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Background Materials
Relating to
H.R. 8423
END STAGE RENAL DISEASE PROGRAM

Prepared by the Staff
of the
COMMITTEE ON FINANCE
UNITED STATES SENATE
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for the Use of the
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I. Background on the Renal Disease Program

End-stage renal disease represents the permanent and irreversible breakdown of the capacity of the kidneys to carry out their function of collecting and disposing of body wastes formed in the blood during the process of metabolism. Treatment involves either the artificial removal of wastes through a procedure known as dialysis or the replacement of the kidney through organ transplantation. Both of these methods of treatment have only become generally available in the last 15 years. Failure to provide treatment results in death. While basic research is being conducted on the causes and prevention of renal disease, the present state of medical knowledge does not offer any prospects for an immediate medical breakthrough.

Periodic dialysis given to patients with renal disease is called routine maintenance dialysis. Such treatments, which ordinarily require 5 or 6 hours, are given at intervals determined by a physician, usually three times a week. Self-dialysis is routine maintenance dialysis performed by the patient at home or in a dialysis facility. "Self-dialysis" requires special training of the patient and the availability of a helper. Patients on maintenance dialysis, whether performed in the home or in a facility, are normally able to carry on their ordinary daily activities.

Transplantation is a surgical procedure which involves the implantation of healthy kidneys obtained either from living donors or from cadavers. A living donor is the preferred source since the rejection rate of living donor organs by the body is much lower.

Costs of treatment

While dialysis and transplantation have become generally available, both methods of treatment are still extremely expensive. The annual cost of dialysis, for example, ranges from $8,000 to $12,000 a year when done at home, and anywhere from $20,000 to $30,000 annually when performed in an institutional setting. Kidney transplantation surgery runs between $20,000 and $25,000. And even a successful transplant patient will incur costs of about $2,000 to $3,000 a year following transplantation for drugs and physicians' services.

Reasons for enactment of renal disease program

Prior to enactment of the medicare renal disease program, the decision to provide treatment was often influenced by financial considerations because of the enormous costs involved. In addition, because so few individuals could afford treatment and so few hospitals could afford to provide it, there were shortages in renal disease equipment, trained personnel, and treatment facilities. In short, the medical profession knew how to aid victims of renal disease, but many were going untreated because of the lock of financing. The enactment in 1972 of the medicare renal disease program was the congressional response to this intolerable situation.

II. Summary of Present Law

The Social Security Amendments of 1972 (Public Law 92–603) provided medicare coverage for people under age 65 for the cost of services and supplies furnished in connection with the treatment of end-stage chronic renal disease. (Renal disease patients age 65 and over are protected under the regular medicare coverage provisions.) Thus, renal disease is the only illness for which the medicare program pays the costs of treatment for almost all Americans.

Scope of coverage

In general, part A of medicare covers, except for specified deductible amounts, inpatient hospital costs of dialysis and kidney transplantation, and part B covers physician services. outpatient hospital services and other out-of-hospital medical services and supplies. Under part B, payment is made for 80 percent of the reasonable charges for covered services above an annual $60 deductible.

Entitlement to benefits

A renal disease patient under age 65 becomes entitled to medicare benefits beginning with the first day of the third month after the month a course of dialysis is initiated, or (if earlier) the first day of the month he is hospitalized for a kidney transplant (provided the transplantation occurs in that month or the next month). An individual's entitlement to this protection ends the last day of the twelfth month after the month he receives a kidney transplant, or his course of dialysis is terminated. If within 12 months after the transplantation the person requires another transplant or returns to dialysis, there is no interruption in entitlement.

Standards for renal disease facilities

The Secretary is authorized to reimburse only those facilities that meet standards to be issued in regulations. These standards must include requirements for minimal utilization rates and for medical review boards to assure the appropriateness of patient care.

Reimbursement for services

Although the renal disease provisions contain aspects unique to the medicare program, no special provision was included in the law with respect to reimbursement for services furnished under these provisions. (During the presentation of the Conference Committee report on the 1972 amendments, the only reference to reimbursement was an indication of congressional intent to authorize the Secretary to define reasonable charges, for part B purposes, in terms related to the reasonable costs of the treatment provided.)

Proposed revision

On September 12, 1977 the House passed H.R. 8423 which would make a number of changes in the end-stage renal disease program.

III. Program Issues

A. Incentives for Use of Self-Dialysis

General Discussion

Under present law, medicare benefits for individuals with chronic renal disease include coverage of dialysis services in all settings—

hospitals, outpatient hospital facilities, free-standing renal dialysis facilities, and in the homes of patients who are undergoing self-dialysis. Once a patient is entitled to benefits and has become stabilized, usually following a short course of dialysis as a hospital inpatient (part A coverage), maintenance dialysis services are normally provided on an outpatient basis (covered under part B). When dialysis takes place in the home, part B also covers 80 percent of the reasonable charges for the rental or purchase of home dialysis equipment and many, but not all, supplies necessary for its effective use.

Although dialysis can be performed in either the home or in an institutional setting the choice of dialysis location has both therapeutic and cost implications. The cost of home dialysis is, over the long run, considerably less than institutional dialysis. Studies indicate that the current annual cost of home dialysis ranges from $8,000 to $12,000 while the annual cost of institutional dialysis ranges from over $15,000 to $30,000. Thus, the cost of facility dialysis is generally twice the cost of home dialysis. Moreover, increased use of home dialysis creates the potential for significant reductions in the need for capital investment in facilities and personnel.

However, since 1972, the year in which the medicare renal disease program was enacted, there has been a steady decline in the percentage of patients on home dialysis. According to the National Dialysis Register, over 40 percent of the total patients on dialysis were dialyzing at home in 1972. By the beginning of 1975, the percentage on home dialysis had declined to 25 percent; and according to data just released by the Department the decline has continued—as of calendar year 1976, according to the data, *less than 10 percent* of dialysis patients are on home dialysis. While various reasons for this decline have been postulated (including changes in the patient population under treatment, professional disinterest in encouraging home dialysis and increased access to institutional facilities), the evidence indicates that one of the major reasons is the existence of financial disincentives for patients to undertake self-care dialysis.

At the same time that the use of home dialysis has been declining, renal disease program costs have been rising at a significantly higher rate than forecast—partly because it was assumed that the use of home dialysis would not decline as sharply as it has. In 1972, for example, it was estimated that the cost of the program would be about $250 million at the end of four years. However, current estimates furnished by the Department indicate that renal disease program costs for fiscal year 1978 will be $0.9 billion and will increase substantially in subsequent years. The following table prepared by the Department illustrates the anticipated increases:

Estimate of annual benefits paid[1]

Fiscal year:	*Benefits in billions*
1980	$1.3
1982	1.9
1987	3.6
1992	6.3

[1] It is worth noting that one of the assumptions on which these estimates are based is that 25 percent of the patient population will be dialyzing in a home setting. As already indicated, however, only 10 percent of the patient population is currently dialyzing at home.

Moreover, the patient population for which these costs would be incurred is a relatively small one. As of March 1977, about 36,000 renal disease patients were covered by the program. The rate of increase in enrolled beneficiaries is about 4 percent per year and is expected to decline to about one-half of 1 percent by 1985. Thus, it is estimated that the program will have an enrolled renal population of approximately 60,000 by 1986 and a stable population of about 75,000 by the year 2000.

While it is true that the high cost of the program is, in part, a reflection of the costly technology required for treatment, and the need in most cases for lifetime care, it is generally agreed that rising program costs are also a reflection of disincentives in the program to the use of lower cost self-dialysis procedures and settings. It is widely conceded that appropriate incentives for more cost-effective use of self-care dialysis settings can significantly contain program costs without impairing the quality or availability of needed services.

Problems

1. Waiting period for self-care training

Issue

Under present law, a renal disease patient under age 65 becomes entitled to medicare benefits beginning with the first day of the third month after the month a course of dialysis is initiated. This 3-month waiting period discourages prompt entry into a self-care training program since the beneficiary would also have to bear the additional cost of this training out-of-pocket. Moreover, once adjusted to facility dialysis, patients are often reluctant to make the change to self-care dialysis.

House Bill

The House bill would provide for waiver of the three-month waiting period in the case of an individual who participates in a self-care training program prior to the end of the third month after the month he initiates a regular course of dialysis.

2. Coverage of supplies necessary to perform home dialysis

Issue

Under present law, home dialysis results in a substantially larger out-of-pocket expense to the patient than facility dialysis. This is so because under the existing medicare benefit structure certain expenses that are covered in an institutional setting are *not* covered at the patient's home. Where dialysis is done in a facility, for example, disposable items and supplies which are necessary for the performance of dialysis (such as syringes, alcohol wipes, sterile drapes, needles, topical anesthesias and rubber gloves) and various types of supportive equipment are covered. When dialysis is performed at home, these items—which represent as much as 15 percent of costs incurred by beneficiaries who self-dialyze at home—are not covered and the patient must pay for them out of his personal funds.

House Bill

The House bill provides coverage for all supplies (including disposable supplies and equipment) required for the effective performance of home dialysis.

3. Coverage of home dialysis support services

Issue

Under present law, mechanisms do not exist to either monitor actual home dialysis performance or provide back-up professional and maintenance assistance in the home. If trained technical personnel (functioning under physician supervision) were permitted to periodically observe the patient's management of his dialysis, assist with difficult access situations, or occassionally function as a dialysis assistant, incentives to continued use of home dialysis would result by precluding the need for unnecessary inpatient treatment or back-up institutional dialysis. Moreover, help in maintaining equipment is generally regarded as a vital element in the overall effort to assist those beneficiaries who might otherwise become discouraged by the problems and expense involved in servicing their own equipment to remain on home dialysis.

House Bill

The House bill provides coverage for periodic support services, to the extent permitted in regulations, furnished by a renal disease facility or hospital to an individual dialyzing at home. Such support services could include periodic monitoring of the patient's adaptation to self-dialysis, emergency visits where necessary, help in the installation and maintenance of dialysis equipment and any additional supportive services the Secretary determines will be useful [illegible] helping patients to remain on home dialysis.

4. Coverage for services of a self-care dialysis unit

Issue

It is generally conceded that many patients who are otherwise highly motivated to undertake self-dialysis are unable to do so because of physical or social circumstances in the home environment. For such patient the only alternative usually available to them is full care maintenance dialysis in an institutional setting. However, a feasible second alternative, which has not received adequate emphasis under present program policies, is self-dialysis in a facility or unit of a facility where the patient can manage his own treatment with a lesser degree of ongoing medical supervision and assistance of ancillary personnel than is required for full care maintenance dialysis.

House Bill

The House bill provides for reimbursement of facilities for the maintenance of a self-dialysis unit in which a patient can manage his own treatment with a lesser degree of ongoing medical supervision and assistance of ancillary personnel than is required for full care maintenance dialysis. A self-dialysis unit must, at a minimum, furnish the services, equipment, and supplies needed for self-care dialysis, have patient-staff ratios which are appropriate to self-dialysis (allowing for such appropriate lesser degree of ongoing medical supervision and assistance) and meet such other requirements as the Secretary may prescribe with respect to the quality and cost-effectiveness of services.

5. *Reimbursement to Facilities for Reasonable Cost of Dialysis Equipment for Home Dialysis Patients*

Issue

Under present law, medicare can provide for either purchase or rental of durable medical equipment. In cases of purchases of more than $50, medicare reimbursement is generally made in monthly installments equivalent to the amounts that would have been paid had the equipment been rented. The payments are continued for as long as the equipment is needed or, in the case of purchase, until the total of the monthly installments equals 80 percent of the purchase price. The patient is, of course, expected to pay for 20 percent of the cost of the equipment.

In the case of a $5,000 dialysis machine, this provision makes patient purchase nearly impossible. In this example, the patient would be faced with financing the total cost of the machine and being reimbursed by medicare for $4,000 of the cost in small monthly payments. The result is that most home dialysis patients rent rather than purchase their own equipment. Medicare rental payments are generally many times the purchase price.

House Bill

The House bill authorizes the Secretary, pursuant to agreements with approved renal dialysis facilities, to reimburse such facilities for the full reasonable cost of the purchase, installation, maintenance and reconditioning for subsequent reuse of artificial kidney and automated dialysis peritoneal machines (including supporting equipment) which are reserved for the exclusive use of entitled renal disease patients dialyzing at home. In order to waive the coinsurance amount the Secretary would be required to assure by formal agreement that the provider or facility will: (a) Use the equipment only for home dialysis patients; (b) recondition the equipment, as needed, for reuse by other home dialysis patients; (c) provide full access for the Secretary to all records and information relating to the purchase, maintenance and use of the equipment; and (d) submit such reports as the Secretary may require with respect to the management and use of the equipment.

B. ELIMINATION OF DISINCENTIVES FOR TRANSPLANTATION

General Discussion

The major disincentives to transplantation are related to certain limitations in the entitlement requirements under present law which expose the transplant candidate to significant financial risk. Yet, successful transplantation, though a costly and hazardous undertaking, can have beneficial consequences for the patient and the program. For the patient, successful transplantation generally means a more normal, productive life; for the program it results in a significant reduction over time in program expenditures. It is estimated, for example, that over a 5-year period, medicare would save over $60,000 for each patient who has a successful transplant.

The cost of a kidney transplant now runs between $20,000 and $25,000. A successful patient would then incur costs of about $3,000 in the first year following transplantation for drugs and physicians services, and between $1,000 and $2,000 a year thereafter. Slightly over 3,000 patients (about 10 percent of the renal patient population) attempted transplantation in 1976, and many professional observers believe that with appropriate encouragement that figure could be significantly increased, if not doubled.

Problems

1. Beginning of coverage

Issue

Under present law, entitlement for a transplant candidate may begin with the first day of the month he is hospitalized for transplantation, provided the transplantation occurs in that month or the next month. Transplantation is a two-step process: First, the removal of the diseased kidney; second, the implantation of a new kidney which, in some cases, may not take place for as long as 6 to 8 weeks after the first step.

House Bill

The House bill modifies present law by beginning coverage for a transplant patient with the month of hospitalization if the surgery takes place within the following 2 months, rather than the following 1 month.

2. Post-transplant coverage

Issue

Under present law, medicare entitlement for a transplant patient terminates at the end of the 12th month following transplantation. However, a great many transplants have not stabilized or cannot be deemed successful after 12 months. (The rejection rate for cadaver transplants during the first year, for example, is about 50 percent.) As a result, many patients are either hospitalized or undergoing intensive out-patient treatment for rejection episodes during or shortly after the twelfth month, at the very time their medicare benefits are being terminated. Clinical experience indicates that while rejections are fairly common during the first 2 years following transplantation, the rejection rate declines significantly after 3 years. Moreover, even successful transplant patients incur substantial medical costs directly related to the transplant for several years following the surgery, although the heaviest costs are incurred in the first 3 years.

House Bill

The House bill extends the period of medicare coverage for patients who undergo transplantation from 12 to 63 months.

3. Transplant failure

Issue

Under present law, a patient whose transplant fails after his entitlement ends is liable for the substantial costs associated both with the failure of the transplant and any dialysis required during the waiting period before medicare coverage assumes.

House Bill

The House bill provides for immediate resumption of medicare coverage whenever a transplant is rejected.

4. Expenses incurred by kidney donors

Issue

All hospital transplantation services are reimbursed on a reasonable cost basis in much the same manner as other hospital services covered under medicare. However, a special consideration in the development of hospital renal transplant policies was the fact that certain costs associated with a potential kidney transplant (such as organ procurement and blood and tissue typing of potential donors) cannot always be assigned to a particular beneficiary. Further, these and other costs involved in a transplant procedure may be incurred before the entitlement of the beneficiary.

Taking these special considerations into account, the concept of a standard kidney acquisition charge was administratively developed. This is a projected average charge established for each transplant hospital by dividing the expected allowable costs for all services associated with kidney acquisition by the estimated number of kidneys to be acquired during the hospital's cost reporting period. The appropriate standard kidney acquisition charge is billed by the transplant hospital to medicare, along with other costs associated with the transplant operation. There is virtually unanimous agreement that this administrative policy has helped significantly to overcome a major financial disincentive to transplantation.

House Bill

The House bill clarifies the Secretary's authority under present law to provide reimbursement for the costs incurred in connection with kidney donations.

C. REIMBURSEMENT METHODS

General discussion

When the Congress enacted the renal disease program in 1972, it did so in full recognition of the fact that substantial difficulties would be encountered in the development of equitable reimbursement policies. Little data was then available either on treatment costs or on prevailing charges. Moreover, there was a great variety of arrangements through which services in the relatively new field of renal dialysis were rendered. As a result, the Congress authorized the Secretary to develop and apply reimbursement policies and procedures on the basis of evolving experience.

Problems

1. Alternative reimbursement methods

Issue

Under present program policies, physicians have a choice between two methods for receiving reimbursement for routine maintenance dialysis services. Under one method, the physician can bill the medicare program reasonable charges for all emergency services he furnishes during a maintenance dialysis episode; the physician looks to the facility for payment for his routine dialysis services and the facility is reimbursed for these payments by the program.

The second method, called "comprehensive reimbursement," provides for payment of a reasonable charge for all medical services furnished to a maintenance dialysis patient during a month, other than inpatient hospital services and services not related to the patient's renal problem that require extra visits. (Reasonable charges for these latter services may be billed separately.) About one-fourth of all nephrologists have elected this method of reimbursement.

House Bill

The House bill clarifies the Secretary's authority under present law to provide reimbursement for physicians' services in connection with routine maintenance dialysis in accordance with alternative reimbursement methods.

2. *Incentive reimbursement for services furnished by renal dialysis facilities to patients dialyzing in the facility*

Issue

The two criticisms most often made of the present "reasonable charges" method for reimbursing renal dialysis facilities is that (1) it does not permit the program to effectively adjust payment limits as prices and circumstances vary or as new facilities come into operation; and (2) it allows facilities to receive reimbursement based on their own charges regardless of the relationship to cost. Although the congressional intent at the time of enactment was to provide for the development of a "charges related to reasonable cost" method, this intent was not sufficiently clarified in congressional reports, and efforts by the Secretary to obtain appropriate cost data from some facilities in accordance with this intent have been challenged.

House Bill

The House bill modifies present law to provide for the implementation of an incentive reimbursement system with respect to dialysis services furnished by facilities to patients dialyzing in the facility. Under the bill, the Secretary would be required to promulgate regulations providing (as part of the reimbursement system) for the implementation of appropriate incentives for encouraging more efficient and effective delivery of dialysis services, including (to the extent and in such combination as he determines feasible), the use of prospectively set rates, a system for classifying comparable facilities, target rates with arrangements for sharing such reductions in cost as may be attributable to more efficient and effective delivery of services, and such other incentives as he finds will encourage more cost-effective delivery consistent with quality care. The incentive reimbursement system, which may be estabilshed on a cost-related or other equitable and economically efficient basis, would become effective with respect to a facility's first accounting period occurring on or after October 1, 1978.

The bill authorizes the Secretary to prescribe in regulations such methods and procedures as are necessary to determine costs incurred in furnishing renal dialysis services and to determine amounts payable in accordance with the incentive reimbursement system. Moreover, such regulations, in the case of services furnished by proprietary facilities may include, if the Secretary finds it feasible and appropriate, provision for recognition of a reasonable rate of return on equity capital, providing such rate of return does not exceed the rate currently provided for in the Social Security Act for other proprietary institutions participating in the medicare program.

In addition, the House bill clarifies the Secretary's authority under present law to (a) require facilities reimbursed on a cost-related basis to agree not to charge beneficiaries more for covered services they provide than the applicable deductible and coinsurance amounts, and (b) to provide for reimbursement to hospitals for their costs attributable to payments made to an organ procurement agency or histocompatibility laboratory in amounts that may not exceed costs incurred by that agency or laboratory. The House bill further provides that renal dialysis facilities reimbursed on a cost-related basis will have the same appeal rights hospitals and other providers of services now have under medicare when a disagreement results with respect to program reimbursement.

3. Incentive reimbursement for services furnished by a renal dialysis facility to patients dialyzing at home under the facility's supervision

Issue

Present law fails to provide an effective incentive reimbursement payment system to encourage patients dialyzing at home under the supervision of a facility.

House Bill

The House bill would authorize the Secretary to provide for payment on the basis of a target reimbursement rate for home dialysis for all necessary home dialysis medical supplies, equipment, and supportive services (including the services of qualified home dialysis aides), as medically necessary to enable patients to continue dialyzing in the home setting. Payment would be made to the facility which is supervising the patient's home care and is willing to assume responsibility for obtaining the necessary equipment, arranging for its maintenance, purchasing medical supplies, and arranging for the provision of needed supportive services.

In establishing the home dialysis target rate (which would be adjusted for regional differences), the Secretary would include his estimate of the cost of providing medically necessary home dialysis supplies and equipment (including such medically necessary routine laboratory services as are required); an allowance, in an amount determined by the Secretary, to cover the cost of providing personnel to aid in home dialysis; and an allowance, in an amount determined by the Secretary, to cover the facility's administrative costs and to provide an incentive for the efficient delivery of home dialysis; but in no event could the target rate exceed 70 percent of the national average reimbursement rate (i.e., the average amount approved by medicare before application of the coinsurance requirement), adjusted for regional variations, for institutional maintenance dialysis in the preceding fiscal year. Any target rate so established for a calendar year would not be subject to renegotiation during that year. Moreover, in establishing such a rate, the Secretary would be authorized to utilize a competitive-bid procedure, a prenegotiated rate procedure, or any other procedure he determines is appropriate and feasible.

D. PEER REVIEW AND PROGRAM GOALS FOR PATIENTS ON SELF-DIALYSIS

Issue

The continuing decline in the proportion of renal patients on home dialysis represents, in the view of many nephrologists, a dangerous trend. Apart from the serious fiscal implications of the decline, these nephrologists argue that the increased reliance on facility dialysis is creating a passive, dependent generation of patients, unwilling to assume any responsibility for the management of their own care or the direction of their lives. While recognizing that home dialysis is not suitable for a substantial number of renal patients, they nonetheless argue that it is medically feasible for anywhere from 30 to 50 percent of renal patients to manage dialysis at home.

House Bill

The House bill assigns responsibility to network peer review organizations for encouraging the use of those treatment settings most compatible with the successful rehabilitation of the patient, for establishing network goals for the identification and placement of suitable candidates in self-care settings and transplantation, and for assessing the performance of facilities in meeting these goals. Under the bill, each renal disease network and its medical review board would be responsible for—

(*a*) Developing, on the basis of normative data derived from the renal disease medical information system and criteria and standards developed within the network, network goals relating to the quality and appropriateness of patient care, including goals with respect to the appropriate proportion of network patients dialyzing in self-care settings and undergoing transplantation;

(*b*) Evaluating the procedures by which facilities in the network assess the appropriateness of patients for proposed treatment modalities;

(*c*) Identifying facilities that are not cooperating towards meeting network goals and assisting them to develop plans for correction; and

(*d*) Submitting an annual report to the Secretary on the network's performance in meeting its goals, including data on the comparative performance of facilities with respect to the placement of suitable candidates in self-care settings and transplantation, and the identification of those facilities that have consistently failed to cooperate with network goals; and recommendations with respect to the need for additional or alternative services or facilities in the network in order to meet the network goals.

The House bill further provides that the Secretary would evaluate the adequacy of each network's goals, in relation to the national objective and the performance of the network in meeting these goals. He may recommend such modifications in the goals and the methods for achieving them as he deems appropriate. Where the Secretary determines, on the basis of the data contained in the network's annual report, that a facility has consistently failed to cooperate with network plans and goals, he may terminate or withhold certification of such facility, with respect to payment for renal disease services, until he determines that such facility is making reasonable and appropriate efforts to cooperate with the network's plans and goals. Similarly, the Secretary would be authorized to terminate or withhold certification of a facility which, having been designated as a site for a self-care dialysis training program, fails to provide the required self-care dialysis training.

The bill establishes as the national objective with respect to the appropriate proportion of patients in self-dialysis settings and transplantation that a majority of new patients being accepted for end-stage renal disease treatment should be in self-care dialysis settings or be transplanted. The bill further requires that the Secretary shall, after consultation with appropriate professional and network organizations, and after taking into account available evidence relating to developments in research, treatment methods, and technology, periodically evaluate and, when he determines necessary, recommend revision of the national objective to the Congress.

In addition, the Secretary would be required, in determining whether to certify additional facilities or expansion of existing facilities within a network, to take into account the network's goals and performance as reflected in the network's annual report, and to assure himself that where a network has a low home dialysis treatment percentage, such percentage can be satisfactorily justified before certifying additional beds or facilities.

E. Studies, Reports, and Administration

1. *Experiments and Studies*

Issue

There is widespread agreement on the need for further study and experimentation with a variety of issues relating to more cost-effective measures for providing renal disease treatment.

House Bill

The House bill requires the Secretary to conduct the following studies and experiments: (a) pilot projects relating to the use of durable medical equipment by renal disease patients; (b) experiments and studies to evaluate methods for reducing the costs of the renal disease program, including experimentation with reimbursement for home dialysis aides and evaluations of the cost-saving potential of the reuse of dialysis filters, and the use of methods of dietary control; (c) studies of methods to increase public participation in kidney and other organ donation programs; (d) a study of reimbursement for physician services furnished to renal patients; and (e) a study of possible ways to assist renal patients not eligible for medicare to meet their medical care costs. The Secretary would be required to submit the results of these studies and experiments, along with any recommendations for legislative changes, to the Congress by October 1, 1978.

2. *Annual report*

Issue

Under present law the Secretary is not required to transmit any data or information to the Congress with respect to the administration and cost of the renal disease program.

House Bill

The House bill requires the Secretary to submit a report on the renal disease program to the Congress on October 1, 1978, and on October 1 of each year thereafter. This report is to include data and information on program experience, operations and cost, as well as information on the results of cost-saving experiments and research into the causes, prevention, and treatment of renal disease.

3. *Administration*

Issue

Some concern has been expressed about the extent of the Secretary's authority under present law to establish the necessary administrative structures in the renal disease networks to assure professional participation in the planning and review of network goals and performance.

House Bill

The House bill clarifies present law by explicitly authorizing the Secretary to establish appropriate organizational and informational structures to effectively administer the program, including renal disease network areas, network organizations to assure professional participation, and a renal disease medical information system. The bill also provides authority for the Secretary to develop mechanisms consistent with the responsibilities assigned to network organizations and their medical review boards, for the coordination of network planning and quality assurance activities with other health planning and peer review activities authorized under the National Health Planning and Resources Development Act (PL 93-641) and the Professional Standards Review Organization provisions of the Social Security Act and for the exchange of aggregate data and information among these organizations.

F. ADDITIONAL CHANGES

1. *Entitlement*

Issue

Under current law an individual must be under 65 years of age to qualify as a renal disease beneficiary. This provision has caused hardship in cases where the onset of renal disease was after 65 and entitlement could only be based on the work of another related individual.

House Bill

The House bill deletes this provision.

2. *Technical Change*

Issue

Current law does not make clear that individuals with end-stage renal disease are deemed to satisfy the entitlement requirements applicable to medicare disability beneficiaries.

House Bill

The House bill clarifies congressional intent.

3. Board of Trustees

Issue

The Department of Health, Education, and Welfare was recently reorganized. Responsibility for the administration of medicare program was transferred from the Social Security Administration to the Health Care Financing Administration.

House Bill

The House bill replaces the Commissioner of Social Security with the Administrator of the Health Care Financing Administration as the Secretary of the Board of Trustees for both the Hospital and the Supplementary Medical Insurance Trust Funds.

O