92d Congress
2d Session

CONFIDENTIAL COMMITTEE PRINT

2

STAFF DATA ON H.R. 1:

MEDICARE-MEDICAID

PART 1: COMMITTEE- AND SENATE-APPROVED AMENDMENTS TO H.R. 17550 NOT INCLUDED IN H.R. 1

PREPARED FOR THE USE

OF THE

COMMITTEE ON FINANCE

UNITED STATES SENATE

RUSSELL B. LONG, *Chairman*

FEBRUARY 24, 1972

Printed for the use of the Committee on Finance

U.S. GOVERNMENT PRINTING OFFICE

72-815 WASHINGTON : 1972

COMMITTEE ON FINANCE

RUSSELL B. LONG, Louisiana, *Chairman*

CLINTON P. ANDERSON, New Mexico
HERMAN E. TALMADGE, Georgia
VANCE HARTKE, Indiana
J. W. FULBRIGHT, Arkansas
ABRAHAM RIBICOFF, Connecticut
FRED R. HARRIS, Oklahoma
HARRY F. BYRD, JR., Virginia
GAYLORD NELSON, Wisconsin

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

TOM VAIL, *Chief Counsel*

(II)

CONTENTS

COMMITTEE-AND SENATE-APPROVED AMENDMENTS TO H.R. 17550 NOT INCLUDED IN H.R. 1

Establishment of Professional Standards Review Organizations

Problem

There are substantial indications that a significant amount of health services paid for by Medicare and Medicaid are in excess of those which would be found to be medically necessary under appropriate professional standards. Furthermore, in some instances services provided are of unsatisfactory professional quality.

Senate 1970 Amendment

The Committee provided for the establishment of Professional Standards Review Organizations sponsored by organizations representing substantial numbers of practicing physicians (usually 300 or more) in local areas to assume responsibility for comprehensive and ongoing review of services covered under the Medicare and Medicaid programs. The purpose of the amendment would be to assure proper utilization of care and services provided in Medicare and Medicaid utilizing a formal professional mechanism representing the broadest possible cross-section of physicians in an area. Appropriate safeguards would be included so as to adequately provide for protection of the public interest and to prevent pro forma assumption and carrying out of the important review activities in the two highly expensive programs. The amendment provides discretion for recognition of and use by the PSRO of effective utilization review committees in hospitals and medical organizations.

Inspector General for Medicare and Medicaid

Problem

There is, at present, no independent reviewing mechanism charged with specific responsibility for ongoing and continuing review of Medicare and Medicaid in terms of the efficiency and effectiveness of program operations and compliance with Congressional intent. While HEW's Audit Agency and GAO have done helpful work, there is a need for day-to-day monitoring conducted at a level which can promptly call the attention of the Secretary and the Congress to important problems and which has authority to remedy some of those problems in timely, effective and responsible fashion.

Senate 1970 Amendment

Under the amendment, an Office of Inspector General for Health Administration would be established within the Department of Health, Education, and Welfare. The Inspector General would be appointed by the President, would report to the Secretary, and would be responsible

for reviewing and auditing the Social Security health programs on a continuing and comprehensive basis to determine their efficiency, economy, and consonance with the Statute and Congressional intent.

The Inspector General would be authorized to issue an order of suspension of a formal regulation, practice, or procedure which he found inconsistent with the law or legislative intent. Generally speaking, such suspension would become effective not less than 30 days after issuance unless specifically countermanded by the Secretary of HEW. Upon issuance of an order of suspension the Inspector General would be required to immediately advise the committees on Finance and Ways and Means as to the findings and basis for the order. If the Secretary countermands, he too would be required to immediately advise the Legislative Committees as to the reasons for his action. Thus, a serious issue involving a question concerning congressional intent would be placed before the committees having jurisdiction in orderly and delineated fashion.

Medicaid Coverage of Mentally Ill Children

Problem

Present law limits reimbursement under Medicaid for care of the mentally-ill in public institutions to those otherwise eligible individuals who are 65 years of age or older.

Senate Amendment

Authorized coverage of inpatient care in State and local mental institutions for Medicaid eligibles under age 21, provided that the care consisted of a program of active treatment, that it was provided in an accredited medical institution, and that the State maintained its own level of fiscal expenditures for care of the mentally ill under 21.

Coverage of Chiropractic Services

Problem

Chiropractors are not currently eligible to participate as physicians in the Medicare program. The House Bill does not include coverage of chiropractors but calls for a study of such services.

Senate Amendment

The Committee amendment deleted the study of chiropractic services called for in H.R. 17550 and substituted a provision providing for the coverage under Medicare of services involving treatment by means of manual manipulation of the spine by a licensed chiropractor who met certain minimum standards established by the Secretary of Health, Education, and Welfare. The same limitations on chiropractic services applicable to Medicare would also pertain to States providing such care under Medicaid.

Conform Medicare and Medicaid Standards for Nursing Care Facilities

Problem

Although the extended care facility, as defined under Medicare in 1965, was an institution offering a different and more highly skilled level of care than the average skilled nursing home, the differences

between the two types of institutions were largely eliminated by the passage in 1967 of legislative standards for skilled nursing homes participating under Medicaid. While the emphasis of the care under the two programs may differ somewhat, patients under both programs require the availability of essentially the same types of services and are often in the same institution. Because of the substantial similarities in the services required, the existence of separate requirements (which even now differ only slightly) and separate certification processes for determining institutional eligibility to participate, is both administratively cumbersome and unnecessarily expensive. The same facility is more often than not approved under both programs.

Senate Amendment

The Committee added to the House bill a provision which would require that health, safety, environmental, and staffing standards for extended care facilities be uniform under Medicare with those established for skilled nursing homes under Medicaid.

Provide for Simplified Reimbursement of ECF's

Problem

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

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

The reasonable cost reimbursement approach of the Medicare program has created several difficulties for extended care facilities. The detailed and expensive cost-finding requirements have proved extremely cumbersome, and the lack of advance knowledge of actual payments impedes effective budgeting and planning. Further, the extended care facility has no incentive to contain costs or control delivery of services since virtually all costs are reimbursable.

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

Senate Amendment

The Committee provision would authorize the Secretary of Health, Education, and Welfare to adopt (and adjust as specified), as reasonable-cost payments for extended care facilities in any State, the rates developed in that State under Medicaid for reimbursement of skilled nursing care, if the Secretary finds that they are based upon reasonable analyses of costs of care in comparable facilities.

Early Diagnosis and Screening for Children

Problem

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

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

Senate Amendment

The Committee provision would authorize the Secretary to establish orderly priorities in the implementation of the presently required health care screening for children programs, with initial priority being given to preschool children. This amendment would, in effect, provide statutory sanction for the policy adopted by HEW in regulations it published subsequent to inclusion of the amendment in H.R. 17550.

Discussion

There appear to be two policy issues which the committee may desire to resolve:

1. The departmental regulation required States to provide screening and treatment for children under age 6 by February 7, 1972. However, by July 1, 1973, States must be providing such services to all eligible children under age 21.

The policy question is whether the phasing-in of children over age 6 should be spread over a longer period of time than the 16 months the regulation now requires.

2. The regulation states that treatment of any illnesses or defects detected may be limited to the amount, duration, and scope of services provided under the State's regular medicaid program. However, if not presently included under medicaid a State must also provide necessary eyeglasses, hearing aids, and other treatment for visual and hearing defects as well as some dental care.

The question here is whether States should be required to exceed the scope of services provided under a medicaid program at a time when, due to recognition of fiscal pressures, Congress has permitted States to cutback on their programs.

Consultants for Extended Care Facilities

Problem

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

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

additional allowance is made for the outside consultants employed to meet the Medicare conditions of participation.

Senate 1970 Amendment

The Committee added to the House bill a provision to authorize State agencies to provide, with the approval of the Secretary, appropriate consultative services to those extended care facilities which request them in such specialty areas as maintenance of medical records and the formulation of policies governing the provision of dietary and social services. Medicare payment would be made directly to the State agency for the salary and related costs incurred in rendering these consultative services. The provision of such services by the State would satisfy the medicare requirements relating to the use of consultants in the specialty areas.

Public Disclosure of Information Regarding Deficiencies

Problem

Physicians and the public are currently unaware as to which hospitals and extended care facilities have deficiencies and which facilities fully meet the statutory and regulatory requirements. This operates to discourage the direction of physician, patient, and public concern toward deficient facilities, which might encourage them to upgrade the quality of care they provide to proper levels.

Senate 1970 Amendment

The Committee added to the House bill a provision under which the Secretary of Health, Education, and Welfare would be required to make reports of an institution's significant deficiencies (such as deficiencies in the areas of staffing, fire safety, and sanitation) a matter of public record readily and generally available at social security district offices if, after a reasonable lapse of time (not to exceed 90 days), such deficiencies were not corrected.

Proposal

The staff and the Department suggests that the amendment be modified so that following completion of a survey of a health care facility or organization, those portions of the survey relating to statutory requirements as well as those additional significant survey aspects required by regulation relating to the capacity of the facility to provide proper care in a safe setting (some 40 factors in all) would be matters of public record. In the case of Medicare, such information would be available for inspection within 30 days of completion of the survey upon request in Social Security District Offices: in the case of Medicaid, the information would be available in local Welfare offices within 90 days of survey completion.

Direct Laboratory Billing of Patients

Problem

The cost of collection from beneficiaries by laboratories of the coinsurance portion of assigned low-cost laboratory charges is often disproportionate to the small amounts involved. The effect of this may result in higher overall laboratory charges so as to recover the collection expense.

Senate 1970 Amendment

Authorized the Secretary to negotiate a payment rate with laboratories which would be considered the full charge for the diagnostic tests involved and for which Medicare reimbursement would be made at 100 percent of the negotiated rate. The negotiated rate could not exceed the total payment (including any coinsurance) that would have been made in the absence of such rate.

Inclusion of American Samoa and Trust Territory of the Pacific Islands Under Title V

Problem

The Trust Territory of the Pacific Islands and American Samoa are not presently eligible to receive formula fund allocations under the Maternal and Child Health and Crippled Children programs as do the States and Puerto Rico and V.I.

Senate Amendment

Authorized inclusion of Samoa and the Trust Territory as eligible for Title V formula grants. Estimated cost; approximately $35,000.

Definition of Physician Under Medicaid

Problem

Physician's services are one of the six mandatory items of health care which a State must include in its Medicaid program. While Committee Report language clearly indicates that services of chiropractors, podiatrists, etc., are optional services, in Michigan, New York, and Georgia efforts are being made to define the mandatory physicians' service to also include chiropractors and podiatrists.

Senate Amendment

Limited definition of "physician" in Medicaid, for purposes of mandatory coverage, to mean a doctor of medicine or a doctor of osteopathy. The other types of practitioner services would remain optional with States in accordance with the intent expressed in the 1965 Finance Committee Report when Medicaid was enacted: The Report stated on page 81:

> Among the items of medical services which the States may include is medical care, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law. Under this provision, a State may, if it wishes, include medical and remedial services provided by chiropractors, optometrists, and podiatrists, and Christian Science practitioners, if such practitioners and services are licensed by the State.

Waiver of Recovery of Erroneous Payment

Problem

Under present law, the Secretary is required to recover overpayments made to or on behalf of an individual where it has been determined that the services paid for were not covered by Medicare. Further an incorrect payment made in behalf of a beneficiary to a provider

which cannot be recovered from the provider is then sought from the beneficiary. A particular problem arises with respect to overpayments discovered long after the payment was made.

Senate 1970 Amendment

Limited Medicare's right of recovery of an erroneous payment to a 3-year period from the date of the payment, where the institution or individual involved acted in good faith. Similarly, the Secretary would specify a reasonable period of time (not to exceed 3 years) after which Medicare would not be required to accept claims for underpayment or nonpayment.

75 Percent Medicaid Matching Funds for Professional Medical Personnel

Problem

Present 75 percent Federal Medicaid matching for professional medical personnel engaged in Medicaid review, and audit activities, does not include such personnel who are not employed by the State agency. This handicaps States in securing outside medical personnel on a contract basis with respect to Medicaid functions.

Senate 1970 Amendment

Authorized 75 percent Federal matching under Medicaid for reasonable costs of contract professional medical personnel.

Proposal

The staff suggests that such matching be limited to 75 percent of the reasonable costs or charges for such personnel.

○