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Materials Relating to

Health Care Cost Containment And Other Proposals

Prepared by the Staff of the

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RUSSELL B. LONG, *Chairman*

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Section 2. Criteria for Determining Reasonable Cost of Hospital Services

Background

The rapid growth in the costs of hospital care has focused increasing attention on hospitals and the methods currently used to reimburse hospitals. Cost-based reimbursement such as that utilized by medicare and medicaid, in particular, has been widely criticized as inflationary. There is little in the way of pressure on hospitals so paid to contain their costs, since, generally, any increases are simply passed along to the third party payors. The present "reasonable costs" procedures under the medicare program are not only inherently inflationary—because there are no effective limits on what costs will be recognized as reasonable—but also contain neither incentives for efficient performance nor true disincentives to inefficient operation.

Summary

The bill modifies the method of reimbursement for hospitals under the medicare and medicaid programs. Under the new method, to be effective with hospital reporting periods that begin after June 30, 1980, reimbursement for most of a hospital's inpatient routine costs (essentially costs other than such ancillary expenses as laboratory, X-ray, pharmacy, etc.) would be related to a target rate based on similar costs incurred by comparable hospitals.

This initial system, described more fully below, would be studied and extended on an as-ready basis. Based on recommendations of a proposed Health Facilities Costs Commission, a permanent system would be developed over time which would establish payment rates and provide incentive payments with respect to all hospital costs and to costs of other institutions and organizations which are reimbursed on a cost basis. Continuing efforts would be made by the Commission to refine and improve the system of classification and comparison so as to achieve the greatest equity possible.

The Secretary would appoint the members of the new Health Facilities Costs Commission on or before January 1, 1980. The Commission would consist of 15 persons who are expert in the health facilities reimbursement area. At least three of the members would be representatives of hospitals and at least eight would be representatives of public (Federal, State and local) health benefits programs.

The method of reimbursement established by the bill for routine hospital costs would be as follows. Comparisons among hospitals would be made by:

1. Classifying hospitals in groups by bed size, type of hospital, rural or urban location, or other criteria established by the Secretary; and

2. Comparing the routine costs (as defined for purposes of applying the medicare routine cost limits under present law) of the hospitals in each group, except for the following routine variable costs: capital and related costs; costs of education and training programs; costs of interns, residents, and nonadministrative physicians; energy costs; and malpractice insurance costs.

When classifying hospitals by type, hospitals which are primary affiliates of accredited medical schools would be a separate category, without regard to bed size.

A per diem target rate for routine operating costs would be determined for each hospital by:

1. Calculating the average per diem routine operating cost for each group of hospitals under the classification system (excluded would be newly-opened hospitals and hospitals which have significant cost differentials because they do not meet standards and conditions of participation as providers of services); and

2. Determining the per diem rate for each hospital in the group by adjusting the labor cost component of the group's average per diem routine costs for area wage differentials. In the first year of the program only, an adjustment would be allowed where the hospital can demonstrate that the wages paid to its employees are significantly higher than the wages other employees in the area are paid for reasonably comparable work (as compared to the ratio for other hospitals in the same group and their areas).

The Secretary would adjust the per diem target rates by adding an annual projected percentage increase in the cost of routine goods and services hospitals purchase, with an adjustment for actual changes at the end of a hospital's accounting year.

Hospitals whose actual routine operating costs fell below their target rate would receive one-half of the difference between their costs and their target rate, with the bonus payment limited to 5 percent of their target rate. In the first year, hospitals whose actual costs exceeded their target rate, but were no more than 115 percent of that rate, would be paid their actual costs. Those with costs above 115 percent of their target rate would have their reimbursement limited to 115 percent of the target rate.

In the second and subsequent years of the program, the hospital's maximum payment rate would be increased by the actual dollar increase in the average target rate for its group during the preceding year. In calculating the group averages, one-half of costs found excessive would be excluded from the calculation.

Adjustments to a hospital's target rate would be made for changes in the hospital's classification. Hospitals which manipulate their patient mix or patient flow, reduce services, or have a large proportion of routine nursing services provided by private-duty nurses would also be subject to an adjustment. Also, a hospital would qualify for any higher target rate that is applicable to the hospitals placed in the bed-size category which contains hospitals closest in bed-size to its actual bed-size.

Adjustments would be made to the target rates of hospitals which demonstrate that their costs exceed their rates because of (1) low utilization justified by unusually high standby costs necessary to meet

the needs of underserved areas; (2) atypical cost patterns of newly opened hospitals; (3) services changed for such reasons as consolidation, sharing, and approved addition of services among hospitals (e.g., costs associated with low utilization of a new wing); and (4) greater intensity of patient care than other hospitals in the same category. Some hospitals have consistently shorter lengths-of-stay in treating patients than their group average for a reasonably similar mix of patients with comparable diagnoses. To the extent that a hospital can demonstrate that the shorter stays result from an "intensity" of service which makes it necessary for the hospital to incur additional costs, such additional costs per day, to the extent reasonable, would be recognized under the "intensity" exception provision.

Hospitals would be exempted from the proposed cost limits if: (a) the hospital is located in a State which has a generally applicable hospital reimbursement control system which applies at least to the same hospitals and kinds of costs as are subject to the new reimbursement reform system; and (b) the State demonstrates to the satisfaction of the Secretary that, using the State's system, total medicare and medicaid reimbursable costs for hospitals in the State will be no greater than if the Federal system had been applicable. A State which exceeds, in the aggregate, the costs which would otherwise have been paid under the Federal programs for any two-year period would be covered under the Federal limits beginning with the subsequent year. The amount of the excessive payments would be recouped over subsequent periods through appropriate reduction (not in excess of one percent annually) in the cost limits otherwise applicable.

States which obtain a waiver would be reimbursed for the medicare program's proportionate share of the cost of operating the State reimbursement control system. The State's medicaid program would pay its proportionate share of costs, which would be matchable with Federal funds as an administrative expense.

Medicare and medicaid would also pay a proportionate share of startup costs of approved State reimbursement control systems. The Federal share of the startup costs would be the same proportion as the Federal payment for inpatient hospital costs in the State bears to the total inpatient hospital costs which are subject to the State system. For example, if the Federal Government pays, through medicare and medicaid, 40 percent of the total hospital costs in the State that are subject to the State system, it would be liable for 40 percent of the State program's startup costs.

Staff recommendation: To ease transition of the proposed reimbursement system, provide that only one-half of the incentives and penalties be applied during the first two years.

POSSIBLE MODIFICATION FOR ADDITIONAL COST SAVING

Background

Section 2 of the bill would moderate increases in reimbursement for hospital routine costs under medicare and medicaid. The proposed reimbursement reform was not made immediately applicable to hospitals' ancillary costs (X-ray, laboratory, pharmacy, etc.) because no methodology has yet been developed for equitable inter-hospital comparisons of ancillary service costs. Thus, insofar as ancillary costs are

concerned, there would be no protection for medicare and medicaid if the hospital industry's voluntary cost containment effort should fail and ancillary costs were to increase excessively.

Modification

Establish limits, effective April 1, 1980, on allowable increases in medicare and medicaid reimbursement for ancillary services if the hospital industry's cost containment goal (an increase not to exceed 11.6 percent) is not met in 1979. The maximum increase permitted for medicare-medicaid reimbursement purposes would be related to increases in the cost of goods that hospitals purchase in order to produce ancillary services and would take account of area wage level differentials. The limits would be recalculated annually until the reimbursement methodology prescribed in the bill could be implemented. implemented.

Cost Savings:

$250 million.

Section 3. Payments to Promote Closing and Conversion of Underutilized Facilities

Background

Studies have pointed to a national surplus of short-term general hospital beds ranging as high as 100,000 or roughly 10 percent of total available beds. Excess capacity contributes significantly to hospital costs since the initial construction and financing expenses have to be recovered through the hospital reimbursement structure. In addition there are the continuing expenses associated with maintenance and non-patient services involved in keeping an empty bed ready for use.

Summary

The bill provides for including in hospital reasonable cost payments, reimbursement for capital and increased operating costs associated with the closing down or conversion to approved use of underutilized bed capacity or services in nonprofit short-term hospitals. In the case of for-profit short-term hospitals, reimbursement would be limited to increased operating costs. This would include costs which might not be otherwise reimbursable because of payment "ceilings", severance pay, "mothballing" and related expenses. In addition, payments could be continued for reasonable cost capital allowances in the form of depreciation or interest which would ordinarily be applied toward payment of debt outstanding and incurred in connection with the terminated beds. In the case of complete closing down of a hospital, payments would continue toward repayment of any debt, to the extent previously recognized by the program, and actually outstanding.

The Secretary would establish a Hospital Transitional Allowance Board which would consider requests for such payments. Appropriate safeguards would be developed to forestall any abuse or speculation. Prior to January 1, 1983, not more than 50 hospitals could be paid a transitional allowance in order to permit full development of procedures and safeguards. This limited application will also provide Congress with an opportunity to assess the effectiveness and economic effect of this approach in encouraging hospitals to close or modify excess and costly capacity without suffering severe financial penalty.

Section 4. Federal Participation in Hospital Capital Expenditures

Background

Under section 1122 of the 1972 amendments, the Secretary is required to seek contract agreements with the States for their review of capital expenditures in hospital and other health care facilities which exceed $100,000, change the bed capacity, or substantially change the services in the facility. HEW may deny medicare and medicaid reimbursement for depreciation or interest costs related to capital expenditures disapproval by the State.

Summary

The bill provides for changes to be made in the current law limitations on medicare and medicaid payments related to hospital capital expenditures. These changes link the procedure more closely to the Federal health planning law (Public Law 93–641) by requiring that the designated planning agency (the State Health Planning and Development Agency as designated under section 1521 of the Public Health Service Act) approve capital expenditures in excess of $150,000 as a condition of medicare and medicaid reimbursement for both capital and direct operating costs associated with those expenditures. Regulations developed by the Department to implement this section should allow for speedy replacement of capital plant and equipment in certain emergency situations.

A special procedure is established for approval of proposed capital expenditures in metropolitan areas which include more than one State or jurisdiction. In such cases the designated planning agencies of all the States or jurisdictions in the area must approve the expenditure, or it would be considered disapproved for purposes of reimbursement, subject to review and reversal by the Secretary.

The bill also makes it clear that the capital expenditures limitation does not apply to simple changes of ownership of existing and operational facilities which create no new beds or services and clarifies that the provision does apply to home health agencies and facilities which are part of a health maintenance organization.

Section 5. Agreements With Physicians to Accept Assignments

Background

Payments for physicians' services under medicare may be made directly to the beneficiary or to the physician furnishing the service depending upon whether the itemized bill method or assignment method is used when requesting payment from the carrier. An assignment is an agreement between the physician and the medicare beneficiary under which the beneficiary "assigns" to the physician his rights to benefits for covered services included in the claim. In return, the physician must agree to accept the reasonable charge determined by the carrier as his full charge for the items or services rendered. A physician may accept or refuse requests for assignments on a bill-by-bill basis.

Total assignment rates and net assignment rates (which excludes claims from hospital-based physicians and group practice prepayment

plans) have been declining. The net assignment rate is presently about 50 percent.

Summary

The bill provides incentives for physicians to accept assignments for all their medicare claims. Under the bill there would be "participating" physicians, a concept employed by many Blue Shield plans.

A "participating" physician is an M.D. or D.O. who voluntarily agrees to accept the medicare reasonable charge, as payment in full for all services to all his medicare patients. Agreements would be cancellable or concluded on the basis of 30 days' notice. "Nonparticipating" physicians could continue to elect to use the assignment method of billing on a claim-by-claim basis, as under present law.

To expedite payment of claims from participating physicians, the bill provides that the Secretary would establish appropriate procedures and forms whereby: (1) such physicians would submit claims on one of various simplified bases, and these claims would be given priority handling by the part B carrier; and (2) such physicians would obtain signed forms from their patients making assignment for all services furnished to them and authorizing release of medical information needed to review the claim.

The bill provides for the payment of an "administrative" cost-savings allowance of $1 per eligible patient to a participating physician covering all services included in a multiple billing listing. Two separate allowances would not be made for billing on two listings of items ordinarily included in a single visit or service or for different services which were provided to the same patient within a 7-day period. With respect to inpatient or outpatient hospital care, the administrative allowances would be payable only in the case of a surgeon or anesthesiologist, or attending physician or consultant whose principal office and place of practice is outside the hospital, and only where such physicians ordinarily bill and collect directly for their services. No administrative allowance would be payable in the case of claims solely for laboratory tests and X-rays undertaken outside of the office of the billing physician.

As an example of how the provision would work, if a physician who does not accept assignments today, and whose routine office visit charge is $10, became a "participating" physician, he would receive an extra $1 allowance for that visit plus probably save at least another $1 in billing, collection and office paperwork costs. In effect, his net practice income from that visit could increase by 20 percent as a result of "participation". The physicians with the lowest charges (often those in rural or ghetto areas) would benefit most from participation, as the cost-savings allowance and the office administrative cost reduction would represent a greater percentage of their charges.

Staff recommendation: Delete provision.

Section 6. Hospital Associated Physicians

Background

Many physicians in the fields of radiology, anesthesiology, and pathology generally engage in a variety of professional activities including teaching, research, administration, and other hospital activities in addition to furnishing or supervising medical services for individual patients.

Under present law, a variety of payment mechanisms are recognized for reimbursement purposes. One form involves an arrangement between physicians and the hospitals under which the physicians' compensation is based on a percentage of departmental gross charges or of net collections. These percentage arrangements generate substantially higher costs to medicare and medicaid than other forms of compensation, which are more directly related to personally rendered professional time and effort.

Summary

The bill preserves the eligibility of radiologists, pathologists and anesthesiologists to be paid by medicare and medicaid on a fee-for-service basis for patient care services which they personally perform or personally direct. Services which the physician may perform for the hospital as an executive, educator or supervisor would be reimbursed only through the hospital insurance program on a reasonable cost basis. Percentage or lease arrangements would ordinarily not be recognized for medicare and medicaid reimbursement purposes to the extent they exceed what would have been paid to an employed physician. These provisions were developed with the help of representatives of the American College of Radiology and the American Society of Anesthesiologists. This section will avoid excessive payment to some physicians for services which they do not personally provide.

The provision in present law which permits 100-percent payment for inpatient radiology and pathology tests, instead of 80 percent as is the case with all other physician services under medicare, would be restricted to physicians who agree to become "participating physicians."

Staff recommendation: Clarify definition of physicians' services so as to assure avoidance of misinterpretation as to the scope of the provision.

Section 7. Use of Approved Relative Value Schedule

Background

Third-party payors have often employed relative value schedules to determine payment rates for the many different services and procedures which physicians perform. These are lists of medical procedures and services which set forth comparative numerical values for each. These useful mechanisms for assessing reasonableness of physicians' fees have recently been cited by the FTC and the Department of Justice as being conducive to price fixing by the physician groups that have traditionally been responsible for their development.

Summary

The bill authorizes the Secretary to approve the use of terminology systems and relative value schedules by physicians in billing medicare, medicaid and for other purposes. The purpose of this amendment is to establish a common language to describe the kinds of services that are covered under public and private health benefit plans and to provide for a more rational basis for evaluating the reasonableness of fees.

Section 8. Teaching Physicians

Background

Section 227 of Public Law 92-603 is intended to make it clear that, under medicare and medicaid, fees-for-service should be paid for medical care in teaching hospitals only where a bona fide private doctor-patient relationship exists. A further delay in the provision's implementation is needed to afford the Secretary of HEW additional time to consult with members of the medical education community and publish the necessary regulations.

Summary

The bill would extend, from October 1, 1978 to October 1, 1979, the implementation date for section 227.

Possible alternative for cost saving in addition to above action.

Background

A possible proposal would apply to teaching hospitals which do not qualify for fee-for-service reimbursement for medical services under medicare because most or all of their nonmedicare patients generally do not pay fees for physicians' services.

Possible alternative

Such institutions could continue to elect to receive 100 percent cost reimbursement for physicians' services and house-staff costs, as under present law. Under the proposal, however, the hospital could, alternatively, elect to have medicare pay fees covering the medical services furnished by attending physician-resident-intern teams in lieu of cost reimbursement for physicians and house staffs provided the services are furnished under circumstances that assure that fees will be billed only where bona fide, private patient-physician relationships exist.

Cost savings:

$200 million.

Section 9. Certain Surgical Procedures Performed on an Ambulatory Basis (Section 18 of S. 507)

Background

There are a number of surgical procedures which are often provided on an inpatient hospital basis even though they can often, consistent with sound medical practice, be performed at far less cost on

an ambulatory basis. Medicare discourages the medically appropriate use of ambulatory surgery because the program does not recognize charges for the use of the special surgical facilities in a physician's private office or a free-standing surgical facility that is not part of a hospital.

Summary

The bill permits medicare reimbursement on the basis of an all-inclusive rate to free-standing ambulatory surgical centers and to physicians performing surgery in their offices for a listed group of surgical procedures. Such procedures include those which are often provided on an inpatient hospital basis but can, consistent with sound medical practice, be performed on an ambulatory basis. The rate would encompass reimbursement for the facility, physician and related services, including normal pre- and post-operative visits and routine laboratory and other diagnostic tests usually associated with the procedure.

The list of procedures eligible for such reimbursement would be specified by the Secretary following consultation with the National Professional Standards Review Council and appropriate medical organizations including specialty groups. Subsequently, procedures could be added or deleted as experience dictated.

Under the bill, the physician operating in his own office who accepts an assignment would have no deductible and coinsurance applied to his ambulatory surgical all-inclusive payment. Similarly, a reimbursement for the use of the facilities in an ambulatory surgical center would be exempted from the deductible and coinsurance where the center accepts assignment. In the case of an ambulatory surgical center, the overhead allowance could be paid directly to the center and the professional fee could be paid directly to the physician. The deductible and coinsurance would be waived for the physician fees for services performed in connection with listed surgical procedures in hospital outpatient departments.

Section 10. Criteria for Determining Reasonable Charge for Physicians' Services

Background

Medicare currently utilizes more than 200 different "localities" throughout the country for purposes of determining part B "reasonable" charges. For example, one State has 28 different localities. This has led in many instances to marked and unjustified disparities in areas of the same State in the prevailing charges for the same service. Additionally, under present law, all prevailing charges are annually adjusted upward to reflect changes in the costs of practice and wage levels. The effect of present law is to further widen the dollar gap between prevailing charges in different localities.

Summary

The bill provides for the calculation of statewide median charges (in any State with more than one locality) in addition to prevailing charges in the locality. To the extent that any prevailing charge in a

locality was more than one-third higher than the statewide median charge for a given service, it would not be automatically increased each year. This provision would not reduce any prevailing charges currently in effect. However, it would operate, to the extent given charges exceed the statewide average by more than one-third, to preclude automatically increasing those charges.

Background

Under existing law, medicare allows a new doctor to establish his customary charge at not greater than the 50th percentile of prevailing charges in the locality.

Summary

The bill would permit new physicians in localities, designated by the Secretary as physician shortage areas, to establish their customary charges at the 75th percentile of prevailing charges (rather than the 50th) as a means of encouraging doctors to move into these communities. It would also permit doctors presently practicing in shortage areas to move up to the 75th percentile on the basis of their actual fee levels.

Section 11. Payment for Certain Antigens Under Part B of Medicare (Section 7 of S. 507)

Background

Current medicare law does not permit reimbursement for an antigen prepared by a physician unless he also administers it. However, it is a common practice, especially in rural areas, for other dispensary practices to be followed—e.g., for a local doctor to refer a patient to an allergist who prepares a supply of antigens for the referring doctor's use.

Summary

The bill amends current law to permit payment under medicare for the preparation by an allergist of a reasonable supply of antigens dispensed or administered under the supervision of a physician.

Section 12. Payment on Behalf of Deceased Individuals (Section 8 of S. 507)

Background

Under present law, medicare can only pay a claim on behalf of a deceased beneficiary where the physician accepts an assignment or where the family has actually paid the bill. Where a physician refuses an assignment, families have encountered difficulty in raising sufficient cash to pay the bill in order to be eligible for payment by medicare.

Summary

The bill would permit payment by medicare to be made to the spouse or other legal representative of a deceased medicare beneficiary on the basis of a nonreceipted bill.

Section 13. Hospital Providers of Long-Term Care Services (Section 2 of S. 507)

Background

Many rural hospitals are the only source of acute care in their communities and as such, are a necessary and vital resource to the people they serve. Although many of these hospitals have recognized that the use of their acute care beds for needed long-term-care services during periods of excess bed capacity would be desirable, current program participation requirements under medicare and medicaid have discouraged these hospitals from doing so.

Under present law, a hospital-based skilled nursing facility (SNF) can participate in medicare and medicaid only if the facility is an identifiable, separate unit within the institution.

This requirement developed primarily to establish a separate cost center for purposes of program reimbursement. However, it has proven to be administratively burdensome and financially detrimental to many small hospitals. In addition, the identification of specific beds, staffing and other program requirements have not allowed sufficient flexibility in meeting episodic demand for acute beds—an important consideration when working with the small total bed complement characteristic of many rural hospitals.

Summary

The bill establishes a simplified cost reimbursement formula which would permit small rural hospitals to avoid the requirement for separate patient placement within the facility and separate cost finding.

Reimbursement for routine SNF services under medicare would be at the average rate per patient-day paid for routine services during the previous calendar year under medicaid to SNFs located in the State in which the hospital is located. Reimbursement under medicaid would be at the rate paid to SNFs and ICFs in the previous year. Reimbursement for ancillary services would be determined in the same manner as under present law.

Reimbursement under the new formula would be allowed in a hospital which (1) has less than 50 beds; (2) is located in a rural area; and (3) has been granted a certificate of need for the provision of long-term-care services.

Since the general staffing pattern in small rural hospitals is relatively fixed due to minimum staffing requirements, there should be opportunities for providing needed long-term-care services at very little additional cost.

The proposed new reimbursement method is optional and hospitals may continue to elect to establish distinct part SNFs as provided for under existing law. In addition, it is not the intention that this provision prohibit States from continuing to use other approved reimbursement methods under State medicaid plans.

The bill provides that within 3 years after enactment the Secretary shall report to Congress concerning whether a similar provision should be extended to other hospitals where there is a shortage of long-term-care beds, regardless of number of beds or geographic location.

Section 14. Reimbursement Rates Under Medicaid for Skilled Nursing Facilities and Intermediate Care Facilities

Background

Present law requires States participating in medicaid to pay skilled nursing facilities (SNFs) and intermediate care facilities (ICFs) on a reasonable cost-related basis. This requirement, added by section 249 of the Social Security Amendments of 1972, gives States the option of using medicare's reasonable cost reimbursement formula for purposes of reimbursing SNFs and ICFs or developing other reasonable cost-related methods of reimbursement acceptable to the Secretary.

There has been considerable controversy over whether the reimbursement mechanisms developed under section 249 may include an allowance in the form of incentive payments related to efficient performances by providers. There was no intent, in enacting section 249, to preclude such allowances if they are related to efficient provider performance.

Summary

The bill allows States the option, when computing reimbursement rates under medicaid to a SNF or ICF, to include reasonable allowances for the facility in the form of incentive payments related to efficient performance.

Note: This section presupposes continuation of Sec. 249. If that section were repealed (see p. 40) this provision would be unnecessary.

Section 15. Medicaid Certification and Approval of Skilled Nursing and Intermediate Care Facilities

Background

At present, the decision as to whether a skilled nursing facility (SNF) or an intermediate care facility (ICF) is qualified to participate in the medicaid (title XIX) program is made by State agencies.

However, for skilled nursing facilities participating under medicare only, or both medicare and medicaid, the Secretary of HEW is the final certifying officer.

State certification of SNF's and ICF's results in lack of uniformity in the application of the Federal standards to which all such facilities are subject.

Use of provider agreements without fixed expiration dates has in the past caused difficulties and delays in decertifying a facility with serious deficiencies.

Summary

The bill would establish a uniform health care facility certification process for medicare and medicaid long term care facilities. As under present law, the appropriate State health agency would survey facilities wishing to participate in either (or both) medicare or medicaid The bill provides, however, that the Secretary make a determination as to eligibility and advise the State if a facility meets the basic requirements for participation as a medicaid SNF or ICF. The Secretary would specify the length of time (not to exceed 12 months) for which approval could be granted.

Facilities dissatisfied with the findings of the Secretary would be entitled to a hearing by the Secretary and to judicial review.

Section 16. Visits Away From Institution by Patients of Skilled Nursing or Intermediate Care Facilities

Background

Until recently, HEW policy has limited Federal payments for the cost of reserving beds in skilled nursing facilities (SNFs) and intermediate care facilities (ICFs) for medicaid patients temporarily away from the institution. The regulations permitted Federal funds to be used to reserve a bed for 15 days each time a patient was in a hospital for acute care. They also permited Federal contributions for a total of 18 days during a 12-month period when patients were visiting their homes or other places for therapeutic reasons.

The Health Care Financing Administration has amended the regulations to remove all limitations on Federal funding of therapeutic absences. Currently, however, there are no requirements in existing law setting forth policies with respect to reserving beds in SNFs an ICFs.

Summary

The bill provides that visits outside of the SNF or ICF would not necessarily constitute conclusive proof that the individual is no longer in need of the services of the SNF or ICF. However, the length and frequency of visits must be considered, together with other evidence, when determining whether the individual is in need of the facility's services. The provision thus prohibits the Secretary from imposing numerical limits. Such matters would be left to professional medical judgment.

Section 17. Notification to State Officials

Background

There have been instances where the Governors and chairmen of the appropriate legislative and appropriation committees in State legislature have not been informed on a timely basis of deficiencies or potential compliance issues involving Federal-State programs authorized under the Social Security Act.

Summary

The bill provides that if the Secretary notifies a State of any audits, quality control performance reports, deficiencies, or changes in Federal matching payments under programs authorized under the act, simultaneous notification would also be made to the Governor of the State and the respective chairmen of the legislative and appropriation committees of that State's legislature having jurisdiction over the affected program.

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Section 18. Repeal of Section 1867 (Section 11 of S. 507)

Background

The original 1965 medicare legislation provided for the establishment of the Health Insurance Benefits Advisory Council (HIBAC). This Council was to provide advice to the Secretary on matters of general policy with respect to the administration of medicare. The Social Security Amendments of 1972 modified the role of the Advisory Council so that its function would be that of offering suggestions for the consideration of the Secretary on matters of general policy in both the medicare and medicaid programs.

Summary

In view of the establishment of other advisory groups, and the Secretary's authority to establish ad hoc advisory bodies, the bill terminates HIBAC.

Section 19. Procedure for Determining Reasonable Cost and Reasonable Charge

Background

Some hospitals and other organizations that are reimbursed by medicare and medicaid deal with contractors, employees or related organizations, consultants, or subcontractors who are paid (in whole or in part, in cash or kind) on the basis of percentage arrangements.

Such arrangements can take several forms. For example, some involve business contracts for such support services as computer and data processing, financial and management consulting, or the furnishing of equipment and supplies to providers of health services, such as hospitals. Charges for such services are subsequently incorporated into the cost base against which medicare and medicaid make their payment determinations.

The contracts for these support services specify that the remuneration to the suppliers of the services shall be based on a percentage of the gross or net billings of the health care facilities or of individual departments. Other examples involve landlords receiving a percentage of provider gross (or net) income in return for office space, equipment, shared waiting rooms, laboratory services, custodial and office help and administrative services. Such arrangements can be highly inflationary and add costs to the programs which may not reflect actual efforts expended or costs incurred.

Summary

The bill provides, except under certain specified circumstances, that reimbursement to contractors, employees or related organizations, consultants, or subcontractors at any tier would not be recognized where compensation or payments (in whole or part, in cash or kind) as based upon percentage arrangements.

The prohibition against percentage arrangements contained in this section of the bill would include payment of commissions and/or finders' fees and lease or rental arrangements on a percentage basis.

It would also apply to management or other service contracts or provision of services by collateral suppliers such as pharmacies, laboratories, etc. The percentage prohibition would flow both ways either from the supplier or service agency back to the provider or organization, or from the original provider or organization to the supplier or service agency.

There is no intent, however, to interfere with certain types of percentage arrangements which are customarily considered normal commercial business practices such as the commission paid to a salesman. Further, the bill does not prohibit reimbursement for certain percentage arrangements such as a facility management contract where the arrangement contributes to efficient and economical operation.

For example, under some existing management contracts, the contractor receives both a percentage of operating expenses as a base management fee, and a share of the net revenues of the institution after all costs have been met. Where the contractor's percentage share of net revenues exceeds the percentage on which the base management fee is calculated, the contractor could have a strong incentive to contain operating expenses. Of course, under such circumstances, the reasonableness of the percentages applicable to the operating expenses would have to be considered in terms of comparison with the costs incurred in the management and/or operation of reasonably comparable facilities which do not utilize such contracts.

Section 20. Ambulance Service (Section 3 of S. 507)

Background

Under present law, medicare will pay for ambulance services to the nearest participating institution with appropriate equipment and facilities where the use of other means of transportation is contraindicated by the individual's condition.

Occasionally, the nearest hospital with appropriate facilities does not have a physician available to undertake the required specialized care. The present alternatives are to bring the physician to the patient—a possible misuse of physician time—or to transport the patient to the more distinct facility at his own expense.

In some areas, particularly rural areas, radiation therapy for cancer is provided by radiation clinics rather than in a hospital. However, transportation by ambulance to a radiation clinic cannot qualify for medicare reimbursement.

Summary

The bill provides medicare reimbursement for ambulance services to a more distant hospital where the nearest hospital lacks the necessary staff. Also, it is intended that the ambulance benefit be extended to cover patients who require ambulance transportation to receive radiation therapy in clinics in areas where the treatment is not available in a hospital.

Section 21. Grants to Regional Pediatric Pulmonary Centers

Background

Pediatric pulmonary centers train health care personnel in the prevention, diagnosis, and treatment of respiratory diseases and pro-

vide needed services for children and young adults suffering from such diseases.

Summary

The bill authorizes up to $5 million annually for grants to public or nonprofit private regional pediatric pulmonary centers which are part of (or affiliated with) institutions of higher learning. This section of the bill is identical (except for effective dates) to an amendment approved by the Senate in 1972 and 1978.

Section 22. Waiver of Human Experimentation Provision for Medicare and Medicaid

Background

Under current law, State medicaid programs may impose nominal cost-sharing requirements on medicaid eligibles. Recently, a State's cost-sharing experiment was challenged as a violation of regulations implementing the human experimentation statute. The challenge would effectively prevent any cost-sharing experiments under the medicaid program, and could seriously hinder other medicaid and medicare cost control efforts.

Summary

The bill waives requirements of the human experimentation statute which may otherwise be held applicable for purposes of medicare and medicaid. For example, the bill waives such requirements with respect to experimentation involving coverage, copayment, deductibles or other limitations on payment for services.

The bill further provides that the Secretary, in reviewing any application for any experimental, pilot or demonstration project pursuant to the Social Secuirty Act, would take into consideration the human experimentation law and regulations in making his decision on whether to approve the application.

The provision would apply only to medicare and medicaid reimbursement and administrative activities not designed to directly experiment with the actual diagnosis or treatment of patients.

Section 23. Disclosure of Aggregate Payments to Physicians

Background

Recent disclosures of physicians receiving large payments under medicare have served unjustifiably to embarrass physicians who serve a large number of elderly patients. The disclosures have also been characterized by a high degree of inaccuracy which has unfairly embarrassed some physicians.

Summary

The bill prohibits the Secretary of HEW from routinely releasing medicare information, and provides that State agencies shall not be required to release medicaid information relating to amounts paid to

physicians under their respective programs, except as otherwise specifically required by Federal law.

Section 24. Resources of Medicaid Applicant to Include Assets Disposed of at Substantially Less Than Fair Market Value (Section 13 of S. 507)

Background

Under present law, States which use the SSI criteria in determining medicaid eligibility for the aged, blind, and disabled may not impose transfer of assets restrictions on those applicants. Thus, an applicant who wants medicaid coverage can transfer assets which could be applied to the cost of medicaid-financed services and immediately become eligible for medicaid. This situation damages program credibility by allowing relatively well off individuals to become eligible for medicaid. It also increases program costs, especially for expenditures for institutional care. The aged, blind, and disabled account for some 64 percent of all program expenditures. They are most likely to need hospital, skilled nursing, and intermediate care facility services which comprise two-thirds of medicaid benefit costs.

Some 25 to 30 States are currently imposing restrictions on the transfer of assets on some medicaid groups but not on others. Title IV–A of the act does not prohibit such State eligibilty conditions. Further, those States which choose to use the more restrictive standards for medicaid eligibility for the aged, blind, and disabled rather than the SSI criteria can impose this eligibility condition if they did so in January 1972.

The only way a State can impose restrictions on asset transfers by SSI recipients is to use the more restrictive standards of medicaid eligibility for the aged, blind and disabled permitted under section 1902(f) of the Social Security Act. However, most States do not choose this option because they either contract with the Secretary (the Social Security Administration) under section 1634 of the Social Security Act to do medicaid eligibility determinations of SSI recipients, or rely on the SSI eligibility lists transmitted from the Social Security Administration for making their own medicaid eligibility determinations.

Summary

The bill requires States to deny eligibilty for medicaid in cases where an otherwise eligible aged, blind, or disabled person disposes of significant assets by giving them away or selling them for substantially less than their fair market value in order to establish medicaid eligibility. Any such transaction will be presumed to be for the purpose of establishing medicaid eligibility unless and until the individual submits adequate evidence to rebut that presumption. States may be allowed some flexibility with regard to procedures which demonstrably are not cost/beneficial, but States will be required to make a good-faith effort to enforce this requirement. Where a State finds that a disposal of assets has occurred, the difference between the fair market value of the asset and the actual amount the individual received for it will

continue to be considered as his asset for purposes of medicaid eligibility for a period of 12 months.

This authority would be administered by the States even though other elements of medicaid eligibility may be determined by the Social Security Administration under the agreements entered into pursuant to section 1634 of the Social Security Act.

Section 25. Rate of Return on Net Equity for For-Profit Hospitals

Background

Under present law, the medicare program allows for-profit hospitals a return on equity capital invested and used in providing patient care. The amount allowable is determined by applying to the proprietary hospitals equity capital one and one-half times the rate of return earned on social security trust funds. This formula produced a rate of return of 12.6 percent in October 1978. Profitmaking hospitals argue that this return compares unfavorably to that of comparable businesses.

Summary

The bill changes the allowed rate of return on for-profit hospitals' net equity. The new rate of return multiplier would be: 2½ times for hospitals entitled to an incentive payment under the incentive reimbursement system in section 2 of the bill; 2 times for hospitals that are reimbursed only their reasonable costs; and 1½ times for hospitals with costs in excess of their routine cost limits. The new rates of return, payable at the time of the hospital's final cost settlement would become effective at the same time as the new incentive reimbursement system—i.e., hospital accounting periods beginning on or after July 1, 1980.

Section 26. Deductible Not Applicable to Expenses for Certain Independent Laboratory Tests (Section 12 of S. 507)

Background

Legislation enacted in 1972 (section 279 of Public Law 92-603) was designed to avoid the unreasonably high administrative costs that independent laboratories and the medicare program incur in the billing and processing of typically inexpensive diagnostic tests. That provision was intended to reduce these billing and processing costs by authorizing the Secretary of HEW to negotiate payment rates with individual laboratories which medicare would pay in full, without any need for the laboratory to bill the patient for the $60 deductible and 20 percent copayment amounts. The negotiated rates could be no higher than medicare would have paid in the absence of the new provision.

The new billing procedure was never utilized because, as a result of a drafting error, the $60 deductible was retained. Thus, since laboratories still have to bill patients for deductible amounts, and since medicare must still determine each patient's deductible status, the savings to laboratories and medicare cannot now be achieved.

Summary

The bill waives the $60 deductible in applying the special laboratory billing procedure, as was intended by section 279 of Public Law 92-603.

Section 27. Payment for Laboratory Services Under Medicaid (Section 20 of S. 507)

Background

The Comptroller General, in a July 1, 1978, report to the Congress, recommended that States be given greater latitude in paying for independent laboratory services under medicaid. States have been restrained in adopting cost-saving contract bidding and negotiated rates with laboratories by an interpretation of the present "freedom of choice" provision. That provision was intended to permit medicaid recipients to choose from among any qualified doctors, drugstores, etc. It was not intended to apply to the types of care or services, such as laboratory services, which the patient ordinarily does not choose.

Summary

The bill allows a State to purchase laboratory services for its medicaid population through competitive bidding arrangements for a 3-year experimental period. Under this provision: (1) services may be purchased only from laboratories meeting appropriate health and safety standards; (2) no more than 75 percent of the charges for such services may be for services provided to medicare and medicaid patients; and (3) the laboratories must charge the medicaid program at rates that do not exceed the lowest amount charged to others for similar tests.

Section 28. Confidentiality of PSRO Data (Section 19 of S. 507)

Background

In authorizing the professional standards review organization (PSRO) program in 1972, the Congress set forth principles, in section 1166 of the Social Security Act, that were to serve as the basis for regulations governing both the disclosure and the confidentiality of information acquired by PSRO's in the exercise of their duties.

Confidentiality is critical to the success of PSRO's because they rely on voluntary service by local physicians. Should all data acquired by PSRO's be disseminated without safeguards, recruitment of physicians to perform PSRO functions would become increasingly difficult. Moreover, the intent of peer review, as opposed to Government regulation, is to allow the profession to attempt to regulate itself with some degree of privacy and candor. In addition, subjecting PSRO's to the Freedom of Information Act (FOIA) would result in increased administrative burdens, large additional expenses for the defense of lawsuits and great uncertainty and delay in the performance of PSRO functions.

However, on April 27, 1978, the U.S. District Court for the District of Columbia held that a PSRO is an "agency" of the Federal Govern-

ment for purposes of the FOIA and is thus subject to the disclosure requirements of this later legislation. This decision, which is currently being appealed, means that the data and information in control of the PSRO must be disclosed, on request, unless the particular information to be protected is specifically identified.

Summary

The bill provides for the confidentiality of PSRO information that identifies an individual patient, practitioner, provider, supplier or reviewer. As under section 1166, as presently worded, information may be disclosed to the extent necessary to carry out program purposes, to assist with the identification of fraudulent and abusive activities, and to assist in the conduct of health planning activities.

It should be noted that the Secretary of HEW in his regular review of PSRO performance can, under present law, evaluate the review activities—including practitioner profiles of practice—and thus safeguard against any general indiscriminate or willful action or inaction by a given PSRO with respect to practitioners.

Section 29. Repeal of 3-Day Hospitalization Requirement and 100-Visit Limitation for Home Health Services (Section 10 of S. 507)

Background

Under present law, a beneficiary is eligible for 100 home health visits per spell of illness under part A of medicare following an inpatient stay in a hospital of at least 3 days. Beneficiaries are also eligible for 100 home health visits per calendar year under part B of medicare whether or not they had been hospitalized previously.

Summary

The bill removes the provision in existing law that limits medicare home health benefits to 100 visits per spell of illness under part A and 100 visits per year under part B. In addition, the bill removes the requirement that a beneficiary has to be an inpatient in a hospital for at least 3 days before he can qualify for part A home health benefits.

Section 30. Payment for Durable Medical Equipment

Background

Under the medicare law, reimbursement for the rental or purchase of durable medical equipment is based largely on the supplier's customary charge for the item and on the prevailing charge for the equipment in the locality. Medicare has experienced problems with this method of reimbursement because of the lack of uniformity in suppliers' billing and charging practices; differences in the level of services offered by different suppliers; the different approaches medicare carriers follow in calculating allowances for medical equipment; and because equipment charges are not set in broadly competitive marketplace.

Summary

The bill establishes a new reimbursement methodology for medical equipment intended to correct these problems. Under the new method, reasonable charges for durable medical equipment would be calculated on a prospective basis and would take into account, in addition to the customary charges, the acquisition costs of the equipment, appropriate overhead (considering the level of delivery services and other necessary services provided by the supplier), and a reasonable margin of profit.

Background

An additional problem has arisen as a result of the provision of present law which authorizes lump-sum payments by medicare for durable medical equipment where purchase would be more economical than rental. In these cases the patient is responsible for paying (in addition to any deductible and coinsurance amounts) any difference between the supplier's charge for the item and the medicare allowable charge. This difference can be substantial since the medicare allowable charge is based on charge levels as they existed from 12 to 24 months in the past.

Summary

The bill would eliminate this lag where the medicare allowable charge is calculated in full accordance with the new methodology by permitting the allowable charges to be calculated (no less often than annually) on a prospective basis.

Section 31. Development of Uniform Claims Forms for Use Under Health Care Programs

Background

The medicare and medicaid programs have added to the paperwork required of physicians, hospitals, skilled nursing facilities, and other health care organizations as a result of the proliferation of forms. For several years, HEW has been working to develop standardized claims forms that might be used by physicians and institutions in billing both medicare and medicaid. This effort has been carried out in conjunction with provider groups, including the American Medical Association, the American Hospital Association, and the American Dental Association. The National Association of Blue Cross-Blue Shield Plans and the Health Insurance Association of America also participated. Standardized physician benefit forms now have been developed and are being used by medicare, medicaid and Blue Shield in several States. A promising uniform hospital benefit form has also been developed.

Summary

The bill requires HEW to adopt, to the extent feasible, standardized claims forms for medicare and medicaid within 2 years of enactment. Such forms could vary in a given State for medicaid if the Secretary determined that, in that State, a uniformed national medicare-medicaid claims forms could not be utilized.

The bill requires the Secretary, in carrying out the requirements of this section, to consult with those charged with the administration of other Federal health care programs, with other organizations that pay for health care, and with providers of health services to facilitate and encourage maximum use by other programs of the uniform claims forms. The bill further requires the Secretary to report to the Congess within 21 months of enactment on: (1) what actions he will take pursuant to this section; (2) the degree of success in encouraging third parties generally to adopt uniform claims forms, and (3) his recomendations for legislative and other changes needed to maximize the use of such forms.

Staff suggestion

The staff suggests that in developing uniform claims forms, the Secretary give consideration to a mechanism authorizing payment by the medicare intermediary of the Part A deductible in behalf of patients with both medicare and medicaid eligibility whose medicaid eligibility can be determined with certainty. The intermediary would bill the State medicaid agency for the appropriate amount.

This would be implemented only by mutual agreement of the Secretary and a given State.

Section 32. Coordinated Audits Under the Social Security Act (Section 4 of S. 507)

Background

The duplication of identical or similar auditing procedures used for the purpose of determining reimbursement under various Federal health benefit programs is costly to both the programs and the entity (such as hospital, skilled nursing facility, or home health agency) participating in the program.

Summary

The bill requires that, if an entity provides services reimbursable on a cost-related basis under title XVIII and titles XIX or V, audits of books, accounts, and records of that entity for purposes of the State programs are to be coordinated through common audit procedures with audits performed for the purposes of reimbursement under title XVIII. Where a State declines to participate in such common audits, the Secretary is to reduce payments that would have been made to the State under titles V or XIX by the amount attributable to the duplicative State audit activity. A State participating in the common audit procedure would continue to receive Federal matching for administrative costs associated with any additional or supplemental audit data or audits that may be necessary under their medicaid and maternal and child health programs.

Section 33. Encouragement of Philanthropic Support for Health Care

Background

Under present medicare policy, in determining the reasonable costs of services furnished by a provider of health services, unrestricted grants, gifts and income from endowments are not deducted from reimbursable costs of the provider.

Summary

The bill provides a statutory base for this policy.

Section 34. Study of Availability and Need for Skilled Nursing Facility Services Under Medicare and Medicaid

Background

Under current law, skilled nursing facilities (SNFs) participating in one of the programs are not required to participate in the other. In some States, there are a larger number of medicaid-only participating SNFs and in other States, the reverse is true. If a greater number of SNFs could be prompted to participate in both programs, a more adequate number of skilled nursing facilities would be available for medicare and medicaid beneficiaries.

Summary

The bill directs the Secretary of HEW to conduct a study of the availability and need for skilled nursing facility services under the Medicare and Medicaid programs. The study would consider the desirability of requiring facilities that wish to participate in one program to participate in both. The study would also investigate possible changes in regulations and legislation which would result in encouraging a greater availability of skilled nursing services.

In developing the study, the Secretary would consult with professional organizations, health experts, private insurers, nursing home providers and consumers of skilled nursing facility services. A report on the Secretary's findings and recommendations would be due 6 months after the date of enactment.

Section 35. Coverage Under Medicare of Certain Dentist's (Section 5 of S. 507)

Background

Under present law, medicare covers the services of dentists when they are performed by a licensed doctor of dental or oral surgery only with respect to (1) surgery related to the jaw or any structure contiguous to the jaw, or (2) the reduction of any fracture of the jaw or any facial bone. The law, therefore, excludes from coverage certain nonsurgical procedures which dentists and oral surgeons are professionally trained and licensed to perform even though the same services are covered when performed by a physician.

Summary

The bill extends the coverage of dental services under medicare to include any services performed by a doctor of dentistry or of dental or oral surgery which he is legally authorized to perform in cases where the services would be covered if performed by a physician.

Section 36. Coverage Under Medicare of Optometrist's Services With Respect to Aphakia (Section 9 of S. 507)

Background

Current medicare law provides reimbursement for diagnosis and treatment of the diseases of the eye when such services are provided by physicians. Certain diseases of the eye result in surgical removal of the lens. The resulting condition, i.e., absence of the lens of the eye, is known as aphakia. Eyeglasses (or contact lenses) which serve as the prosthetic lens for aphakia are covered under the program. Both physicians and optometrists are reimbursed under the program for services to aphakic patients. Unlike physicians, however, the reimbursement to optometerists is limited to dispensing services, the actual fitting and provision of prosthetic lenses. Section 109 of Public Law 94–182 required HEW to conduct a study concerning the appropriateness of medicare reimbursement of services performed (but not presently reimbursed) by optometrists in providing prosthetic lenses for patients with aphakia. In a report transmitted to the Congress on January 12, 1977, HEW recommended that those covered services related to aphakia and within the scope of optometric practice be reimbursable under part B of medicare when provided by optometrists.

Summary

The bill would implement the Department's recommendation.

Section 37. Study of Criteria Employed for Classifying a Facility as a Skilled Nursing Facility

Background

Under present law, a beneficiary must remain, for 60 consecutive days, out of an institution which is determined to be primarily engaged in providing skilled nursing care and related services in order to renew his medicare eligibility for additional days of hospital and skilled nursing facility benefits. Regulations of the Secretary establish the criteria which define the institutions where patients cannot renew benefit eligibilty. In general these institutions consist of: all skilled nursing facilities which participate in medicare and medicaid, some of the intermediate-care facilities that participate in medicaid, and some nursing care institutions that participate in neither program.

The intent of the provisions was to permit beneficiaries to renew their benefit eligibility once they have ended a spell of illness (and, thus, for at least 60 days, no longer needed skilled nursing). However, beneficiaries in skilled nursing institutions who have exhausted their

benefits are sometimes prevented from renewing their eligibility even though they actually receive little or no skilled care. This is especially a problem in States which require the availability of nurses in institutions that are largely for patients who do not need skilled nursing.

Summary

The bill directs the Secretary to review current procedures for applying the benefit-renewal criteria to make sure that they are not too restrictive. The Secretary would report his findings and conclusions to the Congress within 9 months of enactment, together with any legislative recommendations he may wish to propose.

Section 38. Authority for Certain States to Buy-In Coverage Under Part B of Medicare for Certain Medicaid Recipients

Background

The medicare law gave States until January 1, 1970, to request enrollment of their public assistance beneficiaries in part B of the medicare program. States that entered into these so-called "buy-in" agreements pay the part B premiums for the public assistance enrollees. The "buy-in" provision was designed to encourage the highest possible participation of the elderly in the part B program. Alaska, Louisiana, Oregon, Puerto Rico, and Wyoming did not make timely arrangements to enroll their public assistance beneficiaries in the part B program.

Summary

The bill would give the States that wish to do so an additional period of 12 months in which they could elect to make the necessary coverage arrangements.

Section 39. Health Maintenance Organizations Enrolling Over 50 Percent Medicare or Medicaid Recipients (Section 21 of S. 507)

Background

Present law prohibits a health maintenance organization (HMO) which contracts with a State to provide prepaid health services under medicaid from having more than one-half of its members covered by medicaid and medicare. HMO's are given 3 years from the date of their contract with the State medicaid program to meet this condition.

Occasionally, because of administrative delays by HEW in formally finding the HMO to be eligible, an HMO may have difficulty signing up nonmedicaid/medicare members by the end of that 3-year period, and thus be forced to reduce its coverage of medicaid beneficiaries in order to achieve the 50–50 requirements.

Summary

The bill provides that HMO's contracting with States would have up to 3 years after the date the HMO is formally found qualified by the Department of Health, Education, and Welfare to meet the 50-percent requirement.

II. PROVISIONS OF S. 507 "MEDICARE-MEDICAID MISCELLANEOUS AND TECHNICAL AMENDMENTS OF 1979" NOT INCLUDED IN S. 505

Section 6. Flexibility in Application of Standards to Rural Hospitals

Background

Under present medicare law, a hospital must satisfy certain statutory conditions of participation relating to health and safety standards, physical plant, organizational arrangements, and qualified medical, nursing, and technical staff. The Secretary is authorized to prescribe additional requirements he finds necessary in the interest of the health and safety of patients. (Many requirements relating to fire and safety precautions have been promulgated in accordance with this regulatory authority.) Current law also provides authority for the Secretary to waive the statutory 24-hour registered professional nursing service requirement in the case of a rural hospital where he determines the hospital is needed to serve the individuals in the area and the hospital is making a good faith effort to comply with the 24-hour requirement but such compliance is impeded by a lack of qualified nursing personnel in the area. This waiver authority expires on December 31, 1978.

Summary

The bill authorizes the Secretary to apply medicare standards to rural hospitals more flexibly to take into account the availability of qualified technical personnel, the scope of services furnished, and the economic impact of structural standards which if rigidly applied would result in unreasonable financial hardship for a rural hospital; but only to the extent that such differential application of the standards does not jeopardize or adversely affect the health and safety of patients.

Under this provision, it would still be necessary for the Secretary to assure that there is compliance with appropriate quality and safety requirements. For example, with respect to the requirements for nursing services applicable after December 31, 1978, the Secretary may provide for a temporary waiver of the requirements only for such period as he determines that the facility's failure to fully comply with the requirements is attributable to a temporary shortage of qualified nursing personnel in the area, a registered nurse is present on the premises to render or supervise the nursing service during at least the regular daytime shift, and the employment of such nursing personnel as are available to the facility during such temporary period will not adversely affect the health and safety of patients. Similar tests are to be applied by the Secretary with respect to other types of technical personnel, including tests related to the scope of services furnished by the facility and the facility's good faith efforts to fully comply with personnel requirements.

Section 14. Extension of Period for Funding of State Medicaid Fraud Control Units

Background

Section 17 of P.L. 95–142 provided 90 percent Federal matching in fiscal years 1978–1980 for the costs incurred in the establishment and operation (including the training of personnel) of State fraud control units. The increased matching is subject to a quarterly limitation of the higher of $125,000 or one-quarter of one percent of total medicaid expenditures in such State in the previous quarter. This section is intended to encourage States to establish effective investigative units on the State level.

To be eligible for the increased matching rate, the State medicaid fraud control unit must be a single identifiable entity of State government which the Secretary certifies (and annually recertifies) as meeting specific requirements. It must conduct a statewide program for the investigation and prosecution of violations of all applicable State laws relating to fraud in connection with the provision of medical assistance and the activities of medicaid providers. The fraud and abuse control unit must have procedures for reviewing complaints of the abuse and neglect of patients by health care facilities, and, where appropriate, for acting on such complaints or for referring them to other State agencies for action. The entity is required to provide for the collection or referral for collection, of overpayments made to health care facilities. The entity must be organized in a manner designed to promote efficiency and economy and it must employ auditors, attorneys, and investigators and other necessary personnel.

Some States have experienced delays in establishing State fraud control units and have therefore been unable to fully avail themselves of the increased Federal matching authorized under the law.

Summary

The bill extends for two years (until October 1, 1982) the period when 90 percent Federal matching is available for the funding of State medicaid fraud control units. No State may receive such matching for longer than three years.

Section 15. Certification and Utilization Review by Podiatrists

Background

Medicare covers as "physicians' services" the services performed by a podiatrist but only with respect to functions he is legally authorized to perform as such by the State in which he performs them.

As a condition of payment for hospital and other services covered under medicare, existing law requires that a physician certify as to the medical necessity for the service. Also, medicare requires that the utilization review committee of a hospital or skilled nursing facility include at least two physicians. For neither purpose does a podiatrist qualify as a "physician."

Summary

The bill extends medicare recognition to podiatrists as physicians for purposes of physician certification and participation in utilization

review where such recognition is consistent with the policies of any health care institution that is involved. With respect to utilization review, a podiatrist acting as a physician member of a utilization review committee would not take the place of an M.D. or osteopath as one of the two required physician members of the committee.

Section 16. Physician Treatment Plan for Speech Pathology

Background

The Social Security Amendments of 1972 provided for coverage of speech pathology services furnished on an outpatient basis in an organized setting such as a clinic, a rehabilitation agency, or a public health agency. Prior to 1972, outpatient speech pathology services were covered only when furnished by an approved hospital, skilled nursing facility, or home health agency. Present law requires that the patient be referred to the speech pathologist by a physician and that the physician establish and periodically review a plan of treatment which specifies the amount, duration and scope of services to be furnished. However, since speech pathology involves highly specialized knowledge and training, physicians generally do not specify in detail the services needed when referring a patient for such services.

Summary

The bill repeals the existing medicare requirement that a physician establish a detailed plan of treatment for speech pathology services. The requirement for physician referral and periodic physician review of the plan of treatment would be retained.

Section 17. Presumed Coverage Provisions

Background

The 1972 Social Security Amendments directed the Secretary to establish a minimum number of days of care in a skilled nursing facility or visits by a home health agency which would be "presumed" to be covered by type of patient diagnosis. This provision was enacted because skilled nursing facilities and home health agencies were experiencing a high rate of retroactive denials for services they provided on the assumption they would be covered by medicare.

A number of skilled nursing facilities and house health agencies have found the presumed coverage regulations confusing, often mistaking what are minimum days or visits covered as the maximum allowed. The regulations implementing this provision also have created complex administrative procedures to be followed by both the providers and the program. In addition, as a result of other, more effective, waiver of liability provisions included in the same 1972 legislation, the

presumed coverage provisions are rarely used. According to HEW statistics, claims filed by skilled nursing facilities and home health agencies under the presumed coverage provision now represent far less than one-half of one percent of all claims for payment filed by these providers.

Summary

The bill repeals existing medicare provisions authorizing by type of diagnosis, presumed periods of coverage for skilled nursing facility and home health services. Protection against retroactive denials would continue to be afforded by a general waiver of liability provision.

Section 22. Demonstration Projects for Training and Employment of AFDC Recipients as Homemakers and Home Health Aides

Background

It is estimated that as many as 40 percent or more of the aged and disabled persons now in high cost skilled nursing facilities and intermediate care facilities do not necessarily have to be there—and would not be there if proper alternative supportive services were available. Most would prefer to live in familiar surroundings in which they can retain their sense of independence and dignity.

At the same time there are many persons currently on the welfare rolls who, if they received proper training, could become gainfully and usefully employed members of the health professions.

Summary

The bill authorizes the Secretary of HEW to enter into agreements with up to 12 States, selected at his discretion, for the purpose of conducting demonstration projects for the training and employment of AFDC recipients as homemakers or home health aides. Priority would be given to those States which have demonstrated active interest and effort in supporting the concept. Full responsibility for the program would be given to the State health services agency (which may be the State medicaid agency) designated by the Governor.

The program is completely voluntary; an AFDC recipient is under no obligation to enroll and does not risk loss of AFDC funds by refusing to participate. Persons eligible for training and employment would be only those who were continuously on the AFDC rolls for the 90-day period preceding application. Those who enter a training program would be considered to be participating in a work incentive program authorized under part C of title IV of the Social Security Act. During the first year such individual is employed under this program, he or she shall continue to retain medicaid eligibility and any eligibility he had prior to entering the training program for social and supportive services provided under part A of title IV. The individual will be paid at a level comparable to the prevailing wage level in the area for similar work. Federal funding will not be available for the employment of any eligible participant under the project after such participant has been employed for a 3-year period.

The bill requires a State participating in a demonstration project to establish a formal training program which must be approved by the Secretary as adequate to prepare eligible participants to provide part time and intermittent homemaker services and home health aide services to individuals, primarily the aged and disabled, who would, in their absence, be reasonably anticipated to require institutional care. The State shall provide for the full-time employment of those who have successfully completed the training program with one or more public agencies or by contract with nonprofit private agencies. The numbers of people in a State eligible for training and employment would be limited only by their ability to be trained and employed as well as by the number of those in need of home health and homemaker services.

The bill provides that persons eligible to receive home health and homemaker services are the aged, disabled, or others, such as the retarded, who are in need of such services. They must be those for whom such services are not reasonable and actually available and who would otherwise reasonably be anticipated to receive institutional care. Participating States would be required to provide for independent professional review to assure that services are provided to individuals actually needing them. Eligibility for services would be extended to individuals whose income is less than 200 percent of the State's need standard under the AFDC program for households of the same size.

The bill specifies that the type of services included as homemaker and home health aide services include part time or intermittent: personal care, such as bathing, grooming, and toilet care; assisting patients having limited mobility; feeding and diet assistance; home management, housekeeping, and shopping; family planning services; and simple procedures for identifying potential health problems. Authorized services do not include any service performed in an institution or any services provided under circumstances where institutionalization would be substantialy more efficient as a means of providing such services.

The bill provides 90-percent Federal matching for the reasonable costs (less any related fees collected) of conducting the demonstration projects. Such amounts would be paid under the State's medicaid program. Demonstration projects would be limited to a maximum of 4 years plus an additional period up to 6 months for planning and development and a similiar period for final evaluation and reporting. The Secretary is required to submit annual evaluation reports to the Congress and a final report not more than 6 months after he has received the final reports from all the participating States.

Chiropractic Services (Intended to be included in bill but inadvertently omitted)

Background

Under present law, medicare covers only those services of chiropractors which involve treatment of a subluxation (partial dislocation) by means of manual manipulation of the spine. The existence of a subluxation must be demonstrated by x-ray; however, the cost of the x-ray is not covered when performed by a chiropractor.

The x-ray requirement was intended to control costs by excluding from coverage cases in which a subluxation was not evident on an x-ray. The General Accounting Office has indicated that the extent to which x-rays play a part in claims denial is not known. Although chiropractors must have x-rays available upon request, the x-ray is actually reviewed by medicare carriers in only a small number of cases.

The requirement for an X-ray to demonstrate the subluxation of the spine is not necessary in every case, is possibly hazardous, and—since it is not paid for by the program—represents a significant cost to beneficiaries. Since chiropractors would not ordinarily take X-rays in every case to diagnose subluxation of the spine, it is inappropriate to require X-rays, with their accompanying radiation risks, for administrative purposes.

Summary

The bill would modify the requirement for chiropractic coverage so that a subluxation could be demonstrated to exist either through x-ray or other chiropractic clinical findings. Neither the x-ray nor other clinical procedures used by the chiropractor would be covered by medicare.

III. S. 508—APPOINTMENT OF THE ADMINISTRATOR OF THE HEALTH CARE FINANCING ADMINISTRATION

Background

The Health Care Financing Administration (HCFA) is the agency in the Department of Health, Education, and Welfare responsible for administration, coordination, and policymaking for the medicare and medicaid programs. It was established by the Administration in early 1977 in order to provide the means for the orderly consolidation and coordination of these two major health programs.

The Administrator of this agency should be an individual experienced and knowledgeable in health care and health care financing with full awareness of the complexity of the issues involved. This position includes responsibility for both medicare and medicaid. The Administrator of the Social and Rehabilitation Service (an office now terminated) required appointment by the President and confirmation by the Senate primarily because of his responsibility for medicaid. The comparable position of the Commissioner of Social Security requires Presidential appointment and Senate confirmation.

Summary

The bill provides for the Administrator of the Health Care Financing Administration to be appointed by the President with the advice and consent of the Senate. The provision would apply to individuals who serve in the position on or after the date of enactment.

IV. ADDITIONAL STAFF ALTERNATIVES FOR POSSIBLE COST SAVINGS PROPOSALS

Cost savings represent order of magnitude estimates developed by the Finance Committee staff after consultation with staff of the Congressional Budget Office, the General Accounting Office, and the Department of Health, Education, and Welfare.

1. Reimbursement for Outpatient Hospital Care

Background

As a result of various limits placed by public agencies and others on inpatient hospital expenditures, some hospitals have sought to have the patients using their outpatient departments meet a disproportionately large share of the hospitals' total costs.

Possible alternative

To prevent medicare and medicaid from bearing grossly excessive outpatient hospital costs, Medicare reimbursement for these costs and related physician charges could be limited to an amount not greater than double the prevailing charges the program would have paid had the services been furnished in a private physician's office.

Background

In addition, reimbursement to community health centers and other freestanding clinics which are presently paid on a cost-related basis have sometimes proved to be excessive.

Possible alternative

A provision could be adopted under which the clinics in question (other than the recently covered rural clinics) could not be paid more than the prevailing charge that would have been paid for the services had they been furnished in an independent practitioner's office.

Note: Application of the limits could be made based upon a reasonable and adequate sample of patient records of conditions treated, services and charges in each hospital outpatient department. Separate charges would not ordinarily be recognized for services which are ordinarily commonly grouped and a single charge made. Only one visit would be reimbursable for services ordinarily provided during a single visit.

Estimated savings

$200 million.

2. Disproportionate Medicare-Medicaid Payments for Hospital Care

Under present policy, medicare reimburses hospitals for a disproportionately large share of the costs of routine nursing even though there is no objective, convincing evidence that this "plus factor" is warranted. On the other hand, medicare and medicaid are called on to pay a full share of hospitals' malpractice insurance costs even though reliable studies show that the elderly and the poor account for a relatively small portion of the malpractice insurance awards. (The Finance Committee staff previously suggested, along with other staff suggestions submitted to HEW at the Committee's direction, but without

the Committee's formal endorsement, that HEW policy should be modified to provide for an appropriate adjustment to be made to more realistically reflect medicare's share of malpractice insurance costs; the President's Budget includes this proposal and projects savings in fiscal year 1980 of $310 million.)

Possible alternative

No routine nursing plus factor nor any other plus factor would be paid until such time as evidence can be produced which, in the judgment of the Comptroller General, concurred in by the Secretary of HEW, justifies a specific plus factor as warranted under given circumstances for given facilities.

Estimated savings

$200 million.

3. Prohibit Medicare-Medicaid Payment at Hospital Rates for Patients Medically Determined to Need Lesser Levels of Care

Professional Standards Review Organizations (PSROs) have found thousands of medicare and medicaid patients being kept in costly acute-care hospital beds instead of being appropriately placed in nursing facilities or detoxification units.

The situation occurs most frequently in those areas where there is a surplus of hospital beds and a shortage of long-term care beds.

Possible alternatives

(a) Authorize a program of grants and loans to facilitate conversion to long-term care beds of surplus acute hospital beds in public and non-profit hospitals. Priority would be given to high cost urban areas. Priority would be given to complete conversion of a hospital to long-term care as opposed to partial changeover. (b) Effective not later than April 1, 1980, medicare and medicaid payments to hospitals would be made at the average skilled nursing facility or intermediate care facility payment rate (as may be appropriate) rather than the much higher hospital rate for patients medically determined by reviewers as not in need of acute hospital care but who are in need of a program reimbursable level of long-term care. Days of care paid by medicare at the reduced rates would be counted against the patient's eligibility for skilled nursing facility benefits and the skilled nursing facility benefit coinsurance rates would also be applicable. To prevent undue hardship, the limitation would not apply during the first day, to certain terminally ill patients nor in those geographic areas where the appropriate State or local planning agencies certify that there is no general excess of hospital beds, and there is a shortage of long-term care beds.

Where a hospital converts active acute care beds to long-term care usage under this provision, it could be permitted to reconvert those beds back to acute care usage within a period of 2 years without being subject to the sec. 1122 approval process.

Estimated savings

$250 million.

4. Federal Advance Payments to States

Present Federal policies permit States to draw on Federal medicaid funds before they are actually needed to pay recipients. During the

period between the time when the Federal funds are drawn by the State and the time when they are disbursed to medicaid recipients, about 12 days on the average, the funds can draw interest which accrues to the State. HEW has proposed that the gap should be eliminated in fiscal year 1980 in 10 States, producing a one-time saving of $240 million for Medicaid.

Possible alternative

Extend the new "checks paid" policy to all 50 States in 1980.

Estimated savings

(a) $150 million from application of the "checks paid" policy to the medicaid programs of the additional 40 States; (b) An additional $150 million could be saved under AFDC if a similar policy (proposed by HEW for 10 States) were extended to the other 40 States.

5. Competitive Bidding and Negotiated Rates Under Medicaid

States have been restrained from adopting cost-saving contract bidding and negotiated rate arrangements with laboratories under their medicaid programs by an interpretation of the present "freedom of choice" provision of Federal law. That provision was intended to permit medicaid recipients to choose from among any qualified doctors, pharmacies, etc. It was not intended to apply to the types of care or services which the patient ordinarily does not choose.

Similarly, judicial interpretation of the "freedom of choice" provision has hampered cost-saving arrangements by States for the purchase under medicaid of medical devices (such as eyeglasses, hearing aids and wheelchairs) even though these items often do not vary in quality from supplier to supplier.

Possible alternative

Permit States, at their option, to provide such services and items for medicaid purposes through competitive bidding or appropriate negotiated arrangements.

Estimated savings

$100 million.

6. Direct Professional Review Toward Avoiding Unnecessary Routine Hospital Admission Services and Excessive Preoperative Stays

Present policies direct PSROs to review the appropriateness of hospital services received by medicare and medicaid patients. This review has been limited largely to a review of the need for the patient to be admitted to the hospital and on the appropriateness of the length of the stay. PSRO studies have amply demonstrated the extent to which unnecessary or avoidable utilization occurs with respect to certain hospital practices that have not been subject to general across-the-board review, including: diagnostic tests routinely provided on admission without a physician's order; weekend elective admissions to hospitals which are not equipped or staffed to provide needed diagnostic services on weekends; and preoperative stays for elective procedures of more than one day without justification for the additional days.

Possible alternative

Direct PSROs to review these areas of relatively frequent overutilization to assure that payment is made under the public programs only when the routine tests and unusually long preoperative stays for elective conditions are medically appropriate.

For example, as is now the case in some PSROs, elective admissions for surgery that involves preoperative stays of more tha one day would require specific PSRO approval in order to be reimbursable. Similarly, weekend admissions for elective conditions would be reimbursable only where the PSRO finds that the hospital is equipped and staffed to provide necessary services over the weekend.

Estimated savings

$500 million.

7. Delete Statutory Requirement Specifying State Payment of "Reasonable Costs" to Hospitals Under Medicaid

States have complained that present Federal statutory and regulatory requirements with respect to payments for hospitalized medicaid recipients unduly constrain their administrative and fiscal discretion.

Possible alternative

Delete the present statutory requirement and allow States the discretion of determining appropriate Medicaid reimbursement to hospitals (but not in excess of the amount that would be determined to be reasonable under medicare).

Estimated savings

$200 million.

8. Delete Statutory Requirement Specifying State Payment of "Reasonable-Cost-Related" Reimbursement to Skilled Nursing and Intermediate Care Facilities

States have complained that present Federal statutory and regulatory requirements with respect to medicaid patients in long-term care facilities unduly constrain their administrative and fiscal discretion.

Possible alternative

Delete the present statutory requirement and allow States the discretion of determining appropriate levels of nursing home and intermediate care reimbursement.

Estimated savings

$250 million.

9. Apply "Prudent Buyer" Limit to Purchases by Hospitals of Routine Supplies

Studies of hospital purchasing practices undertaken by the General Accounting Office at the request of the Subcommittee on Health of this committee have disclosed instances of costly and wasteful purchasing. The excessive and avoidable costs are being passed on to medicare, medicaid and other payers.

Possible alternative

For the most frequently purchased supplies establish maximum allowable cost limits essentially based upon the median prices at which those items may be procured in given quantities at given points in time. Costs in excess of the maximum allowable amounts would not be recognized by medicare and medicaid.

Estimated savings

$100 million.

10. Medicare Payment Liability Secondary Where Payment Can Also be Made Under Accident Insurance Policy

Under present law, medicare is ordinarily the payor of first resort except in certain cases, e.g., where the patient has no legal obligation to pay, or where workmen's compensation is responsible for payment for the patient's care.

Possible alternative

Where the medicare patient is involved in an accident and his care can be paid for under the insurance policy of the individual who was at fault, medicare would have residual and not primary liability. Under this proposal, medicare would pay for the patient's care in the usual manner and then seek to be reimbursed, where the estimated recoverable amount exceeds $500, by the private insurance carrier after, and to the extent that, its liability has been determined.

Estimated savings

$200 million.

V. ALTERNATIVE APPROACH TOWARD MODERATING HOSPITAL COSTS AND CHARGES THROUGH VOLUNTARY ARRANGEMENT WITH PRIVATE PAYERS

Concern has been expressed over the possibility that hospitals will shift costs which are disallowed under the medicare-medicaid reimbursement formula proposed under S. 505 to other payors. This possibility is of particular concern to organizations that pay hospitals on a charges basis (e.g., Prudential, Metropolitan and other commercial health insurance companies) since, ordinarily, they have no way of knowing the actual cost of the services they pay for.

The Committee may wish to consider (as an alternative to the regulatory approach) two possible approaches, depending upon whether the voluntary effort succeeds or fails.

1. Assuming the success of the voluntary effort as propounded by the health care industry, medicare-medicaid would initially establish payment limits and provide incentive payments based only upon hospitals' routine costs. Subsequently, as the state of the art develops, ancillary costs, such as X-ray, laboratory, pharmacy, etc., would be brought into the system. When a substantial portion of the costs that are covered by medicare-medicaid are subject to incentives and penalties (and thus the risk that hospitals will shift disallowed costs to charge paying third parties becomes substantial) commercial health

insurers could elect to be protected against shifting through constraints on allowable increases in hospital charges.

It will be recalled that, under the medicare-medicaid system proposed in S. 505, the allowable rate of increase in costs for a given hospital is related to that hospital's costs relative to similar hospitals. For example, medicare-medicaid reimbursement for a given hospital with average costs, might be allowed to increase 12 percent while a hospital with costs significantly above the average costs in similar hospitals might be allowed a 6-percent increase in costs. Under the antishifting proposal, hospitals would not be permitted to incerase their charges for patients covered by insurers that elect to participate (and self-pay patients) by more than the percentage increase allowed in medicare cost.

This would protect the many millions of people who are insured by private health insurance from the added premiums that might otherwise have to be paid to finance any excessive and unjustified increases in hospital charges.

Non-governmental costs payers, such as Blue Cross, could also voluntarily opt for the program; in such cases, the rate of increase in Blue Cross reimbursable costs could not exceed the percentage increase in medicare.

2. Under the staff alternative to the administration cost containment proposal ("9% Cap") of the last Congress, an interim mechanism for limiting increases in hospital ancillary costs was developed for use in the event the voluntary effort failed before the Health Facilities Cost Commission had developed appropriate limitations based upon comparison of hospitals' ancillary costs. In this situation, if the voluntary effort failed, private health insurers and self-pay patients could be protected by automatically providing that hospital charges could not be increased by more than the allowable percentage rate of increases in medicare costs under the interim approach.

Both of the above alternatives could be enforced through use of the tax laws.