 of physical therapy under Part B in the office of an independent therapist. The administrative costs of this latter proposal may be as great as the benefit costs.

Proposal

The Staff recommends and the Department would accept a modification of the House provision to:

1. Limit reimbursement to a "salary-related" basis rather than "salary-equivalent" so as to permit payment for acceptable overhead and travel time costs of the independent therapist.
2. Apply the limitation to other types of therapy such as recreational, occupational, and speech.
3. Delete the proposed new benefit for $100 physical therapy in the therapist's office.

Define Conditions of Payment for Supervisory Physicians in Teaching Hospitals

Present Law

Hospitals are reimbursed under the hospital insurance part of Medicare for costs incurred in compensating physicians for teaching and supervisory activities and in paying salaries of residents and interns. In addition, under regulations, reasonable charges are paid under the medical insurance program (part B) for teaching physicians' services to patients.

Problem

The issue of how and whether Medicare should reimburse for the services of a physician when he supervised interns and residents in the care of patients is not treated in either the Medicare Statute or legislative history. Nevertheless, it is clear that charges paid for a physician's services under Medicare should be reasonable in terms of both the patient care services that a particular physician provides as well as the charges made for similar services to other patients—that is, if a physician merely took legal responsibility for care, no fee for service was intended to be paid. Or, if the physician performed the services differently than is usually done when a patient engages his own private physician, the differences were to be reflected in reimbursement.

In some cases, charges have been billed and paid for services rendered in teaching hospitals which clearly did not involve any degree of teaching physician participation. In other cases charges were billed for services that residents and interns rendered in every case where a supervising physician had overall responsibility for their actions, even though he may not actually have become involved in the patient's care. In other instances, charges for covered services were billed in amounts that were out of proportion to the covered service or the charges billed to other patients.

The House included in H.R. 17550 a provision which would recognize services of certain teaching physicians on a costs basis. Under the provision, fee-for-service reimbursement would be contingent on general billing for such services to all patients and collection from those able to pay. A difficulty with this approach is that it tends to encourage hospitals and physicians to inaugurate or expand billing for services for which payment previously had not been expected.

Proposal

The staff and the Department recommend that coverage and reimbursement of patient care services rendered by teaching physicians be substantially modified to more adequately reflect the actual

services furnished by such physicians. To achieve this objective, reimbursement of physician patient care services to patients in the teaching service would be determined on a costs basis reimbursable under Part A. Included as a "cost" would be the salary-equivalent (computed on a time basis) for such services which are donated by a teaching physician. Cost payments for donated services would be made to an appropriate fund designated by the organized medical staff or, in the case of a medical school, to an appropriate fund designated by the teaching faculty.

In recognition that there are some instances in which a truly "private" patient is treated in the teaching service, two exceptions to the cost-based reimbursement would be provided. If the patient was indeed a "private" patient—that is, the patient had been seen by the physician outside the hospital setting, such physician admitted the patient and subsequently provided appropriate post-hospital follow-up—the physician could be reimbursed on a charge basis for his services. Also, if the hospital had, in the two year period ending in 1967, customarily charged patients and collected from a majority of patients in the teaching service on a fee-for-service basis, such hospital could continue to bill and be reimbursed on a reasonable charge basis (fee for service) for the services provided to Medicare patients. Such charges shall be reimbursable under part B. Congressional intent should be made clear that in any borderline or questionable areas concerning whether reimbursement of teaching physicians in a given institution or setting should be on a costs or charges basis, reimbursement should be on a costs basis.

Conform Medicare and Medicaid Standards for Nursing Facilities

Present Law

The Medicare program was intended to cover relatively short-term post-hospital care in skilled nursing institutions certified for participation as extended care facilities. Medicaid covers longer term skilled inpatient care in institutions which qualify as skilled nursing homes. Each program has its own standards for participation and administrative process for certifying compliance by an institution with those standards.

Problem

Although the extended care facility as defined under Medicare in 1965 was an institution offering a different and more highly skilled level of care than the general nursing home, the differences between the two types of institutions were largely eliminated by the introduction of legislative standards for the "skilled" nursing home institution under Medicaid in 1967. While the emphasis of the care under the two programs may differ, patients under both programs require the availability of essentially the same types of services and are often in the same institution. Because of the substantial similarities in the services required, the existence of separate requirements (which even now differ only slightly) and separate certification processes for determining instituional eligibility to participate in both administratively cumbersome and unnecessarily expensive. The same facility is more often than not approved under both programs.

Proposal

The staff and the Department recommended that the law be modified to require that health, safety, environmental and staffing standards for extended care facilities be uniform with those established for skilled nursing homes under Medicaid. States would then be encouraged to consolidate certification activities for the two programs under a single State agency.

Provide for Simplified and More Economical Reimbursement of Extended Care Facilities

Present Law

Under Medicare, reimbursement to extended care facilities is based on the reasonable costs incurred by the facility in providing covered services. While interim payments are made on the basis of projected costs, individual facilities must submit annual reports which identify actual costs incurred; after analysis, retroactive payment adjustments are made to reflect actual costs incurred, to the extent they are deemed reasonable.

Under Medicaid, States generally establish (in advance) per diem or similar rates payable for patients receiving skilled nursing home care. Such rates are ordinarily based on analyses of overall costs of providing such care to eligible recipients.

Problem

The reasonable cost approach of the Medicare program has created several difficulties for extended care facilities. The detailed and expensive cost-finding requirement have proved extremely cumbersome and the lack of advance knowledge of actual payments impedes effective budgeting and planning. Further, the extended care facility has no incentive to contain costs or control delivery of services since actual costs are reimbursable unless considerably out-of-line with costs of similar services in the area.

Under Medicaid, however, institutions know in advance how much income can be expected as well as the types of services which are expected to be furnished to their patients. The skilled nursing home has an economic incentive to contain costs and deliver its services economically and efficiently.

Proposal

The staff and the Department recommend that the Secretary be authorized to adopt as reasonable cost payments for extended care facilities in any State the rates developed in that State under Medicaid for reimbursement of skilled nursing care, if the Secretary finds that they are reasonably based upon analyses of costs of care in comparable facilities These rates could be adjusted by a percentage factor not in excess of 10 percent to take into account items of service or other Medicare requirements not included in the computation of the Medicaid rate. Such adjustments could be made only on a class, size of institution, or geographical basis. Extended care facilities operated by hospitals, however, would continue to be reimbursed under the reasonable cost reimbursement method utilized by the hospital. Where a skilled nursing facility functions in a close formal medical satellite relationship with a hospital, reimbursement should

be made on the basis of Departmental or gross RCC costs not to exceed 150 percent of the amount otherwise payable under the adjusted medicaid skilled nursing facility reimbursement.

○