EXECUTIVE SESSION

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THURSDAY, MARCH 22, 1979

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United States Senate,

Committee on Finance

Washington, D. C.

The committee met, pursuant to notice, at 9:50 a.m. in room 2221, Dirksen Senate Office Building, Hon. Russell B. Long, chairman of the committee, presiding.

Present: Senators Long, Talmadge, Nelson, Gravel, Bentsen, Matsunaga, Moynihan, Baucus, Boren, Bradley, Dole, Packwood, Danforth, Chafee, Heinz, Wallop and Durenberger.

The Chairman. Let us come to order. The committee will come to order.

What is the first thing on the agenda?

Mr. Stern. The first matter is the countervailing duty waiver extension.

Mr. Cassidy. If you will look at Attachment A which is before you, staff document, under the law as amended by the Trade Act of '74, between January 3, 1975 and January 3, 1979, the Secretary of the Treasury could waive the imposition of countervailing duties if the subsidizing foreign country met certain conditions. The conditions were that the foreign government substantially reduced effect of the subsidy; two, that there is

a reasonable prospect of the multinational trade negotiations which will result in codes; three, that the imposition of the countervailing duty which would be waived would jeopardize the multilateral trade negotiations.

This authority did expire January 3 of this year and between January 3 and today, Treasury has been requiring importers of the products which were covered by waivers to post bonds or letters of credit to cover the liability of the countervailing duty. However, the actual countervailing duty has not been collected.

The waiver was exercised in 19 cases between 1975 and 1979. Four of those waivers were revoked; three because the country involved, Uruguay, violated the conditions of the waiver. In one case, Mexican steel plate, the subsidy was removed.

Of the 15 waivers which are in effect right now, three will likely be revoked in the near future because the countries involved have agreed to eliminate their subsidies so that will presumably leave us with twelve waivers in the near future in effect.

The bill which passed the House, H.R. 1147, would continue the waiver authority from January 3, 1979, to September 30, 1979 or until the day in which either the House or the Senate defeats on a vote of final passage the legislation implementing the trade negotiations, or on the date that that bill is enacted, or, as I said, on September 30th, whichever date is earlier.

Existing waivers would continue in effect, that is to say,

the 15 and, in the near future, 12 waivers that were already imposed would continue in effect until September or an earlier date. In addition, new waivers could be imposed or countervailing duties could be waived on new cases if they otherwise met the conditions in the old law.

The revenue effect of this nine-month continuation of the waiver authority would be approximately $35 million loss and I believe Ambassador Strauss may have something else.

The Chairman. You think this is an urgent matter. Would you explain the urgency of it, Ambassador Strauss?

Mr. Strauss. Thank you, Mr. Chairman.

To put this in perspective very succinctly, you will recall, many of you, that this waiver was originally put in place for January 3rd of this year for the purpose of permitting the negotiations to be completed and to see that the negotiators representing this nation could return with a trade package including a code on subsidy and countervails that the Congress would find -- in a general trade package that the Congress would find acceptable.

As you also know, the first couple of years or so of the Tokyo Round were not very productive. It was substantially dormant when this committee approved my going in the job last April and we have moved hard and aggressively and I hope positively since that period of time, and I come before you today saying that it is absolutely essential, if we are going to bring back an

agreement, that we pass and get into law this waiver extension and get it done at the earliest possible time.

I again want to repeat that it is procedural. I, again, want to say that it will give us the opportunity to present before the Senate and the House the trade package itself. I would point out to you one more thing, and then conclude. That is, with respect to the code itself dealing with the subject, while it is far from perfect, it is a good one that we could take pride in and a better one than anyone thought that we would return with and agriculture generally approves it and business generally approves it and labor has expressed no disapproval and I believe that the Congress will approve it if we get a chance to bring it home.

We need this waiver to get it home.

Thank you, sir.

The Chairman. I think that we ought to pass it. As anxious as I am to pass sugar legislation, I do not think I am going to insist on offering my sugar amendment on this bill at this point, Mr. Ambassador. If it looks like it is going to have some other merit, we should have the sugar bill with the others, if only as a sweetener.

Mr. Strauss. Senator, I thank you. We have enough weight on our back right now. Let's not put anything on else on this waiver.

The Chairman. Senator Dole?

Senator Dole. I appreciate the urgency of the legislation. I just wonder if it could not stand one little amendment. If it can carry anything, it can carry the carryover basis repeal.

This was a provision, as you may recall -- or you may not recall, Mr. Ambassador -- that was written into a conference, agreed upon in conference, in 1976 without hearings; without even knowledge. It seems to me that if we could repeal carryover basis that this puts us back to where we were prior to that conference; then we can start over and Treasury can come up and maybe we can work out some tolerable agreement.

I certainly do not want to stand in the way. I want to support MTN. I hope I can, finally. We have been making progress, as you know, in the committee. At the same time, I would like to figure out some proper way to repeal carryover basis. There are not too many good horses around, at least going out of the committee.

Is there anything else going out, Mr. Chairman?

The Chairman. Well, the House is supposed to send us some more bills in short order and if that is the case, I would think that we could put something of this sort on one of those, especially if we could get an agreement over on the House side that they would be willing to let the House vote on it.

I think the House will vote for that amendment, your carry-over basis amendment, if the House has a chance to vote. It may be that we can get some kind of agreement with Mr. Ullman and

Mr. Conable and the powers that be over there. If we send them an amendment that has to do with the carryover basis, that they just offer the House an opportunity to vote on it. I think that is all that you need to insist on with regards to the House, if you put that on some other bill, that they will let them vote on it.

As far as I am concerned, I have no desire of preventing you from having a vote on the carryover basis in the House and the Senate. Frankly, I find much appeal in your position. I think I will probably vote for it. I would rather vote on the Floor for it than in the committee, for the simple reason that we ought to have hearings and that type of thing, but I would prefer it be offered on the Floor as an amendment.

Senator Dole. I am just wondering. I have not tried to make any head count on the committee. There is a great deal of support for repeal of, at least starting over. There may be some merit to some changes recommended by Treasury, but now it seems to me they have shifted the burden. It ought to be shifted back to Treasury.

But what if we could not just pass out a little repealer on carryover basis not attached to the extension of the counter-vailing matter and then we could have a vote on it in the Senate. Before we voted on the extension, the Senate would have spoken and it would be up to the House; if they wanted to reject it, I assume they can reject it.

The Chairman. We do not have anything we can vote on. If you want to offer it on the debt limit bill out there you can offer it, but that opens up a lot of additional controversy.

Mr. Strauss?

Mr. Strauss. I hope that Senator Dole did not conclude -- I did not understand him -- on the little amendment to our bill, because you know, that is like being a little pregnant, Senator Dole. There is no such thing as a little amendment to my waiver bill. This one we have before you now, we need this. We need a clean bill out of there, and we really need to send a message out.

I know you understand this. I know you are trying very hard to be supportive in every way you can. I also know there is a good deal of support for the measure that you are speaking of, but it seems to me we are giving the worst of both worlds. If we tack it on here, we get the worst of both worlds and in so far as our negotiating posture is concerned, representing this nation because we are playing for high stakes and we have had the guns kind of trained back on us a little bit in the posture we have had to stand in, we really need to send a message.

There are those in this world who think -- some within more beyond this country -- that think that other nations have more to lose, or not as much to gain as we do in this trade bill and that this Congress really does not want it anyway. I think that an excuse for people to kill it around the world, kill all these

negotiations, is something this nation cannot stand right now.

I would like to get a clear message out of here with a clean waiver.

Mr. Stern. I might just mention that the Ways and Means did order reported a bill yesterday to extend the past treatment of state legislator's expenses and that is a bill that will be coming over very soon. I did not know whether you wanted to use that one but, any rate, the debt limit and the countervailing duty are the only bills.

The Chairman. I really think that those who want to vote on the carryover basis, their best opportunity, I think, would be to vote on some little bill that is completely noncontroversial, so that, assuming the President vetoes it -- and I am led to believe he is going to veto, that he feels strongly against what I think is the prevailing Senate view on carryover basis -- if he vetoes it, when you seek to override a veto, that you are not losing votes that would be against the legislation.

For example, there are certain people who are against this waiver extension and there maybe some people opposed to that little bill about those legislators. They are going to be sending us some bills in short order, I would think. I have been pressing them to do it.

I have not heard any serious objection from anybody. I think that is the kind of bill you ought to have it on, if the House is willing to have a vote on it, and I think you will have

an agreement to have a vote on it. Put it on the House bill when it is over there.

When will the legislators bill be -- has it passed the House?

Mr. Stern. It affects the tax returns that have to be filed by April 15th, so there is some likelihood that it will be over quite soon.

Senator Dole. When is the last day we can act on the floor on Ambassador Strauss's proposal?

Mr. Stern. Well, the desire was to try to do it before the European Community had its next council meeting.

Senator Dole. When is that?

Mr. Strauss. April 3rd, Senator Dole.

Mr. Cassidy. In order to serve the purpose that Ambassador Strauss wants this bill for, the Senate would have to do something one way or the other before April 3rd, otherwise you delay the whole process in Europe for at least another month, which pushes us back here a month at least.

Basically it is up to the committee whether they want to proceed that way.

Mr. Strauss. Let me make another statement again, to keep perspective. I am not certain that the European Community will go with this bill. There are some serious objections over there. I want you to know that we may run into trouble over there.

We have maintained a posture that this is a firm and a

reasonable position that we are in, that there are not any more compromises for our position, nor are we asking any more from theirs. We are prepared to sign off.

I want to stay firm; I want to stay in the shape we are in. We may miss that deadline, but I want to give them an opportunity to vote without having our country or this Congress as an excuse not to take action and face up to it one way or the other.

Senator Dole. I think there are a lot of us who feel that maybe blackmail is too strong a word when we are told by certain countries that if we do not do this, they are going to scuttle the MTN. We have a record of a trade deficit announced last night in the headlines across the front page of the paper that there are some who wonder why we do not act against unfair foreign trade practices and we should not extend this, in any event.

But I want to be helpful to the administration but I would also like to figure out some little way to take care of some American taxpayers.

Mr. Strauss. I understand that, sir.

Let me just state for the record that this country has not reacted to any blackmail, Senator Dole. I have made it very clear in the early stages in our negotiations that we do not negotiate with a gun at our head. But we have negotiated under this general assumption throughout this thing that we started out with.

I did not pass the '74 Trade Act; I had nothing to do with

it, but it put, for the purposes of these negotiations, an extension in there, the extension waiver, and we led people to believe -- first, we were hoping to complete by January 3rd and the Congress would want to do what it set out to do, that is, have an extension to give time for this to come back, as long as it is reasonable.

So it is not a question of blackmail, although it can be pushed along that line.

Senator Dole. I think, based upon the chairman's statements and Ambassador Strauss's, that I would be willing to forego offering the amendment in the committee but reserving, of course, the right to offer it on the floor. In the meantime, maybe we can work out some other arrangement.

Senator Wallop. Would you yield on that?

Senator Dole. Yes.

Senator Wallop. I, with some reluctance, see you back off from that. One of the problems that we face domestically -- and I realize the complication in your life, Ambassador Strauss -- everything that we have done in recent years by way of taxation makes it less and less possible for an individual to exist and more and more possible for a corporation to exist.

That is exactly what the carryover basis have done. Corporations do not die, people do. Small farmers and shoe stores and people with grocery stores and other things simply cannot continue to bear the burden of taxes on estates that is required. If you

want to back off, I will. I certainly hope that the Chairman's assurances are well-intended and that we will have an opportunity very soon to discuss it, because it is a brutal tax on small people in this country.

The Chairman. He is reserving the right to offer it on the floor and I would urge the Senator to do that, and meanwhile we can see if we can get some agreement with the House that if we send it to them on some other bill, they will let the House vote on it. Frankly, I think that is all you need, Senator, because frankly you have votes on both sides on that.

Mind you, you are going to have a problem with the President but whatever comes down --

Senator Wallop. It is not the only problem I have with the President.

The Chairman. But provided that the bill that it goes down there on is not a controversial bill in its own right, I think you have a good chance to override a veto, if you got vetoed.

Senator Dole. It is not backing off. It is sort of a strategic retreat, I think -- temporary.

Mr. Strauss. Thank you.

The Chairman. If you offer it on the floor, I may vote for it. I may say it is easier to vote for it than to be misunderstood.

If there is no objection, then, we will vote on reporting the bill.

Those in favor, say aye?

(A chorus of ayes.)

The Chairman. Opposed, no?

(No response)

The Chairman. The ayes have it. The bill is reported.

Let us talk about the health cost containment proposal. Ambassador Strauss, do you want to stick around and talk about health costs?

Mr. Strauss. It has been a pleasure to be with you. Thank you very much. You will see enough of me in the next few months. Thank you.

The Chairman. Let us talk about the health bills, then, and see if we can make some progress on hospital cost containment.

Mr. Constantine. Mr. Chairman, we thought that it would be expeditious for the committee if it worked from the blue book, Document B, in your folder. The sequence is several proposals here involving S. 505, the Talmadge-Dole Medicare-Medicaid administrative reimbursement reform bill; S. 507, which is the Dole-Talmadge minor administrative reforms and changes, reimbursement reforms.

Then, there is S. 508, a minor bill to make the Administrator of the Health Care Financing Administration subject to Senate confirmation. In addition, the committee has before it S. 570, the Administration's overall hospital revenues cost containment proposal and I believe that it was Senator Nelson's intention to

raise that at some point, but you can proceed at this point without dealing with that, without dealing with an overall revenues constraint.

Now, Section 2 of the bill, which starts on page one of the document, deals with the criteria for determining reasonable costs and reasonable charges under Medicare and Medicaid. This is essentially similar to the provision which the committee approved as part of H.R. 5285 last October and to which was added the Nelson amendment on overall hospital costs containment.

This, however, does not deal with any kind of regulatory restraint, it simply deals with how Medicaid and Medicare pay the services -- a reimbursement proposal, not a revenues limitation.

There are some changes from the bill that the committee approved last time which are consistent with the bill as originally introduced and there are some minor changes that we would suggest to you based upon the hearings.

This is in the hospital reimbursement under Medicare and Medicaid. One is that there is a Hospital Cost Commission established whose responsibility is to sugge . means of further refining the classification and comparison system in the proposal to make the rough spots smoother over time. On the Commission, there are three representatives of hospitals, providers.

The American Hospital Association suggested that there be five of the fifteen from providers. We would suggest that the

committee accept that. If you accept that provision, we see no objection to it. It will facilitate the changes.

We would also suggest as a further safeguard against any kind of arbitrary action by the Department that where the commission recommends, for example, minor changes in the classification or substantial changes or further refinements or extensions of the cost comparisons under Medicare and Medicaid that where the Secretary disagrees with the commission, because the Secretary has to implement it by regulation, he be required to submit to the Congress with the recommendatilns of the Commission his reasons for not proceeding with it.

Additionally, if the Secretary chose to make a reimbursement change in Medicare and Medicaid -- which he can do under existing law --

Senator Dole. Where are you?

Mr. Constantine. Section 2, Senator.

We would suggest that he submit any changes that he proposed to make to the Hospital Cost Commission for its comment and evaluation, and if the Hospital Cost Commission disagrees that both the Secretary and the Commission send their rationale to the Congress and that the Secretary's proposed change not go into effect for 60 days to give Congress a chance to review the matter, in case there is a serious dispute.

We believe it smooths that out and provides an orderly mechanism for any differences between the two to at least receive

some attention.

Beyond that --

Senator Talmadge. What do you want to do? Do you want to explain this and try to get the committee to approve it section by section as you go?

Mr. Constantine. Yes, sir. That was the intention. We are on Section 2, the Medicare reimbursement reforms. That is essentially Section 2, to review it again, establishes a system of reimbursement for hospitals consisting of classifying and comparing similar hospitals and similar cost centers.

It starts with adjusted routine per diem cost which are the routine costs, the routine nursing and housekeeping administrative costs, and then it provides, as the state of the art advances, for the addition of ancillary services, x-ray, laboratory and so on.

The system here, the classification system in the bill, was worked out with the help of the American Hospital Association and the Association of Medical Colleges. We believe it is probably as good as can be done at this point in time, and with the Cost Commission authorized to make appropriate changes over time as again improvements in the state of the art advances. It is about as orderly a procedure as you can have.

There are exceptions for state rate-making systems here as well, where the state system is superior -- I am sorry, not superior, but restrains Medicare and Medicaid costs, at least

as well as the Federal system.

Senator Talmadge. In nine of those states, as I recall?

Mr. Constantine. There are nine of those which have hospital regulatory systems in place.

Senator Talmadge. They would be exempt, if their system is good, is what we propose?

Mr. Constantine. Yes, sir. So would a state that came forward with a plan. If a new state came forward -- which does not have a regulatory system -- if they said its plan was superior -- the test is that they have to have confidence in it.

If, at the end of any two-year moving period, the aggregate costs in that state are greater for Medicare-Medicaid than otherwise would have been payable allowed, the Federal system then operates in that state and there is a modest reduction over a period of years, so that to recapture the excess revenues that the state may have, or excess payments that the state made under its system.

This is only Medicare and Medicaid payments.

Senator Talmadge. Any questions?

Senator Packwood. Mr. Chairman?

Senator Talmadge. Senator Packwood.

Senator Packwood. I have an amendment to offer identical to the amendment the committee passed last year. The per diem is a reimbursement on the average cost of stay. The western hospitals generally have shorter lengths of stay and they are

discriminated against in this formula. There is no state in the west that has a longer rate of stay, longer length of stay, than the national average.

I know the bill has attempted to address itself -- if you look at page 12, lines 3 to 10, they would allow hospitals to file an exception if they have shorter than average lengths of stays, but it will take two to three years to judge that exception.

I would like to move the language that this committee adopted last year, the language that we adopted which allows hospitals to choose the alternatives, the per diem or the average length of stay, so that western hospitals are not discriminated against, and that language would read as follows: on page 9, line 15, we strike out "and" and we insert "or" and then add the following: "In the case of a hospital's having an average length of stay per patient which is less than the average length of stay per patient for hospitals in the same classification for any accounting year, an amount equal to the average reimbursement for routine operating costs for patients stay for hospitals in the same classification multiplied by the number of patients stays in such hospitals not exceeding the actual routine operating cost for such hospitals."

I would be prepared to argue this further, Mr. Chairman. The committee did agree to it before, and it eliminates the discrimination that most western hospitals otherwise face.

Senator Talmadge. Would you comment on that?

Mr. Constantine. I do not believe the committee adopted it; I believe you offered it last time. I think we pointed out that there was validity to what you say. However, while western hospitals have shorter lengths of stay, they have a substantially greater number of admissions. They have many more admissions than other hospitals and the dilemma with that is that you cannot compare case mix.

The problem is that a hospital which has easier cases -- you know, the lower age cohorts and so on -- could have a substantially shorter length of stay unrelated to efficiency.

Senator Packwood. You know that is not the circumstance. You are not saying that all western hospitals have a different age mix and a different cohort.

Mr. Constantine. Individual hospitals can, Senator.

Senator Packwood. I am talking about the averages in the West. I understand individual hospitals, but every state in the West has a lower average.

Mr. Constantine. Yes, sir, but they have many more admissions. They have a higher admissions rate, shorter stays, but more frequent admissions.

You can encourage readmissions, and so on, we agree with you. It is just how you get there.

Once you get to the ancillary costs, once you get all costs in and the administration claims they will be able to do a case mix by 1981 or '82 -- is that correct? 1981, they say, Senator,

we would be willing to say accept your provision until such time as case mixed can be determined so you can adjust for any of those factors.

Senator Talmadge. Does the Department want to comment on that? Is there anybody here from the Department who can speak to this?

Mr. O'Connor. Robert O'Connor, Assistant Administrator of the Health Care Financing Administration and reimbursement practices. In regulations we just issued last week, we were proposing under present law an exception, a special exception, to provide relief for hospitals with shorter lengths of stay than the average.

Senator Packwood. There is no harm in writing it in this legislation.

Mr. O'Connor. I think there needs to be some kind of relief.

Mr. Constantine. If they see no problem with it, we are not going to tilt at windmills.

Senator Packwood. I move its adoption.

Senator Chafee. Mr. Chairman?

Senator Talmadge. Senator Chafee?

Senator Chafee. If I may ask a question, what is the reverse implication on this on areas of the country where they have fewer admissions but longer stays due to the elderly composition of the population?

Mr. Constantine. They are constrained, Senator.

Senator Chafee. I appreciate that. With the adoption of this amendment is it going to affect those situations in any manner?

Mr. Constantine. We use the average of the hospitals in a given classification; Senator Packwood correct me.

Senator Packwood. It does not show on there as an option. This does not to compel the hospital to use their shorter length of stay basis. It gives them the option, so it does not affect the hospitals that have longer stays. It just does not discriminate against those who have shorter stays.

Senator Chafee. Do you agree?

Mr. Constantine. Frankly, we would have to look at it again. Senator Chafee, if it is discriminatory, if the committee approves Senator Packwood's amendment, if it is discriminatory, if we have the committee's permission to make sure that that did not discriminate, we could take care of that.

Senator Packwood. That is all right with me.

Senator Talmadge. Senator Danforth?

Senator Danforth. I do not understand it, frankly. Does this just happen to have a relationship to a region of the country? Is this a regional element or is it an amendment that would have an effect, say, within a state or within a community? If you have two hospitals across the street from each other and for identical circumstances and identical patients, identical health problems, one keeps them in for a week and the other keeps

them in for five days, would it affect that, or is this just a regional difference we are talking about?

Mr. Contantine. Not reasonable. I think there is a regional pattern that the Senator is pointing out, but there are individual hospitals in all regions which probably would meet Senator Packwood's test.

Senator Danforth. What is the average related to -- supposing one hospital treats a lot of people who have tonsillectomies and appendectomies and so on. Another hospital just happens to have a lot of patients who have, say, cancer or TB. How would that work?

Mr. Constantine. I think that was my earlier point of the case mix. However, Senator Packwood's amendment would operate until such time as there is a proper case mix and ultimately when they have the case mix methodology by 1981 or 1982, that will automatically adjust for those considerations that you are raising, Senator.

Until that time, however, when you can adjust for those kinds of unusual differences where a hospital does have unusual case mixes relative to similar hospitals, Senator Packwood's provision would function.

Senator Danforth. Until that time, would there not be under this sort of a scheme a sort of -- I do not want to argue with you; I do not know whether or not my understanding is -- one of the problems with hospital costs is that you have a lot of

expensive hospitals. There is great pressure on the doctors to fill the hospitals with patients in order to pay for their overhead.

Would there not be a lot of pressure on the hospitals under this kind of a scheme to have a tremendous number of short-term patients to admit anybody who has a high fever for a couple of days?

Senator Packwood. No, because first you can take your option. We are not saying we are going to shift from what the bill says to what I am suggesting. For whatever reason -- usually average stay in 1977 in the United States was 7.6 days; Alaska, 5.1; Colorado, 6.8; Georgia, 6.4; Hawaii, 7.1; Kansas, 7.6; Montana, 6.4; Oregon, 6.2; Texas, 6.6; Wyoming, 5.2.

I do not know why they stay shorter terms in western hospitals on the average. The western hospitals claim a higher per diem cost and more intensive care but a shorter stay. So all this bill does is give them the option of taking either what the bill presently says or what I am suggesting, which is a shorter stay average.

I hate to tell you what Missouri is in terms of the average, but it is not going to change what Missouri is going to do. You are substantially above the average on length of stay, for whatever reason.

Mr. Constantine. We have another provision in there that allows authority for unusual adjustments where a hospital

apparently is manipulating its patient flow and mix and so on. I guess that would take care of where they intentionally did it.

The other things are factors relating to age and population. In some of the midwestern states, we have a substantially higher proportion of older people, younger people. Those kinds of things operate -- low income population in relation to the total population, all osrts of population variables go into it.

You can have a shorter stay. If you have a high rural population they tend to stay longer if they have to travel distances to stay in occupancy levels of hospitals, as you pointed out.

Senator Danforth. What are the options? Suppose that a hospital is running a variable mill of getting patients in and out as fast as it possibly can. What are the options that Senator Packwood's amendment would give that hospital?

Mr. Constantine. That hospital would have the option -- the Department could find under its authority that it was manipulating.

Senator Danforth. Tell me what the options are if the Department did not make any finding. How does this work?

Mr. Constantine. They would get a higher allowable per diem for the routine costs in recognition of the shorter stays than they ordinarily would receive.

Senator Danforth. I do not understand why that makes any sense at all. It seems to me that one of the points of hospital

cost containment is to keep people who have very marginal problems out of the hospital and only admit people who absolutely have to be in the hospital. Therefore, maybe we should be encouraging for the hospitals only to admit people who have very serious ailments who are going to be there for a relatively long period of time.

Mr. Constantine. You have some other provisions.

Senator Talmadge. That is the thrust of the bill, Sentor Danforth.

Senator Danforth. And this is contrary to the thrust.

Senator Packwood. No. It is a pattern of service in western hospitals.

By the way, I did not read Oklahoma. Oklahoma is substantially below the national average also in hospital stays. Only Missouri in this whole group.

Senator Danforth. We are a tough people in Missouri. We only go to the hospital in emergencies.

Senator Packwood. You are sick people.

Senator Talmadge. Are you ready for the question? Any discussion on the question? The question is on the Packwood amendment.

All in favor, please say aye.

(A chorus of ayes.)

Senator Talmadge. Opposed, no?

(A chorus of noes.)

Senator Talmadge. The ayes have it. The amendment is agreed to.

Senator Nelson. Mr. Chairman?

Senator Talmadge. Senator Nelson.

Senator Nelson. I wonder if I could make a comment. I got here late. It was my understanding we were dealing with countervailing duties first, and I did not expect you to get to this this soon.

I personally think that it is inappropriate to be taking up Section 2 without taking up the administration cost containment bill at the same time, because they are dealing with the same subject matter.

Now, I must say -- and I said to the Chairman when I ran into him in the hall -- that I was rather puzzled, if not shocked, to look at a staff document which is entitled "Health Care Cost Containment and Other Proposals" and the President's proposal which passed the Senate last year and is pending before the committee did not even rank by the staff an asterisk explaining why they left it out.

I know that the staff and Jay Constantine want to pass that bill and that one only, and pretty clearly do not want to deal with the President's bill, but I do not think that is their option. I think that is the committee's option.

Now, Section 2 last year -- I happen to agree with a whole lot of things in Senator Talmadge's bill, but not Section 2 -- and

last year, on the floor of the Senate on the roll call vote, the administration's cost containment compromise bill was voted in as a substitute for Section 2.

Now the staff has made a draft without mentioning what we passed on a roll call vote last year. So, be that as it may, I told the chairman, I am astonished by the procedure. I think the President of the United States and the Senate is entitled to have another look in the Finance Committee at a proposal which passed last year which the President has made a major case out of. We ought to discuss it, go through the mark-up session, but not be pre-empted by taking out Section 2 here and eliminating any consideration of the President's proposal.

I would move that we take up the President's proposal and deal with that section by section. Let us not back into it this way. I am totally in agreement -- not totally. I may have some minor differences with Senator Talmadge's bill as to Section 1, but not Section 2, and I think we are entitled to deal with that, not to be pre-empted by a staff document that is put out without consulting a single member of the U.S. Senate here that I know of.

Mr. Constantine. Senator, there is Document C in the folder which was sent out also. It contains a discussion of the administration's proposal.

Senator Nelson. That little sheet?

Mr. Constantine. It is a pretty big sheet, Senator.

Senator Nelson. It did not rank getting in the blue book.

Mr. Constantine. We ran out of room.

Senator Nelson. Did you run out of paper?

Mr. Constantine. They are separate proposals. That is why this one is a separate document for the folder.

Senator Nelson. I see the document; I can see the difference. This is entitled "Health Cost Care Containment and Other Proposals, Committee on Finance, United States Senate," and it goes around to everybody as though this is the document we are dealing with, and not the President of the United States.

All I am saying is that we are now in Section 2; that is hospital cost containment. We passed the President's bill last year; we ought to be taking that up at this stage of the game. That is all I am saying.

Mr. Constantine. Senator, by way of an inadequate explanation, these proposals deal with reimbursement reform, not with regulation of hosiptal revenues for all payers. This just deals with how Medicare and Medicaid pay hospitals.

Senator Nelson. That was the issue we were on last year and had a vote on the Senate floor. The Senate decided you ought to cover all costs, not just Medicare and Medicaid, and that is the issue again this year.

Mr. Constantine. Senator, there were two parts to the bill the Senate voted last year: one, the proposal that was offered that the Senate approved, included provisions similar to these

plus an overall regulatory approach.

The bill this year, the President's proposal this year, is only the overall regulatory approach without the reimbursement, Medicare-Medicaid reimbursement reform. Where it was a comprehensive reform last time, it is now limited to regulatory matters.

We just divided the two things up, as apparently the Administration has.

Senator Talmadge. The two bills are not contradictory.

Senator Nelson. Yes. Section 2 covers hospital cost containment questions.

Mr. Constantine. Senator -- well, I guess it is really how we pay hospitals under Medicare and Medicaid. You could adopt the S. 570, the administration proposal, the Kennedy bill and it would still not solve the problems that Section 2 seeks to deal with. It does not deal with how we reimburse under Medicare and Medicaid.

Senator Nelson. It deals with cost containment questions that are involved in the whole cost containment business, separate from Section 1, and all I am saying is that we should have before us the administration bill. Now we are in hospital cost containment questions; we ought to be talking about them along with Senator Talmadge's proposal.

There is not much sense in going through Section 2, then turning around and taking up a brand new bill on the whole subject matter of hospital cost containment.

Mr. Constantine. We talked yesterday in your office. We talked about when you thought it would be appropriate for you to raise the administration's proposal, and you will recall that we said that after you deal with any kind of reimbursement reform, that one choice was when Section 2 was disposed of, you could then possibly offer the administration proposal.

Senator Nelson. That is not what I said. That is what you said that you thought should be done. You came in and discussed it and offered your opinion, and that was that.

All I am saying, when you are into cost containment, let's take up the administration bill, and secondly, I am puzzled by your failure to deal with the President's bill.

Here we have a President -- we passed it last year, and you treat his on a piece of throwaway paper but you do not include it in the document entitled, "Health Care Containment and Other Proposals." I want to talk about that one. It is the administration bill.

Mr. Constantine. Senator, just by way of apology -- and we will apologize if we did not do it the way you wanted it --

Senator Nelson. Not the way I wanted it, the way the President's proposal ought to be considered.

Mr. Constantine. Last year it was combined in one proposal, last year, two proposals. It is a divided matter. I assure you that we devoted as much time to the sheet here as went into the blue book.

We had as much time spent on it as Document B.

Senator Nelson. I will not comment on that. You go ahead. I just want to deal with the President's bill and I think we ought to be dealing with it in this section and I am a little dismayed by the procedures of the staff in putting out this document and leaving the President's proposals off it. I think all of us ought to be.

Senator Talmadge. I understand there are two proposals before the committee, Senator Nelson. One deals with the hospital containment, the President's bill, and the other is reimbursement on the Medicare-Medicaid. They are not contradictory; they are both aimed at the same objective, as I understand it.

Senator Nelson. If we can get to Section 2, we ought to be dealing with the whole cost containment question. I am not quarreling about the first part. As a matter of fact, I support the Senator's position. The amendment last year was to Section 2.

Senator Talmadge. You may offer an amendment for a substitute. It is in order at this time.

Senator Nelson. It does not make any sense in this bill to go to Section 2 and come back and start on another proposal on hospital cost containment.

Senator Talmadge. Do you want to offer a substitute?

Senator Nelson. Yes, I do.

Senator Talmadge. Senator Nelson is recognized.

Senator Nelson. I offer the administration bill that is pending before us as a substitute and I would like to ask the administration to take up, section by section, the principles involved so that we will have the whole issue before us.

Senator Talmadge. Is there anyone here from the administration?

Mr. Gage. My name is Larry Gage, the Deputy Assistant Secretary for Administration at HEW.

I may say first, by way of introduction, last year Senator Nelson and Mr. Constantine are both correct. We did substitute for Section 2of last year's Talmadge bill. However, we did incorporate the regulatory reforms contained in Section 2 into that amendment and those are reforms to the basic Medicare-Medicaid reimbursement system which we do not consider incompatible with hospital cost containment. They are not incompatible with the bill we have presented to you today.

Senator Talmadge. Would you yield at that point?

Mr. Gage. Yes.

Senator Talmadge. The committee reported two bills to the Senate. It would not be incompatible if the committee did?

Mr. Gage. If the committee reported two bills to the Senate that is correct, sir; they would not be incompatible. The committee report, S. 570, introduced and reported, S. 505 and S. 507. None of those would be necessarily incompatible.

There are a number of provisions in S. 505 and 507 which

require debate on their own merits, but they would not be incompatible.

Senator Talmadge. I asked Senator Nelson if that answered his question and to do whatever he wants to do at this point.

Mr. Gage. Excuse me. We do believe that because of the way in which these proposals were considered last year that considering Section 2 in the abstract and considering a couple of the other items and including one item that had been on the staff buffet in the past without considering the principles of hospital cost containment in the administration's bill might well be inappropriate.

We might suggest that if the committee wants to proceed through the rest of the Talmadge bill at this time and then return to Section 2, we would be amenable to that method of procedure but we think Section 2 should be discussed in the same format and the same context.

But they are not incompatible and we would not necessarily need to see the administration's bill substitued for Section 2. We believe that they can coexist peacefully.

Senator Nelson. Did Section 1 get finished?

Senator Talmadge. We started on Section 1.

Mr. Constantine. Section 1 is the title.

Senator Talmadge. Mr. Constantine?

Mr. Constantine. Section 1 is the title of the bill.

Senator Talmadge. The first provision legislatively.

Senator Nelson. I mean the 39 sections that you had on Medicare. Have we adopted them and agreed?

Senator Talmadge. We have not adopted anything. Mr. Constantine just started explaining. He was on Section 2.

About the time you arrived, I believe we adopted an amendment proposed by Senator Packwood and we were waiting for you to come before we put the vote on Section 2.

Senator Dole. Mr. Chairman?

Senator Talmadge. Senator Dole.

Senator Dole. I move that we move to Section 3 of S. 505 and then return to Section 2, after we reach some agreement with Senator Nelson. Would that be all right?

Senator Nelson. Yes, that is fine. I just want the containment question considered, along with Section 2, because I think that is important.

Senator Talmadge. I thought what we would do, gentlemen, if it meets with the approval of the chairman, take it up section by section, tentatively approve any section that we dealt with subject to review at any time, and Senator Dole has made what I think is a pretty good suggestion. Senator Nelson will not lose any procedural rights by anything the committee does.

We can pass over Section 2 as long as Senator Nelson wants to pass over it.

Senator Nelson. That is fine with me. I just want to take up the hospital cost containment proposal of the administration at

the same time that we take up Section 2, because that is where we dealt with it on the floor of the Senate.

Senator Talmadge. And that right will be guaranteed to the Senator.

We will move over from Section 2 now to Section 3. Mr. Constantine?

Mr. Constantine. Senator, Section 3 provides a series of payments to promote the closing and conversion of underutilized facilities. I do not know the provision approved by the committee in October. It is designed, for example, where you have a hospital financed with revenue bonds of some sort and it is underutilized and they have debt and they close down and they have no means to repay debt. However, it may be in the public interest to just close that hospital down.

Senator Talmadge. This is the section dealing with surplus beds?

Mr. Constantine. Yes, sir. Where the hospital applies. In the first two years, not more than 50 hospitals may do it, so any bugs or manipulative practices can be handled.

This is a provision that is generally supported. The House was generally enthusiastic about it. They think it is rational. It does not force anything on anyone.

Senator Talmadge. Senator Dole?

Senator Dole. It was just called to my attenion -- maybe it has been clarified -- that we need to clarify the end report

language that hospitals may apply for conversion payments before the conversion or closing takes place.

Senator Constantine. Yes, sir. That is a valid point.

Senator Talmadge. Any objection to accepting the Dole provision? Without exception, so ordered.

Is there any objection to this provision? Without objection, Section 3 is tentatively approved.

Mr. Constantine. Section 4 deals with improvements of the approval process for purposes of Medicare and Medicaid reimbursement. Under present law, where a capital expenditure exceeding $100,000 is disapproved, Medicare and Medicaid may not reimburse for capital costs associated with the disapproved expenditure, interest on debt, return on equity, and so on.

This amendment, by the way, is identical with the provision approved by the committee last October. The changes made here are several. One is that it must be an approved expenditure to be eligible. Rather than just approved, approved to be eligible for capital reimbursement. Secondly, if it is not an approved expenditure, not only do we disallow the capital costs associated, but the direct operating costs associated with it so that if, for example, in a state or in an area a specific capital expenditure is disapproved and a benefactor has signed to donate the equipment or facility, that is not much of a deterrent, but if you reimburse the operating costs, that slows it down quite a bit, associated with a nonapproved expenditure.

Another section is designed to deal with those few areas of the country where you have overlapping political jurisdictions, such as the D.C. metropolitan area, where the construction of beds in suburban Maryland or suburban Virginia significantly affects what happens in the District. The District, for example, has a substantial surplus of hospital beds and they are building in the metropolitan areas.

What this says is that unless the HSA's, the planning agencies, in that medical service area agree, they approve it or disapprove it, and the facility has to appeal to the Secretary under those circumstances for approval, simply to avoid an adjoining area totally destroying the planning next to it.

There are probably about ten or twelve areas like that in the country.

Senator Talmadge. Any questions? Any objections?

Senator Dole.

Senator Dole. I do not have an objection, but I understood that the administration might have slight modifications to that section.

Senator Talmadge. Does the administration have any objections?

Mr. Gage. Yes, sir.

We are considering capital expenditure legislation both in 1122 and under the Health Planning Act. Our concern in this case is the differentiating operating expenses associated with

facilities being planned and being able to separate out capital expenditures might be very difficult and we might want to consider various surrogates for the operating expenses under these circumstances.

One of the suggestions we have been considering, for example, we are currently disallowed depreciation. You may want to disallow ten times the depreciation, if we have an opportunity to discuss it.

Senator Talmadge. I do not understand what you are driving at. Can you state it in plain English?

Mr. Gage. I beg your pardon?

Senator Dole. Do you have any suggestions or any recommendations?

Mr. Gage. No, sir. We have legislation. We are in the process of considering it at HEW. We have not yet produced those legislative proposals.

Senator Talmadge. Do you have any suggestions as to how this ought to be modified?

Mr. Gage. I think that probably we can discuss this with the staff. One of the suggestions is to go from operating expenses to some surrogate for operating expenses, such as ten times the limit.

Senator Talmadge. Would you comment on that, Mr. Constantine?

Mr. Constantine. Mr. Chairman, that may or may not have any

relationship to anything. If they have a problem, or the wording were changed to "estimated" --

Senator Talmadge. I am sorry. I am having trouble hearing. May we have order?

Mr. Constantine. If the language were changed to "estimated", direct operating expenditures --

Senator Talmadge. Would that help?

Mr. Gage. Yes.

Senator Talmadge. Is there any objection to the modification given by Mr. Constantine?

If not, it is accepted without objection.

Mr. Constantine. The approval for expenditures of $100,000 or more, this would change it to $150,000 or more, conforming to the planning act. There are other minor conforming things.

There is one thing we should point out to the committee. Unlike some of the other planning legislation, this does not exempt HMO's.

The thesis of the committee in 1972 when it first did this was that no capital expenditures, no one should be exempt, that there is an appropriate appeals process that all types of facilities of those kinds of expenditures should be subject to the approval process.

There is no favorites playing.

Senator Talmadge. Any objection to that?

Mr. Constantine. That may be contrary to the administration's

policy.

Mr. Gage. It is not contrary to administration policy that HMO's be treated equally for purposes of capital expenditures in general. The problem has been discrimination against HMO's which has caused us to issue regulations under the HMO program to guard against undue discrimination, to establish a new facility in an area even where there is a number of excess beds. It is denied the right or ability to purchase, that we want to be careful.

The HMO's are not discriminated against.

Senator Talmadge. Can you comment on that, Mr. Constantine?

Mr. Constantine. Senator, it just says "facilities." There is an appropriate appeals process.

Senator Talmadge. Facilities would include HMO's?

Mr. Constantine. Yes, sir. The facilities of an HMO and the problem of discrimination is just as great as for any other type of organization moving into an area. There is an effective appeals process for everyone under that.

Senator Talmadge. Senator Danforth?

Senator Danforth. Why not discriminate in favor of HMO's? Why not try to encourage them?

Mr. Constantine. The problem with that is that there have been situations for example where you have a hospital in an area that is running at 80 percent occupancy and, say, Kaiser wants to move into that area to build another hospital to compete

and that has serious implications on the existing hospitals by ability.

I do not know what the answer is. I am simply saying, if you favor them under those circumstances, you may very well be doing harm to an existing facility.

Senator Danforth. That may be, but there are those who think that one of the best ways to control excessive medical costs is to encourage the development of HMO's. There are a lot of people who feel that way, as a matter of fact.

Mr. Constantine. Senator, we have held hearings. The committee held hearings last year. There are a lot of problems with the HMO's including many of those which are Federally-funded. The permanent Subcommittee on Investigations delivered an extensive report and I believe Senator Nunn testified as to that.

We have criminal elements in there.

Senator Danforth. There might be some butchers and all kinds of crooks involved in any kind of medical program.

Senator Talmadge. I may say to the Senator, if you would yield at that point, we found excellent HMO's and we have found some bad ones. The same thing, I think, is true of hospitals generally. Most of them are good but we did find some efforts of the Mafia to infiltrate the HMO's.

Some Georgia crook went to Missouri --

Mr. Constantine. I think it was Kansas.

Senator Dole. Probably.

Senator Danforth. That took the wind out of my sails. I do not know about all of this. What I am concerned about, if HMO's -- I am not talking about an ad hominem argument; I am talking about HMO's as a mechanism for delivering health care which is very efficient.

Senator Talmadge. I do not think this relates to that issue.

Senator Danforth. W at I am saying, if HMO requires facilities to get off the ground and if we are trying to encourage HMO's, then maybe we should treat them differently than hospitals for the purpose of this bill. At least maybe we should be reluctant to include them at this time, if we are trying to nurture the concept of HMO's.

Mr. Constantine. There are other laws and appropriations that give them special treatment, special support. There are other statutes and appropriations that do provide special assistance to HMO's.

The problem, Senator, is to exempt them from any kind of review where they can actually -- you may actual have a delicate balance in an area. If you exempt HMO's, from review, not discrimination, you may very well upset what an area has striven for, a fairly orderly distribution, just as anybody else.

There are other preferential statutes in terms of HMO development and funding. This is simply to avoid an HMO's doing

something which distorts an area plan. It just makes them subject to the same rules as anybody else.

Senator Danforth. What is the administration's position?

Mr. Gage. I think that perhaps our concerns would be somewhat alleviated if two points are made clear in adopting an amendment of this sort. This is limited to facilities, does not go to the start up of an HMO itself or other aspects which have traditionally been used, both in the health-planning law and under Section 1122.

Secondly, the concern about discrimination continues to exist. Perhaps if there were some tightly-drawn exception permitted where the Secretary did find that discrimination was taking place, we could probably live with a provision that gives the Secretary the authority to grant an exception where he finds discrimination exists.

Mr. Constantine. There is an appeals process to the Secretary now under Section 1122.

Senator Danforth. Mr. Chairman?

Senator Talmadge. Senator Danforth?

Senator Danforth. I will move to exclude HMO's from this section.

Senator Talmadge. Does the Department have any views on that?

Mr. Gage. Once again, I do agree with Mr. Constantine that the Department's policy is not to exclude all HMO's from review

but to guard against discrimination. I think that an amendment on the order of giving a little more flexibility specifically, as Mr. Constantine points out, there is an overall review process.

Senator Talmadge. Does the Department support the views of Mr. Constantine or Senator Danforth? Who?

Mr. Gage. Well, Mr. Chairman, I like them both.

Senator Talmadge. You cannot have it both ways. You have got to make up your mind. Can you make it up? You have ten seconds to make it up.

Mr. Gage. May I have a little music, please?

Senator Dole. Why do you not work it out with the staff.

Senator Talmadge. Let's tentative approve it if there is no objection. Senator Danforth has an amendment to strike it. I would suggest that the Danforth amendment is rejected. Then we can tentatively approve it and the Department can send us its view.

The question arises on the Danforth amendment.

Senator Danforth. I missed something in discussion, Mr. Chairman.

Mr. Gage. I was saying my ten seconds was about up, Senator. On balance, I would probably tends more towards Senator Danforth's position, if there is not any kind of clear recognition of problems faced by HMO's.

Senator Talmadge. The question is on --

Senator Chafee. Mr. Chairman, if I may state one thing. In the administration's bill, I believe they do exempt HMO's, do they not?

Senator Talmadge. Can you answer that?

Mr. Gage. If you are talking about our health planning bill, we do exempt from hospital cost containmnet, we do exempt HMO facilities, strictly HMO facilities, more than 75 percent of their patients.

Senator Chafee. I think to adopt the Danforth amendment in this particular case is going to upset a delicate balance and, as Mr. Constantine said, you are liable to have a situation where you have a hospital there that is not operating at full capacity. Then to bring an HMO in there which is not controlled, it seems to me can underline the very efforts that we are attempting to achieve here.

I o not get the administration's rationale, even though you are not very vigorous on this, for turning towards Senator Danforth. We have other ways in which we are encouraging HMO's. We are providing financing for them, for example. But to exempt them here -- it causes me problems.

Senator Talmadge. Senator Durenberger?

Senator Durenberger. I represent a community that, without this regulation, is doing a good job of encouraging and balancing both of them, so I do not see the fear that we do have the Mafia helping us one way or the other. I am inclined to

support Senator Danforth's motion. I suspect the truth lies somewhere in between the two and I would rather vote on a better thought-out provision than voting one way or another.

Senator Danforth. Why do I not withdraw it, Mr. Chairman. We will see if we can work something out.

Senator Talmadge. Let's do this. If it is the will of the committee, we will tentatively approve it, subject, however, to the administration's making some recommendations to the staff and then considering it further at a later date. Is that agreeable.

Is there any objection?

Without objection, then, it is tentatively approved with that proviso.

All right.

Mr. Constantine. Section 5 was an attempt by the sponsors of the legislation to deal with a serious problem of decreasing acceptance of assignments by physicians under Medicare and assignment, as you know, is where the physician agrees to accept the Medicare reasonable charge as the full charge and bill the patient only for any deductibles or co-insurance amounts.

The allegation is that Medicare payments lag, and so on, and there just is a decreasing amount.

On the other hand, there was the problem of the tremendous costs of Part B of Medicare. I believe the general revenue share of that, the physicians' side, is well over $8 billion

now, plus the contributions by the elderly.

This was an attempt to say, to encourage physicians to become participating physicians, just another category voluntarily, and a participating physician is one who agrees to accept assignments, that is the Medicare reasonable charge, on all of his patients.

In return for that, he would receive a $1 per visit, essentially $1 per visit, administrative cost savings allowance, plus save essentially another $1 in paperwork because there are simplified billing listings, simple listings, and so on.

The AMA has opposed this. They are opposed on principal. They feel that everybody ought to be paid at the Medicare rate. There does not seem to be much support for it, except from the rural doctors, that this was discussed within Mississippi and Georgia and Colorado and the people who charge maybe $10 for an office visit, or $7 or $8 or $9 who felt that this represented a significant increase in their net from a visit, not an increase in their charge.

In view of that lack of organized support for it, the staff simply recommends that this provision be deleted. It costs money -- yes, sir?

Senator Talmadge. What about the paperwork?

Mr. Constantine. It would save a lot of paperwork.

Senator Dole. Could we just not strike the provision that is going to be up above $94 billion by fiscal year 1981. That

is going to be a cost. We could delete that, but save that part of Section 1868(b) so we can expedite processing and claims.

Would you retain that provision?

Mr. Constantine. Yes, sir. That is all right. Actually, there is no reason why they should not be doing that now.

Senator Talmadge. Let me ask you if I understand what that does. A doctor now has to have a separate piece of paper for every office visit he has.

Mr. Constantine. Yes, sir.

Senator Talmadge. What you would do is have multiple visits on one piece of paper. Is that it?

Mr. Constantine. Yes, sir. Then he could just have a listing of the patients who visit. He could have one signature on file instead of getting every claims form signed, items of that sort.

The idea was the Federal Treasury does not have that much to give away. If it could simplify paperwork, it would save him office costs plus an administrative cost savings allowance that would encourage more physicians to take assignments on their Medicare patients.

That was the thesis.

Senator Talmadge. Any objection to eliminating the provision where we could give them $1 per patient, strike that, and agree to the short form of the report?

Mr. Constantine. A simplified approach.

Senator Talmadge. Without objection, that is approved.

Does the Department have any comment?

Mr. Gaus. I am from the Health Care Financing Administration. We would be pleased to see the $1 per bill provision dropped. We hope, however, as some indication that even the more simplified billing -- I put that in quotes -- may not really be a savings.

Senator Talmadge. There would not be any savings for the Department. The savings would be for the doctor and the multiplicity of pieces of paper, the secretarial work.

Mr. Gaus. I think we would be prepared to try it. Some of our discussions with the physicians have said, however, that they have moved to automated billing services anyway, and there may not be a great savings to them, but I think we are prepared to try.

Senator Talmadge. I read in the paper where Secretary Califano was really declaring war on paper over in your Department. Do you not share his views?

Is there any objection?

Without objection, approved as modified.

Mr. Constantine. Section 6 is the Hospital Associated Physicians. You all have been lobbied the last few days; we have been getting calls, primarily from the pathologists. I guess the staff ought to face this one head-on. We dealt with it for a lot

years.

Yes, sir?

Senator Dole. I think that I have been even offered a free autopsy by some of the pathologists.

Senator Talmadge. You did not buy that, did you?

Senator Dole. I want to defer that for awhile. I think that there are some possibilities to compromise this section which would not do violence to the section and still satisfy what may be some reasonable demands by some of the pathologists.

I think the appropriate time after you have explained, I would like to make a recommendation.

Mr. Constantine. This provision was worked out with the active help and cooperation of the American College of Radiology and the Society for Anaesthesiology. It dealt with problems in their specialties: excessive income unrelated to professional time and effort simply by a contractual arrangement where they got a piece of the action, regardless of whether they were present.

The anaesthesiologists had a somewhat different problem. They had some percentage arrangements. In many cases -- not many cases, not infrequently, they would hire stables of nurse anaesthetists and the nurse anaesthetists would administer the anaesthetic and the anaesthesiologist would bill, and so on.

The leadership of the College of Anaesthesiology agreed and worked and should be commended for responding to that, as

should the radiologists who were getting excessive incomes from percentage arrangements.

The percentage arrangement, in terms of the pathologist, deals primarily with clinical laboratory services. It does not affect anything they do in terms of personal patient care, where they do tissue studies or consultations. They are not affected by that; they are perfectly free to bill under this provision.

The problem is in the areas where the work is done by others in large part, the enormously automated, heavy automation of laboratory tests and so on, where you get 30 or 35 percent of the gross as that stuff piles up.

Arthur Anderson did a study for HEW which shows the difference and it was a rather good cross-section, and what happens? These are 1975 earnings of full-time equivalent hospital-associated physicians. Pathologists on salary averaged $49,200 with 10 percent of that having incomes of between $75,000 and $150,000. Pathologists in a hospital on a percentage arrangement offered 138,200 with 52 percent of them getting between $75,000 and $150,000 and 31 percent getting $150,000 or more.

This was in 1975.

When they visited with us, we suggested that a fair celing might be twice the pay of a United States Senator, but they did not think that was high enough, at that time.

Additionally, the provision in the bill also is based

upon a resolution of the American Medical Association in 1977 which says that hospital associated specialists are entitled to charges for services that they personally provide. They also are entitled to equitable and fair compensation in direction and supervision of the hospital department personnel. That is their general supervisory activities, just as an M.D. who is the administrator of a hospital does not get a fee for every patient in the hospital's beds. They are not working on a commission as well.

The board of the AMA in the resolution they presented also had some language saying, for example, percentage arrangements which are unrelated to the amount of time expended or the skill, education and professional expertise of the physician and which resulted in windfall earnings at the expense of patients, third-party payers and taxpayers, should be avoided.

The administration has approved similar proposals. The Ways and Means Committee of the House and Interstate and Foreign Commerce have expressed concern, just as, I think, the Subcommittee on Health of the Human Resources Committee banned percentage arrangements under the Clinical Laboratory Improvement Act.

The suggestion has been made, I believe, that Section 19 of the bill which deals with other types of percentage arrangements be used to deal with that and Section 6 be dropped. The problem with that is Section 6, apart from defining the anaesthesiologist's services in accordance to what the administration

thinks is fair and what the leadership of the anaesthesiologist thinks is fair, also deals with a definition of these supervisory services, the nonpatient care services as hospital costs. If you shift if, if you simply ban the percentage arrangements, you would have the pathologists direct billing for every urinology, every blood sample, for the total thing. It does not quite get at it.

It may be modified to do if you carried over some of the language from Section 6 to Sectin 19. This is one, in all honesty, that all of us unanimously have dealt with in one form or another. It is one of the worst areas of waste, if not rip-off, in the Medicare program. It stood out like a sore thumb.

The savings in the bill are approximately $50 million a year the first year. The administration has proposed it.

Senator Talmadge. Does the administration support this provision?

Mr. Gage. Yes, sir. We strongly support this and we think everything Mr. Constantine says is correct. We have instances -- staff tells me one case of a Philadelphia hospital where total Medicare A & B hospital costs increased from one year to the next by over $1.5 million, from $950,000 to $2.4 million when they went from a combined billing and paying salaries of the physicians to a lease type of arrangement. We think this is a problem and we agree this should be adopted.

Senator Talmadge. Any questions?

Senator Chafee. We adopted this last year on the floor of the Senate.

Mr. Constantine. We did make one more change in there. The AMA raised some questions. We want to suggest that before you get into the substantive, there was apparently some ambiguity as to other types of physicians in there and the services incidental to a physician's service.

Bob Hoyer has been working with the AMA on that. We believe that language is satisfactory to avoid any unintended fall-out.

Senator Talmadge. Senator Wallop?

Senator Wallop. Mr. Chairman, this is sort of a classic case of babies and the bathwater. I do not quarrel with your scandal-ridden hospitals in Philadelphia. I have got to say, Mr. Chairman, that I object to Mr. Constantine's cynicism about the profession of pathologists. Maybe twice the pay of a U.S. Senator may not satisfy the people you are talking to, but people in my state do not make even any percentage of that.

To heap scorn on them does not do any good.

I understand the AMA's worry about physician-related services have been taken care of. While you did quote part of their testimony, part of their comment, then it should be made clear that although this amendment comes under the heading of hospital-associated physicians the amendment itself is not so limited and the placement of this amendment under that heading is misleading. In fact, this provision amounts to a general

definition of physicians' services in Section 1861.

Is that what you intend it to take care of?

Mr. Constantine. That is right.

Senator Wallop. May I just point out that one of the real worries that we have, while you may contain the cost under Medicare nationwide by a blanket solution of this kind, it may make it in fact virtually impossible for people in a state like Wyoming to either obtain the services, or they will be more expensive by having to ship them to Denver to receive any pathological services at all.

That is the risk. That is the water in which we are wading.

I am sure that is not the intention, but whatever we do we have to be very careful not to eliminate the practice of pathology in rural states which, frankly, in many instances, cannot justify having a pathologist in a hospital but, on the other hand, you cannot justify not having one either. In order to send somebody to Billings, Montana, Denver, Colorado and Salt Lake City -- you have family-associated expenses with that, staying in hotels and motels, travel and other things.

I think whatever we do -- I am sure it is not your intention, but I do not want to throw all the babies out with this particular piece of bathwater.

Senator Talmadge. In these small, rural hospitals it is necessary that a pathologist serve more than one. As a matter of

fact, I think it is the practice in small rural hospitals, they serve sometimes several of these hospitals, as I understand it.

Senator Wallop. In many ways, the only way that condition can exist is --

Senator Talmadge. I do not think that is the issue involved here. The issue involved is whether or not pathologists will get a percentage of the gross, whether they will be paid on a fee for service basis. I share the Senator's view. I think pathologists are probably the most important people associated with any hospital. If you cannot find out what is wrong with you, they cannot treat you. It comes down to that.

I think we all share that view.

I believe Senator Dole wants to be recognized on this issue.

Senator Dole. I want to reaffirm or re-echo the statement of Senator Wallop. We can always bring up the worst-case scenario. We could kill the food stamp program, if we wanted to get into that. We could cite a lot of rip-offs in every Federal program. I assume there must be at least one pathologist who has probably exploited the program.

I supported the provision last year; I am not trying to back away from that. I visited with one of these so-called rural pathologists yesterday who serves ten counties in my state. That would not be the case in some urban area. That is what he

does. He is not flying around in airplanes with a percentage arrangement with each hospital. I think he has a percentage arrangement maybe with one. I have got to believe that he was sincere, saying what we are trying to do is redefine pathology, redefine what pathologists should do, trying to redefine that aspect of medicine.

I think that does cause me some concern. Maybe they had a selfish interest. They kept suggesting we were talking about money; maybe they were really talking about what it meant to them.

But that is what I thought. Maybe Section 19 may be broad in order to take care of the abuses without destroying the profession.

Senator Talmadge. If you would yield at that point, I had a group of pathologists visit me and they were dedicated, honorable people. I happen to know them. They happen to come from my state.

I sent them over to the staff because the staff knew more about it than I did, frankly, and I believe you made some modifications and revisions. What did you do as a result of that? Maybe it will throw some light on the problem.

Mr. Constantine. For one thing, we made changes to clarify that there was spill level.

Senator Talmadge. In this section or Section 19?

Mr. Constantine. Section 6. That is what they were discussing when they came in. We did that.

Secondly, the definition of a pathologist's services and what they do, Senator --

Senator Talmadge. Speak into your mike.

Mr. Constantine. The definition of the two types of services came out of the guidelines of the American College of Pathology verbatim in the bill as to the distinctions in the services. As far as the rural areas are concerned, Senator Wallop, there are two alternatives. One is just write a blank check, you know, and pay whatever they choose or, as the bill says, you certainly are free to bill for the services he renders and the hospital to reasonably compensate him for the services.

Senator Talmadge. When you are talking about a service he personally renders, let's have a little clarificationon that. It is my understanding that you will have one pathologist -- sometimes they have a laboratory with maybe dozens of people working and they take a blood sample for example. It is amazing what they can tell from your blood sample now. They can read that and get a reading on every vital organ in your body, as I understand that. Is that not right?

Mr. Constantine. I will accept that.

Senator Talmadge. How is a pathologist to be paid for what these complex machines do and what these technicians do? How does he determine what his fee is? Maybe he has $200,000 invested in the equipment; maybe he has a dozen employees involved. Then he gets this reading through machines. I assume he has to analyze

it. How does he determine his fee?

Mr. Constantine. If he does analyze it himself personally, he bills for it. That is not affected by this. It is the host of routine tests that, in many rural areas, are done by Ph.D. medical technologists.

Senator Talmadge. In rural areas, he may not have the machines. He may have to get a smear of blood and look at it through a microscope.

Mr. Constantine. They use a laboratory. People do the work in these laboratories. These are with Masters and Ph.D.'s. They testified here on that.

Senator, the definition came out of this, the guidelines for pathologists from the College of American Pathologist. It is their own definition of what their services are.

As far as the rural, really, we fail to see why a reasonable arrangement would deter pathologists from going into rural areas. That is, that he can certainly bill for the services he renders and the hospital compensates him reasonably for his general range of activity, including his travel and all of those other miscellaneous expenses.

Senator Talmadge. Would he be paid on his investment in equipment?

Mr. Constantine. That is a separate thing of course,yes, sir.

Senator Talmadge. That would not preclude this?

Mr. Constantine. No, sir.

Senator Talmadge. Senator Boren?

Senator Boren. The staff has said that the objections to the American Medical Association to the definition of physicians' services has been withdrawn. I want to know how this problem has been taken care of.

I received a unanimous resolution from our own medical association's House of Delegates, not objecting to try to end the abuses, but expressing concern over the very point of the defining physician's services. Also, they raised the point about rural medical care that Senator Wallop has raised.

I wonder how this matter has been taken care of, if, indeed, these assurances are correct.

Mr. Constantine. We will show you the wording. Bob worked on it with Senator Dole's staff and the AMA yesterday on that. If you want to look at the specific language --

Mr. Hoyer. What we did, we wrote the connection between all the things we were saying about the hospital-based physicians and the definition of physician services generally. This, I think, meets the objections of the American Medical Association.

Now, there is a strange drafting device in the Social Security Act. We tend to classify anything you pay for under a charge basis as physicians' services -- podiatrists, chiropractors, all of the things paid through the hospital as being characterized as not being physicians services.

What we made clear in this is that, although there are some services we would reimburse the pathologist for through the hospital, as when he is supervising the hospital technicians and the like, that nevertheless, physicians services. We did this to avoid any implication that we were redefining the practice of medicine.

I think this should be satisfactory to answer both of those points.

Senator Talmadge. Any further questions?

Senator Dole?

Senator Dole. Have these changes been agreed to?

Mr. Constantine. Senator, I have not go so far to say they have been agreed to. If the committee will give us permission, again tentatively, that the definition of physicians' services will be clarified to avoid misinterpretation of the scope of the provision, that will give us some time.

Senator Dole. I would be glad to work with Senator Boren and Senator Wallop to make sure this was clarified. If we can find some magic way, maybe, to solve the problem where you take care of the abuses and do not interfere with legitimate --

Mr. Constantine. It is really the system that is the abuse, the percentage arrangement unrelated to professional time and effort that gives rise --

Senator Dole. Why can we not slip it into the laundry in Section 19?

Mr. Constantine. It is possible to do that, but you would have to carry over some other language. You may be substituting another type of problem system.

Senator Dole. Right, but I think there is the possibility of solving the problem and still not do violence to some of the legitimate concerns that have been expressed. That is what we would like to work out, Mr. Chairman.

Senator Wallop. It is very difficult to read it as it is now.

Senator Dole. Let's set it aside temporarily and come back to Section 6 and we can work with Senator Boren and Senator Wallop.

Senator Talmadge. You want to pass this over temporarily? Without objection, so ordered. Section 6 will go over.

All right. Go ahead.

Senator Baucus. I wonder if I could ask what the appropriate time would be when I could bring up a minor amendment to Section 5?

Senator Talmadge. You can bring it up right now.

Senator Baucus. My understanding, Mr. Chairman -- I was absent when the committee considered Section 5 -- that staff has suggested some minor billing adjustments and simplifications, et cetera for physicians who may or may not accept assignments.

My understanding is that the staff has a $1 per visit.

Senator Talmadge. That has been deleted.

Senator Baucus. Right.

I propose that staff work out language for pilot, demonstration projects, particularly in rural areas and areas of the country where the assignment rates are very low, to try to see if there is some way where we can increase the rate of assignment.

Senator Talmadge. That was what we were trying to do with the provision that was incorporated in the bill and it had strong support in some rural areas and AMA is opposed to it, the Department is opposed to it. How many pilot projects do you want?

Senator Baucus. That is up to negotiation. I am not familiar with how it is best to proceed.

Mr. Constantine. If you said just a reasonable number, that would allow sufficient latitude. Mr. Gaus here handles the demonstrations.

Senator Talmadge. What is the Department's view on that?

Mr. Gaus. We have a series of pilot projects starting soon in both rural and urban areas to determine ways to increase the assignment. We have not included in that list the provision here for the additional dollar. I suspect we could do so.

Senator Baucus. It is my suggestion, too, that perhaps the demonstration projects would be sufficiently flexible so perhaps $1 or $1.50, different assignment rates in different parts of the country and different circumstances just to see what works and what does not work.

Senator Talmadge. After I got out of the Navy, we had a country practitioner who loved Georgia. I think one of my sons cut his finger, or something, and we had an office visit and the fee was 50 cents, which shows you how much inflation has gone up.

What do you think a reasonable number of pilot projects would be, Mr. HEW?

Mr. Gaus. Between five and ten, probably, is sufficient.

I might emphasize here that there are many other ways to improve assignment. While we would obviously consider these projects if the Committee directed we do, there are other ways that we are looking at, such as basically improving the knowledge that the beneficiaries had of which physicians in the community do take assignments, and trying to use, perhaps, the power of the beneficiaries a little more to direct their business to physicians who do take assignments.

Senator Talmadge. Answer my question. How many pilot projects?

Mr. Gaus. Five to ten.

Senator Talmadge. The question is on the Baucus amendment. Any further discussion?

All in favor, say aye.

(A chorus of ayes)

Senator Talmadge. Opposed, no?

(No response)

Senator Talmadge. The amendment is adopted.

Mr. Constantine. Mr. Chairman, on Section 7, in use of approved relative value schedules, there is a shift over to making the argument that for the physicians and the government, the Federal Trade Commission has entered into a series --

Senator Talmadge. This is something the pathologists, as I understand it, strongly support.

Mr. Constantine. Yes, sir. Virtually all of the other specialty groups in medicine.

The FTC opposes this provision. At the same time, they conceded in meetings with us that we need relative values. A relative value schedule is a listing of the units of one service as opposed to another.

For example, the relative value of an appendectomy in units as opposed to a hysterectomy, and those units are theoretically determined based on relative time, skill and effort. That is the idea.

Any fee schedule is implicitly a relative value schedule. The government needs those, the paying program needs those, so we have reference points as to the reasonableness of one procedure as opposed to another. The anaesthesiologists, I believe, have a consent decree now; the radiologists and the pathologists, virtually are under consent, so that all of the RVS's are in limbo.

The argument the FTC used -- well, two or three people getting together could come up with an RVS and our response to

that is that is not really the issue. The question is the validity of the RVS. Does it, in fact, represent the general time, effort and skill between one procedure and another. That was one problem.

They were afraid to turn that over to private medical groups.

The second problem is a definitional one. What are services? That is a very serious one. As the medical group has gone through defining an office visit, they have gone from things like in 1956 -- this is, by the way, Senator, the largest piece of paper that GPO has. It shows what happens to the definition of office visits and exams during 1956 and 1974 under six additions of the California relative value -- CRVS.

It started out there in 1956 and that is where office visits are defined and subdefined, as of the 1974 edition. Medicine, we do not believe, has changed that much.

For example, we had an office visit. It now becomes a brief office visit, intermediate office visit and extensive office visit. There are very few brief visits any more.

The President of the Maine Medical Society said they had $10 for a small abcess and $15 for a large abcess and for the last thirty years, there have been no small abcesses in Maine. It is that kind of thing.

Nevertheless, what the provision provides for, is the first part, the development of appropriate definitions, inviting

various medical groups to submit suggested definitions to the government. There is no loss of right to accept or reject or show where the gaps are.

Following the development of what an office visit is, and those other things that are a problem today, many of those things that I just pointed to have validity. We are not arguing with that.

Following that, the Secretary invites the various specialty groups to submit suggested RVS's. To the extent that those submittals have professionality they can be used under Medicare and Medicaid in any Federal programs. If it is accepted for use in the Federal program, it may then be used by any other third party payer in the country.

It is kind of a back door approach, but if it is good enough for the Federal government, then there is no reason why Blue Shield or any insurer or anyone else should not be able to use the same relative values. But without relative values, you have no reference points to determine the reasonableness of one procedural service as opposed to another.

We believe it is a reasonable compromise. The FTC is kind of frantic, but we believe that under this provision the government gives up nothing because, in the final analysis, the Secretary can say I agree with everything you have done over here except for these procedures.

Senator Talmadge. Does the Department have any views on

this?

Mr. Gage. Mr. Chairman, we are in basic agreement with the thrust of the provision. We do not think we need the legislation to undertake the process that is set out in this legislation. Indeed, we are proceeding with relative value studies of our own. We are going out for the kind of public comment envisioned by Mr. Constantine next month.

We expect to have some kind of regulation issued at least in the MPRN by the summer.

Senator Talmadge. Any discussion?

Mr. Constantine. They go on, this problem has been here, the objections have been there for several years. The Department can do what it wants. I do not think that HEW controls the FTC.

Senator Talmadge. He says he is in accord with you but he wants to delay it, as I understand his answer.

Any objection?

Without objection, agreed to.

Mr. Constantine. Section 8 deals with -- and we will get to Section 8 -- with the teaching physicians who, as you know, there are special reimbursement provisions for supervisory and teaching physicians and medical institutions. With GAO's help, the committee found a fair amount of abuses where health staff residents and interns were providing the services, paid for as hospital employees, with some nominal billing physician and a billing of him in addition, the double dip.

Congress acted in 1972, under Section 227, but that provision has been periodically suspended and delayed because of various problems and actually it was to go into effect last October 1, I believe, and the Department has not implemented it.

Senator Bumpers and some others had an amendment last fall which the Senate approved to postpone, to suspend, the operation of Section 227 until October 1 of this year because the Department is working on some things there to try to deal with some of the problems, and we certainly would agree that it ought to be suspended.

In addition, we would suggest as one of the options of the section, a third choice. We have a problem with hospitals where they basically deal with nonpaying patients or public patients. They have no private patients under those circumstances.

What the law tried to address, look, if nobody else is paying, why should Medicare be singled out to pay? Why should Medicare lead, rather than follow?

So the law deals where a majority of patients are billed and then Medicare and Medicaid pays as well for these services. But there are these situations where, very honestly, we have had about 20 medical school deans come up and say they need the money. Most of their medical centers do not have private patients who pay. They cannot meet the majority of paying patients' tests.

Their argument has been all along that they have a team approach in the medical centers, that you cannot say that anyone really does the job, that you have a faculty member plus a resident and intern, and the staff suggestion is that a third alternative for those primarily public hospitals, medical centers, in addition to being paid on a full-cost basis, that they also be given the choice of being paid on a fees basis, prevailing fee, and let the school, let the center, divide it up.

For example, if we pay $800 for a catarract removal and they have a so-called team with the teaching physician and a resident and an intern than that or more than that, we pay them the $800 and they figure out who gets what.

But we will not pay for the house staff and the hospital costs as well. They would simply divide up the money.

It is just another option for them without mandating it.

Senator Talmadge. What is the recommendation? Is that the alternative, or the other?

Mr. Constantine. An additional. In addition to suspending, we recommend that you add a further option to Section 227 giving the institution a further choice.

Senator Talmadge. You have a cost saving of $200 million. Where are you going to save that money?

Mr. Constantine. Senator, right now that is a staff estimate. The Department does not agree with that estimate.

What the Department thinks is that the law is being enforced.

The GAO believes that we are now being double dipped. Not only are we paying, in the majority of cases, for the physicians' fee, the nominal billing physician, but also for the house staff as well, even though they do not meet what very well would be a statutory test.

Senator Talmadge. Paying for the cost of teaching plus the cost of the service?

Mr. Constantine. Yes, sir.

Senator Talmadge. Giving them an option that they could claim the cost of teaching or the fee, but not both?

Mr. Constantine. That is exactly right.

A further option; it does not mandate it.

Senator Talmadge. Any discussion? Any objection?

Senator Danforth. The proposal until now has been simply to further extent this, right?

Mr. Constantine. Suspend. We are saying both. You suspend, but at this end, you are suspending existing law until October 1. We are saying at this end, among those options which are suspended until October 1.

Senator Talmadge. Any further discussion?

Senator Chafee. In effect it takes effect October 1?

Mr. Constantine. Yes, sir, as it would without this.

Senator Talmadge. If you did not extend it, it would take effect last year?

Mr. Constantine. If you did nothing but suspend it until

October 1, more restrictive provisions would obtain. This is another option that is added if nothing else is changed by October 1.

Senator Danforth. Another option?

Mr. Constantine. For the hospital which does not have a majority of its patients paying fees.

Senator Chafee. Is there any reason to suspect that anything is going to take place before October 1?

Mr. Constantine. Yes, sir. The Department has been working on a variety of changes. We have always had these changes coming; they keep coming. Then they come in and say we are not ready; would you suspend it again.

This happens to be the way of the world, I guess. We are still waiting, for example, for the Home Health Agency Report that Senator Dole's amendment required be submitted as of last October and it still has not been received from the Department. It is very hard to bank on compliance with dates.

Senator Talmadge. Any further discussion? Any objection? Without objection, agreed to.

Mr. Constantine. We would, however, like to modify the cost savings. We do not want to inflate it. That was the estimate we worked out with GAO. We would rather go with whatever CBO comes up with, or the administration.

Senator Talmadge. Without objection, agreed to.

Mr. Constantine. Section 9, the provision to encourage

the provision appropriately of ambulatory surgical services.

Very often -- this, you will recall, Senators, was stimulated by Dr. McDonald, and this amendment has had excellent response from both the administration and the medical societies and support.

Many procedures are being performed as an inpatient which could be done as an outpatient because of the reimbursement system.

Senator Talmadge. What you are trying to do here, as I understand it, where a minor operation can be performed in a doctor's office or a clinic, you would permit him to do that under very tight controls and not throw him in a hospital where the costs would be infinitely more. Is that what you are driving at?

Mr. Constantine. Basically, that is true. Today, if a physician does a procedure in his office, we pay him the professional fee but we do not go into the overhead factors he has in his office. That is, he may have to gear up, get some equipment, additional staffing and so on. So he is better off doing it in the hospital in that regard.

However, what this amendment says -- and we have not heard any opposition expressed to it -- it simply says in addition to the fee, doctor, we will do a reasonable sample survey of overhead costs for doing minor procedures in your office. That overhead factor is added to your professional fee. If you

take an assignment for that, Medicare will pay you not only the full package amount, but also waive the coinsurance on the deductible, so not only do you have no billing problems, but the patient is better off as well.

Senator Talmadge. Do you have any idea how much this would save?

Mr. Constantine. We believe and the insurers we have talked to say it would save a great deal of money, but it is very hard to put a precise number on it.

I know that in the Atlanta area they estimate that over 10 percent of the admissions and the people in New York, Dr. Melcher, head of the 3 million GHI, 10 percent of admissions are for procedures that could be done on a noninstitutional basis out of the institution.

We would also suggest as a further modification of this, Senator, to encourage pre-operative work, to stimulate that, and it is related. I think we might as well do that now. Today, the patient goes into the outpatient department of the hospital and is going to be admitted in the next couple of days to be worked up on an ambulatory basis before they are admitted for surgery, say, we charge that patient the Part B deductibe and coinsurance.

Once they are in the hospital bed, however, there is no more coinsurance because there is not a coinsurance on Medicare.

What we would recommend to you is to encourage treating them on an ambulatory basis, is that where a patient is admitted

within seven days that there be no deductible or coinsurance charged for the outpatient department work-up.

We will not recommend now, but ultimately we also believe you ought to do the same thing with a physician's office, where the physician does the work-up in his office within seven days of admission of his patient and the hospital accepts those findings and if there is a review, there is no reason to force him to hospitalize the patient to do those procedures.

Senator Talmadge. Any discussion? Any objections?

Without objections, it is agreed to as modified.

Mr. Constantine. Section 10, an additional provision which was approved by the committee as a part of H.R. 5285 to deal with those states where they have multiple prevailing charge areas. A number of states, such as California, I believe, has 30 different areas where we calculate Medicare reasonable charges. New York does, too.

Other states have a single area where there is no problem. But you wind up with enormous extremes in a number of these states for the same procedure where there is no rhyme or reason.

The example we used for the committee -- we have not updated it -- was something like $450 for a hemorrhoidectomy in Los Angeles a few years ago and $280 in San Francisco, for Medicare. They are both essentially similar cost of living areas.

What this says is you take the statewide average for given procedures in California and any area of the state, prevailing

charge area where the charge exceeds more than one-third of the state average for that, that Medicare pays. We automatically do not increase that.

We do not reduce the fellow who is above that. We will not increase them automatically each year. Under present law, Medicare annually increases the prevailing charge by a factor relating to cost of factor and wage level changes in areas, simply to further avoid widening the gap, the disparity between physicians performing the same procedure in the same state, and it puts a limit, so you just do not automatically do it.

Senator Talmadge. This will cost money, will it not?

Mr. Constantine. No, sir, this saves some money.

Senator Talmadge. Any discussion?

Senator Danforth?

Senator Danforth. Senator Dole wanted to be present when this section was gone over.

Senator Talmadge. We will pass over it.

Mr. Constantine. Section 11, a very minor provision that the committee has approved several times and the Senate has approved but somehow has never gotten into the law, to deal with the allergist. A GP who refers his patient to an allergist and the allergist examines him and prepares the antigens may not be paid directly for those antigens. He has to send it out to the GP, and so on.

This permits the allergist to be paid directly for the

preparation of a reasonable amount of antigen.

Senator Talmadge. What is an antigen?

Mr. Constantine. An allergy shot, basically.

Senator Talmadge. Can you define it so that I can understand it?

Mr. Hoyer. If you have hay fever --

Senator Talmadge. Something to stop hay fever? I can understand that.

Any objections? Without objection, agreed to.

Mr. Constantine. Section 12 is another minor provision which the Senate has improved and the House has approved in different bills and never gotten together. This is to permit the payment of Medicare to pay on the basis of a nonreceipted bill for deceased beneficiaries so that the family will have the money to pay the doctor.

Senator Talmadge. It sounds reasonable. I think a doctor should be paid for his services.

Mr. Constantine. I think now we require that there must be a receipted bill. It is a chicken and egg kind of thing.

Senator Talmadge. Any objection? Without objection, it is agreed to.

Mr. Constantine. Section 13 is the famous swing approach to permit smaller, rural hospitals --

Senator Talmadge. That is a part of your plan to try to close unneeded hospitals and use them for long-term medical care?

In other words, a nursing home where they are needed. Is that it?

Mr. Constantine. Not quite; it is related to that. This is to permit better usage of the under-utilized rural hospital which is staff, and the hospitals are enthusiastic about it. The administration supports it. We have had no problem with this whatsoever.

Senator Talmadge. It will also save money?

Mr. Constantine. Yes, sir. It makes the smaller rural hospitals more viable.

Senator Talmadge. Tell us what you proposed to do.

Mr. Constantine. We propose to do nothing with it, Senator. The only argument that has been made -- not an argument, suggestion -- is to increase the bed size from 50 beds, I believe, 60 beds, to 100 beds.

We think that that suggestion is premature. The argument is that in a larger hospital they have the capacity to establish a distinct private facility and we would recommend to you that you go with the provision as is. There is a theory to demonstrate in there, and then find out how far you want to expand that.

Senator Talmadge. Do you have any idea how much this provision would save?

Mr. Constantine. Really, Senator, it is hard to put a number. It is a systems savings. You make the hospital viable. They can spread their payroll costs. It is very hard to put a

number on it.

Senator Talmadge. Any discussion? Any objection?

Without objection, it is agreed to.

Mr. Constantine. This section gives states in reimbursing the nursing homes the option of including a reasonable incentive payment related to efficient performance and determination of payments to states. This was also approved by the committee last year as consistent with the earlier intent. However, this provision -- one of the staff's recommendations is that Section 249 be repealed. That is a provision that requires that states reimburse nursing homes on a reasonable cost-related basis.

The provision of the Finance Committee amendment in 1972, it has been very poorly administered by HEW, in our opinion. It would save a quarter of a billion dollars. The estimate is a quarter of a billion. The argument that has been made against it is that the states, of course, in the exercise of their good judgment be motivated only by budgetary concerns and would pay substandard rates; therefore, people would get poor care.

Senator Boren. On this section, to get a sense of the committee -- and I think the present Section 14 is certainly an improvement over the existing law -- I would like to propose that we amend Section 14 by striking it and substitute a repeal of Section 249.

In other words, this is the comment that staff has just made, an outright appeal of Section 249, which is estimated it

would save $250 million.

I would just cite the experience we had in Oklahoma where we previously had negotiated rates with the nursing homes and when we had to change from the negotiated rates to the cost based reimbursement. Administrative cost to the state government went up about $500,000 a year and I am told by our director down there that the cost for reimbursement to the nursing homes are going to go up to an exceptional degree as long as they are able for us to come in and negotiate.

I think one of the things we have heard in this whole area of reimbursement is, as we go to cost-based reimbursement, this tends to increase the cost of the whole program. I offer this just to get a sense of the committee. It is something from my own experience that, I think, would work better.

Senator Talmadge. Let's hear some comment from Mr. Constantine and the Department.

Mr. Constantine. Senator, the provision was a committee amendment; the Department poorly implemented it. It is a question of whether you trust the states to do the right thing or whether they will be motivated by budgetary considerations and arbitrarily cut.

It is really a sense of whether you feel that states will do what they have to do to assure reasonable care under Medicaid for their citizens.

Senator Talmadge. Let me see if I understand what you

said. You think that the Boren amendment is wise?

Mr. Constantine. The staff has no objection to it, or we would not argue against it. We included it in the budget buffet as one of the things the committee might consider as a money saver.

Senator Talmadge. Let's hear from the Department, then.

Mr. Gage. Mr. Chairman, we do share the concern expressed by Mr. Constantine. If you simply permit states to use their economic power in a sense to negotiate very low rates, that you may be squeezing some of the poor patients out of the longterm care system altogether.

This was first raised, as Mr. Constantine said, in the context of his budget smorgasbord and we would like to think about this some more. We are opposed to an outright repeal.

Senator Talmadge. Let me see if I can summarize what you said and what Mr. Constantine said, now. Both of you think that the Boren amendment is unwise?

Mr. Constantine. No, sir.

Senator Talmadge. You do not? You think the Boren amendment is wise?

Mr. Constantine. We see no objection to it, Senator.

Senator Talmadge. I still do not know where you stand.

Mr. Constantine. What we are saying is that it is a judgment call for the committee as to whether it wants to maintain a system where the states must pay under this system, and the

Department has very elaborate regulations implementing it, which I do not think the committee envisaged when they put the amendment in in '72; or you feel the states will generally be forced to do the right thing and give them the discretion to do that, because there would be hue and cry if they went overboard.

Senator Talmadge. What is the Department's view?

Mr. Gage. We would oppose a repeal.

Senator Talmadge. Any further discussion? Senator Danforth?

Senator Danforth. Senator Dole would like to be heard.

Senator Talmadge. Do you want to put it off?

Senator Danforth. If we intend to repeal 249.

Senator Talmadge. This will go over.

All right; go ahead.

Mr. Constantine. Section 15 deals with modification of present law where the certification of nursing homes and intermediate care facilities in compliance with Federal requirements is essentially done by state health departments.

If a facility is -- both Medicare and Medicaid participates in both and the Secretary is the final certifying officer, or if it is a facility which is a Medicare only, he is the final certifying officer. It is essentially a paper thing, a residual kind of authority.

This provision was approved by the Committee as a part of the previous bill. The purpose of this was that there have been

instances dragging through the courts truly, you know, serious kinds of nursing home problems in New York and California.

They have had, for example, they have drifted three or four years with the Federal government putting the money in. The purpose of this is to simply say, the Federal government, as far as it is concerned, can pull the plug; if this is a fire trap or poor care is being provided, or there is extensive fraud, there is a hearing procedure in here.

Now, one or two states have raised the question about your taking something away from us as the final certifying authority but, in effect, the states are doing it now for us. Is that correct?

Yes, they do the surveys for us now. Simply a residual thing. We have a gross situation where a bad situation is going to exist for years, and it gives the Federal government a chance to wash its hands of the fact.

Senator Talmadge. Any discussion? Any objection?

Without objection, it is agreed to.

Mr. Constantine. Section 16 is the provision that the committee previously approved in October. It deals with essentially saying a patient may leave the facility, a nursing home, and the number of times he may leave is a matter for professional determination. The Department has imposed an arbitrary fixed number of days.

The Department since has, by regulation, done the same

thing that is in here.

We suggested last year you put it in the law because what they give, they can take away. We believe that provision should be retained again.

Senator Talmadge. Any discussion? Any objection?

Senator Chafee. I am not sure what you are recommending. You are recommending we get away from the arbitrary end limit, or you are recommending that the matters be left to professional medical judgment?

Mr. Constantine. Go away from arbitrary limits and go to professional judgment.

Senator Chafee. The local physicians?

Mr. Constantine. Local physicians and the state. I think the Department said if you had not more than six visits --

Mr. Gaus. Our previous regulation said four was the limit. We have now removed it and left it totally to the discretion of the physician. I guess we opposed this provision on the grounds that we do not need the legislation; in fact, we are doing what this provision wants us to do anyway.

Senator Chaffe. This was an area for abuse if you are not careful, in my judgment.

Senator Talmadge. Why should a Federal official in Washington make a professional determination as to how often a patient should go home? It is absurd on the face of it.

Senator Chafee. I will not argue with that.

Senator Talmadge. Any objection?

Mr. Constantine. The only problem is that it cuts both ways. You can have abuse of the other stuff. It is very rigid.

Senator Talmadge. Any objection? Without objection, it is agreed to.

Mr. Constantine. Section 17 is a provision which got a standing ovation from the National Conference of State Legislators and the National Governors Conference. They complained consistently, and with validity, that there were serious problems in Medicaid programs and other programs. They did not know anything about it until the place was blowing up Massachusetts.

They said they were presented a few years ago with $100 million operating deficit in their Medicaid program. They had to issue bonds to fund it.

This simply says where there are reports indicating deficiencies, and so on, that the appropriate members of the legislature and the governors be notified, not just the administrators.

Senator Talmadge. That seems reasonable enough. Any objections? Without objection, so ordered.

Mr. Constantine. Last time it was for the whole Social Security Act.

Senator Talmadge. Without objection.

Mr. Constantine. Section 18 is next, the Advisory Council has outlived its usefulness. This is a repeal of that

body. It is virtually inactive now. A task force which the committee decided should make court.

This repeal was voted on on two other occasions by the committee. It puts an end to one advisory group.

Senator Talmadge. Any objection? Without objection, it is agreed to.

Mr. Constantine. Section 19, I might suspect you might want to go over until we also review Section 6 on the hospital-based physicians.

Senator Talmadge. Without objection, we will go over.

Mr. Constantine. Section 20 is one of those things that makes sense again, particularly in states with large distances to travel. Under the existing Medicare law, we say we will pay for the ambulance to the nearest hospital qualified to provide the service; that is, a certified hospital.

The dilemma in the original law was that no one wanted to make a judgment as to the qualifications of the staff. There was reluctance today.

That situation led to someone, for example, who needed neurosurgery being taken to a hospital 120 miles away and only being paid for 10 miles because that was the nearest Medicare certified hospital, although it did not have a neurosurgeon within ten miles.

Senator Talmadge. What you are trying to do is make the patient service with that hospital?

Mr. Constantine. Exactly, Senator. We will pay the ambulance service to the appropriate hospital in terms of the service the patient needs.

Senator Talmadge. Any objection? Without objection, it is approved.

Mr. Constantine. Section 22 was the subject of Ralph Nader --

Senator Talmadge. You skipped 21.

Mr. Constantine. The pediatric pulmonary centers amendment is one the Senate has passed about three times previously; it was the Talmadge amendment about four or five years ago. It is endorsed by the Lung Association.

These are centers that provide back-up support to attending physicians. There are 11 of them, including one that I visited in Honolulu. They are very impressive. They provide for premature children with breathing problems and, as medics, the attending physicians and the tough cases there, they work with the local doctors. They have training programs.

They do receive Federal support now but this establishes a permanent support base for them, because they have difficulty in maintaining proper staff from year to year.

It is a very high yield area at very low expense to the government and the committee has approved it repeatedly.

Senator Talmadge. Any objection? Without objection, it is agreed to.

Mr. Constantine. Section 22 is a waiver of the human experimentation provision for Medicare and Medicaid. This one allows -- and this provision is in the form approved by the Senate last October to meet some of the concerns Senator Kennedy expressed. The human experimentation provision was never intended, we believe, to deal with a state putting a copayment on for drug prescriptions or using deductibles for certain services.

It was to deal with such things as forced abortions or sterilization or what you will, and Georgia, I think, was where the first case arose where Georgia sought to put some copayments on prescriptions under Medicaid and were held by one of the courts to be in violation of the Human Experimentation Act, so the whole thrust of that thing was really to tie a states' hand and doing essentially administrative and reimbursement approaches.

The original provision that the commission approved said the Human Experimentation Act does not apply to those kinds of administrative arrangements. Senator Kennedy had some concerns, some of the other members had some concerns.

We believe that this provision is the provision that the Senate approved. We think it essentially takes care of the kind of problem Georgia encountered, and every other state would encounter, if someone chose to challenge them under the Human Experimentation Act.

Senator Talmadge. Any objection? Without objection, agreed to.

Mr. Constantine. Section 23 is essentially, prohibits the Secretary of HEW from routinely releasing the payments to physicians. There have been a lot of errors in those lists. They promise to do better. It does not prevent the release under appropriate circumstances, but just the routine release.

This was a provision that was approved by the committee last October as well.

Senator Talmadge. Any objection?

Without objection, it is agreed to.

Mr. Gage. Excuse me, Mr. Chairman. You suggested that I interrupt. Both of these last two provisions are opposed by the administration.

Senator Talmadge. Which last two?

Mr. Gage. 22 and 23.

Senator Talmadge. You are opposed to 22 also?

Mr. Gage. Yes.

Senator Talmadge. I resubmit the question. HEW opposes it.

All those in favor, please say aye?

(A chorus of ayes)

Senator Talmadge. Cpposed, no?

(No response)

Senator Talmadge. The ayes seem to have it. Let's have a show of hands.

All in favor of Section 22, hold up your hands?

(A show of hands)

Senator Talmadge. Contrary?

(No response)

Senator Talmadge. Not withstanding the Department's views, the committee approves it.

Senator Chafee. Mr. Chairman, a quick question. As I understand the ground rules we are operating under here, we get another crack at this?

Senator Talmadge. Oh, yes. Anything we agree to today is tentative. The policy of this committee has always been, and I certainly endorse that policy, that until we order the bill reported to the Senate, it is always subject to review.

Now, we go to item 24. The Department opposes that?

Mr. Constantine. The Department opposed Section 23 under the disclosure.

Senator Talmadge. 23, not 24.

Mr. Constantine. They do not want the Secretary's authority for routine disclosure of aggregate payments to physicians restricted.

Senator Talmadge. The Secretary's view might be well taken if they would do it right. This is, of course, tax money. Under my theory, any tax money should be a matter of information to the taxpayers any time they see fit.

I think the problem has arisen that they have reported dead people earning huge sums and wrong information. What is the

problem you are trying to correct there, Mr. Constantine?

Mr. Constantine. I do not know what they are doing to correct it.

Senator Talmadge. I know we interrogated Secretary Califano about that at a hearing last year. He assured the subcommittee at that time that, faithfully, in the future it would be reported accurately, because we had information that they were reporting people who were dead.

Mr. Constantine. He promised to reform. It is up to you to judge whether he has reformed in a manner satisfactory to you.

Senator Talmadge. What does this do? Put a flat prohibition?

Mr. Constantine. No, sir. It says "routine disclosure."

Senator, one of the problems with that routine disclosure, I guess we can almost say the committee directed us in 1969 -- Bill Fullerton did an investigation and developed the first list of payments to doctors.

Senator Talmadge. Fullerton is now the man that is Inspector General?

Mr. Constantine. No, he is on his own. He left the Department in disgust.

Senator, he recommended -- we did the first listings; it later became the model for these, but we recommended to the committee that those names not be released, to use code names,

for several reasons. We were not confident of the numbers. Number two, they can be subject to misinterpretation.

You can have a physician on a list, even if they are accurate --

Senator Talmadge. He could be paid $200,000 and lose money on the deal.

Mr. Constantine. That is right. They could show $100,000 for a physician. That might be the total income from his practice.

Senator Talmadge. There might be six doctors involved.

Mr. Constantine. Or it could be 10 percent of another fellow's income. You have totally different things.

In ghetto areas, in areas where we have trouble getting doctors, it may be setting that fellow up for someone thinking he has a lot of money he should not have.

It may be a deterrent to physician participation in the program. Why do they need the publicity when they have the choice of patients? Why take all of this on?

As against that, you have the public's right to know, if you want to argue that, and who gets what money. There must be some middle ground where the Secretary can routinely screen those, pull out the high rollers without just putting those names out on the table for anybody's speculation.

Senator Talmadge. What is the pleasure of the committee? Any objection?

Senator Danforth. Any objection to what?

Senator Talmadge. To approving 23, any objection?

Without objection, it is agreed to. Go ahead.

Mr. Constantine. Section 24, a provision that was included at the request of several states so that they could pursue -- Michigan, particularly, and I think Vermont was another one; a number of others -- so that where a Medicaid applicant disposed of assets within a year for the purpose of securing Medicaid eligibility that the state could recapture and move in those situations.

Senator Talmadge. Let me see if I understand what you are driving at.

I have a mother who is entitled to SSI and Medicaid, except she has more resources than she should have to be eligible for Medicaid. So therefore, she sells me her resources at 10 cents on the dollar and, ipso facto, becomes eligible for Medicaid.

Is that what you are driving at?

Mr. Constantine. Yes, sir. If she does that, what this says, within twelve months, it is subject to action by the state recovery.

Senator Talmadge. What you are trying to do is eliminate fraud in the program, is that it?

Mr. Constantine. It depends. I guess it is fraud, eliminate temptation.

Senator Talmadge. Any objection?

Mr. Constantine. We would have a suggestion here. The committee sought, in some of the language last time, we think appropriately, as to allowing leeway as to how you estimate the value of the assets. I think Senator Packwood raised some provisions to come up with --

Senator Talmadge. Has your suggestion been cleared with Senator Packwood? What is the recommendation?

Mr. Constantine. That the states that originally wanted the option --

Senator Talmadge. "May not" and not "shall"?

Mr. Constantine. May and not shall. If the state does not think it solves the problem, they may have to go to a very elaborate --

Senator Talmadge. Rather than being mandatory, it is permissive. Is that what you recommend?

Mr. Constantine. Yes, sir.

Senator Talmadge. Any objection to approving this as modified? Without objection, it is agreed to.

Mr. Constantine. Section 25, the rate of return on net equity, was Senator Long's amendment, the chairman's amendment, last time, in as much as it does relate to hospital costs. I understand that Senator Nelson would like that to go over also.

Senator Talmadge. Without objection, we will go over.

Mr. Constantine. Section 26 is a very minor technical change to correct a drafting error in 1972 where the Congress

intended to delete and waived deductible and copayment requirements, where we could negotiate with the laboratory and cut out all the paperwork for 30 or 40 cents of coinsurance.

Inadvertently, we omitted saying deductible and we just took out coinsurance. It was the staff drafting error.

Senator Talmadge. Any objection? Without objection, it is agreed to.

Mr. Constantine. Section 27 is identical with an amendment that the committee approved, and it has been approved by the House Ways and Means and Interstate Foreign Commerce Committees, to authorize the states under Medicaid programs to negotiate for the provision of laboratory services or to have competitive bidding without being violative of the Ffeedom of Chbice Act.

The Freedom of Choice provision was another Finance Committee amendment in 1967 and that was really essentially designed to deal with a recipient's choice -- I guess we redrafted it -- recipient's choice of physician rather than laboratory. Most patients do not choose laboratories, and it has been a choice of high cost to the states often, and this gives a better quality control and is solely discretionary to the state. It does not force it on the state.

Senator Talmadge. Any objection? Without objection, it is approved.

Mr. Constantine. In connection with this, we had a staff suggestion in the buffet that you may want to consider to

authorize the states at their option to negotiate by competitive bidding for other types of equipment and supplies which do not essentially, vary significantly, such as eyeglasses, hearing aids, whatever arrangements they can make to moderate their costs.

Senator Talmadge. What are you talking about now?

Mr. Constantine. Giving them a Freedom of Choice provision. That is, permitting the states to engage in competitive bidding on negotiated contracts for certain types of equipment and services that do not vary from supplier to supplier significantly, such as eyeglasses and hearing aids.

It permits the states -- Oregon is doing it now with savings and other states. It is an option for the state.

The only safeguard we would recommend is that the state must assure that reasonability within a reasonable area of the patient.

I think the Department would accept it with assurance of reasonableness.

Senator Talmadge. Any objection? Without objection, approved.

Mr. Constantine. On Section 28, confidentiality of PSRO data, the committee in the present statute has a very general, broad confidentiality exemption.

Senator Talmadge. This is an old issue that has been kicking around here a long time. Senator Laxalt was concerned about it.

Is that the same issue?

Mr. Constantine. No, Senator. Senator Laxalt's issue was the confidentiality of medical records in terms of patient records in a given hospital. This one is one that the committee dealt with. The statute said all PSRO records are confidential except as the Secretary may authorize by regulation to be disclosed in the patients, practitioners and providers. It is a general exemption.

The court says this explains -- one of the courts says that it is to override an exemption and that the Freedom of Information Act -- there is movement, Ralph Nader's group is moving to get all of that information, practitioner profiles, everything they use.

We believe that would bring the PSRO program to a screeching halt because those profiles say, watch this. It is not legal evidence. They are just saying watch him.

Anyway, the committee approved an exemption from the Freedom of Information Act, which the Department supported. However, we were subject to a jurisdictional challenge on the floor by Senator Abourezk, you will recall, Senator, and the committee dropped the amendment on the floor to avoid a point of order which would have jeopardized the entire bill.

Now, we have redrafted this. It has been redrafted so that we believe it is within the -- almost, as Bob says, within the exemption of the Freedom of Information Act by specifying and

we have one minor change there.

Mr. Hoyer. Senator, we would like to amend the provision to list the organizations to whom the information could be disclosed. This is to bring it into even better conformity with the Freedom of Information Act.

Senator Talmadge. Whom would it be made available to?

Mr. Hoyer. It would be made available to the Medicare-Medicaid payment agencies, fraud and abuse agencies, and to other agencies that would use it.

Mr. Constantine. They are already mentioned under existing law.

Senator Talmadge. Does the Department support that view?

Mr. Gage. We do support most of this amendment. We are very concerned -- the way it is drafted, it appears to be extended to hospitals, to providers. We do distribute data regarding length of stay developed by PSROs referring to hospitals.

Senator Talmadge. See if you can work with the staff to improve the language.

Is there any objection?

Senator Danforth. I understand Senator Schweiker has taken an interest in this, particularly in the language that has been used. Has this been worked out with him?

Mr. Constantine. We have been working very closely with his staff, yes, sir.

Senator Talmadge. If there is no objection, it will be approved tentatively and get the advice of the Department, and Senator Schweiker's staff on it, if you will.

Mr. Constantine. Section 29, Senator, this is -- the committee has approved this previously. They are appealing the three-day hospitalization requirement as a condition of eligibility for home health services, hospital billing, the 100-visit limitation, unlimited home health visits under Medicare.

The committee approved this previously. Also, a part of S. 507, the Dole-Talmadge bill.

Senator Talmadge. Any objection? Without objection, it is agreed to.

Mr. Constantine. Section 30.

Senator Danforth. Senator Dole would like Section 30 put over.

Senator Talmadge. Without objection, it will go over.

Mr. Gage. If you will permit me, the Department opposes this on budgetary grounds.

Senator Talmadge. Which one?

Mr. Gage. Section 29.

Senator Talmadge. You are opposed?

Mr. Gage. It does represent a budgetary impact.

Senator Talmadge. Is there any objection to approving it? Without objection, it is tentatively approved and can be raised again.

What will that cost, incidentally?

Mr. Constantine. $11 million.

Mr. Gage. $11 million in '79 and $14 million in fiscal '80.

Senator Talmadge. All right. Section 30 will go over.

Section 31?

Mr. Constantine. Section31 is Senator Nelson's amendment that simply requires to HEW to adopt to the extent feasible standardized claim forms for Medicare and Medicaid.

Mr. Gaus.. We support this. In fact, we are attempting to do it under current authorities, but we do not oppose the clear legislative mandate to do so.

Senator Talmadge. Any objection? Without objection, approved.

Mr. Constantine. Now, Section 32 is a provision that more than saves money to pay for the unlimited home health benefits under Medicare and that is to have coordinated audits under Medicare for Medicare and Medicaid hospitals. The committee approved this previously. I do not have the savings number on that.

Mr. Gage. In fiscal '80, $28 million under Medicaid plus $6 million under Medicare.

Senator Talmadge. Does the Department support it?

Mr. Gage. We do support it.

Senator Talmadge. Without objection,. it is agreed to.

Mr. Constantine. Section 33.

Senator Danforth. Senator Heinz has asked that Section 33 be put over.

Senator Talmadge. Without objection, it will be put over.

Mr. Constantine. This is another I believe is Senator Nelson's amendment, modification of an amendment offered by Senator Nelson. You will recall that he offered an amendment that required a facility participating under Medicaid must also participate under Medicare and there was a lot of controversy over that provision. He withdrew it, modified it at that time on the floor, I believe, to study the availability and need for skilled nursing facilities services rather than mandating joint participation, dual participation.

Now the Department, we understand, contrary to its earlier position, now supports dual participation.

Mr. Gaus. Yes, we favor the original amendment.

Senator Talmadge. You do not favor this?

Mr. Gaus. We do not favor a study.

Senator Talmadge. Let's put it off until Senator Nelson is here. Does Senator Nelson want this amendment?

Mr. Constantine. I think you had better put it over. I think he would want his first amendment obviously.

Senator Talmadge. We will put it over until Senator Nelson is here.

Mr. Constantine. The Department has changed its position.

Senator Talmadge. We will put it over until Senator Nelson

is here.

Mr. Constantine. Bob, do you want to explain the dentists?

Mr. Hoyer. The definition in present law of what you can pay a dentist --

Mr. Constantine. Excuse me. Senator Dole would like this to go over.

Senator Talmadge. This will go over until Senator Dole is here.

Mr. Constantine. The optometrists.

Mr. Hoyer. An optometrist can now be paid -- this is Section 36. When a catarract patient has a lens of his eye removed, there is always something substitued: eyeglasses, or a contact lens and the contact lens, if it is used, is covered under Medicare just as an item of medical equipment.

If an optometrist supplies it, by fitting it to the patient and watching his acceptance of it, it will pay for the item of equipment, the contact lens, but not for the optometric service he provides to that patient.

What we are doing here is providing coverage for the services he renders to the patient as well as the item of equipment so that it would put him on a parity with an opthamologist who would be doing the same thing.

Senator Talmadge. What arethe views of the Department on this?

Mr. Gaus. We support the provision.

Senator Talmadge. Any objection? Without objection, it is approved.

Mr. Constantine. Section 37.

Mr. Hoyer. Senator, Section 37 calls for another study because of a problem in Medicare. In Medicare, you can use up your 100 days of hospital benefits, your 150 days of hospital benefits, 100 days of skilled nursing home benefits, and never again qualify for new benefits unless you are out of a nursing care institution for 60 days.

The present definition of the kind of institution you have to be out of includes some purely domicillary institutions and purely domicillary patients who really are not sick any longer but, if they should get sick, can never again qualify for hospital benefits or nursing home benefits.

We are asking Senator Dole's amendment from last year -- we are simply asking for a study by HEW to look into their classification of facilities to see if we are denying the wrong people the opportunity to be qualified.

Senator Talmadge. All this mandates is a study. What is the Department's view?

Mr. Gage. We have no objection.

Senator Talmadge. Any objection? Without objection, it is agreed to.

Mr. Constantine. Section 38, it was Senator Gravel's amendment which the committee agreed to. There are something

like six states which have not purchased Part B coverage for their Medicaid recipients who are also eligible for Medicare. They are aged recipients and under the law, there was a deadline which expired, and no matching; no Federal matching is available for those services which could have been covered by Medicare if the state had bought in.

Senator Talmadge. All this does is protect the states?

Mr. Constantine. Gives them another whack at it.

Senator Talmadge. Any objection on the part of the Department.

Mr. Constantine. The Department is opposed, I assume?

Mr. Gage. We are opposed to this on budgetary grounds. It will cost an additional $24 million.

Senator Talmadge. Why should we deny it to Alaska, Louisiana, Oregon, Puerto Rico and Wyoming?

Mr. Gage. I think we will rethink that position.

Senator Talmadge. Any objection? Without objection, approved.

Mr. Constantine. This is Section 39. Do you want to take that, another provision that the committee agreed to?

Mr. Hoyer. For an HMO to participate in Medicaid, at least half of its patients have to be other than Medicare, Medicaid patients.

Senator Talamdge. What is the view of the Department on it?

Mr. Gage. We support this amendment.

Senator Talmadge. Any objection? Without objection, it is approved.

Mr. Constantine. Mr. Chairman, if you would like to proceed with the Dole-Talmadge bill --

Senator Talmadge. I guess Senator ought to be here when we consider this.

Mr. Constantine. Senator Dole apparently has no objection. Most of these provisions you have dealt with previously. If you want to clean this up as well, or you can carry it over.

Senator Talmadge. How long will it take? It is 12:20. We are going to have to meet again anyway, because we have passed over several items.

We do not have a quorum.

Mr. Constantine. About ten minutes.

Senator Talmadge. Do you want to stay for ten minutes? Go ahead.

Mr. Constantine. Page 26. What we did here, we only included those provisions in S. 307 which were not previously dealt with. They were duplicative provisions, two bills with similar provisions.

Senator Talmadge. These items were approved?

Mr. Constantine. Items you have not dealt with in 505.

Section 6 deals with the flexibility of application of standards to rural hospitals. It is a waiver authority that expired on December 31, 1978. The House has, I believe, is moving

to renew it. There is no opposition.

Senator Talmadge. Any objection?

Senator Boren. This extends the waiver authority?

Mr. Constantine. Yes, sir.

Senator Talmadge. Without objection, agreed to.

Mr. Gage. We have certain modifications which we will request which I believe are acceptable to Senator Dole, to waive the 24-hour nursing basis requirement on a case by case basis.

Senator Talmadge. A modification of this?

Mr. Gage. Just a modification.

Senator Talmadge. May I suggest this? We will tentatively approve it. You and the staff work on the modification with Senator Dole. If it is agreeable with him, we will agree to it.

Any objection to that procedure? Without objection, it is so ordered.

Go ahead.

Mr. Constantine. Section 14 would extend the period for the funding of State Medicaid fraud control units, 90 percent funding for a period so that, in effect, prior to 1982 a state may have up to 90 percent matching for three years.

Senator Talmadge. You are extending current law?

Mr. Constantine. We are just extending the period. That is right, yes, sir. We are extending it.

Senator Talmadge. Does the Department approve it?

Mr. Gage. We oppose this, once again, on budgetary grounds.

Senator Talmadge. How much money is involved? It looks to me if you eliminate fraud, you will save money.

Mr. Gage. Fiscal 1981 budget impact is $16.9 million.

Senator Talmadge. Would you not recoup more than that by the fraud provisions?

Mr. Constantine. If the units are effective, they would. They cannot judge the effectiveness of the units.

Senator Talmadge. Any objection? Without objection, it is approved.

Mr. Constantine. The next provision authorizes for podiatrists to serve on physician review committees.

Senator Talmadge. Extends it to podiatrists?

Mr. Constantine. Yes.

Senator Talmadge. Without objection, agreed to.

Mr. Constantine. Speech pathologists.

Mr. Hoyer. Senator, right now speech pathology is covered under Medicare if it is provided as a home health service or an outpatient rehabilitation service. The physician has to refer the patient to the speech pathologist. Right now, there is a requirement that the same physician has to write out a detailed plan of treatment.

The physician can usually point the speech pathologist in the right direction but is really not expert enough in speech pathology to do that detailed planning. We are eliminating the

requirement that the plan be detailed.

Senator Talmadge. Any objection on the part of the Department?

Mr. Gaus. No objection.

Senator Talmadge. Without objection, agreed to.

Mr. Hoyer. Section 17, presumed coverage provisions. Back in 1972 we were having a problem with patients going to nursing homes and home health agencies and being denied, so certain authority was written into the law so that rules be written, patients would be presumed eligible for Medicare benefits for brief periods of time while their actual eligibility was being worked out.

That provision has proved to be ineffective. The presumptions are usually taken for guarantees of coverage, minimums rather than maximums, and the fact is, they simply are not being used, so we think it would be simpler to just drop that provision from the law.

Senator Talmadge. What is the view of the Department?

Mr. Gage. We support this provision.

Senator Talmadge. Without objection, it is approved.

Mr. Constantine. Section 22 is identical with the provisions of S. 421 approved by the committee, virtually, and in virtually identical form to train AFDC recipients in twelve states on a demonstration basis as homemaker and home health aids who would serve in public and bona fide nonprofit agencies to provide

services to people who reasonably would be expected to be in institutions. This is one that the states are enthusiastic about.

Senator Talmadge. What you are doing here is taking welfare people and training them and making them hospital attendants. That sounds to me to be a welare provision. I know one or two states who have done that, I believe, by special approval. New Mexico, as I recall. Georgia is very enthusiastic about it.

Mr. Constantine. Georgia estimates a potential need for 5,000. Hawaii, Michigan is very interested, Virginia.

Senator Talmadge. Any objection? Without objection, it is agreed to.

Mr. Constantine. That takes care of S. 507 to the extent that its provisions have not already been dealt with.

Chiropractors, I am sorry. Senator, we saved one of the best for last. Medicare now requires that in order to be eligible for treatment by means of manual manipulation of the spine by a chiropractor that there be an x-ray showing a sublexation, a break in the spine. It is simply -- apparently there was some suspicion of chiropractors and it has some objective evidence of the need for service.

As a practical matter, we asked GAO to look at this some years back and their radiological consultants say you could show a sublexation on everyone over age 65. Not only are you exposing older people to unnecessary radiation risk and

incurring a cost on their behalf, but it really does not safeguard anything.

In 507, the statement introducing the bill, it said that deletion of the x-ray requirement was in there. Unfortunately, due to a technical error, it was not included. It should have been a part of the text.

We would strongly recommend that the x-ray requirement come out.

Senator Talmadge. Any objection? Without objection, so ordered.

Mr. Gage. I might note, Mr. Chairman, that the Department is opposed to this amendment. It is also proposing to terminate chiropractor benefits altogether under this program.

Senator Talmadge. Any objection? Without objection, it is approved.

Go ahead.

Mr. Constantine. You might as well dispose of S. 508 at the same time. It has one provision, Mr. Chairman, and that is to make the appointment of the Administrator of the Health Care Financing Administration subject to Senate confirmation. It is misdated here.

In the last amendment, the last bill had it that anyone occupying the office, anytime after date of enactment. The present proposal is for a person appointed to that office in the future.

Senator Talmadge. Exempt the present?

Mr. Constantine. Right.

Senator Talmadge. Any objection? Without objection, agreed to.

Does that wrap it up?

The Majority Leader has announced we will not have a session tomorrow. I assume many Senators will be out of town. Do you want to try to meet tomorrow? Senator Dole, is he going to be out of town?

Senator Danforth. Yes, he will.

Senator Talmadge. When did the chairman want this committee to meet again?

Mr. Stern. It was scheduled for 9:30. There was a nomination. I could review the situation with him.

Senator Talmadge. Why do you not do this if it is agreeable with the committee? Leave it to the discretion of the chairman, Senator Long, and he will either call a session or not. Is that agreeable?

Mr. Stern. All right. We will notify all the Senators' offices, then.

Senator Talmadge. Without objection, Senator Long will make a determination as to whether or not we will meet tomorrow.

Thank you very much. I appreciate your cooperation.

We will stand in recess, subject to the call of the chair.

(Whereupon, at 12:30, the committee recessed, to reconvene

at the call of the chair.)

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