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3

STAFF DATA ON H.R. 1

MEDICARE-MEDICAID

SENATE-APPROVED AMENDMENTS TO H.R. 17550 INCLUDED IN H.R. 1 WITH CHANGES

COMMITTEE ON FINANCE
UNITED STATES SENATE
RUSSELL B. LONG, *Chairman*

MARCH 1, 1972

Prepared by the staff and printed for the use of the Committee on Finance

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Following are Committee and Senate-approved amendments to H.R. 17550, which are also included in H.R. 1. These amendments have been modified in lesser or greater degree from the versions previously approved by the Committee. In most instances the staff suggests that language substantially similar to that approved by the Committee on Finance in 1970 be substituted for the provisions in H.R. 1.

Hospital Insurance for the Uninsured

(SECTION 202)

Problem

A substantial number of people reaching or presently over age 65 are ineligible for Social Security and thus cannot secure Part A (hospital insurance) covereage under Medicare. These people have difficulty in securing private health insurance coverage with benefits as extensive as those of Medicare.

House Bill

Permits persons age 65 or over who are ineligible for Part A of Medicare to voluntarily enroll for hospital insurance coverage by paying the full cost of coverage (initially estimated at $31 monthly and to be recalculated annually). Where the Secretary of HEW finds it administratively feasible, those State and other public employee groups which have, in the past, voluntarily elected *not* to participate in the Social Security program could opt for and pay the Part A premium costs for their retired or active employees age 65 or over.

Change from 1970 Senate Provision

Provision included in both the House and Senate passed versions of H.R. 17550. Senate version also required enrollment in Part B as condition of "buying" into Part A.

Incentives for States To Undertake Required Institutional Care Review Activities and To Emphasize Comprehensive Health Care Under Medicaid

(SECTION 207)

Problem

Both GAO and the HEW Audit Agency have found substantial unnecessary and overutilization of costly institutional care under Medicaid, accompanied by insufficient usage of less costly alternative out-of-institution health care. There is no provision in present law which places affirmative responsibility upon States to assure proper patient placement. As a practical matter, the Department of H.E.W. has seldom if ever, recovered from a State amounts improperly spent for non-covered care or services.

House Bill

1. Unless a State can make a showing satisfactory to the Secretary that the State has an effective program of control over the utilization of nursing home and hospital care, to discourage overutilization of

institutional care, effective June 30, 1971, the House bill provides for a one-third reduction in the Federal Medicaid matching share for stays in a fiscal year which exceed: (a) 60 days in a general or TB hospital; (b) 60 days in a skilled nursing home.

2. Federal matching would be available, in any year, for only 90 days in a mental hospital (except that an additional 30 days would be allowed if the State shows that the patient will benefit. There would be no Federal matching for care in a mental hospital beyond 120 days in any year. In addition, there would be no Federal matching for care in a mental hospital after 365 days of such care during a patient's lifetime.

3. The House bill would also provide for an increase of 25% (up to a maximum of 95%) in the Federal Medicaid matching formula for amounts paid by States under contracts with Health Maintenance Organizations or other comprehensive health care facilities.

4. Further, the bill would provide authority for the Secretary to assure that average Statewide reimbursement for intermediate care in a State is reasonably lower than average payments for higher-level skilled nursing home care in that State.

Change from 1970 Senate Provision

1. A somewhat similar provision was included in the House version of H.R. 17550. The major Senate modification to that provision, suspension of the reduction in nursing home matching if adequate utilization controls exist in a State, has been incorporated into H.R. 1 except that the State must now make an affirmative showing of proper control rather than the Secretary making a negative finding of noncompliance.

2. The 25 percent increase in Federal matching percentages for amounts paid to HMO's is a new feature of the provision it replaces last year's 25 percent increase in Federal matching for all outpatient clinic and home health services. The 25 percent "bonus" was deleted from the House bill by the Finance Committee last year.

Proposal

1. It is suggested that, in addition to the utilization review requirement, it be made clear that States must also be conducting the independent professional audits of patients as required by present law which are intended to assure that the patient is getting the right care in the right place.

2. The staff suggests making inapplicable the 90-day or 120-day annual limitation and the 365-day lifetime limitation on care in mental hospitals, but only in a State which makes a satisfactory showing to the Secretary that it has an effective program of control over the utilization of mental hospital care. If proper procedures assure that the mentally-ill patient needs the care and is benefiting from it, it would seem inappropriate to cut off Federal matching utilizing arbitrary limitations on the number of days of covered care in a year and lifetime.

3. The staff suggests deleting the House provision which calls for a 25% increase in matching for amounts paid to HMO's, since if HMO's deliver services more efficiently, and economically, it would be in the States interest to deal with HMO's without an increase in matching. There is also the policy issue as to the advisability of subsidizing States to encourage one form of medical organization and practice over others.

4. The staff suggests that intermediate care services also be subject to a reduction in Federal matching after 60 days, unless the State provides satisfactory assurance that required review is being undertaken. This appears appropriate in view of the shift of intermediate care to Medicaid in legislation enacted subsequent to House consideration of H.R. 1. At present, the House bill does not subject ICF's to the requirement of proper review.

5. Finally, the staff would suggest that the Secretary's validation of State utilization controls should be made on site in the States and such findings should be a matter of public record. The purpose here is to assure actual—rather than paper—compliance with the proposed statutory requirements.

Limitation on Federal Payments for Disapproved Capital Expenditure

(SECTION 221)

A hospital or nursing home can, under present law, make large capital expenditures which may have been disapproved by the State or local health care facilities planning council and still be reimbursed by Medicare and Medicaid for capital costs (depreciation, interest on debt, return on net equity) associated with that expenditure.

House bill

Prohibits reimbursement to providers under the Medicare and Medicaid programs for capital costs associated with expenditures of $100,000 or more which are specifically determined by the State or local Health Facilities Planning Council to be inconsistent with State or local health facility plans.

Change from 1970 Senate Provision

The House did not include the Senate modification which would waive the provision with respect to construction included in formal plans for expansion or replacement toward which preliminary expenditures of $100,000 or more had been made during the three-year period ended December 17, 1970 by a health care facility providing services as of December 18, 1970. The purpose of the Senate provision was to permit a hospital which had expended extensive amounts toward a program of development or expansion to complete it without, at the same time, opening the door wide to indiscriminate avoidance of the intent of the provision.

Proposal

The staff suggests inclusion of the 1970 Senate modification.

Experiments in Prospective Reimbursement and Peer Review

(SECTION 222)

Problem

Reimbursement on the present reasonable costs basis contains little incentive to decrease costs or to improve efficiency, and retrospective cost-finding and auditing have caused lengthy delays and confusion. Payment determined on a prospective basis might provide an incentive to cut costs. However, under prospective payment providers might press for a rate less favorable to the Government than the

present cost method, and they might cut back on the quality, range and frequency of necessary services so as to reduce costs and maximize return.

House Bill

Instructs the Secretary to experiment with various methods of prospective reimbursement, and to report to the Congress with an evaluation of such experiments by July 1, 1973. The provision further authorizes experiments with peer review mechanisms such as Professional Standards Review Organizations.

Change from 1970 Senate Provision

Although the House and Senate passed versions of H.R. 17550 were identical the House has now added authorization to experiment with peer review mechanisms and deleted the requirement that descriptions of all proposed experiments be sent to the Committees on Ways and Means and Finance.

Proposal

1. The staff suggests that the portion of the House and Senate H.R. 17550 provision requiring that informational descriptions of proposed experiments be sent to the Finance Committee to be included in H.R. 1. The legislative history indicates that the Committee on Ways and Means does not desire to be informed in advance concerning proposed experiments, as they have deleted that requirement which they had previously approved.

2. As the Committee has now agreed to the Professional Standards Review Amendment, it would appear appropriate to delete the references in the House provision to experiments with peer review.

Limitations on Coverage of Costs

(SECTION 223)

Problem

Certain institutions may incur excessive costs, relative to comparable facilites in the same area, as a result of inefficiency or "the provision of amenities in plush surroundings." Such excessive costs are now often reimbursed under Medicare.

House Bill

Authorizes Secretary to establish limits on overall direct or indirect costs which will be recognized as reasonable for comparable services in comparable facilities in an area. He may also establish maximum acceptable costs in such facilities with respect to items or groups of services (for example, food costs, or standby costs). The beneficiary is liable for any amounts determined as excessive (except that he may not be liable for excessive amounts in a facility in which his admitting physician has a direct or indirect ownership interest). The Secretary is required to give public notice as to those facilities where beneficiaries may be liable for payment of costs determined as not "necessary" to efficient patient care.

Change from 1970 Senate Provision

Essentially the same as the House and Senate passed versions of H.R. 17550 except that the House *did not* include the Senate modification specifying that disallowed costs must be "grossly" in excess of reasonable costs.

Limitation on Prevailing Charge Levels

(SECTION 224)

Problem

Under the present reasonable charge policy, Medicare pays in full any physician's charge that falls within the 75th percentile of customary charges in an area. (The 75th percentile is the amount which would cover 75 percent of all charges for a given medical service. For example, if charges for appendectomies range from $150 to $400 with 75 percent of the charges being made for $325 or less, $325 would constitute the 75th percentile for Medicare purposes.) However, there is no limit on how much physicians, in general, can increase their customary charges from year to year and thereby increase Medicare payments and costs.

House Bill

Recognizes as reasonable, for Medicare reimbursement purposes only, only those charges which fall within the 75th percentile of customary charges in an area. Starting in 1973, increases in physicians' fees allowable for Medicare purposes, would be limited by a factor which takes into account increased costs of practice and the increase in earnings levels in an area.

With respect to reasonable charges for medical supplies and equipment, the bill would provide for recognizing only the lowest charges at which supplies of similar quality are widely available.

Change from 1970 Senate Provision

Similar to both the House and Senate passed versions of H.R. 17550, except that H.R. 1 does not include the Senate modification allowing recognition of the *lower* charges in an area, as opposed to the *lowest* charges, for supplies and equipment.

Proposal

Staff suggests change so as to include Senate language. The purpose here is to assure availability and to recognize minor variations in pricing which may be reasonable in light of the provision of additional necessary but non-standard services by some suppliers in an area.

Reductions in Care and Services Under Medicaid Program

(SECTION 231)

Problem

As has been extensively noted in previous Committee hearings and reports, the Medicaid program has been a significant burden on State finances. In an effort to reduce financial pressure upon States, Section 1902(d) (originating as a Finance Committee amendment in 1969) of Title 19 provides that a State may reduce the range and duration or frequency of the services it provides under its Medicaid program, but it cannot reduce its aggregate expenditures for Medicaid from one year to the next. This maintenance of effort requirement has forced a few States to either cut back on other programs or to consider dropping Medicaid.

House Bill

Provides for a continuance of the maintenance of effort clause with respect to the six mandatory health care services. The provision would,

however, amend section 1902(d) by restricting the maintenance of effort requirement to those six basic services. The State would be able to modify the scope, extent and expenditures for optional services provided, such as drugs, dental care and eyeglasses.

Change from 1970 Senate Provision

The Senate version of H.R. 17550 repealed section 1902(d) entirely, and included a provision to waive the maintenance of effort requirement for Missouri retroactive to July 1, 1970. The Department advises that the Missouri situation has been worked out and that the specific provision for relief of that State is no longer necessary.

Proposal

In view of the fact that the Committee had deleted 1902(d) and was upheld in its decision on a rollcall vote on the floor, the staff suggests that the Committee might want to consider deletion of 1902 (d) entirely.

Determination of Reasonable Hospital Costs Under Medicaid

(SECTION 232)

Problem

Many States maintain that use of the Medicare formula for Medicaid reimbursement can result in their paying more than the actual costs of providing inpatient care to Medicaid recipients and hampers their efforts at controlling the costs of hospital care.

House Bill

Allows States to develop their own methods of hospital reimbursement rather than requiring States to reimburse hospitals under Medicaid on the basis of the Medicare reasonable cost formula. The method developed must cover actual reasonable costs but may not exceed the reasonable cost determined under Medicare.

Change from Senate Provision

Similar to both the House and Senate passed versions of H.R. 17550, except that the House has transferred from amendment language to report language the condition stating that hospitals or private patients should not subsidize the costs of inpatient care for title 19 recipients nor should payment for such recipients subsidize the costs of caring for other patients.

Suggestion

Hospitals argue that under the House provision States will reimburse them for less than the cost of Medicaid services and urge that the House provision be deleted. The staff feels the provision should be retained in the bill but it recommends that the 1970 language be reinstated in the bill to assure hospitals that States are expected to pay the full reasonable costs for medically-necessary hospital care they provide and may not limit reimbursement to less than reasonable costs.

Payments to States Under Medicaid for Installation and Operation of Claims Processing and Information Retrieval Systems

(SECTION 235)

Problem

Many States do not have effective claims administration or properly designed information storage and retrieval systems for their Medicaid programs and do not possess the financial and technical resources to develop them.

House Bill

Authorizes 90 percent Federal matching payments toward the cost of designing, developing and installing mechanized claims processing and information retrieval systems deemed necessary by the Secretary. The Federal government would assist States with technical advice and development of model systems. Federal matching at 75 percent would be provided toward the costs of operating such systems.

Change from 1970 Senate Provision

Similar to both the House and Senate-passed versions of H.R. 17550, except that the House has added a provision to provide 90% matching for 2 years (up to a total of $150,000 annually) for the development of cost determination systems for State-owned general hospitals.

Proposal

The staff suggests modification of the House provision so as to:

(1) Authorize regional or multi-State data processing systems rather than State-by-State systems, unless the Secretary finds that a system for a single State would be more feasible, economical, and efficient.

(2) Require that the design of any such new systems, to the extent feasible, be compatible with Medicare data processing requirements so as to permit expansion of the system, if necessary, where suitable carrier or intermediary performance is not available. The intent is not to create excess capacity but to assure a system capable of being rationally expanded to assist in Medicare administration, if that became necessary.

Use of State Health Agency To Perform Certain Functions Under Medicaid

(SECTION 239)

Problem:

Under present law, one State Agency (such as the health department) may certify health facilities for participation in medicare, and a different agency may be required to certify the same institution for participation in medicaid, resulting in a duplication of effort.

Also, some State agencies lack the capability to perform Statewide utilization reviews of services provided under Medicaid.

House Bill

Requires that the same State health agency (or other appropriate State medical agency) certify facilities for participation under both Medicare and Medicaid.

Requires that Federal participation in Medicaid payments be contingent upon the State health agency establishing a plan for statewide review of appropriateness and quality of services rendered.

Change from 1970 Senate Provision

Identical to the Senate-passed version of H.R. 17550 except for technical modification. The House has included the Senate modification with provides for the use of the appropriate State medical agency (such as a State Department of Hospitals), rather than limiting the requirement to the State health agency.

Proposal

The staff suggests acceptance of the House amendment.

Program for Determining Qualifications for Certain Health Care Personnel

(SECTION 241)

House Bill

Requires the Secretary to develop and apply appropriate means of determining the proficiency of health personnel who are disqualified or restricted in responsibility under present regulations because of lack of formal training or educational requirements.

Change from 1970 Senate Provision

Similar to a Senate amendment to H.R. 17550 except that the Senate stipulated that all health personnel initially licensed after December 31, 1975, would be expected to meet otherwise required formal training or educational criteria.

Proposal

The staff suggests including the Senate termination date of Dec. 31, 1976 for the proficiency testing provision since without such a cutoff date, future health personnel would have considerably less incentive to complete their formal training. The staff also suggests adding clarifying language to the committee report indicating that persons eligible for proficiency testing would have to have some prior practical experience in the profession involved or in a related field.

Penalties for Fraudulent Acts and False Reporting Under Medicare and Medicaid

(SECTION 242)

Problem

Present penalty provisions applicable to Medicare do not specifically include as fraud such practices as kickbacks and bribes. There is no criminal penalty provision applicable to Medicaid. Additionally, there are no penalties at present for false reporting with respect to health and safety conditions in participating institutions.

House Bill

Establishes penalties for soliciting, offering or accepting bribes or kickbacks, or for concealing events affecting a person's rights to benefit with intent to defraud, and for converting benefit payments to improper use, of up to one year's imprisonment and a $10,000 fine or both. Additionally, the bill establishes false reporting of a material

fact as to conditions or operations of a health care facility, for purposes of Medicare or Medicaid certification, as a misdemeanor subject to up to 6 months' imprisonment, a fine of $2,000 or both.

Change from 1970 Senate Provision

Similar to a Senate amendment to H.R. 17550. The House expanded the amendment to include as an offense the acts of (1) concealing knowledge of events affecting a person's right to benefits with intent to defraud, and (2) converting benefits to improper use a Federal crime.

Proposal

(1) The staff suggests the House modification be approved with changes making clear that the provisions apply to institutions as well as individuals and to recertifications as well as initial certifications.

(2) Staff also suggests such modification as may be needed to coordinate the new offenses regarding bribes and kickbacks with the new rules denying deductions for such payments for tax purposes. (Sec. 162(c)(3) of the Internal Revenue Code).

Provider Reimbursement Review Board

(SECTION 243)

Problem

Under present law, there is no specific provision for an appeal by a provider of services of a fiscal intermediary's final reasonable cost determination, although administrative procedures exist to assist providers and intermediaries to reach reasonable settlement on disputed items.

House Bill

Establishes a Provider Reimbursement Review Board to consider disputes between a provider and intermediary where the amount at issue is $10,000 or more and where the provider has filed a timely cost report. Decisions of the Review Board would be final unless the Secretary reversed the Board's decision within 60 days. If such a reversal occurs the provider would have the right to obtain judicial review.

Change from 1970 Senate Provision

Similar to a Senate Amendment to H.R. 17550. The House did not include those portions of the Senate amendment which would allow providers, as a group, to appeal aggregate amounts of $10,000 on a common issue; and which would allow appeals to the Board by a provider where the intermediary fails to make timely final costs determinations.

Proposal

1. Staff suggests approval of prior Senate language modified so as to authorize a joint appeal where the aggregate amount is $50,000 instead of $10,000. This would avoid a possible "jam-up" of the Review Board with a multiplicity of appeals.

2. The staff also suggests that the Report include a request to the Secretary that he report to the legislative committees at the end of the first year of operation of the provision concerning its capacity to function effectively and equitably as well as any suggestions he might have for improvement of the process.

3. Additionally, subsection (d) of the section, could be modified so as to authorize the Board to make rules and establish procedures in accordance with regulations of the Secretary rather than in unilateral fashion. Because this Board is partially composed of provider representatives, it is difficult to expect it to work with the same impartiality and objectivity as would ordinary independent hearing examiners.

Physical Therapy Services and Other Services Under Medicare

(SECTION 251)

Problem

1. Physical therapy is presently covered as an inpatient service, and as an outpatient service when furnished through a participating facility or home health agency. Services cannot be provided in a therapist's office, even though it may be more accessible to the beneficiary than the participating facility.

2. An additional problem relating to physical therapy is that a patient can exhaust his inpatient benefits and continue to receive payment for treatment *only* if the facility can arrange with another facility to furnish the therapy as an outpatient service. For example, a hospitalized patient would receive necessary physical therapy as a Part A benefit during his 90 days of coverage. But, if his hospital stay exceeded 90 days, he would be required to secure such services under Part B from a Home Health Agency—even though the hospital, itself, was capable of providing the needed therapy conveniently.

3. Another problem is the rapidly increasing cost of physical therapy services and findings of abuse in institutions.

House Bill

1. Would include as covered services under Part B, physical therapy provided in the therapist's office under such licensing as the Secretary may require and pursuant to a physician's written plan of treatment.

2. Would authorize a hospital or extended care facility to provide outpatient physical therapy services to its inpatients, so that an inpatient could conveniently receive his Part B benefits after his inpatient benefits have expired.

3. Would control physical therapy costs by limiting total payments in one year for services by an independent practitioner in his office or the patient's home to $100, and by limiting reimbursement for services provided by physical and other therapists in an institutional setting to a reasonable salary-related basis rather than fee-for-service basis.

Change from 1970 Senate Provision

Last year, the Senate deleted the provision which established a separate benefit of up to $100 of physical therapy services in the therapist's office or patient's home.

Proposal

The staff suggests deletion of the $100 outpatient physical therapy benefit, inasmuch as it has potential for substantial abuse and because H.E.W. advises that the cost of administration may approach or exceed the cost of the benefit. It is also suggested that factors recognizing travel time, etc. be included in the calculation of salary-related reimbursement, to the extent feasible.

Collection of Part B Premium By Railroad Retirement Board

House Bill

Where a person is entitled to both Railroad Retirement and Social Security monthly benefits, his premium payment for Part B benefit would be deducted from his Railroad Retirement in all cases. The Railroad Retirement Board is given authority to choose the carrier for Part B benefits for its beneficiaries.

Change from 1970 Senate Provision

Senate provisions did not grant the Railroad Retirement Board authority to choose the carrier for Part B benefits for its beneficiaries.

Proposal

The Staff suggests that in the interest of program efficiency and economy, and in view of the fact that the Comptroller General has reported costly inefficiencies in the provision of Medicare benefits to Railroad retirees by the present carrier, the provision be deleted so that the Secretary of H.E.W. will continue to have authority to designate the carrier for Railroad retirees.

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4. The staff suggests that intermediate care services also be subject to a reduction in Federal matching after 60 days, unless the State provides satisfactory assurance that required review is being undertaken. This appears appropriate in view of the shift of intermediate care to Medicaid in legislation enacted subsequent to House consideration of H.R. 1. At present, the House bill does not subject ICF's to the requirement of proper review.

5. Finally, the staff would suggest that the Secretary's validation of State utilization controls should be made on site in the States and such findings should be a matter of public record. The purpose here is to assure actual—rather than paper—compliance with the proposed statutory requirements.

Limitation on Federal Payments for Disapproved Capital Expenditure

(SECTION 221)

A hospital or nursing home can, under present law, make large capital expenditures which may have been disapproved by the State or local health care facilities planning council and still be reimbursed by Medicare and Medicaid for capital costs (depreciation, interest on debt, return on net equity) associated with that expenditure.

House bill

Prohibits reimbursement to providers under the Medicare and Medicaid programs for capital costs associated with expenditures of $100,000 or more which are specifically determined by the State or local Health Facilities Planning Council to be inconsistent with State or local health facility plans.

Change from 1970 Senate Provision

The House did not include the Senate modification which would waive the provision with respect to construction included in formal plans for expansion or replacement toward which preliminary expenditures of $100,000 or more had been made during the three-year period ended December 17, 1970 by a health care facility providing services as of December 18, 1970. The purpose of the Senate provision was to permit a hospital which had expended extensive amounts toward a program of development or expansion to complete it without, at the same time, opening the door wide to indiscriminate avoidance of the intent of the provision.

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