COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES

WASHINGTON, D.C. 20515

September 7, 1972

MEMORANDUM

To: Mr. Paul Miltich
Office of Honorable Gerald R. Ford

From: Office of Minority Counsel

Re: Telephone request

In response to your telephone request earlier today, we are sending material relating to proposals affecting nursing homes and similar institutions under H.R. 1 as passed by the House. In addition to a Committee Print summarizing the House-passed bill, there is a Xerox copy of more elaborate explanations of pertinent provisions from the House Report on H.R. 1. Also enclosed is a summary of tentative modifications in these proposals made by the Senate Finance Committee.

This a large amount of material, but we have attempted to highlight the particular provisions which are likely to be of greater interest to you, and a further condensation of these provisions may be found in a marked section of remarks (copy also enclosed) by Mr. Byrnes on the House floor during debate on H.R. 1.

As noted earlier in our telephone conversation, the Chairman of our committee has indicated that further consideration of various national health insurance proposals will not be possible this year. The Committee held 4 1/2 weeks of public hearings on these measures late in 1971. When the Committee does resume deliberations on national health insurance, it undoubtedly will again review the medicare and medicaid programs.

If you have any questions about the enclosed material, or if we may be of further service in any additional way, please let us know.

92d Congress
1st Session

COMMITTEE PRINT

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

SUMMARY OF PROVISIONS OF

H.R. 1

THE "SOCIAL SECURITY AMENDMENTS OF 1971"

AS REPORTED TO THE

HOUSE OF REPRESENTATIVES

ON

MAY 26, 1971

(House Report No. 92–231)

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THE "SOCIAL SECURITY AMENDMENTS OF 1971"

AS REPORTED TO THE HOUSE OF REPRESENTATIVES ON MAY 26, 1971
(HOUSE REPORT NO. 92–231)

I. PROVISIONS RELATING TO THE SOCIAL SECURITY CASH BENEFITS PROGRAM

Five-percent increase in social security benefits.—Social security benefits would be increased by 5 percent. The minimum benefit would be increased from $70.40 to $74.00 a month. The average old-age insurance benefit payable for the effective month would rise from an estimated $133 to $141 a month and the average benefit for aged couples would increase from an estimated $222 to $234 a month. Special benefits for persons age 72 and over who are not insured for regular benefits would be increased from $48.30 to $50.80 for individuals and from $72.50 to $76.20 for couples.

Effective date.—Benefits payable for June 1972.

Number of people affected and dollar payments.—27.4 million beneficiaries would become entitled to higher payments and 16,000 people would be made newly eligible. About $2.1 billion in additional benefits would be paid in the first full year.*

Automatic increase in benefits, the contribution and benefit base, and in the earnings test

(*a*) Increases in benefits:

Social security benefits would be automatically increased according to the rise in the cost of living. Increases could occur only once a year, provided that the Consumer Price Index increased by at least 3 percent and that legislation increasing benefits had neither been enacted nor become effective in the previous year.

(*b*) Increases in contribution and benefit base:

In any year in which an automatic benefit increase becomes effective, the social security contribution and benefit base would be automatically increased according to the rise in average wages covered under the social security program (if wage levels had gone up sufficiently).

* Hereinafter the first full year, when referring to the effects of changes in the social security cash benefits or medicare programs, refers to the 12 months beginning July 1972.

(c) Change in earnings test:

In any year in which an automatic benefit increase becomes effective, the exempt amount under the retirement test would be automatically increased in the same manner as the contribution and benefit base is increased—according to the rise in average wages covered by the program.

Effective date.—First possible increase effective for January 1974.

Special minimum primary insurance amounts

A special minimum benefit would be provided for people who worked for 15 or more years under social security. The benefit would be equal to $5 multiplied by the number of years of coverage the person has under the social security program, up to a maximum of 30 years. The highest minimum benefit under this provision would be $150 for a person who had 30 or more years of coverage. The special minimum would not be raised under the automatic benefit increase provisions.

Effective date.—January 1972.

Number of people affected and dollar payments.—300,000 people would get increased benefits on the effective date and $30 million in additional benefits would be paid in the first full year.

Increased widow's and widower's insurance benefits

A widow (or widower), including those already on the rolls, would be entitled to a benefit equal to 100 percent of the amount her deceased husband would be receiving if he were still living. Benefits applied for before age 65 would be reduced according to the widow's age at the time of application.

Effective date.—January 1972.

Number of people affected and dollar payments.—3.4 million people would receive increased benefits on the effective date, and $764 million in additional benefits would be paid in the first full year.

Increased benefits for those who delay retirement beyond age 65

A worker's old-age benefit would be increased by 1 percent for each year (½ of 1 percent for each month) in which the worker between ages 65 and 72 does not receive benefits because he is working after age 65. No increased benefit would be paid under the provision to the worker's dependents or survivors.

Effective date.—Prospective only for computations and recomputations after 1971 based on earnings after 1970.

Number of people affected and dollar payments.—400,000 people would receive increased benefits, and $11 million in additional benefits would be paid, in the first full year.

Age-62 computation point for men.

Under present law, the method of computing benefits for men and women differs in that years up to age 65 must be taken into account

in determining average earnings for men, while for women only years up to age 62 must be taken into account. Also, benefit eligibility is figured up to age 65 for men and up to age 62 for women. Under the bill, these differences, which provide special advantages for women, would be eliminated by applying the same rules to men as now apply to women.

The new provision would become effective over a 3-year transition period. The number of years used in computing benefits for men would be reduced in three steps. Men who reach age 62 in 1972 would have only years up to age 64 taken into account; men who reach age 62 in 1973 would have only years up to age 63 taken into account; men reaching age 62 in 1974 or later would have only years up to age 62 taken into account in determining average earnings. The number of quarters of coverage needed for insured status for men would also be reduced in three steps, with the first step in the reduction effective for January 1972 and subsequent reductions in 1973 and 1974.

Effective date.—Prospective only, in 3 annual steps, becoming fully effective for men reaching 62 in 1974 and after.

Dollar payments.—$6 million in additional benefits would be paid in the first full year.

Additional dropout years

One additional year of low earnings—in addition to the 5 years provided under present law—for each 15 years of covered work could be dropped in computing the average monthly wage on which benefit amounts are based.

Effective date.—Benefits payable on the basis of the earnings of people who reach age 62 or die after 1971 or whose first month of entitlement to disability insurance benefits is after December 1971.

Dollar payments.—$17 million in additional benefits would be paid in the first full year.

Election to receive actuarially reduced benefits in one category not to be applicable to certain benefits in other categories

Under present law, when a person receives a benefit in one benefit category that is reduced because it is taken before age 65, and also receives another benefit in a different benefit category beginning with the same month or a later month, the second benefit is generally reduced to reflect the reduction in the first benefit. For example, when a woman applies for a retirement benefit prior to age 65, it is reduced under the actuarial reduction formula; if she applies for a spouse's benefit at age 65 or later, it is reduced to take account of the fact that she took her retirement benefit early. The bill would eliminate the actuarial reduction of the spouse's benefit in such cases. The same rule would apply to men entitled to dependent husbands' benefits.

Effective date.—The sixth month following the month of enactment.

Number of people affected and dollar payments.—100,000 people would receive increased benefits on the effective date, and $20 million in additional benefits would be paid in the first full year.

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Computation of benefits based on combined earnings

A working married couple each of whom had at least 20 years of covered earnings under the program after marriage could have their earnings for each year combined up to the maximum amount of taxable earnings for that year. If they elected to have their earnings combined, each member would receive a benefit equal to 75 percent of the benefit based on their combined earnings. Payments to the surviving spouse based on the combined earnings would continue at the 75-percent rate. Dependents' and other survivors' benefits would not be affected. The provision would be an alternative to present law and would apply only if higher payments would result.

Effective date.—Prospective only for people who attain age 62 in or after January 1972.

Dollar payments.—$11 million in additional benefits would be paid in the first full year.

Liberalization of the retirement test

The amount that a beneficiary under age 72 may earn in a year and still be paid full social security benefits for the year would be increased from the present $1,680 to $2,000. Under present law, benefits are reduced by $1 for each $2 of earnings between $1680 and $2880 and for each $1 of earnings above $2880. The bill would provide for a $1 reduction for each $2 of all earnings above $2000; there would be no $1-for-$1 reduction as under present law. Also, in the year in which a person attains age 72 his earnings in and after the month in which he attains age 72 would not be included, as under present law, in determining his total earnings for the year.

Effective date.—Taxable years ending after 1971.

Number of people affected and dollar payments.—In the first full year, 700,000 people would receive increased payments and 390,000 people who get no payments under present law could get some payments. Additional benefits amounting to $484 million would be paid in the first full year.

Reduced benefits for widowers at age 60

Widowers under age 62 could be paid reduced benefits (on the same basis as widows under present law) starting as early as age 60.

Effective date.—January 1972.

Childhood disability benefits

Childhood disability benefits would be paid to the disabled child of an insured retired, deceased, or disabled worker, if the disability began before age 22, rather than before 18 as under present law. In addition, a person who was entitled to childhood disability benefits could become re-entitled if he again becomes disabled within 7 years after his prior entitlement to such benefits was terminated.

Effective date.—January 1972.

Number of people affected and dollar payments.—13,000 additional people would become immediately eligible for benefits on the effective date, and $14 million in additional benefits would be paid in the first full year.

Continuation of student's benefits through end of semester

Payment of benefits to a child attending school would continue through the end of the semester or quarter in which the student

(including a student in a vocational school) attains age 22 (rather than the month before he attains age 22) if he has not received, or completed the requirements for, a bachelor's degree from a college or university.

Effective date.—January 1972.

Number of people affected and dollar payments.—55,000 students would have their benefits continued beyond age 22, and $16 million in additional benefits would be paid, in the first full year.

Benefit-eligibility requirements for a child adopted by an old-age or disability insurance beneficiary

The provisions of present law relating to eligibility requirements for child's benefits in the case of adoption by old-age and disability insurance beneficiaries would be modified to make the requirements uniform in both cases. A child adopted after a retired or disabled worker becomes entitled to benefits would be eligible for child's benefits based on the worker's earnings if the child is the natural child or stepchild of the worker or if (1) the adoption was decreed by a court of competent jurisdiction within the United States, (2) the child lived with the worker in the United States for the year before the worker became disabled or entitled to an old-age or disability insurance benefit, (3) the child received at least one-half of his support from the worker for that year, and (4) the child was under age 18 at the time he began living with the worker.

Effective date.—January 1968.

Nontermination of child's benefits by reason of adoption

A child's benefit would no longer stop when the child is adopted.

Effective date.—Month of enactment.

Elimination of the support requirements for divorced women

Under present law, benefits are payable to a divorced wife age 62 or older and a divorced widow age 60 or older if her marriage lasted 20 years before the divorce, and to a surviving divorced mother. In order to qualify for any of these benefits a divorced woman is required to show that: (1) she was receiving at least one-half of her support from her former husband, (2) she was receiving substantial contributions from her former husband pursuant to a written agreement, or (3) there was a court order in effect providing for substantial contributions to her support by her former husband. The bill would eliminate these support requirements for divorced wives, divorced widows, and surviving divorced mothers.

Effective date.—January 1972.

Number of people affected and dollar payments.—10,000 additional women would become immediately eligible for benefits on the effective date, and $18 million in additional benefits would be paid in the first full year.

Waiver of duration-of-marriage requirement in case of remarriage

The duration-of-marriage requirement in present law for entitlement to benefits as a worker's widow, widower, or stepchild—that is, the period of not less than nine months immediately prior to the day on which the worker died that is now required (except where death was accidental or in the line of duty in the uniformed service, in which case the period is three months)—would be waived in cases where the

worker and his spouse were previously married, divorced, and remarried, if they were married at the time of the worker's death and if the duration-of-marriage requirement would have been met at the time of the divorce had the worker died then.

Effective date.—January 1972.

Disability insured status for individuals who are blind

Under present law, to be insured for disability insurance benefits a worker must be fully insured and meet a test of substantial recent covered work (generally 20 quarters of coverage in the period of 40 calendar quarters preceding disablement). The bill would eliminate the test of recent attachment to covered work for blind people; thus a blind person would be insured for disability benefits if he is fully insured—that is, he has as many quarters of coverage as the number of calendar years that elapsed after 1950 (or the year he reached age 21, if later) and up to the year in which he became disabled.

Effective date.—January 1972.

Number of people affected and dollar payments.—30,000 additional people would become immediately eligible for benefits on the effective date, and $29 million in additional benefits would be paid in the first full year.

Wage credits for members of the uniformed services

Present law provides for a social security noncontributory wage credit of up to $300, in addition to contributory credit for basic pay, for each calendar quarter of military service after 1967. Under the bill, the additional noncontributory wage credits would also be provided for service during the period January 1957 (when military service came under contributory social security coverage) through December 1967.

Effective date.—January 1, 1972.

Number of people affected and dollar payments.—130,000 additional people would receive larger benefits on the effective date, and $39 million in additional benefits would be paid in the first full year.

Reduction in waiting period for disability benefits

The present 6-month period throughout which a person must be disabled before he can be paid disability benefits would be reduced by one month (to 5 months).

Effective date.—January 1972.

Number of people affected and dollar payments.—950,000 people would receive increased benefits, and $105 million in additional benefits would be paid, in the first full year.

Disability insurance benefits applications filed after death

Disability insurance benefits (and dependents' benefits based on a worker's entitlement to disability benefits) would be paid to the disabled worker's survivors if an application for benefits is filed within 3 months after the worker's death, or within 3 months after enactment of this provision.

Effective date.—For deaths occurring after 1969.

Disability benefits affected by the receipt of workmen's compensation

Under present law, social security disability benefits must be reduced when workmen's compensation is also payable if the combined payments exceed 80 percent of the worker's average current earnings before disablement. Average current earnings for this purpose can be computed on two different bases and the larger amount will be used. The bill adds a third alternative base, under which a worker's average current earnings can be based on the one year of his highest earnings in a period consisting of the year of disablement and the five preceding years.

Effective date.—January 1972.

Number of people affected and dollar payments.—65,000 people would receive increased benefits on the effective date, and $4 million in additional benefits would be paid in the first full year.

Optional determination of self-employment earnings

Self-employed persons could elect to report for social security purposes two-thirds of their gross income from nonfarm self-employment, but not more than $1,600. (This optional method of reporting is similar to the option available under present law for farm self-employment.) A regularity of coverage requirement would have to be met and the option could be used only five times by any individual.

Effective date.—Taxable years beginning after 1971.

Payments by an employer to the survivor or estate of a former employee

Amounts earned by an employee which are paid after the year of his death to his survivors or his estate would be excluded from coverage. Under present law, such wages are covered and social security taxes must be paid on these wages but the wages cannot be used to determine eligibility for or the amount of social security benefits.

Effective date.—January 1972.

Coverage of members of religious orders who are under a vow of poverty

Social security coverage would be made available to members of religious orders who have taken a vow of poverty, if the order makes an irrevocable election to cover these members as employees of the order.

Effective date.—Upon enactment.

Self-employment income of certain individuals living temporarily outside the United States

Under present law, a U.S. citizen who retains his residence in the United States but who is present in a foreign country or countries for approximately 17 months out of 18 consecutive months, must exclude the first $20,000 of his earned income in computing his taxable income for social security and income tax purposes. The bill would provide that U.S. citizens who are self-employed outside the U.S. and who retain their residence in the United States would not exclude the first $20,000 of earned income for social security purposes and would compute their earnings from self-employment for social security purposes in the same way as those who are self-employed in the U.S.

Effective date.—Taxable years beginning after 1971.

Penalty for furnishing false information to obtain a social security number

Provides criminal penalties when an individual furnishes false information in applying for a social security number with intent to deceive the Secretary as to his true identity.

Trust fund expenditures for rehabilitation services

Provides an increase in the amount of social security trust fund monies that may be used to pay for the costs of rehabilitating social security disability beneficiaries. The amount would be increased from 1 percent of the previous year's disability benefits (as under present law) to 1¼ percent for fiscal year 1972 and to 1½ percent for fiscal year 1973 and subsequent years.

Dollar payments.—Additional payments for the cost of vocational rehabilitation services would amount to $17 million in the first full year.

Other OASDI amendments

Other changes relate to social security coverage of policemen and firemen in Idaho, public hospital employees in New Mexico, Federal Home Loan Bank employees, employees of the Government of Guam, and students employed by certain nonprofit organizations; retroactive payments for certain disabled people; social security benefits for a child entitled on the earnings record of more than one worker; benefits for certain dependent grandchildren; recomputation of benefits to survivors of a deceased worker who was entitled to both social security and railroad retirement benefits; authorization for the Managing Trustee of the social security trust funds to accept money gifts or bequests; and preserving the amount of a family's benefit when the worker's benefit is increased.

II. PROVISIONS RELATING TO MEDICARE, MEDICAID, AND MATERNAL AND CHILD HEALTH

A. ELIGIBILITY AND PAYMENT FOR BENEFITS

Extending health insurance protection to disabled beneficiaries

Health insurance protection under title XVIII would be extended to persons entitled to monthly cash benefits under the social security and railroad retirement programs because they are disabled, after they have been entitled to disability benefits for at least two years.

Effective date.—July 1972.

Number of people affected and dollar payments.—About 1.5 million disabled social security and railroad beneficiaries would be eligible for both hospital benefits and physician coverage under medicare. About $1.85 billion in benefits would be paid on behalf of disabled beneficiaries in the first full year of the program.

Hospital insurance for the uninsured

People reaching age 65 who are ineligible for hospital insurance benefits under medicare would be able to enroll, on a voluntary basis, for hospital insurance coverage under the same conditions under which people can enroll under the supplementary medical insurance part of medicare. Those who enroll would pay the full cost of the protection—$31 a month at the beginning of the program—rising as hospital costs rise. States and other organizations, through agreements with the Secretary, would be permitted to purchase such protection on a group basis for their retired (or active) employees age 65 or over.

Effective date.—January 1972.

Amount of supplementary medical insurance premium

The supplementary medical insurance premium will be determined as under present law for months through June 1972 ($5.30 through June 1971 and $5.60 from July 1971 through June 1972.) Thereafter, the Secretary of Health, Education, and Welfare would, as under present law, determine and promulgate for each year a monthly enrollee premium for both aged and disabled. However, the enrollee premiums would be increased only in the event of the enactment of legislation providing for a general benefit increase or in the event of an automatic general benefit increase. In any given year, the premium would rise by no more than the percentage by which cash benefits had been increased across the board in the interval since the premium was last increased. The premium amount paid by the beneficiary would never exceed one-half of total program costs.

Effective date.—July 1972.

Change in supplementary medical insurance deductible

The Medicare part B deductible, currently $50 per year, would be increased to $60.

Effective date.—January 1972.

Coinsurance under hospital insurance and the lifetime reserve

Coinsurance equal to one-eighth of the inpatient hospital deductible would be imposed for each day of inpatient hospital coverage during a benefit period beginning with the 31st day and continuing through the 60th day. This amount is now $7.50, but would increase as the inpatient hospital deductible increases (as hospital costs rise). (Coinsurance for the 61st through the 90th day would remain equal to one-fourth of the inpatient hospital deductible.) The lifetime reserve, under which the beneficiary pays one-half of the hospital deductible, would be increased from 60 days to 120 days.

Effective date.—Hospital stays beginning after 1971.

Automatic enrollment for supplementary medical insurance

People entitled to hospital insurance benefits would be automatically enrolled and covered for supplementary medical insurance benefits unless they indicate they do not want to be enrolled for such coverage.

Effective date.—January 1972.

Incentives for comprehensive care under medicaid

Incentives would be created for States to contract with health maintenance organizations or similar facilities. At the same time, disincentives would be provided to discourage prolonged stays in institutions. Specifically, there would be—

(1) an increase of 25 percent (up to maximum of 95 percent) in the Federal Medicaid matching percentage to States under contract with HMO's or other comprehensive health care facilities;

(2) a decrease in the Federal medical assistance percentage by one-third after the first 60 days of care in a general or TB hospital;

(3) a reduction in the Federal percentage by one-third after the first 60 days of care in a skilled nursing home unless the State establishes that it has an effective utilization review program;

(4) a decrease in Federal matching by one-third after 90 days of care in a mental hospital and provision for no Federal matching after 275 additional days of such care during an individual's lifetime except that the 90-day period may be extended for an additional 30 days if a doctor certifies that the patient will benefit therapeutically from such an additional period of hospitalization; and

(5) authority for the Secretary to compute a reasonable cost differential for reimbursement between skilled nursing homes and intermediate care facilities.

Effective date.—July 1, 1971, except that the reasonable cost differential provision would be effective January 1, 1972.

Cost sharing under medicaid

The Secretary of Health, Education, and Welfare would be able to require the payment of a premium, related to income, for those eligible as medically indigent (non-cash recipients) under a State medicaid program. In addition, states would be permitted to impose a nominal cost sharing with respect to cash recipients, but applying only to services not required to be provided under the State program. States could apply copayment provisions to the medically indigent which are not related to income.

Effective date.—July 1, 1972.

Determination of payments under medicaid

Families eligible for cash assistance would have a deductible under medicaid equal to one-third of the family's earnings above $720 (after deducting the earnings of school children and any costs of required child care) less the difference between the medicaid standard and the payment standard, if any, in that State. All States would be required to impose such a deductible. Any family with income below the State medicaid standard would be eligible for medicaid assistance.

Effective date.—July 1, 1972.

Relationship between medicare and Federal employees benefits

Effective with January 1, 1975, no payment would be made under medicare for the same services covered under a Federal employees health benefits plan, unless in the meantime the Secretary of Health, Education, and Welfare certifies that such plan or the Federal employees health benefits program has been modified to make available coverage supplementary to medicare benefits and that Federal employees and retirees age 65 and over will continue to have the benefit of a contribution toward their health insurance premiums from either the Government or the individual plan.

Effective date.—January 1975.

Medicare benefits for people living near United States border

Medicare beneficiaries living in border areas of the United States would be entitled to covered inpatient hospital care outside the United States if the hospital they use is closer to their residence than a comparable United States hospital and if it has been accredited by a hospital approval program with standards comparable to medicare standards. Coverage would also be extended in these cases to physicians' and ambulance services furnished in conjunction with covered foreign hospital care.

Effective date.—January 1972.

B. IMPROVEMENTS IN OPERATING EFFECTIVENESS

Limitation on Federal participation for capital expenditures

Reimbursement amounts to providers of health services and health maintenance organizations under the medicare, medicaid, and maternal and child health programs for capital costs, such as depreciation and interest, would not be made with respect to large capital expenditures which are inconsistent with State or local health facility plans. States would be required to establish procedures by which a facility or organization proposing a capital expenditure may appeal a decision by a planning agency.

Effective date.—July 1972 (or earlier if requested by a State).

Experiments and demonstration projects in prospective reimbursement and incentives for economy

The Secretary of Health, Education, and Welfare would be required to develop experiments and demonstration projects designed to test various methods of making payment to providers of services on a prospective basis under the medicare, medicaid, and maternal and child health programs. In addition, the Secretary would be authorized to conduct experiments with methods of payment or reimbursement designed to increase efficiency and economy (including payment for services furnished by organizations providing comprehensive, mental, or ambulatory health care services); with areawide or communitywide peer review, utilization review, and medical review mechanisms; and with performance incentives for intermediaries and carriers.

Effective date.—Enactment.

Limits on costs recognized as reasonable

The Secretary of Health, Education, and Welfare would be given authority to establish and promulgate limits on provider costs to be recognized as reasonable under medicare based on comparisons of the cost of covered services by various classes of providers in the same geographical area. Hospitals and extended care facilities could charge beneficiaries for the costs of services in excess of those that are found necessary to the efficient delivery of needed health services (except in the case of an admission by a physician who has a financial interest in the facility).

Effective date.—July 1972.

Limits on prevailing charge levels

Physicians' charges determined to be reasonable under the present criteria in the medicare, medicaid, and maternal and child health law would be limited by providing: (a) that after December 31, 1970, medical charge levels recognized as prevailing may not be increased beyond the 75th percentile of actual charges in a locality during the calendar year elapsing prior to the start of the fiscal year; (b) that for fiscal year 1973 and thereafter the prevailing charge levels recognized for a locality may be increased, in the aggregate, only to the extent justified by indexes reflecting changes in costs of practice of physicians and in earnings levels; and (c) that for medical supplies, equipment, and services that, in the judgment of the Secretary, generally do not vary significantly in quality from one supplier to another, charges

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allowed as reasonable may not exceed the lowest levels at which such supplies, equipment, and services are widely available in a locality.

The existing Health Insurance Benefits Advisory Council is to conduct a study of the methods of reimbursement of physicians' fees under medicare and report to the Congress no later than July 1, 1972.

Effective date.—(See provision.)

Limits on skilled nursing home and intermediate care facility costs

The average per diem costs for skilled nursing homes and intermediate care facilities countable for Federal financial participation under medicaid would be limited to 105 percent of such costs for the same quarter of the preceding year. Increases resulting from higher labor costs due to minimum wage legislation would not count in computing the cost figure.

Effective date.—January 1, 1972.

Payments to health maintenance organizations

Medicare beneficiaries could choose to have all covered care, except emergency services, provided by a health maintenance organization (a prepaid group health or other capitation plan). The Department of Health, Education, and Welfare would contract with such organizations, and would reimburse them on a monthly per capita basis at a rate equivalent to 95 percent of the estimated per capita costs of medicare beneficiaries in the area who are not enrolled in such organizations. Profits accruing to the organization, beyond its retention rate for nonmedicare members, would be passed on to the medicare enrollees in the form of expanded benefits.

Effective date.—January 1972.

Payments for services of teaching physicians

Medicare would pay for the services of teaching physicians on the basis of reasonable costs, rather than fee-for-service charges, unless a bona fide private patient relationship had been established or the hospital had, in the 2-year period ending in 1967, and subsequently, customarily charged all patients and collected from at least 50 percent of patients on a fee-for-service basis. Medicare payments would also be authorized on a cost basis for services provided to hospitals by the staff of certain medical schools.

Effective date.—Accounting periods beginning after June 30, 1971.

Advance approval of extended care and home health services under medicare

The Secretary of Health, Education, and Welfare would be authorized to establish minimum periods of time (by medical condition) after hospitalization during which a patient would be presumed, for payment purposes, to require extended care level of services in an extended care facility. The attending physician would certify to the condition and related need for the services. A similar provision would apply to post-hospital home health services.

Effective date.—January 1972.

Termination of payments to suppliers of services who abuse the medicare or medicaid programs

The Secretary of Health, Education, and Welfare would be given authority to terminate payment for services rendered by a supplier of health and medical services found to be guilty of program abuses.

Program review teams would be established to furnish the Secretary professional advice in carrying out this authority.

Effective date.—Enactment.

Elimination of requirement that States have comprehensive medicaid programs

The existing requirement that States have comprehensive medicaid programs by 1977 would be repealed.

Effective date.—Enactment.

Reductions in care and services under medicaid

The states would be permitted to eliminate or reduce the scope and extent of health services which are optional under the Federal medicaid statute, e.g., outpatient drugs, eyeglasses and dental care. States would have to provide the same dollar amounts for their required health services.

Effective date.—Enactment.

State determinations of reasonable hospital costs under medicaid

States would be allowed to develop methods and standards for reimbursing the reasonable cost of inpatient hospital services. Such costs could not exceed medicare rates.

Effective date.—July 1, 1972, or earlier if a State plan so provides

Government payment no higher than charges

Payments for institutional services under the medicare, medicaid, and maternal and child health programs could not be higher than the charges regularly made for these services.

Effective date.—July 1971.

Institutional planning under medicare

Health institutions under the medicare program would be required to have a written plan reflecting an operating budget and a capital expenditure budget.

Effective date.—Sixth month following month of enactment.

Federal matching for automated medicaid systems

Federal matching for the cost of designing, developing, and installing mechanized claims processing and information retrieval systems would be set at 90 percent and 75 percent for operation of such systems.

Effective date.—July 1, 1971.

Prohibition of reassignments

Medicare (part B) and medicaid payments to anyone other than a patient, his physician, or other person providing the service, would be prohibited, unless the physician (or, in the case of medicaid, another type of practitioner) is required as a condition of his employment to turn over his fees to his employer or unless there is a contractual arrangement between the physician and the facility in which the services were provided under which the facility bills for all such services.

Effective date.—Enactment date for medicare; July 1, 1972 (or earlier at the option of the State) for medicaid.

Institutional utilization review under medicaid

The same utilization review committees now reviewing medicare cases in hospitals and nursing homes would be required to review medicaid cases in institutions utilized by medicare.

Stopping payment where hospital admission not necessary under medicare

If the utilization review committee of a hospital or extended care facility, in its sample review of admissions, finds a case where institutionalization is no longer necessary, payment would be cut off after 3 days. This provision parallels the provision in present law under which long-stay cases are cut off after 3 days when the utilization review committee determines that institutionalization is no longer required.

Effective date.—Third month following the month of enactment.

Use of health agencies in medicaid

State medicaid programs would be required—

(1) To establish and implement plans, prepared by the State health agency, or other appropriate State medical agency, for the professional review of care provided to medicaid recipients, and

(2) Provide that the State medical agency which licenses health institutions shall perform that function for medicaid.

Effective date.—July 1, 1972.

Medicaid and comprehensive health care programs

A state medicaid plan would not be out of compliance if it arranged for medicaid care through a comprehensive health plan in one or more areas which provided more services than are generally provided under the State's medicaid plan.

Effective date.—Enactment.

Program for determining qualifications for certain health care personnel

The Secretary of Health, Education, and Welfare would be required to develop and employ proficiency examinations to determine whether health care personnel, not otherwise meeting specific formal criteria now included in medicare regulations, have sufficient training, experience, and professional competence to be considered qualified personnel for purposes of the medicare and medicaid program.

Effective date.—Enactment.

Penalty for fraudulent acts under medicare and medicaid

Present penalty provisions relating to the making of a false statement or representation of a material fact in any application for medicare payments would be broadened to include the soliciting, offering, or acceptance of kickbacks or bribes, including the rebating of a portion of a fee or a charge for a patient referral, by providers of health care services. The penalty for such acts would be imprisonment up to one year, a fine of $10,000, or both. Similar penalty provisions would apply under medicaid.

Anyone who knowingly and willfully makes, or induces the making of, a false statement of material fact with respect to the conditions and operation of a health care facility or home health agency in order to secure medicare or medicaid certification of the facility or agency, would be guilty of a misdemeanor punishable by up to 6 months' imprisonment, a fine of not more than $2,000, or both.

Effective date.—Enactment.

C. MISCELLANEOUS AND TECHNICAL PROVISIONS

Physical therapy and other therapy services under medicare

Under medicare's supplementary medical insurance program, up to $100 per calendar year of physical therapy services furnished by a licensed physical therapist in his office or the patient's home under a physician's plan would be included in covered charges. Hospitals and extended care facilities could provide physical therapy services under part B to inpatients who have exhausted their days of hospital insurance coverage. Where physical therapy and other ancillary services are furnished by a provider of services, or by others under arrangements with the provider, medicare reimbursement to the provider would in all cases be based on a reasonable salary payment for the services.

Effective date.—January, 1972.

Coverage of supplies related to colostomies

Medicare coverage would be provided for colostomy bags and supplies directly related to colostomy care.

Effective date.—Enactment.

Ptosis bars

Coverage would be provided under part B of medicare for ptosis bar devices required for the care of individuals suffering from paralysis or atrophy of the eyelid muscle.

Effective date.—Enactment.

Intermediate care facilities under medicaid

The provisions for optional coverage of intermediate care facilities would be moved from title XI of the Act (here it applies, by reference to the cash assistance titles) to title XIX as an optional service. Services in a public institution for the mentally retarded could qualify if the primary purpose is to provide health or rehabilitation services and if the patient is receiving active treatment.

Effective date.—January 1, 1972.

Coverage prior to application under medicaid

States would be required to provide medicaid coverage for care and services furnished in or after the third month prior to the application of an eligible person.

Effective date.—July 1, 1972.

Certification of hospitalization for dental care

A dentist would be authorized to certify the necessity for hospitalization to protect the health of a medicare patient who is hospitalized for a noncovered dental procedure.

Effective date.—Third month after month of enactment.

Grace period for paying medicare premium

Where there is good cause for a medicare beneficiary's failure to pay supplementary medical insurance premiums, an extended grace period of 90 days would be provided.

Effective date.—Enactment.

Extension of time for filing medicare claims

The time limit for filing supplementary medical insurance claims would be extended where the medicare beneficiary's delay is due to administrative error.

Effective date.—Enactment.

Waiver of enrollment period requirements where administrative error is involved

Relief would be provided where administrative error has prejudiced an individual's right to enroll in medicare's supplementary medical insurance program.

Effective date.—July 1966.

Three-year limitation on medicare enrollment dropped

Eligible beneficiaries would be permitted to enroll under medicare's supplementary medical insurance program during any prescribed enrollment period. Beneficiaries would no longer be required to enroll within 3 years following first eligibility or a previous withdrawal from the program.

Effective date.—Enactment.

Waiver of medicare overpayment

Where incorrect medicare payments were made to a deceased beneficiary, the liability of survivors for repayment could be waived if the survivors were without fault in incurring the overpayment.

Effective date.—Enactment.

Medicare fair hearings

Fair hearings, held by medicare carriers in response to disagreements over amounts paid under supplementary medical insurance, would be conducted only where the amount in controversy is $100 or more.

Effective date.—Enactment.

Collection of medicare premium by the railroad retirement board

Where a person is entitled to both railroad retirement and social security monthly benefits, his premium payment for supplementary medical insurance benefits would be deducted from his railroad retirement benefit in all cases. The Railroad Retirement Board is given authority to choose the carrier for part B benefits for its beneficiaries.

Effective date.—Applicable to premiums becoming due after the fourth month following the month of enactment.

Prosthetic lenses furnished by optometrists

The definition of physician, for purposes of the medicare program, would be amended to include a licensed doctor of optometry, but only with respect to establishing the medical necessity of prosthetic lenses (which are already covered under the program).

Effective date.—Enactment.

Social services requirement in extended care facilities

The present requirement for social services in extended care facilities under medicare would be removed.

Effective date.—Enactment.

Refund of excess premiums

In the event of the death of a medicare beneficiary, any hospital or medical insurance premiums paid for any month after the month of his death will be refunded to his estate or to a survivor.

Effective date.—Enactment.

Waiving of requirement for skilled nursing homes in rural areas

The requirement that skilled nursing homes under medicaid have at least one full-time registered nurse on the staff would be waived for up to one year at a time over a five-year period where the skilled nursing home is in a rural area and certain other conditions are met.

Effective date.—Enactment.

Exemption of Christian Scientist sanatoriums from certain requirements under medicaid

Christian Scientist sanatoriums under medicaid would be exempted from provisions in the bill which require certain health-related functions or conditions.

Effective date.—Enactment.

Requirements for nursing home administrators

States would be permitted to provide under medicaid for a permanent waiver of a nursing home administrator who had been such an administrator for more than 3 years before the time the basic provision became effective (July 1970).

Effective date.—Enactment.

Termination of Nursing Home Administration Advisory Council

The National Advisory Council on Nursing Home Administrations under medicaid would be terminated.

Effective date.—Thirty days after enactment.

Increase in limit on payments to Puerto Rico for medicaid

The present limit of $20 million on the annual Federal payment for medicaid would be raised to $30 million. The present matching rate of 50 percent would be retained.

Effective date.—Fiscal year 1972.

Provider reimbursement review board under medicare

Providers of services, under certain circumstances, would be permitted to appeal to a review board (established by the Secretary specifically to conduct such reviews) from a decision of the fiscal intermediary concerning the amount of program reimbursement, if the amount in controversy is at least $10,000.

Chiropractors' services

The Secretary of Health, Education, and Welfare would conduct a study of the desirability of covering chiropractors' services under medicare, utilizing the experiments and experience under the medicaid program. A report on the study, including the experience of other programs paying for chiropractors' services, would be submitted to the Congress within 2 years after enactment of the bill.

Effective date.—Enactment.

Extension of title V to American Samoa and the Trust Territory of the Pacific

The crippled children and maternal and child health provisions of title V of the Act would be extended to American Samoa and the Trust Territory of the Pacific.

Effective date.—Fiscal years beginning after June 30, 1971.

FINANCING OASDHI

In order to finance the changes in the OASDHI program as amended by the bill, the limit on taxable earnings would be increased to $10,200 effective January 1972 and the following schedule of OASDI and HI tax rates would be provided:

SOCIAL SECURITY TAX RATES AND MAXIMUM ANNUAL SOCIAL SECURITY TAXES FOR EMPLOYEES, EMPLOYERS, AND SELF-EMPLOYED

	Employees and employers, each				Self-employed			
	OASDI, percent	HI, percent	Total, percent	Maximum tax	OASDI, percent	HI, percent	Total, percent	Maximum tax
Present law:								
1971 [1]	4.6	0.6	5.2	$405.60	6.9	0.6	7.5	$585.00
1972 [2]	4.6	.6	5.2	468.00	6.9	.6	7.5	675.00
1973–75 [2]	5.0	.65	5.65	508.50	7.0	.65	7.65	688.50
1976–79 [2]	5.15	.7	5.85	526.50	7.0	.7	7.7	693.00
1980–86 [2]	5.15	.8	5.95	535.50	7.0	.8	7.8	702.00
1987 and after [2]	5.15	.9	6.05	544.50	7.0	.9	7.9	711.00
H.R. 1 (excluding effect of the automatic adjustment provisions):								
1971 [1]	4.6	.6	5.2	405.60	6.9	.6	7.5	585.00
1972–74 [3]	4.2	1.2	5.4	550.80	6.3	1.2	7.5	765.00
1975–76 [3]	5.0	1.2	6.2	632.40	7.0	1.2	8.2	836.40
1977 and after [3]	6.1	1.3	7.4	754.80	7.0	1.3	8.3	846.60

[1] Tax rates apply to annual earnings up to $7,800.
[2] Tax rates apply to annual earnings up to $9,000.
[3] Tax rates apply to annual earnings up to $10,200.

1ST-YEAR BENEFIT COSTS AND NUMBER OF PERSONS AFFECTED BY OLD-AGE, SURVIVORS, DISABILITY, AND MEDICARE PROVISIONS OF H.R. 1

[Amounts in millions; numbers of persons in thousands]

Provision	1st-year benefit costs [1]	Present-law beneficiaries immediately affected [2]	Newly eligible persons [3]
Total	$5,438		
Cash benefit changes applicable to both present and future beneficiaries:			
5 percent benefit increase—effective June 1972	2,073	27,400	16
Other cash benefit changes—generally effective January 1972:			
Retirement test changes:			
$2,000 exempt amount; 1 for 2 above $2,000	473	680	390
Earnings in year of attainment of age 72	11	20	
Increased benefits for widows and widowers to 100 percent of PIA (limited to OAIB)	764	3,400	
Children disabled at ages 18–21	14		13
Noncontributory credits for military service after 1956	39	150	
Election to receive larger future benefits by certain beneficiaries eligible for more than 1 actuarially reduced benefit	20	100	
Eliminate support requirement for divorced wives and surviving divorced wives	18		10
Student child's benefits continued after age 22 to end of semester	16	55	
Special minimum PIA up to $150	30	300	
Liberalized workmen's compensation offset (80 percent of high 1 year)	4	65	
Liberalized disability insured status provision for the blind (drop 20/40 requirement)	29		30
Increased allowance for vocational rehabilitation expenditures	17		
Subtotal	3,508	(4)	459
Cash benefit changes applicable only to future beneficiaries—effective January 1972:			
Age 62 computation point for men	6		
Benefits based on combined earnings of husband and wife	11		
Credit for delayed retirement	11	400	
Additional drop-out year for every 15 years of coverage	17		
Reduce disability waiting period to 5 months	105	950	
Subtotal	150	(4)	
Total, cash benefit changes	3,658	(4)	459
Medicare benefit changes:			
Hospital insurance for disabled beneficiaries [5]	1,500		1,500
Supplementary medical insurance for disabled beneficiaries [5]	350		1,500
Change in supplementary medical insurance deductible—effective January 1, 1972	−70	19,800	
Total, Medicare changes	1,780	19,800	1,500

[1] Represents additional benefit payments in the 12-month period beginning July 1, 1972.
[2] For cash benefits, present-law beneficiaries whose benefit for the effective month would be increased under the provision; for Medicare, persons with insurance protection.
[3] For cash benefits, persons who cannot receive a benefit under present law for the effective month, but who would receive a benefit for such month under the provision; for Medicare, persons who gain insurance protection.
[4] Figures not additive because a person may be affected by more than one provision.
[5] Effective July 1, 1972.

III. PROVISIONS RELATING TO ASSISTANCE FOR THE AGED, BLIND, AND DISABLED

The existing Federal-State programs of aid to the aged, blind, and permanently and totally disabled would be repealed, effective July 1, 1972, and a new, totally Federal program would be effective on that date. The new national program is designed to provide financial assistance to needy people who have reached age 65 or are blind or disabled and would be established by a new Title XX of the Social Security Act. The program would be administered by the Social Security Administration through its present administrative framework and facilities.

The eligibility requirements and other legislative elements of the new program are as follows:

Eligibility for and amount of benefits

Individuals or couples could be eligible for assistance when their monthly income is less than the amount of the full monthly payment.

Full monthly benefits for a single individual would be $130 for fiscal year 1973; $140 for fiscal year 1974, and $150 thereafter. Full monthly benefits for an individual with an eligible spouse would be $195 for fiscal year 1973, and $200 for fiscal year 1974 and thereafter. Benefits would not be paid for any full month the individual is outside the U.S.

The Secretary would establish the circumstances under which gross income from a trade or business, including farming, is large enough to preclude eligibility (net income notwithstanding). In addition, people who are in certain public institutions, or in hospitals or nursing homes getting medicaid funds, would be eligible for benefits of up to $25 a month. People who fail to apply for annuities, pensions, workmen's compensation, and other such payments to which they may be entitled would not be eligible.

Definition of income

In determining an individual's eligibility and the amount of his benefits, both his earned and unearned income would have to be taken into consideration. The definition of earned income would follow generally the definition of earnings used in applying the earnings limitation of the social security program. Unearned income would mean all other forms of income, among which are benefits from other public and private programs, prizes and awards, proceeds of life insurance not needed for expenses of last illness and burial (with a maximum of $1,500), gifts, support, inheritances, rents, dividends, interest, and so forth. For people who live as members of another person's household, the value of their room and board would be deemed to be 33⅓ percent of the full monthly payment.

The following items would be excluded from income:

1. Earnings of a student regularly attending school, with reasonable limits.
2. Irregular earned income of an individual of $30 or less in a quarter and irregular unearned income of $60 or less in a quarter.
3. The first $85 of earnings per month and one-half above that for the blind and disabled (plus work expenses for the blind). The first $60 of earnings per month and one-third above that for the aged.
4. The tuition part of scholarships and fellowships.
5. Home produce.
6. One-third of child-support payments from an absent parent.

7. Foster care payments for a child placed in the household by a child-placement agency.

8. Assistance based on need received from certain public or private agencies.

9. Vocational rehabilitation allowances.

Exclusions from resources

Individuals or couples cannot be eligible for payments if they have resources in excess of $1,500. The following items would be excluded from resources:

1. The home to the extent that its value does not exceed a reasonable amount.

2. Household goods and personal effects not in excess of a reasonable amount.

3. Other property which is essential to the individual's support (within reasonable value limitations).

4. Life insurance policies (if their total face value is $1,500 or less).

Other insurance policies would be counted only to the extent of their cash surrender value.

The Secretary would prescribe periods of time and manners in which excess property must be disposed of in order that it not be included as resources.

Meaning of terms

An eligible individual must be a resident of the United States, Puerto Rico, the Virgin Islands, or Guam and a citizen or an alien admitted for permanent residence, and be aged, blind, or disabled.

Aged individual: One 65 years of age or older.

Blind individual: An individual who has central visual acuity of 20/200 or less in the better eye with the use of a correcting lens, or equivalent impairment in the fields of vision.

Disabled individual: An individual who is unable to engage in any substantial gainful activity by reason of a medically determinable physical or mental impairment which is expected to last, or has lasted, for 12 months or can be expected to end in death. (This definition is now used for social security disability benefits.)

Eligible spouse: An aged, blind, or disabled individual who is the husband or wife of an individual who is aged, blind, or disabled.

Child: An unmarried person who is not the head of a household and who is either under the age of 18, or under the age of 22 and attending school regularly.

Determination of marital relationship: Appropriate State law will apply except that, if two people were determined to be married for purposes of receiving social security cash benefits, they will be considered to be married, and two persons holding themselves out as married in the community in which they live would be considered married for purposes of this program.

Income and resources of a spouse living with an eligible individual will be taken into account in determining the benefit amount of the individual, whether or not the income and resources are available to him. Income and resources of a parent may count as income of a disabled or blind child.

Rehabilitation services

Disabled and blind beneficiaries would be referred to State agencies for vocational rehabilitation services. A beneficiary who refused without good cause any vocational rehabilitation services offered would not be eligible for benefits.

Optional State supplementation

A State which provides for a State supplement to the Federal payment could agree to have the Federal Government make the supplemental payments on behalf of the State. If a State agrees to have the Federal Government make its supplemental payments, the Federal Government would pay the full administrative costs of making such payments, but if it makes its own payments, the State would pay all of such costs.

States could but would not be required to cover under medicaid persons who are made newly eligible for cash benefits under the bill.

The Federal government, in administering supplemental benefits on behalf of a State, would be required to recognize a residency requirement if the State decided to impose such a requirement.

Payments and procedures

Benefits could be paid monthly, or otherwise, as determined by the Secretary of Health, Education, and Welfare. Benefits could be paid to an individual, an eligible spouse, partly to each, or to another interested party on behalf of the individual. The Secretary could determine ranges of incomes to which a single benefit amount may be applied.

Cash advances of up to $100 could be paid if an applicant appears to meet all the eligibility requirements and is faced with a financial emergency. Applicants apparently eligible for benefits on the basis of disability could be paid benefits for up to three months while their disability claim was in process.

The Secretary may arrange for adjustment and recovery in the event of overpayments or underpayments, and could waive overpayments to achieve equity and avoid penalizing people who were without fault.

People who are, or claim to be, eligible for benefits and who disagree with determinations of the Secretary, could obtain hearings if they request them within 30 days. Final determinations would be subject to judicial review in Federal district courts, but the Secretary's decisions as to any fact would be conclusive and not subject to review by the courts.

The right of any person to any future benefit would not be transferable or assignable, and no money payable under the program would be subject to execution, levy, attachment, garnishment, or other legal process.

If an individual fails to report events and changes relevant to his eligibility without good cause, benefits which may be payable to the individual would be terminated or reduced.

The heads of other Federal agencies would be required to provide such information as the Secretary of HEW needs to determine eligibility for benefits.

Penalties for fraud

A penalty of up to $1,000 or up to one year imprisonment, or both, would be provided in case of fraud under the program.

Administration

The Secretary of HEW may make administrative and other arrangements as necessary to carry out the purposes of the program and the States could enter into agreements to administer the Federal benefits during a transitional period.

Evaluation and research

The Secretary of HEW would continually evaluate the program, including its effectiveness in achieving its goals and its impact on related programs. He could conduct research and contract for independent evaluations of the program. Up to $5 million a year would be appropriated to carry out the evaluation and research. Annual reports to the President and the Congress on the operation and administration of the program would be required.

IV. PROVISIONS RELATING TO FAMILY PROGRAMS

The present program of aid to families with dependent children (AFDC) would be repealed effective July 1, 1972, and two new totally Federal programs would take effect on that day. The new programs would be adopted for a period of five years (through fiscal year 1977) in order to give Congress an opportunity to review their operation before continuing them in subsequent years. The new programs would be established by a new Title XXI in the Social Security Act. A description of the two new programs follows:

Families in which at least one person is employable would be enrolled in the Opportunities for Families Program, administered by the Department of Labor. Families with no employable person would be enrolled in the Family Assistance Plan administered by the Department of Health, Education, and Welfare.

A—OPPORTUNITIES FOR FAMILIES PROGRAM

Registration for employment and training

Every member of a family who is found to be available for work by the Secretary of Health, Education, and Welfare would be required to register for manpower services, training and employment.

An individual would be considered available for work unless such person—

(1) Is unable to work or be trained because of illness, incapacity, or age;

(2) Is a mother or other relative caring for a child under age 6 (age 3 beginning July 1974);

(3) Is the mother or other female caretaker of a child, if the father or another adult male relative is in the home and is registered.

(4) Is a child under the age of 16 (or a student up to age 22);

(5) Is needed in the home on a continuous basis because of illness or incapacity of another family member.

Nevertheless, any person (except one who is ill, incapacitated, or aged) who would be exempted from registering by the above provisions could voluntarily register.

Every person who registered (other than a volunteer) would be required to participate in manpower services or training and to accept available employment. An individual could not be required to accept employment however—

(1) If the position offered is vacant due to a strike, lockout, or other labor dispute;

(2) If the wages and other employment conditions are contrary to those prescribed by applicable Federal, State, or local law, or less favorable than those prevailing for similar work in the locality, or the wages are less than an hourly rate of ¾ of the highest Federal minimum wage ($1.20 per hour under present law);

(3) If membership in a company union or non-membership in a bona fide union is required;

(4) If he has demonstrated the capacity to obtain work that would better enable him to achieve self-sufficiency, and such work is available.

Child care and other supportive services

The Secretary of Labor directly or by using child care projects under the jurisdiction of the Department of Health, Education, and Welfare, would provide for child care services for registrants who require them in order to accept or continue to participate in manpower services, training, employment, or vocational rehabilitation.

The Secretary of Labor would be authorized funds to provide child care by grant or contract. Families receiving such services might also be required to pay all or part of the costs involved.

Health, vocational rehabilitation, family planning, counseling, social, and other supportive services (including physical examinations and minor medical services) would also be made available by the Secretary of Labor to registrants as needed.

Operation of manpower services, training and employment programs

The Secretary of Labor would develop an employability plan designed to prepare recipients to be self-supporting. The Secretary would then provide the necessary services, training, counseling, testing coaching, program orientation, job training, and followup services to assist the registrant in securing employment, retaining employment, and obtaining opportunities for advancement.

Provision would also be made for voluntary relocation assistance to enable a registrant and his family to be self-supporting.

Public service employment programs would also be used to provide needed jobs. Public service projects would be related to the fields of health, social service, environmental protection, education, urban and rural development and redevelopment, welfare, recreation, public facility and similar activities. The Secretary of Labor would establish these programs through grants or by contract with public or nonprofit agencies or organizations. The law would provide safeguards for workers on such jobs and wages could not be less than the higher of the prevailing or applicable minimum wage or the Federal minimum wage.

Federal participation in the costs of an individual's participation in a public service employment program would be 100 percent for the first year of his employment, 75 percent for the second year, and 50 percent for the third year.

States and their subdivisions that receive Federal grants would be required to provide the Secretary of Labor with up-to-date listings of job vacancies. The Secretary would also agree with certain Federal agencies to establish annual or other goals for employment of members of families receiving assistance.

Allowances of individuals participating in training

An incentive allowance of $30 per month would be paid to each registrant who participates in manpower training (States would have the option of providing an additional allowance of up to $30). Necessary costs for transportation and similar expenses would also be paid.

Utilization of other programs

The Secretary of Labor would be required to integrate this program as needed with all other manpower training programs involving all sectors of the economy and all levels of government.

Rehabilitation services for incapacitated family members

Family members who are incapacitated would be referred to the state vocational rehabilitation service. A quarterly review of their incapacities would usually be made.

Each such incapacitated individual would be required to accept rehabilitation services that are made available to him, and an allowance of $30 would be paid him while he receives such services. (States would have the option of providing an additional allowance of up to $30.) Necessary costs for transportation and similar expenses would also be paid.

Evaluation and research; reports

The Secretary of Labor would be authorized to conduct research and demonstrations of the program and directed to make annual evaluation reports to the President and the Congress. An appropriation of $10,000,000 would be authorized for these purposes.

B—FAMILY ASSISTANCE PLAN

Payment of benefits

All eligible families with no member available for employment would be enrolled and paid benefits by the Secretary of Health, Education, and Welfare.

Rehabilitaiion services and child care for incapacitated family members

Family members who are unemployable because of incapacity would be referred to State vocational rehabilitation agencies for services. A quarterly review of their incapacities would usually be made. Such persons would be required to accept services made available, and would be paid a $30 per month incentive allowance plus transportation and other related costs. (States would have the option of providing an additional allowance of up to $30.)

Child care services would also be provided if needed to enable individuals to take vocational rehabilitation services.

Evaluation and research; reports

The Secretary of Health, Education, and Welfare would be authorized to conduct research and demonstrations of the family assistance plan and directed to make annual evaluation reports to the President and the Congress. An appropriation of $10,000,000 would be authorized for this purpose.

C—DETERMINATION OF BENEFITS

Uniform determinations

Both Secretaries would be required to apply the same interpretations and applications of fact to arrive at uniform determinations of eligibility and assistance payment amounts under the two family programs.

Eligibility for and amount of benefits

Family benefits would be computed at the rate of $800 per year for the first two members, $400 for the next three members, $300 for the next two members and $200 for the next member. This would provide $2,400 for a family of four, and the maximum amount which any family could receive would be $3,600. A family would not be eligible if it had countable resources in excess of $1,500.

If any member of the family fails to register, take required employment or training, or accept vocational rehabilitation services, the family benefits would be reduced by $800 per year.

Benefits would be determined on the basis of the family's income for the current quarter and the three preceding quarters.

After a family has been paid benefits for 24 consecutive months, a new application would be required which would be processed as if it were a new application.

The Secretary could determine that a family is not eligible if it has very large gross income from a trade or business.

Families would have to apply for all other benefits available to them in order to be eligible.

Definition of income

Earned income would follow generally the definition of earnings used in applying the earnings limitation of the social security program. Unearned income means all other forms of income among which are benefits from other public and private programs, prizes and awards, proceeds of life insurance not needed for last illness and burial (with a maximum of $1,500), gifts, support, inheritances, grants, dividends, interests and so forth.

The following items would be excluded from the income of a family:

1. Earnings of a student regularly attending school, with limits set by the Secretary.
2. Irregular earned income of an individual of $30 or less in a quarter and irregular unearned income of $60 or less in a quarter.
3. Earned income used to pay the cost of child care under a schedule prescribed by the Secretary.

4. The first $720 per year of other earned income plus one-third of the remainder.
5. Assistance based on need received from public or private agencies, except veterans' pensions.
6. Training allowances.
7. The tuition part of scholarships and fellowships.
8. Home produce.
9. One-third of child support and alimony.
10. Foster care payments for a child placed in the family by a child placement agency.

The total of the exclusions under (1), (2), and (3) above could not exceed $2,000 for a family of four rising by $200 for each additional member to an overall maximum of $3,000.

Exclusions from resources

A family cannot be eligible for payments if it has resources in excess of $1,500. In determining what is included in the $1,500 amount, the following items are excluded:

1. The home to the extent that its value does not exceed a reasonable amount.
2. Household goods and personal effects not in excess of a reasonable amount.
3. Other property which is essential to the family's self-support.

An insurance policy would be counted only to the extent of its cash surrender value except that if the total face value of all such policies with respect to an individual is $1,500 or less, no cash surrender value will be counted.

The Secretary would prescribe periods of time, and manners in which, property must be disposed of in order that it would not be included as resources.

Meaning of family and child

A family would be defined as two or more related people living together in the United States where at least one of the members is a citizen or a lawfully admitted alien and where at least one of them is a child dependent on someone else in the family.

No family will be eligible if the head of the household is an undergraduate or graduate student regularly attending a college or university. Benefits would not be payable to an individual for any month in which he is outside the United States.

The term "child" means an unmarried person who is not the head of the household, and who is either under the age of 18 or under the age of 22 if attending school regularly.

Appropriate State law would be used in determining relationships.

The income and resources of an adult (other than a parent or the spouse of a parent) living with the family but not contributing to the family would be disregarded.

If an individual takes benefits under adult assistance, he could not be eligible for family benefits.

Optional State supplementation

If a State decides to supplement the basic Federal payment, it would be required to provide benefit amounts that do not undermine the earnings disregard provision. A State could agree to have the Federal Government make the supplementary payments on behalf of the State. If a State agrees to have the Federal Government make its supplemental payments, the Federal Government would pay the full administrative costs of making such payments, but if it makes its own payments the State would pay all of such costs.

States could but would not be required to cover under medicaid persons who are made newly eligible for cash benefits under the bill.

The Federal Government, in administering supplemental benefits on behalf of a State, would be required to recognize a residency requirement if the State decided to impose such a requirement.

D—PROCEDURAL AND GENERAL PROVISIONS

Payments and procedures

The Secretary would be permitted to pay the benefits at such times as best carry out the purposes of the title and could make payments to a person other than a member of the family or to an agency where he finds inability to manage funds. The Secretary's decision would be subject to hearing and review.

The family benefits could not be paid to an individual who failed to register, or take work, training or vocational rehabilitation.

Cash advances of $100 or less could be paid if an applicant appears to meet all the eligibility requirements and is faced with a financial emergency.

The Secretary may arrange for adjustment and recovery in the event of overpayments or underpayments, with a view toward equity and avoiding penalizing people who were without fault.

People who are, or claim to be, eligible for assistance payments, and who disagree with determinations of the Secretary, could obtain hearings if they request them within 30 days. Final determinations would be subject to judicial review in Federal district courts, but the Secretary's decisions as to any fact would be conclusive and not subject to review by the courts. The Secretary would also be given authority to appoint qualified people to serve as hearing examiners without their having to meet the specific standards prescribed under the Administrative Procedure Act for hearing examiners.

The right of any person to any future benefit would not be transferable or assignable, and no money payable under this title would be subject to execution, levy, attachment, garnishment, or other legal process.

In addition, the Secretary would establish necessary rules and regulations dealing with proofs and evidence, and the method of taking and furnishing the same, in order to establish the right to benefits.

Each family would be required to submit a report of income within 30 days after the end of a quarter and benefits would be cut off if the report was not filed. If a family failed, without good cause, to report income or changes in circumstances as required by the Secretary, it

would be subject to a penalty of $25 the first time, $50 the second time and $100 for later times.

The head of any Federal agency would be required to provide such information as the Secretary of HEW needs to determine eligibility for benefits under this title.

Penalties for fraud

A penalty of $1,000 or 1 year imprisonment, or both, would be provided in the case of fraud under the program.

Administration

Both the Secretary of Health, Education, and Welfare and the Secretary of Labor could perform their functions directly, through other Federal agencies, or by contract. An additional Assistant Secretary is authorized in the Department of Labor to head up the new program in that Department.

Child care

The Secretaries of Labor and Health, Education, and Welfare are each given the authority and responsibility for arranging day care for their respective recipients under the Opportunities for Families Program and the Family Assistance Plan who need such day care in order to participate in training, employment, or vocational rehabilitation. Where such care can be obtained in facilities developed by the Secretary of Health, Education, and Welfare, these would be utilized.

Insofar as possible, arrangements would be made for after school care with local educational agencies. All day care would be subject to standards developed by the Secretary of Health, Education, and Welfare, with the concurrence of the Secretary of Labor. Both Secretaries would have authority to make grants and contracts for payment of up to 100 percent of the cost of care. The Secretary of Health, Education, and Welfare would have total responsibility for construction of facilities. $700 million would be authorized for the provision of child care services in the first fiscal year, and such sums as Congress may appropriate in subsequent years. In addition, $50 million would be authorized for construction and renovation of child care facilities for each fiscal year.

Obligations of parents

A deserting parent would be obligated to the United States for the amount of any Federal payments made to his family less any amount that he actually contributes by court order or otherwise to the family.

Any parent of a child receiving benefits who travels in interstate commerce to avoid supporting his child would be guilty of a misdemeanor and subject to a fine of $1,000, imprisonment for 1 year, or both.

The Secretary would report to appropriate officials cases of child neglect or abuse which came to his attention while administering the program.

Local committees to evaluate program

Local advisory committees would be set up throughout the country, with a minimum of one in each State, which would evaluate and report on the effectiveness of the elements of the program designed to help people become self-supporting. Each committee would be composed of representatives from labor, business, and the public, as well as public officials not directly involved in the administration of the programs.

V. OTHER RELATED ASSISTANCE PROVISIONS

ADOPTION AND FOSTER CARE SERVICES UNDER CHILD WELFARE

Authorizations of $150 million for fiscal year 1972 and higher amounts for subsequent years would be provided for payments to the States to support foster care and related services.

PROVISIONS RELATED TO NEW ASSISTANCE PROGRAMS

Effective date for adult assistance and family programs

Major changes made in the assistance programs would be effective July 1, 1972. The child care provisions would become effective upon enactment of the bill. The amendments which provide benefits to families where the father and mother are both present, neither is incapacitated, and the father is not unemployed (the "working poor") would become effective January 1, 1973.

Prohibition against participation in food stamp program by recipients of payments under family and adult assistance programs

The bill would amend the Food Stamp Act of 1964 by providing that families and adults eligible for benefits under the assistance programs in this bill would be excluded from participation in the food stamp program.

Special provisions for Puerto Rico, the Virgin Islands, and Guam

There would be special provisions for Puerto Rico, the Virgin Islands, and Guam. The amounts used in the family assistance plan and the aid to the aged, blind, and disabled (other than the $720 amount of annual earnings to be disregarded and the $30 per month incentive allowances) would be adjusted by the ratio of the per capita income of each of these jurisdictions to the per capita income of the lowest of the 50 States.

Determination of medicaid eligibility

The Secretary would be able to enter into agreements with States under which the Secretary would determine eligibility for medicaid both for those eligible for Federal payments and the medically needy in cases where the State covered the medically needy. The State would pay half of the Secretary's additional administrative costs arising from carrying out the agreement.

Effective date.—July 1, 1972.

Transitional administration of public assistance

The Secretary of Health, Education, and Welfare could enter into agreements with States under which a State would administer the Federal assistance program for a period of up to one year from the beginning of the program.

Limitations on increases in State welfare expenditures

States would be guaranteed that, if they make payments supplementary to the Federal adult or family programs, it would cost them no more to do so than the amount of their total expenditures for cash public assistance payments during calendar year 1971, to the extent that the Federal payments and the State supplementary payments to recipients do not exceed the payment levels in effect under the public assistance programs in the State for January 1971. The value of food stamps would be taken into account in computing whether the guarantee would go into effect if the State pays in cash the value of food stamps. Most States would save money under the provisions of the bill; this provision would guarantee that no State would lose money.

Limitation on Federal expenditures for social services

The Federal Government would continue to provide 75 percent matching funds to the States for child care and family planning services on an open-end appropriation basis. Federal matching for other specified social services would be limited to the amounts appropriated by the Congress.

PUBLIC ASSISTANCE AMENDMENTS EFFECTIVE IMMEDIATELY

Additional remedies for State noncompliance with provisions of assistance titles

The Secretary would be able to require States to make payments to people who did not receive all money due them because the State failed to comply with a Federal requirement.

The Secretary could require a State which is in noncompliance with a Federal requirement to set up a timetable and method for assuring compliance, or could request the Attorney General to bring suit to enforce the Federal requirements.

Effective date.—Enactment.

Statewideness not required for services

A State would be permitted to furnish social services in one area of a State without being required to furnish such services in all geographic areas of the State.

Effective date.—Enactment.

Optional modification in disregarding income under AFDC

States would be permitted, between enactment and July 1, 1972, to modify their present AFDC programs so as to substitute the earnings disregard provisions in the family assistance provisions (cost of child care, plus $720, plus one-third of the remainder) for provisions of present law (the first $30 and one-third of the remainder after which actual work expenses are deducted).

A State could also apply the maximum dollar limits in the family programs on child care and student earnings ($2,000 for a family of four rising to $3,000 for a family of nine or more) to its present AFDC program.

Effective date.—Enactment.

Individual programs for family services not required

States would no longer be required to prepare a separate plan of services for each individual who is eligible for AFDC.

Effective date.—July 1, 1972, or earlier if the State so chooses.

Enforcement of support orders

States would be required to secure support for a spouse of a parent from the other parent (of children receiving assistance payments) where he has deserted or abandoned his spouse, utilizing reciprocal arrangements with other States to obtain or enforce court orders for support.

Effective date.—July 1, 1972, or earlier, if the State plan so provides.

Separation of social services and cash assistance payments

Each State would be required to submit a proposal to the Secretary by January 1, 1972 providing for the administrative separation of handling eligibility for cash payments and the provision of social services by July 1, 1972.

Increase in Federal matching to States for costs of establishing paternity and collecting child support payments

Federal matching would be increased from 50 percent to 75 percent for State costs incurred in establishing the paternity of AFDC children and locating and collecting support from their absent parents.

Effective date.—Enactment.

Vendor payments for special needs

States would be permitted to provide for non-recurring items of special need by means of vendor payments.

Increase in Federal matching—WIN program

Effective immediately, the Federal matching under the WIN program would be increased from 80 to 90 percent. This provision expires June 30, 1972.

VI. PROVISIONS FOR TAX CHANGES (OTHER THAN PAYROLL TAXES)

Child Care Deduction

Under present law, a child care deduction of $600 per child, but not more than $900, is available for child care expenses in certain cases. Generally, this amount is available in the case of such expenses incurred by a widow or widower or certain other married couples with an incapacitated spouse and also in the case of married couples with incomes of not over $6,000.

The new provision retains the basic child care provision of present law but increases from $6,000 to $12,000 the income a married couple may have and still be eligible for this deduction, In addition, the amount of child care expenses which may be deducted is increased from $600 for the first child to $750, and to $1,125 for two children, and to $1,500 for three or more children. These changes are effective with respect to taxable years beginning on or after January 1, 1972.

Retirement Income Credit

Under present law, a retirement income credit of up to $1,524 multiplied by 15 percent ($229) is allowed for single persons age 65 or over having "retirement income"—that is, income from pensions, dividends, interest, rents or other passive income sources. However, this credit is available only if the individual had ten prior years of

earned income above $600. The income eligible for this credit is reduced, however, by social security, railroad retirement or other tax-exempt pension income. It is also reduced by 50 percent of earnings over $1,200 and 100 percent of earnings over $1,700. (This earnings limitation, however, does not apply to those age 72 and over.) For married couples a credit equal to one and one-half times the credit referred to above is generally available under present law. However, in some cases where both can qualify for the credit a credit of up to twice that referred to above is available.

In addition, under present law, the retirement income credit determined substantially as indicated above is available for retirement income received from governmental units where the individual is under age 65, except that the credit is reduced on a dollar-for-dollar basis for earnings above $900 (between age 62 and 65 the earnings test described above applies).

The committee has adopted a substitute retirement income credit which is both more liberal and also will be easier to compute on the return form. This credit for a single person will be based upon $2,500 instead of $1,524. It will not be necessary for the individual involved to have "retirement income" as he is required to have under present law or 10 years of prior earnings of $600 or more. However, as under present law, the $2,500 will be reduced for social security, railroad retirement and other tax-exempt pension income. Also, as under present law, it will be reduced for earned income above a specified level (if the individual is under age 72). However, the amount will only be reduced for 50 percent of earnings above $2,000 instead of 50 percent of earnings above $1,200 plus 100 percent of earnings above $1,700.

As under present law, the amount derived in this manner is multiplied by 15 percent in order to obtain the credit (the new figure gives a maximum credit of $375).

For a married couple, both over age 65, the retirement income credit is to be based upon $3,750 instead of the $2,500 applicable to a single person. Otherwise the credit is to be computed in the same manner indicated above except on the basis of the combined experience of the husband and wife.

For those below age 65 receiving Government pension income the $2,500 also becomes applicable but, as under present law, only with respect to Government pension income. The earnings test for these persons is raised from $900 to $1,000 if under age 62 but for those above that age, the $2,000 earnings test applies.

Potential fiscal year 1973 costs of Assistance provisions under H.R. 1

[In billions of dollars; negative amounts indicate decreases]

	Federal			State and local [1]			Net cost to all governments
	Current law	H.R. 1	Net cost	Current law	H.R. 1	Net cost	
Payments to families	$3.9	[2] $5.8	$1.9	$3.3	$3.1	—$0.2	$1.7
Less savings from public service jobs		—.3	—.3				—.3
Subtotal	3.9	5.5	1.6	3.3	3.1	—.2	1.4
Payments to adult categories	2.2	4.1	1.9	1.4	1.5	.1	2.0
Cost of cash assistance	6.1	9.6	3.5	4.7	4.6	—.1	3.4
Federal cost of "hold harmless" provision		1.1	1.1		—1.1	—1.1	
Food programs	2.4	1.0	—1.4				—1.4
Cost of maintenance payments	8.5	11.7	3.2	4.7	3.5	—1.2	[3] 2.0
Child care	.3	.8	.5				.5
Training	.2	.5	.3				.3
Public service jobs		.8	.8				.8
Supportive services		.1	.1				.1
Administration	.4	1.1	.7	.4		—.4	.3
Cost of related and support activities	.9	3.3	2.4	.4		—.4	2.0
Total cost of program	9.4	15.0	5.6	5.1	3.5	—1.6	4.0
Impact of other programs		—.1	—.1				—.1
Grand total	9.4	14.9	5.5	5.1	3.5	—1.6	3.9

[1] Assumes that the States, through supplemental programs, maintain benefit levels including the value of food stamp bonuses.
[2] Includes only 6 months of payments to families in which both parents are present, neither is incapacitated, and the father is employed. The effective date for this provision is Jan. 1, 1973.
[3] Net benefit increases to recipients.

Projected recipients under current law and persons eligible for assistance under H.R. 1, fiscal years 1973–1977

(In millions)

	1973	1974	1975	1976	1977
Persons eligible for benefits under H.R. 1:					
Persons in families:					
Not now covered under present programs	9.1	8.1	7.2	6.4	5.7
Covered under present programs	10.3	10.6	10.9	11.2	11.5
Aged, blind and disabled	6.2	6.6	7.1	7.2	7.2
Total eligibles under H.R. 1	25.6	25.3	25.2	24.8	24.4
Recipients under current law:					
Persons in families with dependent children	11.6	12.6	13.6	14.7	15.8
Aged, blind and disabled	3.4	3.4	3.5	3.5	3.6
Total recipients under current law	15.0	16.0	17.1	18.2	19.4

Potential State savings under assistance provisions of H.R. 1 [1]

[In millions of dollars]

	1973	1974	1975	1976	1977
Alabama	$32.4	$38.4	$45.4	$47.2	$49.1
Alaska	2.5	3.1	3.7	4.4	5.1
Arizona	21.5	22.6	23.8	25.2	26.5
Arkansas	19.7	20.4	21.3	22.1	22.9
California	234.9	294.9	356.5	402.5	447.7
Colorado	13.3	16.6	19.8	21.5	23.1
Connecticut	21.3	25.7	30.2	34.8	39.1
Delaware	1.8	2.1	2.5	3.0	3.6
District of Columbia	12.6	17.0	21.5	23.4	25.1
Florida	170.3	177.8	185.3	192.9	200.2
Georgia	57.8	53.4	55.0	56.7	58.3
Hawaii	7.0	7.8	8.6	9.6	10.7
Idaho	1.5	1.9	2.2	2.8	3.4
Illinois	62.1	78.9	95.6	112.4	129.2
Indiana	8.6	10.5	12.6	14.7	16.9
Iowa	26.7	28.6	30.5	32.6	34.6
Kansas	14.2	15.6	17.0	18.7	20.3
Kentucky	12.6	13.6	14.5	15.5	16.3
Louisiana	65.4	68.5	71.7	74.9	78.1
Maine	3.6	4.4	5.4	6.4	7.5
Maryland	41.9	44.7	47.5	50.4	53.2
Massachusetts	44.3	57.3	70.4	83.7	96.9
Michigan	45.4	58.2	71.2	84.2	97.2
Minnesota	15.2	19.4	23.8	28.1	32.6
Mississippi	23.3	24.2	25.2	26.4	27.5
Missouri	12.1	14.9	20.5	22.6	24.7
Montana	2.5	2.7	2.9	3.2	3.5
Nebraska	3.1	3.9	4.7	5.6	6.6
Nevada	1.1	1.2	1.2	1.8	2.1
New Hampshire	2.3	2.9	3.6	4.4	5.2
New Jersey	50.1	64.4	78.6	93.1	107.6
New Mexico	7.3	7.8	8.2	8.7	9.1
New York	188.4	238.7	289.2	339.6	390.1
North Carolina	31.9	33.0	34.1	35.2	36.4
North Dakota	1.2	1.2	1.4	1.8	2.2
Ohio	64.0	69.3	74.6	79.9	85.3
Oklahoma	38.3	40.2	42.0	43.9	45.6
Oregon	15.9	17.4	18.9	20.5	22.0
Pennsylvania	51.3	69.9	88.5	107.2	125.9
Rhode Island	6.3	7.7	9.3	11.0	12.7
South Carolina	13.8	14.5	15.2	16.0	16.7
South Dakota	2.5	2.8	3.3	3.7	4.3
Tennessee	34.2	35.1	36.1	37.0	38.0
Texas	57.1	59.7	61.4	65.1	67.7
Utah	3.4	3.6	3.9	4.3	4.7
Vermont	1.1	1.3	1.7	2.1	2.5
Virginia	10.4	12.9	15.5	18.2	20.9
Washington	11.4	15.9	20.6	25.2	30.0
West Virginia	18.3	18.7	19.2	19.7	20.3
Wisconsin	33.3	35.5	37.6	39.9	42.1
Wyoming	1.2	1.3	1.5	1.9	2.2
Guam	.22	.22	.32	.33	.33
Puerto Rico	26.1	27.6	29.1	30.7	32.2
Virgin Islands	1.1	1.2	1.2	1.4	1.4
Total	1,643.8	1,911.1	2,185.5	2,438.1	2,687.4

[1] Assumes that the States, through supplemental payments, maintain January 1971 payment levels including the value of food stamps and agree to Federal administration of supplemental payments.

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See pp. 13-45

92d Congress
2d Session

COMMITTEE PRINT

Social Security and Welfare Reform

Summary of the Principal Provisions of H.R. 1 as Determined by the Committee on Finance

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

JUNE 13, 1972

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INTRODUCTION

This summary describes briefly, in general terms, the significant features of the provisions of H.R. 1, the Social Security Amendments of 1971 as ordered reported to the Senate by the Committee on Finance. The description of minor and technical amendments included in the bill may not be contained here but will be reflected in the text of the Committee bill and will be explained in the Committee report accompanying the bill.

As ordered reported by the Committee, H.R. 1 represents the most massive revision of the Social Security laws Congress has ever undertaken. The bill would increase benefits by $17.6 billion over the estimated costs if present law were continued. The social security cash benefits alone will increase by $7 billion in 1973 ($7.4 billion in 1974) largely because of the 10-percent increase in benefits approved by the Committee. Medicare benefits will rise by $3 billion by 1974 as the new program for coverage of the disabled and for the provision of drugs become effective.

But perhaps the most significant features of the bill are those seeking to reform the welfare laws. In addition to upgrading the level of benefits for needy old age, blind, and disabled Americans (at an added cost of $2.2 billion in 1974) the Committee bill offers a bold, new approach to the problem of increasing dependency under the program of Aid to Families With Dependent Children. Specifically, where the youngest child in an AFDC family has reached school age (or where the family is headed by a male) the family would no longer be eligible for welfare as it is today, but instead the head of the family would be offered a guaranteed job opportunity. He, or she, would be given an opportunity to become independent through employment and sufficient financial incentives are provided by the bill to encourage him or her to prefer employment in the private economy to work in the guaranteed job. Moreover, unlike today, the Federal Government's incentive to help these families locate suitable jobs would be enhanced because under the Committee plan the entire cost of the employment program would be borne by the Federal Government whereas AFDC costs are shared with the States. The cost of this new system of employment opportunity is estimated at $4.5 billion in 1974, with virtually all the expense incurred to increase the income of the poor who work.

The Social Security, Medicare, and Medicaid Programs

SOCIAL SECURITY CASH BENEFITS

As passed by the House, H.R. 1 would increase social security cash benefits by $3.9 billion in 1973 and $4.3 billion in 1974. A little over half of this increase is related to the 5-percent across-the-board benefit increase in the House bill.

The Committee bill would increase social security cash benefit payments by $7.4 billion in 1974. The major item of cost relates to the 10 percent benefit increase in the Committee bill, twice the amount of the increase in the House bill.

Another major feature of the Committee bill would provide a special minimum benefit to low-wage workers with long-time attachment to employment covered under social security. A retired worker with at least 30 years of covered employment would be guaranteed a benefit of at least $200 (if the worker is married, the couple would receive a benefit of at least $300).

The individual provisions of the Committee bill are described below.

1. PROVISIONS OF THE HOUSE BILL CHANGED AND NEW PROVISIONS ADDED BY THE COMMITTEE

Increase in Social Security Benefits

The Committee bill provides for a general 10-percent increase in social security benefits in place of the 5-percent increase in the House-passed bill. The increase would be effective with the benefit checks that will be delivered July 3.

However, it seems unlikely that Congress could take final action on the bill in time for the higher amounts to show up in the July checks. The increase, therefore, will be paid retroactively after the bill is enacted.

Under the Committee bill about 27.8 million social security beneficiaries will receive higher benefits and about $4.3 billion in additional benefits will be paid in 1974 as a result of the 10 percent benefit increase. The average retirement benefit would rise from an estimated $133 to $147 a month, rather than to $141 as under the House bill. The average benefits for aged couples would increase from an estimated $223 to $247 a month, rather than to $234 a month under the House-passed bill. A worker with maximum earnings creditable under social security who retired at age 65 this year would get a monthly benefit of $237.80 rather than $216.10 as under present law. If he and his wife both become entitled to benefits at age 65, they would get $356.70 rather than $324.20 under present law.

The minimum benefit would be increased by 5 percent from $70.40 to $74.00, as in the House-passed bill.

Special benefits for people age 72 and over who are not insured for regular benefits would be increased by 5 percent, as in the House-passed bill, from $48.30 to $50.80 for individuals and from $72.50 to $76.20 for couples.

Special Minimum Benefits

The House-passed bill would provide a special minimum benefit of $5 multiplied by the number of years in covered employment up to thirty years, producing a benefit of at least $150 a month for a worker who has been employed for 30 years under social security coverage. The Committee bill replaces this with a provision for a special minimum benefit under the social security program which would provide a payment of $200 per month ($300 for a couple) for persons who have been employed in covered employment for thirty years. This benefit would be paid as an alternative to the regular benefits in cases where a higher benefit would result.

Specifically, the Committee bill would provide a special minimum of $10 per year for each year in covered employment in excess of ten years (for purposes of this special minimum, there would be no credit for the first ten years of employment). Under this provision, the new higher minimum benefit would become payable to people with 18 or more years of employment; at that point, the special minimum benefit—$80—would be more than the regular minimum. A worker with twenty years of employment under social security would thus be guaranteed a benefit of at least $100; one with twenty-five years would be guaranteed at least $150, while one with thirty years would receive at least $200 a month. Minimum payments to a couple would be one and one-half times these amounts.

The level of payments under the present law, the House bill, and the Committee bill are shown in the following table:

TABLE 1.—COMPARISON OF MONTHLY BENEFITS UNDER PRESENT LAW, HOUSE BILL, AND COMMITTEE BILL

Average monthly earnings	Years of employment under social security	Retirement benefit for an individual under— Present law	House Bill	Committee Bill
$200	20	$128.60	$135.10	$141.50
$200	25	128.60	135.10	150.00
$200	30 or more	128.60	150.00	200.00
$250	20	145.60	152.90	160.20
$250	25	145.60	152.90	160.20
$250	30 or more	145.60	152.90	200.00
$300	20	160.90	169.00	177.00
$300	25	160.90	169.00	177.00
$300	30 or more	160.90	169.00	200.00

Effective date.—January 1973.

Number of people affected and dollar payments.—1.3 million people would get increased benefits on the effective date and $300 million in additional benefits would be paid in 1974.

Automatic Increases in Benefits, the Tax Base, and the Earnings Test

The Committee bill retains the provisions in the House bill providing for automatic annual increases in social security benefits as the cost of living rises. These increases would go into effect each January whenever the Consumer Price Index goes up by at least 3 percent. However, the Committee did change the method of financing the additional benefits paid under the automatic mechanism. Under the Committee bill, the financing would be directly related to the amount of the additional benefits and one-half would be provided from an increase in the tax rate and one-half from an increase in earnings (presently $9,000 and increasing to $10,200 beginning January 1973 under the Committee bill) subject to the social security tax. Under the House-passed bill, the financing mechanism would not be related to the cost of the automatic benefit increase, but rather to changes in wage rates. Under the House bill, the increased benefits would be financed entirely through an increase in the taxable wage base.

Effective date.—The first cost-of-living increase would be possible for January 1975.

Increased Benefits for Those Who Delay Retirement Beyond Age 65

The Committee bill includes the provisions in the House bill which would provide for an increase in social security benefits of one percent for each year after age 65 that the individual delays his retirement. However, the committee modified the provision so that the additional benefit would apply to persons already retired, rather than only to those coming on the social security rolls after the bill's enactment.

Effective date.—January 1973.

Number of people affected and dollar payment.—5 million people would get increased benefits on the effective date and $180 million in additional benefits would be paid in 1974.

Reduction in Waiting Period for Disability Benefits

Under the House bill, the present 6-month period throughout which a person must be disabled before he can be paid disability benefits would be reduced by one month (to 5 months). Under the committee bill, the waiting period would be reduced 2 months to a 4-month period.

Effective date.—January 1973.

Number of people affected and dollar payments.—950,000 beneficiaries would become entitled to higher benefit payments on the effective date and 8,000 additional people would become entitled to benefits. About $250 million in additional benefits would be paid in 1974.

Benefits for a Child Based on the Earnings Record of a Grandparent

Under the House bill, coverage would be extended to grandchildren not adopted by their grandparents if their parents have died and if the grandchildren were living with a grandparent at the time the grandparent qualified for benefits. The Committee approved the House provision but extended it to instances where the grandchild's parents either are totally disabled or have died, and the grandchild is living with a grandparent.

Effective date.—January 1973.

Refund of Social Security Tax to Members of Certain Religious Faiths Opposed to Insurance

Under present law, members of certain religious sects who have conscientious objections to social security by reason of their adherence to the established teachings of the sect may be exempt from the social security self-employment tax provided they also waive their eligibility for social security benefits. This exemption was written largely to relieve the Old Order Amish from having to pay the social security tax when, because of their religious beliefs, they would never draw social security benefits.

The Committee bill would extend the exemption (by a refund or credit against income taxes at year end) from social security taxes to members of the sect who are "employees" covered by the Social Security Act as well as the "self-employed" members of the sect. The employee would have to file an application for exemption from the tax and waive his eligibility for social security and medicare benefits just as the self-employed members must presently do. Although a qualified individual would be exempt from the tax, his employer would continue to deduct the tax from his pay and to pay the employer tax. Later the employee could claim a refund or a tax credit. However, the provision specifically provides that there would be no forgiveness of the employer portion of the social security tax as the Committee believes this would create an undesirable situation in which an employer would have a tax incentive to hire people of one religious belief in preference to those of other religious beliefs.

Effective date.—January 1973.

Sister's and Brother's Benefits

The Committee bill includes a provision (not contained in the House bill) to extend social security coverage to dependent sisters and to dependent disabled brothers.

Effective date.—January 1973.

Number of people affected and dollar payments.—50,000 additional people would become eligible for benefits on the effective date and $70 million in additional benefits would be paid in 1974.

Disability Benefits for Individuals Who Are Blind

The Committee bill includes provisions (not contained in the House-passed bill): (a) making disability benefits payable to blind persons who have six quarters of coverage earned at any time; (b) changing the definition of disability for the blind to permit them to qualify for benefits regardless of their capacity to work and whether they work; (c) permitting the blind to receive disability benefits beyond age 65 without regard to the retirement test; and (d) excluding the blind from the requirement that disability benefits be suspended when a beneficiary refuses without good cause to accept vocational rehabilitation.

Effective date.—January 1973.

Number of people affected and dollar payments.—250,000 additional people would become eligible for benefits on the effective date and $200 million in additional benefits would be paid in 1974.

Issuance of Social Security Numbers and Penalty for Furnishing False Information to Obtain a Number

The Committee bill includes a number of provisions (not contained in the House bill) dealing with the method of issuing social security account numbers. Under present law, numbers are issued upon application, often by mail, upon the individual's motion.

Under a Committee amendment, numbers in the future generally would be issued at the time an individual enters the school system; for most persons, this would be the first grade. In the case of noncitizens entering the country under conditions which would permit them to work, numbers would be issued at the time they enter the country or in the case of a person who may not legally work at the time he is admitted to the United States, the number would be issued at the time his status changes. In addition to these general rules, numbers would be issued to persons who do not have them at the time they apply for benefits under any federally financed program.

As a corollary to this more orderly system of issuing social security account numbers, the Committee bill would provide criminal penalties for (1) knowingly and willfully using a social security number that was obtained with false information for any purpose or (2) using someone else's social security number or other use of a social security number to conceal one's true identity (such as by counterfeiting a social security number) for such purposes. The penalties provided would be a fine of up to $1,000 or imprisonment for up to one year or both. These criminal penalties perfect and improve upon features of the House bill relating to false information with respect to social security numbers.

Treatment of Income From Sale of Certain Literary or Artistic Items

The Committee bill includes a provision (not contained in the House bill) to exclude income from sale of certain literary or artistic items created before age 65 from income for purposes of determining the amount of benefits to be withheld under the social security earnings test. Under existing law, such income is not counted if the literary work was copyrighted before age 65. Under the amendment, the time of copyright is immaterial so long as the work which produced the literary or artistic item was performed before age 65.

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Underpayments

The Committee bill includes a provision (not contained in the House bill) under which additional relatives (by blood, marriage, or adoption) would be added to the present categories of persons listed in the law who may receive social security cash payments due but unpaid to a deceased beneficiary.

Payments by an Employer to Disability Beneficiaries or to the Survivor or Estate of a Former Employee

Under the House bill amounts earned by an employee which are paid after the year of his death to his survivors or his estate would be excluded from coverage. The Committee bill would extend the provision to payments made to disability insurance beneficiaries. Under present law, such wages are covered and social security taxes must be paid on these wages but the wages cannot be used to determine eligibility for or the amount of social security benefits.

Death Benefits Where Body Is Unavailable

Under Public Law 92-223, expenses of memorial services can be counted as funeral expenses for the purpose of the social security lump sum death payment, even though the body is unavailable for burial or cremation. The provision applies only with respect to deaths after December 29, 1971. The Committee bill would cover deaths occurring after 1960, thus spanning the entire period of the Vietnam action.

2. PROVISIONS OF THE HOUSE BILL THAT WERE NOT CHANGED BY THE COMMITTEE

Increase in Widow's and Widower's Insurance Benefits

Under present law, when benefits begin at or after age 62 the benefit for a widow (or dependent widower) is equal to 82½ percent of the amount the deceased worker would have received if his benefit had started when he was age 65. A widow can get a benefit at age 60 reduced to take account of the additional 2 years in which she would be getting benefits.

Both the House bill and the Committee bill would provide benefits for a widow equal to the benefit her deceased husband would have received if he were still living. Under the bill, a widow whose benefits start at age 65, or after, would receive either 100 percent of her deceased husband's primary insurance amount (the amount he would have been entitled to receive if he began his retirement at age 65) or, if his benefits began before age 65, an amount equal to the reduced benefit he would have been receiving if he were alive.

Under the bill, the benefit for a widow (or widower) who comes on the rolls between 60 and 65 would be reduced (in a way similar to the way in which widows' benefits are reduced under present law when they begin drawing benefits between ages 60 and 62) to take account of the longer period over which the benefit would be paid.

Effective date.—January 1973.

Number of people affected and dollar payments.—3.8 million people would get increased benefits on the effective date and $1 billion in additional benefits would be paid in 1974.

Age 62 Computation Point for Men

Under present law, the method of computing benefits for men and women differs in that years up to age 65 must be taken into account in determining average earnings for men, while for women only years up to age 62 must be taken into account. Also, benefit eligibility is figured up to age 65 for men but only up to age 62 for women. Under both the House bill and the Committee bill, these differences, which provide special advantages for women, would be eliminated by applying the same rules to men as now apply to women.

Effective date.—The new provision would become effective, starting January 1973, over a 3-year transition period.

Liberalization of the Retirement Test

The amount that a beneficiary under age 72 may earn in a year and still be paid full social security benefits for the year would be increased from the present $1,680 to $2,000. Under present law, benefits are reduced by $1 for each $2 of earnings between $1,680 and $2,800 and for each $1 of earnings above $2,880. The bill would provide for a $1 reduction for each $2 of all earnings above $2,000; there would be no $1-for-$1 reduction as under present law. Also, in the year in which a person attains age 72 his earnings in and after the month in which he attains age 72 would not be included, as under present law, in determining his total earnings for the year.

Effective date.—January 1973.

Number of people affected and dollar payments.—1.1 million beneficiaries would become entitled to higher benefit payments on the effective date and 400,000 additional people would become entitled to benefits. About $650 million in additional benefits would be paid in 1974.

Childhood Disability Benefits

Childhood disability benefits would be paid to the disabled child of an insured retired, deceased, or disabled worker, if the disability began before age 22, rather than before 18 as under present law. In addition, a person who was entitled to childhood disability benefits could become re-entitled to childhood disability benefits if he again becomes disabled within 7 years after his prior entitlement to such benefits was terminated.

Effective date.—January 1973.

Number of people affected and dollar payments.—13,000 additional people would become eligible for benefits on the effective date and $16 million in additional benefits would be paid in 1974.

Continuation of Child's Benefits Through the End of a Semester

Payment of benefits to a child attending school would continue through the end of the semester or quarter in which the student (including a student in a vocational school) attains age 22 (rather

than the month before he attains age 22) if he has not received, or completed the requirements for, a bachelor's degree from a college or university.

Effective date.—January 1973.

Number of people affected and dollar payments.—55,000 present beneficiaries would have their benefits continued and 6,000 additional people would become eligible for benefits on the effective date and $18 million in additional benefits would be paid in 1974.

Eligibility of a Child Adopted by an Old-Age or Disability Insurance Beneficiary

The provisions of present law relating to eligibility requirements for child's benefits in the case of adoption by an old-age insurance beneficiary or by disability insurance beneficiaries would be modified to make the requirements uniform in both cases. A child adopted after a retired or disabled worker becomes entitled to benefits would be eligible for child's benefits based on the worker's earnings if the child is the natural child or stepchild of the worker or if (1) the adoption was decreed by a court of competent jurisdiction within the United States, (2) the child lived with the worker in the United States for the year before the worker became disabled or entitled to an old-age or disability insurance benefit, (3) the child received at least one-half of his support from the worker for that year, and (4) the child was under age 18 at the time he began living with the worker.

Effective date.—January 1973.

Nontermination of Child's Benefits by Reason of Adoption

A child's benefit would no longer stop when the child is adopted.

Effective date.—January 1973.

Disability Benefits Affected by the Receipt of Workmen's Compensation

Under present law, social security disability benefits must be reduced when workmen's compensation is also payable if the combined payments exceed 80 percent of the worker's average current earnings before disablement. Average current earnings for this purpose can be computed on two different bases and the larger amount will be used. The bills add a third alternative base, under which a worker's average current earnings can be based on the one year of his highest earnings in a period consisting of the year of disablement and the five preceding years.

Effective date.—January 1973.

Dependent Widower's Benefits at Age 60

Widowers under age 62 could be paid reduced benefits (on the same basis as widows under present law) starting as early as age 60.

Effective date.—January 1973.

Waiver of Duration-of-Marriage Requirement in Case of Remarriage

The duration-of-marriage requirement in present law for entitlement to benefits as a worker's widow, widower, or stepchild—that is, the period of not less than nine months immediately prior to the day on which the worker died that is now required (except where death was accidental or in the line of duty in the uniformed service, in which case the period is three months)—would be waived in cases where the worker and his spouse were previously married, divorced, and remarried, if they were married at the time of the worker's death and if the duration-of-marriage requirement would have been met at the time of the divorce had the worker died then.

Effective date.—January 1973.

Wage Credits for Members of the Uniformed Services

Present law provides for a social security noncontributory wage credit of up to $300, in addition to contributory credit for basic pay, for each calendar quarter of military service after 1967. Under the bill, the additional noncontributory wage credits would also be provided for service during the period January 1957 (when military service came under contributory social security coverage) through December 1967.

Disability Insurance Benefits Applications Filed After Death

Disability insurance benefits (and dependents' benefits based on a worker's entitlement to disability benefits) would be paid to the disabled worker's survivors if an application for benefits is filed within 3 months after the worker's death, or within 3 months after enactment of this provision for deaths occurring after 1969.

Coverage of Members of Religious Orders Who Are Under a Vow of Poverty

Social security coverage would be made available to members of religious orders who have taken a vow of poverty, if the order makes an irrevocable election to cover these members as employees of the order.

Self-Employment Income of Certain Individuals Living Temporarily Outside the United States

Under present law, a U.S. citizen who retains his residence in the United States but who is present in a foreign country or countries for approximately 17 months out of 18 consecutive months, must exclude the first $20,000 of his earned income in computing his taxable income for social security and income tax purposes. The bill would provide the U.S. citizens who are self-employed outside the United States and who retain their residence in the United States would not exclude the first $20,000 of earned income for social security purposes and would compute their earnings from self-employment for social security pur-

poses in the same way as those who are self-employed in the United States.

Trust Fund Expenditures for Rehabilitation Services

Provides an increase in the amount of social security trust fund moneys that may be used to pay for the costs of rehabilitating social security disability beneficiaries. The amount would be increased from 1 percent of the previous year's disability benefits (as under present law) to 1¼ percent for fiscal year 1972 and to 1½ percent for fiscal year 1973 and subsequent years.

3. OTHER CASH BENEFIT AMENDMENTS

Other amendments included in the Committee's bill relate to the executive pay level of the Commissioner of Social Security; the coverage of U.S. missionaries working outside the U.S.; retroactive benefits for certain disabled persons; social security benefits for a child entitled on the earnings of more than one person; filing of disability applications; social security coverage for students employed at State operated schools; and social security coverage of Registrars of Voters in Louisiana; coverage of certain policemen and firemen in West Virginia; and wage credits for Americans of Japanese ancestry who were interned by the U.S. Government during World War II.

In addition, in order to pay for a portion of the long-range costs associated with the 10-percent across-the-board benefit increase, the Committee deleted the House-passed amendments relating to actuarially reduced benefits in one category not being made applicable to certain benefits in other categories; the computation of benefits based on combined earnings of a married couple; and to the dropping of additional years of low earnings from the computation of average earnings.

PRINCIPAL MEDICARE-MEDICAID PROVISIONS

1. PROVISIONS OF HOUSE BILL NOT SUBSTANTIALLY MODIFIED BY COMMITTEE

Medicare Coverage for Disabled Beneficiaries

(Section 201)

Problem

The disabled, as a group, are similar to the elderly in those characteristics—low incomes and high medical expenses—which led Congress to provide health insurance for older people. They use about seven times as much hospital care, and about three times as much physicians' services as does the nondisabled population. In addition, disabled persons are often unable to obtain private health insurance coverage.

Finance Committee Amendment

Effective July 1, 1973, a social security disability beneficiary would be covered under Medicare after he had been entitled to disability benefits for not less than 24 consecutive months. Those covered would include disabled workers at any age; disabled widows and disabled dependent widowers between the ages of 50 and 65; beneficiaries age 18 or older who receive benefits because of disability prior to reaching age 22; and disabled qualified railroad retirement annuitants. An estimated 1.5 million disabled beneficiaries would be eligible initially. Estimated first full-year cost is $1.5 billion for hospital insurance and $350 million for supplementary medical coverage.

Hospital Insurance for the Uninsured

(Section 202)

Problem

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

Finance Committee Amendment

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

for and pay the Part A premium costs for their retired or active employees age 65 or over.

The Finance Committee amendment requires enrollment in Part B of Medicare as a condition of buying into Part A.

Part B Premium Charges

(Section 203)

Problem

During the first 5 years of the program it has been necessary to increase the Part B premium almost 100 percent—from $3.00 monthly per person in July 1966 to a scheduled $5.80 rate in July 1972. The government pays an equal amount from general revenues. This increase and projected future increases represent an increasingly significant financial burden to the aged living on incomes which are not increasing at a similar rate.

Finance Committee Amendment

The Committee bill will limit Part B premium increase to not more than the percentage by which the Social Security cash benefits had been generally increased since the last Part B premium adjustment. Costs above those met by such premium payments would be paid out of general revenues in addition to the regular general revenue matching.

Automatic Enrollment for Part B

(Section 206)

Problem

Under present law, eligible individuals must initiate action to enroll in Part B of Medicare. Nearly 96 percent of eligible older people so enroll. Some eligibles, however, due to inattention or inability to manage their affairs, fail to enroll in timely fashion and lose several months or even years of necessary medical insurance coverage.

Finance Committee Amendment

Effective July 1, 1973, the change provides for automatic enrollment under Part B for the elderly and the disabled as they become eligible for Part A hospital insurance coverage. Persons eligible for automatic enrollment must also be fully informed as to the procedure and given an opportunity to decline the coverage.

Relationship Between Medicare and Federal Employees' Benefits

(Section 210)

Problem

Federal retirees and older employees have been required to take full coverage and pay full premiums for Federal employee coverage despite the fact that the Federal Employees' Programs *will not pay* any benefits for services covered under Medicare. Thus the retiree, who also

has earned entitlement to Medicare, is paying a portion of his premium to F.E.P. for coverage for which no benefits will be paid him. This is particularly true in the case of hospitalization. The F.E.P. does not presently offer such employees or retirees with dual eligibility the option of electing a lower-cost policy or one which supplements rather than duplicates Medicare benefits.

Finance Committee Amendment

Effective January 1, 1975, Medicare would not pay a beneficiary, who is also a Federal retiree or employee, for services covered under his Federal Employee's health insurance policy which are also covered under Medicare unless he has had an option of selecting a policy *supplementing* Medicare benefits. If a suplemental policy is not made available, the F.E.P. would then have to pay first on any items of care which were covered under both the F.E.P. program and Medicare.

Limitation on Federal Payments for Disapproved Capital Expenditure

(Section 221)

Problem

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

Finance Committee Amendment

The Committee bill will prohibit reimbursement to providers under the Medicare and Medicaid programs for capital costs associated with expenditures of $100,000 or more which are specifically determined to be inconsistent with State or local health facility plans.

Experiments in Prospective Reimbursement and Peer Review

(Section 222)

Problem

Reimbursement on the present reasonable costs basis contains little incentive to decrease costs or to improve efficiency, and retrospective cost-finding and auditing have caused lengthy delays and confusion. Payment determined on a prospective basis might provide an incentive to cut costs. However, under prospective payment providers might press for a rate less favorable to the Government than the present cost method, and they might cut back on the quality, range and frequency of necessary services so as to reduce costs and maximize return.

Finance Committee Amendment

The Committee bill instructs the Secretary to experiment with various methods of prospective reimbursement, and to report to the Congress with an evaluation of such experiments. In view of its adoption of the Professional Standards Review amendment, the Committee deleted the portion of this section authorizing peer review experimentation.

Limitations on Coverage of Costs

(Section 223)

Problem

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

Finance Committee Amendment

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

In cases where emergency care is involved, however, patients would not be liable for any differential in costs related to the emergency care.

Limitation on Prevailing Charge Levels

(Section 224)

Problem

Under the present reasonable charge policy, Medicare pays in full any physician's charge that falls within the 75th percentile of customary charges in an area. However, there is no limit on how much physicians, in general, can increase their customary charges from year to year and thereby increase Medicare payments and costs.

Finance Committee Amendment

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

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

Payment for Physicians' Services in the Teaching Setting

(Section 227)

Problem

Physicians in private practice are generally reimbursed on a fee-for-service basis for care provided to their bona fide private patients. Difficulties have arisen in determining how and whether payments should be made in teaching hospitals where the actual care is often

rendered by interns and residents under the direction (sometimes nominal) of an attending physician who is assigned to (but not selected by) the Medicare patient.

The issue relates to the compensation of the attending physician often termed the supervisory or teaching physician. The salaries of interns and residents are now covered in full as a Part A hospital cost. In general, patients were not billed for the services of teaching physicians prior to Medicare and, since Medicare, billings have been essentially limited to Medicare and Medicaid patients. The proceeds are most frequently used to finance and subsidize medical education rather than being paid directly to the teaching doctor. While charges have often been billed on a basis comparable to those charged by a private physician to his private patients the services provided are often less.

Finance Committee Amendment

The Committee bill provides that services of teaching physicians would be reimbursed on a costs basis unless:

(A) The patient is bona fide private or;

(B) The hospital has charged all patients and collected from a majority on a fee-for-service basis.

For donated services of teaching physicians, a salary cost would be imputed equal to the prorated usual costs of full-time salaried physicians. Any such payment would be made to a special fund designated by the medical staff to be used for charitable or educational purposes.

Advance Approval of ECF and Home Health Coverage

(Section 228)

Problem

Uncertainty about determinations of eligibility for care in an extended care facility or home health program following hospitalization have created major difficulties for intermediaries, institutions and beneficiaries. The essential problem is in determining whether the patient is in need of skilled nursing and medical services or in fact, needs a lesser level of care. Retroactive claims denials resulting from determinations that skilled care was not required, while often justified, have created substantial friction and ill will.

Finance Committee Amendment

The Committee bill authorizes the Secretary to establish, by diagnosis, minimum periods during which the post-hospital patient would be presumed to be eligible for benefits.

Termination of Payment to Suppliers of Service

(Section 229)

Problem

Present law does not provide authority for the Secretary to withhold future payments for services rendered by an institution or physician who abuse the program, although payments for past claims may be withheld on an individual basis where the services were not reasonable or necessary.

Finance Committee Amendment

The Secretary would be authorized to suspend or terminate Medicare payments to a provider found to have abused the program. Further, there would be no Federal participation in Medicaid payments which might be made subsequently to this provider. Program review teams would be established in each State to furnish the Secretary with professional advice in discharging this authority.

Elimination of Requirement That States Move Toward Comprehensive Medicaid Program

(Section 230)

Problem

The Medicaid program has been a significant burden on State finances. Section 1903(e) of Title 19 requires each State to show that it is making efforts in the direction of broadening the scope of services in its Medicaid program and liberalizing eligibility requirements for medical assistance. These required expansions of Medicaid programs have been forcing States to either cut back on other programs or to consider dropping Medicaid. The original date for attainment of those objectives was 1975. The Finance Committee, the Senate and the House approved an amendment in 1969 postponing the date to 1977.

Finance Committee Amendment

The Committee bill would repeal section 1903(e).

Relationship Between Medicaid and Comprehensive Health Programs

(Section 240)

Problem

State agencies often cannot make pre-payment arrangement which might result in more efficient and economical delivery of health services to Medicaid recipients because such arrangements might violate present Title 19 requirements that the same range and level of services be available to all recipients throughout the State.

Finance Committee Amendment

The Committee bill would permit States to waive Federal statewideness and comparability requirements with approval of the Secretary if a State contracts with an organization which has agreed to provide health services in excess of the State plan to eligible recipients who reside in the area served by the organization and who elect to receive services from such organization. Payment to such organizations could not be higher on a per-capita basis than the per-capita medicaid expenditures in the same general area.

Program for Determining Qualifications for Certain Health Care Personnel

(Section 241)

Problem

There is a shortage of qualified manpower in the health care field and many facilities have difficulty hiring sufficient qualified personnel.

At the same time there are persons available who do not meet full licensing or Medicare educational requirements, but who have had years of experience and have been granted "waivered" status (for example, waivered licensed practical nurses).

Finance Committee Amendment

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

In order to encourage young people to complete required training, all health personnel initially licensed after Dec. 31, 1975 would be expected to meet otherwise required formal educational and training criteria.

Penalties for Fraudulent Acts and False Reporting Under Medicare and Medicaid

(Section 242)

Problem

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

Finance Committee Amendment

The Committee bill would establish penalties for soliciting, offering or accepting bribes or kickbacks, or for concealing events affecting a person's rights to benefits with intent to defraud, or for converting benefit payments to improper use, of up to one year's imprisonment and a $10,000 fine or both. Concealing knowledge of events affecting a person's right to benefits with intent to defraud, and converting benefits to improper use would also be a Federal crime subject to the same penalty. Additionally, the bill establishes false reporting of a material fact as to conditions or operations of a health care facility as a misdemeanor subject to up to 6 months' imprisonment, a fine of $2,000, or both.

Prosthetic Lenses Furnished by Optometrists Under Part B

(Section 264)

Problem

Medicare will pay for prosthetic lenses furnished by an optometrist, provided that the medical necessity for such lenses has been determined by a physician.

Optometrists contend that to require their patients to obtain a physician's order for prosthetic lenses is unfair to both the patient and the optometrist. Moreover, because the physician who furnishes the order is generally an opthalmologist, the requirement may serve to encourage patients to use an ophthalmologist in preference to an optometrist.

Finance Committee Amendment

The Committee bill provides that, for the purposes of the medicare program, an optometrist be recognized as a "physician" under section 1861(r) of the Act, but only with respect to establishing the medical necessity of prosthetic lenses for medicare beneficiaries. An optometrist would not be recognized as a "physician" for any other purposes under medicare and no additional services performed by optometrists would be covered by the proposal.

2. PROVISIONS OF HOUSE BILL SUBSTANTIALLY MODIFIED BY COMMITTEE

Failure by States To Undertake Required Institutional Care Review Activities

(Section 207)

Problem

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

House Bill

1. Unless a State can make a showing satisfactory to the Secretary that the State has an effective program of control over the utilization of nursing home care, effective January 1, 1973, the House bill provides for a one-third reduction in the Federal Medicaid matching share for stays in a fiscal year which exceed 60 days in a skilled nursing home.

2. Federal matching would be available, in any year, for only: (a) 60 days of care in a general or TB hospital, and (b) 90 days in a mental hospital (except that an additional 30 days would be allowed in a mental hospital if the State shows that the patient will benefit). There would be no Federal matching for care in a mental hospital beyond 120 days in any year. In addition, there would be no Federal matching for care in a mental hospital after 365 days of such care during a patient's lifetime.

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

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

Finance Committee Changes

1. In addition to the utilization review requirement, States must also conduct the independent professional audits of patients as required by present law which are intended to assure that the patient is getting the right care in the right place.

2. Where a State makes a satisfactory showing to the Secretary that it has an effective program of control over the utilization of hospital and mental hospital care: (a) the 60-day limitation in general and TB hospitals, and (b) the 90-day or 120-day annual limitation and the 365-day lifetime limitation on care in mental hospitals, would not apply. If proper procedures assure that the patient needs the care and is benefiting from it, it seemed inappropriate to cut off Federal matching utilizing arbitrary limitations.

3. The Committee deleted the House provision calling for a 25% increase in matching for amounts paid to HMO's, since if HMO's deliver services more efficiently, and economically, it would be in the States' interest to deal with HMO's without an increase in matching.

4. Intermediate care services would also be subject to a reduction in Federal matching after 60 days, unless the State provides satisfactory assurance that required review is being undertaken. This appeared appropriate in view of the shift of intermediate care to Medicaid in legislation enacted subsequent to House consideration of H.R. 1.

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

Cost Sharing Under Medicaid

(Section 208)

Problem

Under present law, States may require payment by the medically indigent of premiums, deductibles and co-payment amounts with respect to Medicaid services provided them but such amounts must be "reasonably related to the recipient's income." However, States cannot require cash assistance recipients to pay any deductibles or co-payments.

House Bill

This section contains 3 provisions:

1. It requires States which cover the medically indigent to impose monthly premium charges. The premium would be graduated by income in accordance with standards prescribed by the Secretary and details regarding the operation of the premium would be left to the Secretary's discretion. The House Committee report indicates that it would be expected that premiums would be fixed on a state-by-state basis at whatever level would be required to result in a savings under the medically indigent program of approximately 6 percent.

2. States could, at their option, require payment by the medically-indigent of deductibles and co-payment amounts which would not have to vary by level of income.

3. With respect to cash assistance recipients, nominal deductible and co-payment requirements, while prohibited for the six mandatory services required under Federal law (inpatient hospital services; outpatient hospital services; other X-ray and laboratory services; skilled nursing home services; physicians' services; and home health services),

would be permitted with respect to optional Medicaid services such as prescribed drugs, hearing aids, etc.

Finance Committee changes

The provision would be modified by the Committee bill as follows:

1. The House bill permits States to impose co-payments and deductibles on the medically-indigent. The change limits such amounts to co-payments on patient-initiated elective services only, such as the initial office visits to physicians and dentists.

2. The House bill also allows States to impose co-payments and deductibles on the indigent for optional Medicaid services. The committee deleted this provision, as the savings ($5 million) would most probably be exceeded by the administrative costs.

Mandatory Medicaid Deductible for Families With Earnings

(Section 209)

Problem

Under present law, AFDC families with earnings can, at a certain earnings point lose eligibility for Medicaid. This has been called the "Medicaid Notch". This notch is believed to act as a potential work disincentive, since at a certain income level a family may precipitously lose Medicaid eligibility if it has additional earnings.

House Bill

Section 209 would remove this "notch" by requiring AFDC families with earnings to pay a Medicaid deductible. In States without a medically indigent program this deductible would be equal to one-third of all earnings over $720. The deductible amount is identical to the amount of earnings which AFDC families would be allowed to retain as an incentive to work. This approach eliminates any sudden loss of Medicaid eligibility. However, although eligible for Medicaid, every dollar of a recipient's retained earnings raises his Medicaid deductible by one dollar.

In those States with programs for the medically indigent, an AFDC recipient would not have to pay the deductible until his retained earnings exceeded the difference between a State's cash assistance level and its medically indigent level. At this point, however, his Medicaid deductible would increase dollar for dollar with his retained earnings.

Finance Committee Changes

Although the House provision eliminates any sudden loss of eligibility for Medicaid, the provision acts as a substantial work disincentive, since the Medicaid deductible increases dollar for dollar with retained earnings.

In order to avoid establishing a substantial work disincentive the Committee amended Section 209 to deal with the "Medicaid Notch" by allowing Work Program families otherwise eligible for Medicaid, who would ordinarily lose eligibility as a result of earnings from employment, to remain eligible for Medicaid for one year. At the expiration of that year, such families could elect to continue in Medicaid by paying a premium of 20 percent of income in excess of $2,400 annually (excluding work bonus amounts). Additionally, other families participating in the Work Program (see Title IV) which are otherwise ineligible for Medicaid in a State could also voluntarily elect to participate by paying a premium of 20 percent of income (excluding work bonus) above $2,400. Costs of coverage for those families on a premium basis would be subsidized by the Federal Government to the extent premium income did not cover the costs of benefits for those families.

The Committee retained that portion of Section 209 of the House bill which gives States the option of covering under Medicaid aged, blind and disabled persons made newly eligible as a result of the increases in payment levels to these persons proposed by the Committee.

Medicare Benefits for Border Residents

(Section 211)

Problem

At present, coverage for care in a foreign hospital near the U.S. border is available only where an emergency occurs *within* the United States and where the foreign institution is the closest adequate facility. This limitation creates difficulty in securing necessary non-emergency care by border residents who ordinarily do and would use the nearest hospital suited to their medical needs, which may be a foreign hospital.

House Bill

Authorizes use of a foreign hospital by a U.S. resident where such hospital was closer to his residence or more accessible than the nearest suitable United States hospital. Such hospitals must be approved under an appropriate hospital approval program.

In addition, the provision authorizes Part B payments for necessary physicians' services furnished in conjunction with such hospitalization.

Finance Committee Changes

The Committee approved the House provisions; it also authorized Medicare payments for emergency hospital and physician services needed by beneficiaries in transit between Alaska and the other continental States.

Payments to Health Maintenance Organizations

(Section 226)

Problem

Certain large medical care organizations seem to make the delivery of medical care more efficient and economical than the medical care community at large.

Medicare does not currently pay these comprehensive programs on an incentive capitation basis, and consequently any financial incentives to economical operation in such programs have not been incorporated in Medicare.

Two areas of potential concern arise in dealing with HMO's. The first area of concern involves the quality of care which the HMOs will deliver. Most existing large HMOs provide care which is generally accepted as being as of professional quality. However, if the Government begins on a widespread basis, to pay a set sum in advance to an organization in return for the delivery of all necessary care to

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a group of people, there must be effective means of assuring that such organizations will not be tempted to cut corners on the quality of their care (e.g., by using marginal facilities or by not providing necessary care and services) in order to maximize their return or "profit." Under present reimbursement arrangements, although there may be no incentive for efficiency, neither is there an incentive to profit through underservicing and other corner-cutting.

The second problem area involves the reimbursement of HMO's. If an HMO were to enroll relatively good risks (i.e., the younger and healthier Medicare beneficiaries), payment to that organization in relation to average per capita non-HMO costs—without accurate actuarial adjustments—could result in large "windfalls" for the HMO, as the current costs of caring for these beneficiaries might turn out to be much less than Medicare's average per capita costs. Additionally, ceilings on windfalls might be evaded because an HMO conceivably could inflate charges to it by related organizations thereby maximizing profits through exaggerated benefit costs.

It may not always be possible to detect and eliminate such windfalls through actuarial adjustment. Further, once a valid base reimbursement rate is determined, an issue remains as to the extent to which the HMO, and the Government should share in any savings achieved by an HMO.

House Bill

The House bill authorizes Medicare to make a single combined Part A and B payment, prospectively on a capitation basis, to a "Health Maintenance Organization," which would agree to provide care to a group not more than one-half of whom are Medicare beneficiaries who freely choose this arrangement. Such payments may not exceed 95 percent of present Parts A and B per capita costs in a given geographic area.

The Secretary could make these arrangements with existing prepaid groups and foundations, and with any new organization which meets the broadly defined term "Health Maintenance Organization."

Finance Committee Changes

Agreeing with the desirability of authorizing reasonable per capita payments to organizations which have demonstrated a capacity to provide quality health care, and recognizing the above problems, the Committee authorized the following approach as a modification of the HMO provision in the house bill:

ELIGIBILITY FOR INCENTIVE REIMBURSEMENT

The Secretary would be authorized to contract on an incentive capitation basis for Medicare services with substantial, established HMO's: (1) with reasonable standards for quality of care at least equivalent to standards prevailing in the HMO's area, and which can be adequately monitored, and (2) which have sufficient operating history and sufficient enrollment to provide an adequate basis for evaluating their ability to provide appropriate health care services and for establishing a combined Part A-Part B capitation rate.

General Requirements

Such reimbursement would be authorized for HMOs which: (1) have been in operation for at least two years, and (2) have a minimum of 25,000 enrollees, not more than one-half of whom are age 65 or over.

Exception

The Secretary would be authorized to make exceptions to the minimum enrollment requirement in the case of HMOs in smaller communities or sparsely populated areas which had demonstrated through at least 3 years of successful operation, capacity to provide health care services of proper quality on a prepaid basis and which have at least 5,000 members.

Reimbursement

The combined Part A-Part B per capita payment would be determined and administered as follows:

1. An eligible HMO approved by the Secretary for per capita reimbursement would submit, at least 90 days prior to the beginning of a prospective Medicare contract year, an operating costs and enrollment forecast. On the basis of the estimate and available information regarding Medicare costs in the HMO's area, the HMO and the Secretary would arrive at an interim per capita reimbursement rate. The rate would reflect estimated costs of the HMO for its enrolled population but might not exceed 100 percent of the estimated "adjusted average per capita cost" (as defined below).

2. At the beginning of the contract period, the HMO would be paid monthly, in advance, the interim per capita prepayment for the Medicare beneficiaries actually enrolled. The HMO would submit interim cost estimates on a quarterly basis and the interim payment could be adjusted as indicated in such estimates, subject however to the limitations set forth below.

3. The HMO would submit, annually, independently certified financial statements, including certified costs statements allocating HMO operating costs to the Medicare population in proportion to utilization of HMO resources. Allocations may use statistical, demographic and utilization data collection and analysis methods acceptable to the Secretary in lieu of fee-for-service or cost-per-service methods in the case of an HMO which does not operate on a fee-for-service basis. Such statements would be developed in accordance with Medicare accounting principles but not necessarily on the basis of actual case-by-case patient services. All HMO's would be subject to audit in accordance with the selective audit procedures of the Bureau of Health Insurance and would also be subject to audit and review by the Comptroller General (and the Inspector General for Health Care administration).

4. The Secretary would retroactively determine on an actuarial basis what the per capita costs for Part A and Part B services for the HMOs' Medicare population would have been if the population had been served through other health care arrangements in the same general area and not enrolled in the HMO. That is to say there would be a calculation, on the basis of experience in the same or similar geographical areas, of the cost for the non-HMO group of similar size, age distribution, sex, race, institutional status, disability status, cost experi-

ence for the Medicare contract year in question, and other factors deemed by the actuaries to be relevant and material such as unusual usage of low-cost hospitals and non-usage of specialists. This figure defined as "adjusted average per capita cost" would be determined as promptly as practical after the end of a contract period. Many of the difficulties and uncertainties of previously suggested methods of rate determination are minimized or eliminated by making this determination after the fact. For example, the makeup of the enrolled population and Medicare cost experiences—within and outside of the HMO—would be known, rather than merely estimated.

5. If the HMO's costs for the types of expenses reimbursable under medicare are less than the adjusted average per capita cost the difference, called "net savings" would be divided and allocated as follows:

Savings between 90 percent and 100 percent would be divided equally between the Government and the HMO. Savings between 80 percent and 90 percent would be divided 75 percent to the Government and 25 percent to the HMO. Savings below the 80 percent level would be allocated entirely to the Government.

Thus, assuming an HMO operated at 80 percent of adjusted average per capita costs, it would receive a share equal to 7½ percent of the adjusted average per capita costs and the Government would retain 12½ percent of those costs.

6. At the option of the HMO, it could apply any amount of its share of the saving toward improved benefits, reduced supplemental premium rates, or other advantages for beneficiaries or retain the money. It could not, however, make cash refunds to beneficiaries.

7. If, on the other hand, HMO costs exceed adjusted average per capita costs, the "excess costs" would be allocated between the government and the HMO in the following manner:

Any amount of excess between 100 percent and 110 percent would be divided equally between the Government and the HMO. Excess costs between 110 percent and 120 percent would be borne 25 percent by the HMO and 75 percent by the Government. Costs in excess of 120 percent would be borne entirely by the Government. Any losses incurred would carry forward and be recovered, proportionally, by the HMO and the Government in the future. Any losses by the Government would have to be recovered in full before any "savings" could be paid to an HMO in future years.

Reductions in Care and Services Under Medicaid Program

(Section 231)

Problem

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

House Bill

The House bill provides for a continuance of the maintenance of effort clause with respect to the six mandatory health care services. The provision would, however, amend section 1902(d) by restricting the maintenance of effort requirement to those six basic services. The State would be able to modify the scope, extent and expenditures for optional services provided, such as drugs, dental care and eyeglasses.

Finance Committee Changes

The Committee substituted for the House provision an amendment repealing Section 1902(d)—entirely. This action is consistent with Committee and Senate action on H.R. 17550 in 1970.

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

(Section 235)

Problem

Many States do not have effective claims administration or properly designed information storage and retrieval systems for their Medicaid programs and do not possess the financial and technical resources to develop them. Their recourse today is to contract with private companies for their data processing.

House Bill

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

2. Authorizes 90% matching for 2 years (up to a total of $150,000 annually) for the development of cost determination systems for State-owned general hospitals.

Finance Committee Changes

The Committee deleted the first part of the House provision retaining, however, the part authorizing funds for cost-determination systems.

Provider Reimbursement Review Board

(Section 243)

Problem

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

House Bill

The House bill establishes a Provider Reimbursement Review Board to consider disputes between a provider and intermediary where the amount at issue is $10,000 or more and where the provider has filed a timely cost report. Decisions of the Review Board would be final

unless the Secretary reversed the Board's decision within 60 days. If such a reversal occurs the provider would have the right to obtain judicial review.

The House provision is similar to a Senate amendment to H.R. 17550 in 1970. The House did not include those portions of the earlier Senate amendment which would allow providers, as a group, to appeal aggregate amounts of $10,000 on a common issue; and which would allow appeals to the Board by a provider where the intermediary fails to make timely final costs determinations.

Finance Committee Changes

The Committee substituted the 1970 Senate language and added language requiring the Secretary to report to the legislative committees at the end of the first year of operation of the provision concerning its capacity to function effectively and equitably as well as any suggestions he might have for improvement of the process.

Physical Therapy Services and Other Services Under Medicare

(Section 251)

Problem

Physical therapy is presently covered as an inpatient service, and as an outpatient service when furnished through a participating facility or home health agency. Services cannot be provided in a therapist's office.

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

Another problem is the rapidly increasing cost of physical therapy services and findings of abuse of the benefit.

House Bill

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

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

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

Finance Committee Changes

The Committee modified the House provision by adopting language to assure that factors, such as travel time, be included in the calculation of salary-related reimbursement and deleting the provision that would have established a new and separate benefit of up to $100 annually for services provided by an independent physical therapist in his office or in a patient's home.

Additionally, the Committee will include in its Report instructions to the Secretary designed to assure that reasonable arrangements may be undertaken in rural and smaller population centers to enhance availability of physical therapy in those areas.

Waiver of Registered Nurse in Rural Skilled Nursing Facility

(Section 267)

Problem

There are some rural nursing homes which can obtain a registered nurse to work one shift 5 days a week, but which are unable to obtain the services of an additional registered nurse to work on the other 2 days, generally the weekend.

House Bill

The House bill would allow a complete waiver of the requirement for a registered nurse in a rural nursing home, if there is no other skilled nursing home in the area to meet patient needs. Under the bill a skilled nursing home could function without any skilled nurse at all.

Finance Committee Changes

The Committee modified the provision granting waivers for certain rural skilled nursing facilities which are unable to assure the presence of a full-time registered nurse in such facilities 7 days a week. The Committee modification would allow a rural skilled nursing home, which has one full-time registered nurse and is making good faith efforts to obtain another, a special waiver of the nursing requirement with respect to not more than two shifts, such as over a weekend. This special waiver would be authorized if the facility had only patients whose physicians indicated that each such patient could be without a registered nurse's services for a 48-hour period. If the facility had any patients for whom physicians had indicated a need for daily skilled nursing services, the facility would have to make arrangements for a registered nurse or a physician to spend such time as was necessary at the facility on the uncovered day to provide the skilled services needed.

Coverage of Chiropractic Services

Problem

Chiropractors are not currently eligible to participate as physicians in the Medicare program.

House Bill

The House Bill calls for a study regarding the coverage of chiropractors.

Finance Committee Changes

The Committee on Finance deleted the study of chiropractic services called for in the House bill 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 meets 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.

3. NEW PROVISIONS ADDED BY THE FINANCE COMMITTEE

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.

Finance Committee 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 practicing physicians in an area. Appropriate safeguards are included so as to adequately provide for protection of the public interest and to prevent pro forma assumption in 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.

Coverage of Drugs Under Medicare

Problem

The costs of outpatient prescription drugs represent a major item of medical expense for many older people, especially for those suffering from chronic and serious illness conditions. The costs of such drugs are not presently covered under the Medicare program.

Finance Committee Amendment

The Committee amended Part A of Medicare to cover the costs of certain specified drugs, purchased on an outpatient basis, which are necessary in the treatment of the most common, crippling or life-threatening chronic disease conditions of the aged. Beneficiaries would pay $1 toward the cost of each prescribed drug included in the reasonable cost range for the drug involved.

The amendment would cover specific drugs used in the treatment of the following conditions: arthritis, cancer, chronic cardiovascular disease, chronic kidney disease, chronic respiratory disease, diabetes, gout, glaucoma, high blood pressure, rheumatism, thyroid disease and tuberculosis. The amendment would limit reimbursement to certain drugs used in the treatment of these conditions. For example, people with chronic heart disease often use digitalis drugs to strengthen their heartbeat, anticoagulant drugs to reduce the danger of blood clots and drugs to lower their blood pressure. These types of drugs would be covered under the amendment as they are necessary in the treatment of the heart condition and they are not types of drugs which would be used by people without heart conditions.

Other drugs which might be used by those with chronic heart conditions (such as sedatives, tranquilizers and vitamins) would not be covered as they are drugs which are generally less expensive, less critical in treatment and much more difficult to handle administratively, as many patients without chronic heart disease may also utilize these types of medications.

The major provisions of the amendment are:

Eligibility.—Medicare beneficiaries with one or more of the following conditions:

- Diabetes.
- High blood pressure.
- Chronic cardiovascular disease.
- Chronic respiratory disease.
- Chronic kidney disease.
- Arthritis, gout and rheumatism.
- Tuberculosis.
- Glaucoma.
- Thyroid disease.
- Cancer.

Benefits.—Would include those drugs:

- Necessary over a prolonged period of time for treatment of the above conditions;
- Generally subject to use only by those with the above conditions.

This recommendation would exclude drugs not requiring a physician's prescription (except for insulin), drugs such as antibiotics which are generally used only for a short period of time, and drugs such as tranquilizers and sedatives which may be used by eligible beneficiaries but also by many other persons.

A list of the covered drug categories and illustrative drug entities follows:

THERAPEUTIC CATEGORY AND DRUG ENTITY

Adrenocorticoids (e.g., Cortisone, Dexamethasone, Hydrocortisone, Prednisone)
Anti-arrhythmics (e.g., Quinidine)
Anti-coagulants (e.g., Dicumarol)
Anti-hypertensives (e.g., Reserpine)
Anti-neoplastics (e.g., Cyclophosphamide, Flourouracil, Mercaptopurine, Methotrexate, Vincristine)
Anti-rheumatics (e.g., Phenylbutazone)
Bronchial dialators (e.g., Isoproterenol)
Cardiotonics (e.g., Digitoxin, Digoxin)

Coronary vasodilators (e.g., Nitroglycerin)
Diuretics (e.g., Hydrochlorothiazide)
Gout suppressants (e.g., Colchicine)
Hypoglycemics (e.g., Insulin)
Miotics (e.g., Philocarpine)
Thyroid hormones (e.g., Thyroid)
Tuberculostatics (e.g., Aminosalicylate, Isoniazid)

Reimbursement and Cost Controls.—The amendment would utilize a reasonable charge reimbursement method, and would incorporate a formulary approach. The formulary established could include only drug entities in categories specified above. Participating pharmacies would file either their usual and customary markups or professional fee schedules as of June 1, 1972, which would then be applied to the estimated acquisition cost of the drug product. The usual and customary charge, including mark-up or professional fee, for purposes of program payments and allowances, could not exceed the 75th percentile of charges by comparable vendors in an area for similar quantities of the dosage form of the drug. Outpatient drugs dispensed by a participating hospital or extended care facility would be reimbursed on the regular Part A Medicare costs basis. Increases in prevailing mark-ups or fees would be limited in a fashion essentially parallel to that applicable to physicians' fees.

Financing.—Part A Medicare payroll tax.

Cost.—$700 million with a $1 co-payment per prescription. There would be an offsetting reduction in Federal-State Medicaid costs of $100 million as a result of this Medicare drug coverage.

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 the General Accounting Office 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.

Finance Committee 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 to those otherwise eligible individuals who are 65 years of age or older.

Finance Committee Amendment

The Committee bill would authorize coverage of inpatient care in mental institutions for Medicaid eligibles under age 21, provided that the care consists of a program of active treatment, that it is provided in an accredited medical institution, and that the State maintains its own level of fiscal expenditures for care of the mentally ill under 21.

The amendment also provided for demonstration projects of the potential benefits of extending Medicaid mental hospital coverage to mentally ill persons between the ages of 21 and 65.

Public Disclosure of Information Regarding Deficiencies

Problem

Physicians and the public are currently unaware as to which hospitals, extended care facilities, skilled nursing home and intermediate 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.

Finance Committee 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 or the absence thereof (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. 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 would be matters of public record. In the case of Medicare, such information would be available for inspection within 90 days of completion of the survey upon request in Social Security District Offices, and, in the case of Medicaid, the information would be available in local Welfare offices.

Extended Care Facilities—Skilled Nursing Facilities

Problem

Serious problems have arisen with respect to the skilled nursing home benefit under medicaid and the extended care benefit under medicare.

In the case of medicare, the definition of eligibility has been extremely difficult to apply objectively and, consequently, has led to great dissatisfaction on the part of patients, providers and practitioners, resulting in many facilities' refusal to participate in medicare and widespread retroactive denial of benefits.

Medicaid has its own set of problems with respect to skilled nursing home care. These include, according to the General Accounting Office and the HEW Audit Agency, widespread inappropriate placement of patients in skilled nursing homes who more properly belong in other institutional settings—such as intermediate care facilities—and widespread noncompliance with required standards. It appears difficult to insist that a skilled nursing facility meet all necessary standards without, at the same time, assuring that reimbursement is equitable for necessary care in the proper setting. In general, that is not the case today. The Comptroller General and others have reported on the often irrational payment mechanisms developed and utilized by many States in reimbursing for nursing home care. On an aggregate basis, it appears that nursing homes are not underpaid. However, because of the arbitrary payment structures in many States, in all probability, many facilities are being overpaid for the care they provide while others are being underpaid.

Finance Committee Amendments

a. *Conforming Standards for Extended Care and Skilled Nursing Home Facilities.*—The Committee bill would establish a single definition and set of standards for extended care facilities under Medicare and skilled nursing homes under Medicaid. The provision creates a single category of "skilled nursing facilities" which would be eligible to participate in both health care programs. A "skilled nursing facility" would be defined as an institution meeting the present definition of an extended care facility and which also satisfies certain other Medicaid requirements set forth in the Social Security Act. These changes are intended to reduce duplicative activity and red-tape.

b. *"Level of Care" Requirements for Extended Care.*—To make the Medicare extended-care benefit more equitable and suitable to the post-hospital needs of older citizens, as well as to avoid the problem of retroactive denials of coverage which have plagued Medicare patients and facilities, the Committee bill would change the level of care requirements with respect to entitlement for extended care benefits under Medicare. Present law would be amended to authorize skilled care benefits for individuals in need of "skilled nursing care and/or skilled rehabilitation services on a daily basis in a skilled nursing facility which it is practical to provide only on an inpatient basis." Medicare coverage would also continue during short-term periods (e.g. a day or two) when no skilled services were actually provided but when discharge from a skilled facility for such brief period was neither desirable nor practical.

c. *14-Day Transfer Requirement for Extended Care Benefits.*—Under existing law, Medicare beneficiaries are entitled to extended care benefits only if they are transferred to an extended care facility within 14 days following discharge from a hospital. The Committee modified this with respect to certain patients. An interval of more than 14 days would be authorized for patients whose conditions did not permit immediate provision of skilled services within the 14-day limitation (e.g., patients with fractured hips whose fractures have not mended to the point where physical therapy and restorative nursing can be utilized). An extension not to exceed 2 weeks beyond the 14 days would also be authorized in those instances where an admission to an ECF is prevented because of the non-availability of appropriate bed space in facilities ordinarily utilized by patients in a geographic area.

d. *Reimbursement Rates for Care in Skilled Nursing Facilities.*—The Committee added a provision amending Title 19 to require States, by July 1, 1974, to reimburse skilled nursing and intermediate care facilities on a reasonable cost-related basis, using acceptable cost-finding techniques and methods approved and validated by the Secretary of HEW. Cost reimbursement methods which the Secretary found to be acceptable for a State's Medicaid program would be adapted, with appropriate adjustments, for purposes of Medicare skilled nursing facility reimbursement in that State.

e. *Skilled Nursing Facility Certification Procedures.*—The Committee also added a provision under which the Secretary of HEW would decide whether a facility qualifies to participate as a "skilled nursing facility" in both the Medicare and Medicaid programs. The Secretary would make that determination, based principally upon the appropriate State health agency evaluation of the facilities. A State could, for good cause, decline to accept as a participant in the Medicaid program a facility certified by the Secretary but could not overrule the Secretary and receive Federal Medicaid matching funds for any institution not approved by the Secretary. The Committee also incorporated into the amendment proposals of the President regarding full Federal financing of skilled nursing facility and intermediate care facility survey and inspection costs attributable to the Medicare and Medicaid program and the training of additional Federal and State nursing facility inspection personnel.

Authority for Demonstration Projects Concerning the Most Suitable Types of Care for Beneficiaries Ready for Discharge From a Hospital or Skilled Facility

Problem

It is not unusual for a previously hospitalized medicare beneficiary to need services other than those covered under the program. A beneficiary who is discharged from a hospital may need further institutional care for a condition for which he was hospitalized, but the care required is not skilled care.

Finance Committee Amendment

The Committee authorized the Secretary of HEW to experiment with methods for determining suitable levels of care for Medicare patients who are ready for discharge from hospitals and skilled nursing facilities and no longer require skilled care, including some

terminally-ill patients but who are unable to maintain themselves at home without some sort of additional assistance. The experiments and demonstration projects could include (1) making Medicare payment for each day of care provided in an intermediate care facility, count as one covered day of skilled nursing facility care, if the care was for the condition for which the person was hospitalized, (2) covering the services of homemakers, where institutional services are not needed. Such experiments would be aimed at determining whether such coverage could effectively lower long-range costs by postponing or precluding the need for higher cost institutional care or by shortening the period of such care, and ascertaining what eligibility rules may be appropriate and the resultant costs of application of various eligibility requirements, if the project suggests that extension of such coverage generally, would be desirable.

Physicians' Assistants

Problem

Over the past few years, a number of programs have been developed to train physicians' assistants. These assistants are seen as a way to extend the physician's productivity and to bring care to many who would otherwise not receive it. HEW is currently supporting the training of these physicians' assistants. There are some 100 experimental training programs for physician assistants and nurse practitioners. Each of these, however, is structured differently, reflecting the lack of agreement among professionals on the experience and education that should be required of training program applicants, the content of the programs, or the responsibilities and supervision that are appropriate for their graduates. These unresolved issues have prompted the American Medical Association, the American Hospital Association, the American Public Health Association, as well as the Department (in its "Report on Licensure and Related Health Personnel Credentialing") and other organizations to ask for a moratorium on State licensure of the new categories of health personnel.

Some feel that it is inconsistent for HEW to support the training of these personnel, while Medicare does not, in some instances, recognize all their services as reimbursable items.

Under present law, part B of Medicare pays for physicians' services. Within the scope of paying for physicians' services, the program pays for services commonly rendered in a physician's office by para-medical personnel. For example, if a nurse administers an injection in the office, Medicare will recognize a small charge by the physician for that service.

Medicare will not pay where a physician submits a charge for a professional service, performed by a para-medical person, in cases where the service is traditionally performed by a physician. For example, the program would not recognize a charge for a complete physical exam conducted by a nurse.

Additionally, Medicare will not recognize a physician's charge for a service performed by a para-medical person outside of the physician's office. In other words, he would not be reimbursed for an injection administered by a para-medical employee in a nursing home. Others argue that Medicare does reimburse physicians for services

provided by these new physicians' assistants, so long as they are services commonly provided by para-professional personnel in a physician's office. They go on to argue that, until the training and licensure of physicians' assistants becomes more uniform, it would be inappropriate for Medicare to take the lead in encouraging doctors—by generous reimbursement to use physicians' assistants to work independently or to expand their responsibilities.

Finance Committee Amendment

The committee authorized demonstration projects to determine the most appropriate and equitable methods of compensating for the services of physicians' assistants (including nurse practitioners). The objectives are development of non-inflationary and less-costly alternatives which do not impede the continuing efforts to expand the supply of qualified physicians' assistants.

The Role of the Joint Commission on the Accreditation of Hospitals in Medicare

Problem

Several problems have arisen with respect to the JCAH role in the Medicare certification process. Present law specifies that an institution may be deemed to meet the certification requirements of Medicare if it is accredited as a hospital by the Joint Commission on Accreditation of Hospitals.

In addition, under the definition of a hospital, the section states that an institution must meet such requirements as the Secretary finds necessary in the interests of health and safety, except that such other requirements may not be higher than the comparable requirements prescribed for the accreditation of hospitals by the Joint Commission on the Accreditation of Hospitals. Another section of the law does allow an individual State to set higher standards.

The JCAH survey process is not subject to Federal review, and all JCAH survey reports are confidential, available only to the Commission and the facility concerned. Consequently, the Federal agencies responsible to the Congress for the administration of Medicare, are not in a position to audit the validity of the overall JCAH survey process and are thus unable to determine the extent to which specific deficiencies may exist in the vast majority of participating hospitals, since JCAH survey reports are not available to the Social Security Administration. A further problem arises because, under present law, Medicare is barred from setting any standards which are higher than comparable JCAH requirements. This has been interpreted by Social Security to also bar establishment of any standards in an area where JCAH has remained silent. Since the law does not refer to any specific JCAH standard, but rather to any standards prescribed by the JCAH, the law serves as an almost total and blanket delegation of authority over hospital standards to a private agency. Thus, if the Joint Commission chooses to lower a standard, Medicare is obliged to also accept that reduced standard. Though the Federal Government is tied to JCAH standards, a State may promulgate higher standards for facilities within the State.

Finance Committee Amendment

The Committee approved a provision under which the State certification agencies, as directed by the Secretary, would survey on a random sample basis (or where substantial allegations of noncompliance have been made) hospitals accredited by the Joint Commission on Accreditation of Hospitals. This would serve as a mechanism to validate the JCAH survey process. If deficiencies from the JCAH standards were found to exist in an institution, the Medicare standards and compliance procedures would be applied in that facility. To implement this authority, JCAH hospitals would, as a condition of participating in Medicare, agree, if included in a survey, to furnish the State agency or the Secretary on request with copies of the JCAH survey report on a confidential basis. The Joint Commission on Accreditation of Hospitals has indicated that it would cooperate fully with such validation surveys and the Secretary would be expected to consult with and cooperate with JCAH in these activities.

Under the provision the Secretary would be authorized to promulgate standards as necessary for health and safety after consultation with JCAH and with adequate lead-time without being bound to JCAH standards.

Maternal and Child Health

Problem

The intent of the 1967 Amendments was to divide available funds between formula grants to the States, and special project grants for a few years, so that the Federal Government could fund innovative special project grants which the States might not be able to support out of their formula funds. The 1967 Amendments terminated special project grants as of fiscal year 1973 and converted all the project money to formula grants on the rationale that after a few years' time the States would recognize the value of and continue to support worthwhile project grants as part of an overall State program. Two problems have occurred in the interim. First the special project grant has been utilized primarily in urban ghetto areas, while the formula funds are weighted in favor of rural States. Therefore, a shift of funds from urban States with project grants to rural States without project grants would occur if the project grants were terminated. Additionally, many project grant directors feel that with the pressure on State finances, State health departments would be reluctant to use new formula funds to continue support for project grants however worthy they might be.

Finance Committee Amendment

The Committee added to H.R. 1 a provision which extends for two additional fiscal years (through June 30, 1974) the present special project grant authorization contained in Title V of the Social Security Act to support maternal and child health programs.

Coverage of Speech Pathologists and Clinical Psychologists Under Medicare

Problem

While speech pathology and clinical psychology services are at times useful to aged persons with certain disorders, such services are relatively inaccessible to the aged due to the small percentage of speech pathologists who are employed by providers eligible to participate in the Medicare program. Part of the problem is the fact that the provider clinic or agency must be physician-directed.

Finance Committee Amendment

Coverage of the services of clinical psychologists and speech therapists on an outpatient basis is presently available under Medicare if the services of such personnel are rendered in a physician-directed clinic or outpatient department. The Committee included a provision removing the requirement that such care necessarily be rendered in a *physician-directed* clinic or outpatient department. However, the services would still have to be provided in an organized setting, and under a plan of care and treatment established by a physician who would retain overall responsibility for the patient's care. Additionally, with respect to psychological treatment, such costs would be included in and limited by the overall $250 annual limitation on reimbursement for outpatient treatment of mental illnesses.

Provide Secretary Greater Discretion in Selection of Intermediaries and Assignment of Providers to Them

Problem

A group or association of providers of services—hospitals, extended care facilities, and home health agencies—have the option of nominating an organization (including the Federal Government) to act as the "fiscal intermediary" between the providers and the Government. (No such nomination is available with respect to carriers in part B of Medicare.)

The Secretary is authorized to enter into an agreement with an organization or agency only if he finds that to do so would be consistent with effective and efficient administration of the program. The Secretary may terminate an agreement with an intermediary if he finds that it has failed to carry out the agreement or that continuation of the agreement is inconsistent with efficient administration of the program.

Problem

It would be helpful to strengthen administrative prerogatives in the assignment of new providers to intermediaries and the reassignment of existing providers. The Secretary should have the primary authority to determine to which intermediary providers may be reassigned when they wish to change intermediaries or where continued availability of a particular intermediary in a given locale is inefficient, ineffective, or otherwise not in the best program interest. That is, the Secretary should consider the wish of the provider, but be able to take a different course of action in the interest of effective program operation.

Finance Committee Amendment

The Finance Committee amended section 1816 so as to authorize the Secretary to assign and reassign providers to available intermediaries. He would take into account any preferences expressed by the providers, but would not be bound by their choice. The primary consideration for his assignment action would be the effective and efficient administration of the Medicare program.

Disclosure of Information Concerning Medicare Agents and Providers

Problem

As part of its responsibility for administration of the Medicare program, the Social Security Administration regularly prepares formal evaluations of the performance of contractors—carriers and intermediaries—and State agencies, which assist SSA in program administration. In addition, SSA also prepares program validation review reports, which are intended to be used as management devices for informing intermediaries of findings and recommendations concerning selected providers of services and some of the aspects of their own Medicare operations.

These evaluations and reports are of significant help in reviewing either the overall administrative performance of an individual contractor or a particular aspect of its operation. Additionally, the summary evaluations comparing the performance of one contractor with that of another are very useful. However, these evaluations and reports are not available to the public in general.

The Finance Committee recognized the dichotomy which exists in this situation. On the one hand is the need for public awareness of the deficiencies of contractor performance with the accompanying pressures for improvement in administration that only such awareness can bring. On the other hand, there is the need to avoid premature public disclosure of this type of information and to provide contractors with sufficient opportunity to respond to the information in the reports before their publication to avoid release of erroneous findings, without rebuttal, which may prove damaging to their reputations.

Finance Committee Amendment

To meet this problem, the Committee amendment provides that the SSA regularly make public the following types of evaluations and reports: (1) individual contractor performance reviews and other formal evaluations of the performance of carriers, intermediaries, and State agencies, including the reports of follow-up reviews; (2) comparative evaluations of the performance of contractors—including comparisons of either overall performance or of any particular contractor operation; (3) program validation survey reports—with the names of individuals deleted.

The proposal would require public disclosure of future reports. Such reports would include only those which are official in nature and not include internal working documents such as informal memoranda, etc. Under the proposal, public disclosure of evaluations and reports would not be made until the contractor, State agency, or facility was given suitable opportunity for comments as to the accuracy of the findings and conclusions of the evaluation or report with such comments being made part of the report where the portions originally objected to have not been modified in line with the comment.

Disclosure of such evaluations and reports should not lessen the effort of SSA in its present information-gathering activities nor is the provision in any way to be interpreted as otherwise limiting disclosure of information required under the Freedom of Information Act.

Access to Subcontractors' Records

Problem

It has come to the Committee's attention that subcontractors under the Medicare program apparently can create subsidiary and related organizations and thereby avoid requirements in Medicare contracts calling for production of pertinent financial books, documents, papers and records of the subcontractor involving transactions related to the subcontract. Although the Medicare statute does not require production by a subcontractor of his cost and other financial records, the Secretary generally has obtained access under the terms of his prime contracts.

Finance Committee Amendment

Under the Committee bill, a requirement would be included under titles XVIII and XIX providing that the Secretary must include in any prime contract a provision that prime contractors which in the future arrange for performance of part of their services by subcontractors, would make available to the government, on a consolidated basis, cost and financial data for subcontractors and organizations related to the subcontractor which perform any part of the services where the aggregate subcontract cost is $25,000 or more.

Similarly, it would be required that subcontracts specify that the subcontractor, and organizations related to the subcontractor, which perform any part of the subcontract would produce pertinent financial books, documents, papers and records upon request by the Secretary, the Comptroller General, the Inspector General, and, in the case, of the Medicaid program, appropriate State officials.

Failure to comply with these requirements would be grounds for terminating an intermediary's or carrier's (the prime contractor) participation in the Medicare program.

Duration of Subcontracts

Problem

Under present law, Medicare intermediaries and carriers (the prime contractors) are generally contracted for under terms which permit the Secretary to cancel the contract at the end of each year. If he fails to give the necessary notice of cancellation, the contract is automatically renewed for another year.

Instances have come to light where some of these prime contractors have entered into subcontracts which extend beyond the time at which the Secretary could terminate the prime contract. This seems inconsistent with the concept of the annual contract renewal procedure.

Proposal

To deal with this situation, the Committee bill would specify in the statute that future subcontracts may not be entered into for periods longer than the remaining term of a prime contract unless such subcontracts are subject to the same contract renewal limitations applicable to the prime contract.

Waiver of Beneficiary Liability in Certain Situations Where Medicare Claims Are Disallowed

Problem

Under present law, whenever a Medicare claim is disallowed, the ultimate liability for the services rendered falls upon the beneficiary.

This is true even when the program has paid the claim and subsequently it is determined that the claim should be reopened and disallowed. The result is that in many cases a beneficiary is liable for payment even though he acted in good faith and did not know that the services he received were not covered, and even though the hospital, physician or other provider of services was at fault.

Finance Committee Amendment

Under the Committee bill, a beneficiary could be "held harmless" in certain situations where claims were disallowed but the beneficiary was without fault. In such situations the liability would shift either to the Government or to the provider—depending upon whether, for example, the provider utilized due care (i.e., acted reasonably) in applying Medicare policy in his dealings with the beneficiary and the Government. In the future, Professional Standards Review Organizations would be expected to give priority to determinations, either in advance or concurrent, designed to minimize the problem of retroactive denials.

Where the beneficiary was aware, or should have been aware, of the fact that the services were not covered, liability would remain with the beneficiary and the provider could either exercise his rights under State law to collect for the services furnished or appeal the determination through the Medicare appeals process.

Where neither the beneficiary nor the provider knew that noncovered services were involved, the Government would assume liability for payment as though a covered service had been furnished. (This situation would arise in many cases disallowed because the services were not medically necessary or did not meet the level of care requirements.) However, when Medicare made such a payment, it would make certain that the provider is put on notice that the type of service rendered was not covered with the result that in subsequent cases involving similar situations and further stays or treatments in the given case, he could not contend that he exercised due care. Thus, the Government's liability would be somewhat limited.

Where the provider did not exercise due care (that is, he knew or reasonably could be expected to know that such care was not covered), liability would shift to the provider, assuming that there was good faith on the beneficiary's part. The provider would be told that he could appeal the intermediary's decision, both as to coverage of the services and due care. If, on the other hand, he exercised his rights under State law and received reimbursement from the beneficiary, the Medicare program would indemnify the beneficiary (subject to deductibles and coinsurance) and would be required to seek to recover amounts so paid from the provider.

Family Planning

Problem

Though Federal law and policy permit and encourage States to extend services to low income families likely to become welfare recipients as well as families already on welfare, most States have not taken advantage of this opportunity.

The progress which has been made under the 1967 Amendments has not met the committee's expectations. The annual report by the Department of Health, Education, and Welfare covering family planning services includes information which makes clear that the mandate of the Congress that *all* appropriate AFDC recipients be provided family planning services has not been fulfilled.

Finance Committee Amendment

The Committee amended the House bill to authorize 100 percent Federal funding for the costs of family planning services. The Committee amendment would also require States to make available on a voluntary and confidential basis such counseling, services, and supplies, directly and/or on a contract basis with family planning organizations throughout the State, to present, former or likely recipients who are of child-bearing age desiring such services. The amendment would also reduce the Federal share of AFDC funds by 2 percent, beginning in fiscal year 1974, if a State in the prior year fails to inform the adults in AFDC families and on workfare of the availability of family planning services and/or if the State fails to actually provide or arrange for such services for persons desiring to receive them.

Penalty for Failure To Provide Required Health Care Screening

Problem

Many States have failed to implement the statutory requirement—or have implemented it only partially—because of their contention that the screening of all children under age 21 is not possible given available financial and health care resources. Under HEW regulations States must now provide health care screening to children under age 6.

Finance Committee Amendment

Under the Committee amendment, States will be required to provide screening services to all eligible children between the ages of 7 and 21 by no later than July 1, 1973. The amendment also includes a provision that would reduce the Federal share of AFDC matching funds by 2 percent, beginning is fiscal year 1975, if a State (a) fails to inform the adults in AFDC families and on workfare of the availability of child health screening services; (b) fails to actually provide or arrange for such services; or (c) fails to arrange for or refer to appropriate corrective treatment children disclosed by such screening as suffering illness or impairment.

Outpatient Rehabilitation Coverage

Problem

Medicare presently provides a home health benefit under both Part A and Part B. Under Part A, a beneficiary may receive up to 100 home health visits in the year following discharge from a hospital or ECF. Part B covers up to 100 home health visits in a calendar year without a prior hospitalization requirement. To receive home health benefits under Part A or Part B, a patient must be homebound and require skilled nursing care on an intermittent basis or physical or speech therapy. Home health services must ordinarily be provided in the home; however, if use of equipment which cannot be taken to the home is involved, the services may be provided at an outpatient facility. Medicare also provides, under Part B, coverage of outpatient

hospital services, and of outpatient physical therapy services provided by certain organized rehabilitation agencies.

There is a relatively small but effective group of free-standing rehabilitation facilities which provide a range of rehabilitation services on an outpatient basis, including some services which would be covered under Medicare if they were provided by participating home health agencies or by hospital outpatient departments. Under present law, Medicare payment cannot be made when such services are provided by free-standing rehabilitation facilities.

Finance Committee Amendment

The amendment would consolidate the present Part B home health and outpatient physical therapy benefits. Coverage under the new benefit would be on two levels: homebound beneficiaries would be entitled to the full range of benefits, while beneficiaries who were not homebound would be entitled to rehabilitation benefits only. In order to qualify for rehabilitation services under the combined benefit, a beneficiary would have to have a need for physical or speech therapy. (That is, an individual who was not homebound could receive in the rehabilitation center covered clinical psychologists' services, medical social services or occupational therapy only if he also required physical or speech therapy.)

The new consolidated benefit would be subject to a coverage limit of 100 visits in a calendar year, as is the present Part B home health benefit. (There would be no change in the provisions of present law relating to Part A home health benefits or Part B outpatient hospital services.)

Home health agencies could provide the full range of benefits provided under the combined benefit. Qualified organizations (including providers of outpatient physical therapy services under present law and free-standing rehabilitation facilities) would be able to provide such rehabilitation services included in the combined benefit as the Secretary found they were qualified to provide. A rehabilitation center would not necessarily have to provide services to homebound patients in order to qualify.

Medicare Coverage for Spouses and Social Security Beneficiaries Under Age 65

Present Law

Under present law, persons aged 65 and over who are insured or are deemed to be insured for cash benefits under the social security or railroad retirement programs are entitled to hospital insurance (part A). Essentially all persons aged 65 and over are eligible to enroll for medical insurance (part B) without regard to insured status. The House bill includes a provision that would permit persons aged 65 and over who are not insured or deemed insured for cash benefits to enroll in part A, at a premium rate equal to the full cost of their hospital insurance protection ($31 a month through June 1973).

Problem

Many additional social security cash beneficiaries find it difficult to obtain adequate private health insurance at a rate which they can afford. This is particularly true if they are of an advanced age, say,

age 60–64. Frequently, these older beneficiaries—retired workers, widows, mothers, dependents, parents for example—have been dependent upon their own group coverage or that of a related worker who is now deceased for health insurance protection. It is a difficult task for such older persons to find comparable protection when they no longer are connected to the labor force.

Finance Committee Amendment

The provision makes Medicare protection available at cost to spouses aged 60–64 of Medicare beneficiaries and to other persons age 60–64 (such as a beneficiary who elects early retirement at age 62) entitled to benefits under the Social Security Act.

Alcoholism and Addiction

Problem

Under the House bill, alcoholics and addicts would be defined as disabled (applying the general social security definition of disability) for purposes of welfare eligibility. However, alcoholics and addicts would not receive cash assistance if treatment were available which they refused.

The Committee was concerned that this provision might result, in many cases, in alcoholics and addicts receiving cash payments without being involved—or only nominally involved—in treatment programs.

Finance Committee Amendment

The Committee approved an amendment establishing a program designed to encourage appropriate care and treatment of alcoholics and addicts. Below is a brief outline of the program:

Outline

Persons medically determined (as described below) to be alcoholics and addicts would not be eligible for welfare benefits under aid to the disabled.

Alcoholics and addicts who meet the income and resources test for welfare and who meet a definition of disability parallel to the social security definition—that is who are unable to engage in any substantial gainful activity by reason of a medically determinable addictive dependence on alcohol or drugs which has lasted or can be expected to last for a period of 12 months—would be eligible to receive help in an alcoholism or addiction treatment program which would be established under Title XV if the State wishes to institute such a program. Once enrolled in the treatment program, the alcoholic or addict would be referred to a local treatment organization or agency certified by the appropriate State agency designated under the Comprehensive Alcohol Abuse and Treatment Act of 1970 or the Drug Abuse and Treatment Act of 1972.

In a State which provides welfare payments under categories other than aid to the disabled to persons medically determined to be alcoholics or addicts (for example, an alcoholic mother or an addicted child on AFDC) the person must be referred for care and treatment to the appropriate agency as a condition of continued eligibility for Federal matching. Refusal of care and treatment by an

addict or alcoholic would result in termination of payments for that individual.

To assure maintenance of expenditure levels in the primary Federal programs directed toward treatment and rehabilitation of alcoholics and addicts and to avoid any shifting of the bulk of those expenditures to Title XV, the Committee required that:

(*a*) Title XV expenditures for care and treatment (including social services) not exceed amounts appropriated, allocated, and actually available in States for care and treatment of alcoholics and addicts.

(*b*) If a reduction in other Federal expenditures is made, either through reduction in appropriations or expenditure levels (including impounding of appropriated funds), then the Federal matching funds available under Title XV would be reduced proportionate to such decreases.

To be eligible for reimbursement under Title XV, the individual treatment program must be carried out under a professionally developed plan of rehabilitation designed to terminate dysfunctional dependency on alcohol or drugs and which must be renewed at three-month intervals. Additionally, the plan must include to the maximum extent feasible a program of work rehabilitation including participation in the new employment program established under the Committee bill.

If proper treatment or rehabilitation would be thwarted by the lack of maintenance funds for the enrolled alcoholic or addict, maintenance payments to the patient or protective payments could be made with Title XV funds. Maintenance payments may not exceed comparable welfare payments and the question of maintenance versus protective payments must be specifically reviewed at least every three months.

Matching under Title XV would be at the rates otherwise provided for the types of payments made. For example, medical care and treatment would be matched at Medicaid rates and cash payments would be matched at the rates applicable to the category under which the person would otherwise be aided.

FINANCING SOCIAL SECURITY BENEFITS

In considering how to finance the Committee bill, the actuarial assumptions on which the cost estimates are based were reviewed.

Up to this time, the costs of the social security cash benefits programs have been based on the assumption that over the long-run neither benefit nor wage levels will change. While this has not been considered to be a forecast of what will happen, it has been considered a valid measure of the relative long-range costs of various changes in the program, and it has long been used to determine what levels of social security taxes are needed to pay for the program. Because the nature of the assumptions runs counter to the rising wage trends that have actually occurred, most reevaluations of the actuarial cost estimates have shown that the tax schedules in the law at the time of the reevaluation were higher than needed to pay for the benefits in the law.

In view of this, an Advisory Council on Social Security in April 1971 submitted a report which recommended a revision in the long-range actuarial assumptions that have been used in determining the cost of the social security program and which are, therefore, the basis for the schedule of tax rates that is in the law. In essence, the Council's recommendation is that the actuarial projections should properly assume an increase in both wages and prices in future years.

In the past decade, the balance in the social security trust funds has generally equalled one year's worth of benefits. The Advisory Council has suggested that the trust fund balance remain equal to one year's benefit payments, but the Council felt the balance could safely be 75 percent of one year's benefit payments. The Committee bill incorporates a tax schedule calculated to maintain a trust fund balance at least equal to three-quarters of one year's worth of benefits.

The tax schedule based on this assumption is compared with the schedule in present law and in the House-passed bill in the following table.

TABLE 2.—SOCIAL SECURITY TAXES UNDER PRESENT LAW, HOUSE BILL, AND COMMITTEE BILL

	Maximum wages taxable	OASDI, percent	HI, percent	Total, percent
Employers and Employees				
Present law:				
1971	$7,800	4.6	0.6	5.2
1972	9,000	4.6	.6	5.2
1973–75	9,000	5.0	.65	5.65
1976–79	9,000	5.15	.7	5.85
1980–86	9,000	5.15	.8	5.95
1987 and after	9,000	5.15	.9	6.05

TABLE 2- SOCIAL SECURITY TAXES UNDER PRESENT LAW, HOUSE BILL, AND COMMITTEE BILL—Continued

	Maximum wages taxable	OASDI, percent	HI, percent	Total, percent
House bill (excluding effect of the automatic adjustment provisions):				
1971	7,800	4.6	.6	5.2
1972–74	10,200	4.2	1.2	5.4
1975–76	10,200	5.0	1.2	6.12
1977 and after	10,200	6.1	1.3	7.4
Committee bill (excluding effect of the automatic adjustment provisions):				
1972	9,000	4.6	0.6	5.2
1973–77	10,200	4.55	1.15	5.7
1978–80	10,200	4.65	1.35	6.00
1981–84	10,200	4.65	1.5	6.15
1985–93	10,200	4.65	1.6	6.25
1994–2010	10,200	4.65	1.7	6.35
2011 and after	10,200	5.7	1.7	7.4
Self-employed persons				
Present law:				
1971	7,800	6.9	.6	7.5
1972	9,000	6.9	.6	7.5
1973–75	9,000	7.0	.65	7.65
1976–79	9,000	7.0	.7	7.7
1980–86	9,000	7.0	.8	7.8
1987 and after	9,000	7.0	.9	7.9
House bill (excluding effect of the automatic adjustment provisions):				
1971	7,800	6.9	.6	7.5
1972–74	10,200	6.3	1.2	7.5
1975–76	10,200	7.0	1.2	8.2
1977 and after	10,200	7.0	1.3	8.3
Committee bill (excluding effect of the automatic adjustment provisions):				
1972	9,000	6.9	0.6	7.5
1973–77	10,200	6.8	1.15	7.95
1978–80	10,200	7.0	1.4	8.4
1981–84	10,200	7.0	1.5	8.5
1985–93	10,200	7.0	1.6	8.6
1994 and after	10,200	7.0	1.7	8.7

It should be noted that the tax base and the tax rates shown in this schedule for years after 1974 do not reflect any wage base or tax rate increases, provided for in the Committee bill, which may be needed to finance the automatic cost-of-living benefit increases in the bill. Under these provisions, the cost of the increases will be met by increasing both the tax rates and the tax base as necessary each time there is a cost-of-living increase in benefits.

Social Security Cash Benefits

The income and outgo of the social security cash benefit trust funds are shown on the following table.

TABLE 3.—SOCIAL SECURITY CASH BENEFIT PROGRESS OF TRUST FUNDS UNDER PRESENT LAW AND UNDER THE SYSTEM AS MODIFIED BY THE COMMITTEE BILL, CALENDAR YEARS 1972–77 [1]

(Dollars in billions)

Calendar year	Income		Outgo		Net increase in funds		Assets, end of year	
	Present law	Finance Committee bill	Present law	Finance Committee bill	Present law	Finance Committee bill	Present law	Finance Committee bill
1972	$46.2	$46.2	$41.0	$43.1	$5.2	$3.1	$45.6	$43.5
1973	53.7	51.0	43.0	49.5	10.7	1.5	56.3	45.0
1974	57.9	55.0	44.9	52.3	13.0	2.6	69.3	47.7
1975	61.5	60.0	46.9	57.4	41.6	2.6	83.9	50.3
1976	66.5	63.5	49.8	60.3	17.6	3.2	101.5	53.4
1977	70.3	68.5	51.1	66.2	19.2	2.3	120.7	55.7

[1] These estimates assume that the following changes will become effective on Jan. 1, of:

Year	Benefit (percent) increase	Contribution and benefit base	Annual exempt amount under retirement test
1975	5.8	$11,400	$2,280
1977	5.5	12,600	2,520

Hospital Insurance

The schedule of taxes adopted for hospital insurance is designed to provide sufficient income to pay for the present program (including projected deficits under current financing) for the costs of the program. The schedule adopted will cause the trust fund to increase from $6.4 billion at the end of 1973 to $14.8 billion at the end of 1977. The income, outgo, and year-end balance of the fund for the period 1973–1977 are shown in the following table.

TABLE 4.—PROGRESS OF HOSPITAL INSURANCE TRUST FUND, 1973–77 [1]

[Dollars in billions]

Calendar year	Income	Outgo	Fund at end of year
1973	$12.6	$8.8	$6.4
1974	14.1	11.3	9.2
1975	15.4	12.9	11.7
1976	16.4	14.6	13.5
1977	17.7	16.4	14.8

[1] Assumes that the tax base will increase to $11,400 in 1975 and to $12,600 in 1977.

The Welfare Programs

The original Social Security Act of 1935 established our Federal-State grant programs which today provide assistance to the aged, blind, and disabled, and to needy families with children. Unlike the federally administered social security program, the welfare titles of the Social Security Act do not set benefit levels nor describe in detail methods of administering the welfare programs; States establish their own assistance programs within the broad guidelines of the Federal law.

Within the past 5 years, however, the Federal-State relationships have undergone substantial change. Three factors have played an important role in the changing relationships.

1. The tremendous growth in the Aid to Families with Dependent Children rolls has created both a fiscal and administrative burden which many States find difficulty coping with.
2. A number of court decisions have had far reaching impact on all aspects of the welfare programs under the Social Security Act, sometimes using the very broadness of the Federal statute (intended to allow States more latitude) against the States by saying that what the Congress did not expressly permit it must not have intended to permit. This position was explicitly stated by the Supreme Court in *Townsend* v. *Swank* (opinion dated December 20, 1971), where it was said that "at least in the absence of congressional authorization for the exclusion clearly evidenced from the Social Security Act or its legislative history, a State eligibility standard that excludes persons eligible for assistance under federal AFDC standards violates the Social Security Act and is therefore invalid under the Supremacy Clause."
3. The Department of Health, Education, and Welfare has issued a series of regulations beginning in January 1969, whose effect has been to make it easier to get on welfare and harder to get off welfare, regulations which many States have vigorously, but unsuccessfully, opposed.

Under present law each State plays the central role in determining the nature of its welfare program, within the broad outline of Federal law. The Committee bill largely reiterates this aspect.

AID TO THE AGED, BLIND, AND DISABLED

Present Law

Three categories of adults are eligible for Federally supported assistance: persons 65 and over, the blind (without regard to age), and permanently and totally disabled persons 18 years of age and older. Each State establishes a minimum standard of living (needs standard) upon which assistance payments are based; any aged, blind or disabled person whose income is below the State needs standard will

be eligible for some assistance, although the State need not pay the full difference between the individual's income and the needs standard.

Generally speaking, all income and resources of an aged, blind or disabled person must be considered in determining the amount of the assistance payment (though a portion of earnings may be disregarded as a work incentive). States also place limitations on the real and personal property an aged, blind or disabled individual may retain without being disqualified for assistance.

Monthly State payments to an aged, blind or disabled individual with no other income range between $70 and $250 and for an aged couple between $97 and $350.

Committee Amendments

The Committee bill would continue State administration of the programs of aid to the aged, blind, and disabled (in contrast to the federalized administration called for by the House bill) but would set a Federal guanteed minimum income level for aged, blind, and disabled individuals as discussed below.

National Minimum Welfare Standards and Disregard of Social Security or Other Income

Under the Committee's bill, State public assistance programs for needy individuals who are aged, blind, and disabled would have to assure those with no other income a monthly assistance payment of at least $130 for an individual or $195 for a couple. In addition the Committee bill would provide that the first $50 of social security or other income would not cause any reduction in these minimum assistance payments.

As a result, aged, blind, and disabled welfare recipients who also have monthly income from social security or other sources (which are not need-related) of at least $50 would, under the Committee bill, be assured total monthly income of at least $180 for an individual or $245 for a couple.

At present, only seven States have old age assistance programs which will guarantee a monthly income of at least $180 for an individual receiving social security benefits (Alaska, Idaho, Illinois, Massachusetts, Nebraska, South Dakota, and Washington). These States would, of course, be free to continue providing assistance at levels higher than the minimum standards required by the Committee action.

The cost to the States of providing additional assistance would be less under the Committee bill than under the House-passed version of H.R. 1; State savings are discussed under the heading "Fiscal Relief for States."

Earned Income Disregard

In addition to providing for a monthly disregard of $50 of social security or other income, the Committee approved an additional disregard for aged, blind or disabled recipients of $50 of earned income plus one-half of any earnings above $50. This will enable those recipients who are able to do some work to do so without suffering a totally offsetting reduction in their assistance grants.

Other Income Disregards

The Committee provided that in determining an individual's income for purposes of adult assistance, any rebate of State or local taxes (such as real property or food taxes) received by an aged, blind or disabled recipient would not be counted as income or assets.

This disregard would apply to the first $130 of income guaranteed an adult recipient (the Federal share); States would be free to determine how they wish to treat such tax rebates with respect to the State's share of welfare payments (if any) to such recipients.

Eligibility for Other Benefits

Adopting a provision of the House bill, the Committee bill requires applicants for and recipients of aid to the age, blind, and disabled, as a condition of welfare eligibility, to apply for any other benefits they are eligible for (such as social security, unemployment insurance, workmen's compensation, etc.).

Definitions of Blindness and Disability

Under present law each State is free to prescribe its own definition of blindness and disability for purposes of eligibility for aid to the blind and aid to the permanently and totally disabled.

The Committee approved amendments setting a Federal definition for blindness and disability.

The term "disability" would be defined as "inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than 12 months." Under the disability insurance program, this definition is now found in section 223(d)(1) of the Social Security Act. The provisions of the disability insurance program further specify that this definition is met only if the disability is so severe that an individual "is not only unable to do his previous work but cannot, considering his age, education, and work experience, engage in any other kind of substantial gainful work which exists in the national economy, regardless of whether such work exists in the immediate area in which he lives, or whether a specific job vacancy exists for him, or whether he would be hired if he applied for work." (Sec. 223(d)(2)(A)).

The term "blindness" would be defined as central visual acuity of 20/200 or less in the better eye with the use of correcting lens. (Sec. 216(i)(1)(B).) Also included in this definition is the particular sight limitation which is referred to as "tunnel vision."

However, States will be permitted to continue assistance to disabled or blind individuals who were already on the rolls under the existing State definition, but who would not meet the Federal definition of blindness or disability.

Age Limit for Aid to the Disabled

Present law requires that an individual be 18 years or older in order to be eligible for aid to the disabled; the House bill would have deleted

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this age requirement. The Committee bill retains the provision of existing law.

Medicaid Coverage

Under present law, the States are required to cover all cash assistance recipients under the Medicaid program. The Committee bill, like the House version, would exempt from this requirement newly eligible recipients who qualify because of the previously agreed provision of a $130 minimum benefit with a disregard of $50 of social security and other income.

Social Services

The Committee also approved an amendment, similar to a provision in the House bill, clarifying the types of social services for which Federal funding may be provided and setting a limitation on authorizations for appropriations for social services. This amendment is described in the section dealing with general welfare provisions, child welfare services, social services, and other provisions.

Prohibition of Liens in Aid to the Blind

The Committee bill prohibits the imposition of liens against the property of blind individuals as a condition of eligibility for aid to the blind.

Other Eligibility Requirements

The Committee decided that there would be no uniform Federal eligibility rules as in the House bill. The determination will be left to the States on such questions as assets, resources, relative responsibility and other eligibility factors except those specified above or in the section of this summary entitled "General Welfare Provisions, child welfare services, social services, and other provisions."

Administrative Costs

The Committee bill requiring minimum payment levels will make many individuals newly eligible for aid to the aged, blind, and disabled who are not now eligible, with a corresponding impact on State administrative costs. Under present law the Federal Government pays 50 percent of the cost of all administrative expenses.

The Committee decided that the Federal Government pay the States an amount equal to 100 percent of their calendar year 1972 administrative costs related to the aged, blind, and disabled, plus 50 percent of additional costs. The 1973 budget, relating to the period from July 1972 to June 1973, estimates an expenditure of $408 million for administration of aid to the aged, blind, and disabled; the State share of this amount is $204 million.

Statistical Material

TABLE 5.—RECIPIENTS OF AID TO THE AGED, BLIND, AND DISABLED, DECEMBER OF SELECTED YEARS

Year	Number of recipients	Percent increase since 1960
1940	2,143,000	
1945	2,128,000	
1950	2,952,000	
1955	2,883,000	
1960	2,781,000	
1961	2,721,000	−2
1962	2,710,000	−3
1963	2,713,000	−3
1964	2,725,000	−2
1965	2,729,000	−2
1966	2,745,000	−1
1967	2,802,000	+1
1968	2,810,000	+1
1969	2,959,000	+6
1970	3,098,000	+8
1971	3,172,000	+14
1972	3,341,000	+20
1973:		
Current law	3,500,000	+26
Committee bill	(not available)[1]	
1974:		
Current law	3,600,000	+29
Committee bill	(not available)[1]	

[1] The estimate of recipients of Aid to the Aged, Blind, and Disabled under the Committee bill will be included in the Committee report.
Source: Department of Health, Education, and Welfare.

TABLE 6.—**OLD-AGE ASSISTANCE:** MONTHLY AMOUNT FOR BASIC NEEDS UNDER FULL STANDARD AND LARGEST AMOUNT PAID FOR BASIC NEEDS, BY STATE, NOVEMBER 1971

	Aged individual		Aged couple	
	Monthly amount for basic needs	Largest amount paid for basic needs	Monthly amount for basic needs	Largest amount paid for basic needs
Alabama	$146	$103	$242	$206
Alaska	250	250	350	350
Arizona	118	118	164	164
Arkansas	149	105	249	210
California	178	178	320	320
Colorado	140	140	280	280
Connecticut	176	176	224	224
Delaware	140	140	197	197
District of Columbia	150	113	206	155
Florida	114	114	210	210
Georgia	100	91	165	165
Guam	140	140	201	201
Hawaii	132	132	205	205
Idaho	182	182	219	219
Illinois	183	183	224	224
Indiana	185	80	247	160
Iowa	122	117	186	178
Kansas	141	110	190	147
Kentucky	96	96	160	160
Louisiana	147	100	235	188
Maine	115	115	198	198
Maryland	130	96	187	131
Massachusetts	189	189	280	280
Michigan	165	165	218	218
Minnesota	158	158	210	210
Mississippi	150	75	218	150
Missouri	181	85	257	170
Montana	120	111	192	175
Nebraska	182	182	235	235
Nevada	169	169	271	271

TABLE 6.—**OLD-AGE ASSISTANCE:** MONTHLY AMOUNT FOR BASIC NEEDS UNDER FULL STANDARD AND LARGEST AMOUNT PAID FOR BASIC NEEDS, BY STATE, NOVEMBER 1971—Continued

	Aged individual		Aged couple	
	Monthly amount for basic needs	Largest amount paid for basic needs	Monthly amount for basic needs	Largest amount paid for basic needs
New Hampshire	$173	$173	$238	$238
New Jersey	162	162	222	222
New Mexico	116	116	155	155
New York	159	159	219	219
North Carolina	115	115	150	150
North Dakota	125	125	190	190
Ohio	126	126	208	208
Oklahoma	130	130	212	212
Oregon	141	113	200	160
Pennsylvania	138	138	208	208
Puerto Rico	54	22	88	34
Rhode Island	163	163	211	211
South Carolina	87	80	121	121
South Dakota	180	180	220	220
Tennessee	102	97	142	142
Texas	119	119	192	192
Utah	106	106	142	142
Vermont	177	177	233	233
Virgin Islands	52	52	103	103
Virginia	152	152	199	199
Washington	192	192	247	247
West Virginia	146	76	186	97
Wisconsin	108	108	164	164
Wyoming	139	108	195	186

TABLE 7.—**AID TO THE BLIND AND AID TO THE PERMANENTLY AND TOTALLY DISABLED:** MONTHLY AMOUNT FOR BASIC NEEDS UNDER FULL STANDARD AND LARGEST AMOUNT PAID FOR BASIC NEEDS, BY STATE, NOVEMBER 1971

	Blind individual		Disabled individual	
	Monthly amount for basic needs	Largest amount paid for basic needs	Monthly amount for basic needs	Largest amount paid for basic needs
Alabama	$105	$75	$122	$71
Alaska	250	250	250	250
Arizona	118	118	118	118
Arkansas	149	105	149	105
California	192	192	172	172
Colorado	103	103	123	123
Connecticut	176	176	176	176
Delaware	189	150	117	117
District of Columbia	150	113	150	113
Florida	114	114	114	114
Georgia	100	91	100	91
Guam	140	140	140	140
Hawaii	132	132	132	132
Idaho	182	182	182	182
Illinois	183	183	183	183
Indiana	185	125	185	80
Iowa	161	156	122	117
Kansas	141	110	141	110
Kentucky	96	96	96	96
Louisiana	106	101	84	66
Maine	115	115	115	115
Maryland	130	96	130	96
Massachusetts	223	223	178	178
Michigan	165	165	165	165
Minnesota	158	158	158	158

TABLE 7.—**AID TO THE BLIND AND AID TO THE PERMANENTLY AND TOTALLY DISABLED:** MONTHLY AMOUNT FOR BASIC NEEDS UNDER FULL STANDARD AND LARGEST AMOUNT PAID FOR BASIC NEEDS, BY STATE, NOVEMBER 1971—Con.

	Blind individual		Disabled individual	
	Monthly amount for basic needs	Largest amount paid for basic needs	Monthly amount for basic needs	Largest amount paid for basic needs
Mississippi	$150	$75	$150	$75
Missouri	255	100	170	80
Montana	132	123	120	111
Nebraska	182	182	182	182
Nevada	155	155	(1)	(1)
New Hampshire	173	173	173	173
New Jersey	162	162	162	162
New Mexico	116	116	116	116
New York	159	159	159	159
North Carolina	126	126	115	115
North Dakota	125	125	125	125
Ohio	126	126	126	116
Oklahoma	130	130	130	130
Oregon	151	151	141	113
Pennsylvania	150	150	138	138
Puerto Rico	54	22	54	22
Rhode Island	163	163	163	163
South Carolina	104	95	87	80
South Dakota	180	180	180	180
Tennessee	102	97	102	97
Texas	116	110	116	105
Utah	116	116	106	106
Vermont	177	177	177	177
Virgin Islands	51	52	52	52
Virginia	153	153	152	152
Washington	192	192	190	190
West Virginia	146	76	146	76
Wisconsin	108	108	108	108
Wyoming	139	108	127	108

[1] No program.

GUARANTEED JOB OPPORTUNITY FOR FAMILIES

The whole Nation has become increasingly concerned at the rapid growth of the welfare rolls in recent years, and with good reason.

By far the major factor in this growth has been the increase in the number of persons receiving Aid to Families with Dependent Children. From 5.3 million recipients at the end of 1967, the number of AFDC recipients doubled during the next four years. The soaring costs of this program have forced States to shift funds into welfare that would otherwise go for education, health, housing and other pressing social needs. There is universal agreement that something must be done, but there remains much confusion about the nature of the problem that must be solved. The Committee feels that a more expensive and expansive welfare program is *not* the answer.

The soaring welfare rolls reflect three developments.

First, they show that there are a large number of children in this country who are needy and whose parents in most cases are not working.

Second, they show an alarming increase in dependency on the taxpayer. The proportion of children in this country who are receiving AFDC has climbed sharply, from three percent in the mid-fifties to nine percent today. This means that an increasing number of families are becoming dependent on welfare and staying dependent on welfare.

Third, the growth in the AFDC rolls reflects increasing family breakup and increasing failure to form families in the first place. Births out of wedlock, particularly to teenage mothers, have increased sharply in the past decade. Two striking statistics highlight the problem: the number of families headed by women increased by 15 percent between 1970 and 1971, while the number of families with both father and mother present declined in absolute numbers during the same one-year period. Today, almost 8 million women and children receive welfare because of the "absence of the father from the home"—principally due to family breakup or failure of the father to marry the mother of his child.

Many persons who strongly advocate increasing welfare benefits have simply glossed over the problems of family breakup and the increase of births out of wedlock. Even more importantly, they have avoided discussing the problem of increasing dependency.

In an article that appeared in the *New York Magazine* in November, 1971, Nathan Glazer raises the fundamental question of what increasing dependency on welfare has done for recipients in New York City:

> Has it reduced starvation and given them more food? Has it improved their housing? Has it improved their environment? Has it improved their clothing? Has it heightened their self-respect and sense of power? Has it better and more effectively incorpo-

rated them into the economic and political life of the city? . . . Blanche Bernstein, director of research at the New School's Center for New York City Affairs, has estimated that 50 percent of the increase in welfare recipients in New York City during the 1960's was due to desertion and 25 percent was due to illegitimate births. She reports that in 1961 there were 12,000 deserted families on welfare in New York City. By 1968 there were 80,000. What happened in New York City was not an explosion in welfare alone. The city witnessed an explosion in desertion and in illegitimacy. . . .

Welfare, along with those who pressed its expansion, deprived the poor of New York of what was for them—as for the poor who preceded them—the best and indeed only way to the improvement of their condition, the way that involved commitment to work and the strengthening of family ties. In place of this, the advocates of revolution through welfare explosion propagated a false and demeaning sense of the "rights" of the poor, one which had disastrous consequences . . .

Relief is necessary to the poor. In any civilized society it must be given generously, and if needed, extensively. But it should be the aim of every society to find and encourage other means to the maintenance of a decent standard of living than the distribution of charity. For whatever the position of modern advocates of welfare rights, welfare can never, if given regularly on an extensive scale, be other than alms, and whatever alms did for the souls of those who gave them, they could not be good for the souls of those who received them. Every society—capitalist, socialist, or "welfare state"—tries to find ways to replace money relief and to make it unnecessary. To advocate its expansion as a means of dealing with distress is one thing; to advocate its expansion as a means of breaking the commitment to work with its attendant effects on self-respect and on family life is irresponsible.

The fundamental problem is raised somewhat differently in an article entitled "Welfare: the Best of Intentions, the Worst of Results" that appeared in the August, 1971, issue of *Atlantic Magazine.* The author, Irving Kristol, begins by quoting from the 19th century social commentator Alexis de Tocqueville:

> There are two incentives to work: the need to live and the desire to improve the conditions of life. Experience has proven that the majority of men can be sufficiently motivated to work only by the first of these incentives. The second is only effective with a small minority. . . . A law which gives all the poor a right to public aid, whatever the origin of their poverty, weakens or destroys the first stimulant and leaves only the second intact.

At this point, we are bound to draw up short and take our leave of Tocqueville. Such gloomy conclusions, derived from a less than benign view of human nature, do not recommend themselves either to the twentieth-century political imagination or to the American political temperament. We do not like to think that our instincts of social compassion might have dismal consequences—not accidentally but inexorably. We simply cannot believe that the universe is so constituted. We much prefer, if a choice has to be made, to have a good opinion of mankind and a poor opinion of our socio-economic system. . . .

> Somehow, the fact that more poor people are on welfare, receiving more generous payments, does not seem to have made this country a nicer place to live—not even for the poor on welfare, whose condition seems not noticeably better than when they were poor and off welfare. Something appears to have gone wrong: a liberal and compassionate social policy has bred all sorts of unanticipated and perverse consequences. . . .
>
> To raise such questions is to point to the fundamental problems of our welfare system, a vicious circle in which the best of intentions merge into the worse of results.

As Congress examines fundamental questions concerning the effect of dependency on welfare, it must also take note of developments in American society, such as the changing role of women in America and the increasing public demand for action to improve the quality of life in this country.

When the AFDC program was first established under the Social Security Act of 1935, American society generally viewed a mother's role as requiring her to stay at home to take care of her children; she would be considered derelict in her duties if she failed to do so. But values have changed, and today, one-third of all mothers with children under age six are members of the labor force, and *more than half* of the mothers with school-age children only are members of the labor force. Furthermore, in families where the father is not present, two-thirds of the mothers with children under age six are in the labor force. This number has been growing steadily in the past 20 years, and it may be expected to continue to grow.

At the same time, it is widely recognized today that many important tasks in our society remain undone, such as jobs necessary to improve our environment, improve the quality of life in our cities, improve the quality of education in our schools, improve the delivery of health services, and increase public safety in urban areas. The heads of welfare families are qualified to perform many of these tasks. Yet welfare pays persons not to work and penalizes them if they do work. Does it make sense to pay millions of persons not to work at a time when so many vital jobs go undone? Can this Nation continue to consider unemployable mothers of school-age children on welfare and pay them to remain unemployed when more than half of mothers with school-age children in the general population are already working?

It is the Committee's conclusion that paying an employable person a benefit based on need, the essence of the welfare approach, has not worked. It has not decreased dependency—it has increased it. It has not encouraged work—it has discouraged it. It has not added to the dignity in the lives of recipients, and it has aroused the indignation of the taxpayers who must pay for it.

As President Nixon has stated:

> In the final analysis, we cannot talk our way out of poverty; we cannot legislate our way out of poverty; but this Nation can work

its way out of poverty. What America needs now is not more welfare, but more "workfare". . . . This would be the effect of the transformation of welfare into "workfare," a new work-rewarding program.

The Committee agrees that the only way to meet the economic needs of poor persons while at the same time decreasing rather than increasing their dependency is to reward work directly by increasing its value. The Committee bill seeks to put the President's words into practice by:

(1) Guaranteeing employable family heads a job opportunity rather than a welfare income; and by

(2) Increasing the value of work by relating benefits directly to work effort.

In meeting these objectives the Committee bill will substantially increase Federal expenditures to low-income working persons, but the increased funds that go to them—about $2.4 billion—will be paid in the form of wages and wage supplements, not in the form of welfare, since the payments will be related to work effort rather than to need. Under the welfare system, an employed person who cuts his or her working hours in half receives a much higher welfare payment; under the Committee bill, a person reducing his or her work effort by half would find the Federal benefits also reduced by half.

Description of Program

Under the guaranteed employment program recommended in the Committee bill, persons considered employable would not be eligible to receive their basic income from Aid to Families with Dependent Children but would be eligible on a voluntary basis to participate in a wholly federally financed employment program. Thus, employable family heads would not be eligible for a guaranteed welfare income, but would be guaranteed an opportunity to work.

In the description of the guaranteed job program that follows, it is assumed that the Federal minimum wage will rise to at least $2.00 per hour.

The following table shows which families would continue to be eligible for welfare and those which would no longer be eligible to receive their basic income from welfare under the Committee bill:

Eligible for Welfare	*Not Eligible To Receive Basic Income from Welfare* [1]
1. Family headed by mother with child under age 6	1. Family headed by able-bodied father
2. Family headed by incapacitated father where mother is not in the home or is caring for father	2. Family headed by mother with no child under 6 (unless the mother is attending school full time)
3. Family headed by mother who is ill, incapacitated, or of advanced age	

Eligible for Welfare—Continued

4. Family headed by mother too remote from an employment program to be able to participate
5. Family headed by mother attending school full time even if there is no child under 6
6. Child living with neither parent, together with his caretaker relative(s) (though State may deny welfare if his mother is also receiving welfare)

Not Eligible To Receive Basic Income from Welfare [1]*—Continued*

[1] These families would be eligible for State supplementation if the State payment level is over $2,400 a year for the family and if otherwise eligible under the State requirements.

An estimated 40 percent or 1.2 million of the 3 million families currently receiving Aid to Families with Dependent Children would have to obtain their basic source of income from employment once the Committee bill becomes effective.

All heads of families, whether eligible for welfare or not, as well as heads of families no longer eligible for welfare, could volunteer to participate in the new employment program.

The Committee bill provides three basic types of benefit to heads of families:

1. A guaranteed job opportunity with a newly established Work Administration paying $1.50 per hour for 32 hours and with maximum weekly earnings of $48.

2. A wage supplement for persons employed at less than $2.00 per hour (but at least at $1.50 per hour) equal to three quarters of the difference between the actual wage paid and $2.00 per hour.

3. A work bonus equal to 10 percent of wages covered under social security up to a maximum bonus of $400 with reductions in the bonus as the husband's and wife's covered wages rise above $4,000.

Work Incentives Under the Program

The program would guarantee each family head an opportunity to earn $2,400 a year, the same amount as the basic guarantee under the House bill for a family of four. It also strengthens work incentives rather than undermine them, as shown in the table below.

In table 8, the three types of employment are compared under the guaranteed employment program.

The table also shows what happens to total family income under the proposal if the father works 40 hours a week (32 hours in the case of Government employment), 20 hours a week, or no hours a week.

The sources of income shown are: (a) wages paid by the employer, (b) wages paid by the Government, either as employer or in the form of a wage supplement to the employee (for those in jobs paying less

than $2.00 per hour), and (c) the work bonus equal to 10 percent of wages covered under social security.

The table shows these major points about the Committee plan:

(1) Since the participant is paid for working, his wages do not vary with family size. Thus a family with one child would have no economic incentive to have another child. This feature also preserves the principle of equal pay for equal work.

(2) As the employee's rate of pay increases, his total income increases.

(3) As the employee's income rises due to higher pay in a regular job, the cost to the Government decreases. $1.50-per-hour employment by the Government costs the taxpayer $48 for a 32-hour week; working 40 hours for a private employer at the same $1.50 hourly rate gives the employee a $33 boost in income while cutting the cost to the Government by $27. Moving to an unsubsidized job at $2.00 per hour increases the employee's income another $7 while saving the Government about $13 more.

(4) The less the employee works, the less he gets. No matter what the type of employment, the employee who works half-time gets half of what he would get if he works full time; he gets no Federal benefit if he fails to work at all.

(5) The value of working is increased rather than decreased. Working 32 hours for the Government is worth $1.50 per hour; when a private employer pays $1.50, the value of working to the employee is $2.02 per hour; and working at $2.00 per hour is worth $2.20 per hour to the employee. This will assure that any participant in private employment will receive more than $2.00 an hour. Under the House bill, by way of contrast, the value of working is decreased rather than increased, since the family would be eligible for welfare benefits if the family head does nothing.

Wage paid by employer	Actual value of 40 hours of employment under— House Bill (cents)	Committee bill
$1.50	73	$2.02
$2.00	[1] 90	2.20

[1] $1.23 for a family of 2; $1.04 for a family of 3.

(6) Earnings from other employment do not decrease the wages received for hours worked. Thus an individual able to work in private employment part of the time increases his income and saves the Government money. Virtually no policing mechanism is necessary to check up on his income from work.

TABLE 8.—WORK INCENTIVES UNDER THE COMMITTEE BILL

	Employed by— Government at $1.50 per hour	Private employer at $1.50 per hour	Private employer at $2.00 per hour
40 hours worked (32 hours if Government employment):			
Wages paid by—			
Employer		$60.00	$80.00
Government	$48.00	15.00	
Special 10-percent payment		6.00	8.00
Total Government payment	48.00	21.00	8.00
Total income	48.00	81.00	88.00
20 hours worked: (16 hours if Government employment):			
Wages paid by—			
Employer		30.00	40.00
Government	24.00	7.50	
Special 10-percent payment		3.00	4.00
Total Government payment	24.00	10.50	4.00
Total income	24.00	40.50	44.00
No hours worked	0	0	0
Hourly value of working	**1.50**	**2.02**	**2.20**

Work Disincentives Under Present Law and Administration Proposal

By way of contrast, under present law a mother who is eligible for welfare is guaranteed a certain monthly income (at a level set by the State) if she has no other source of income; if she begins to work, her welfare payment is reduced. Specifically, in addition to an allowance for work expenses, her welfare payment is reduced $2 for each $3 earned in excess of $30 a month. Generally, then, for each dollar earned and reported to the welfare agency, the family's income is increased by 33 cents.

The House bill uses the same basic approach as present law but substitutes a flat $60 exemption plus one-third of additional earnings for the present $30 plus work expenses plus one-third of additional earnings. The disincentive effects of this are clearly illustrated in

the following examples of the effect of the House bill on the head of a family of 4 as shown in table 9:

(1) The less the individual works, the more the Government pays. For example, an individual working at $2.00 per hour for 20 hours receives $26.60 more in welfare than an individual working 40 hours a week at that wage; if he does not work at all, his government benefit goes up by $44.10.

(2) An individual cutting back on his work effort decreases his income by a relatively smaller amount, or, said another way, the value of work is substantially lower under the House bill than under the Committee bill. The total income of an individual working at $2.00 per hour for 20 hours under the House bill is only about $13 less than his total income if he works full time at that wage. An individual who works not at all receives only $36 less than the $82 received by an individual working 40 hours at $2.00 an hour.

(3) The value of working is decreased rather than increased. Since the family is eligible for $46.20 in welfare for doing nothing, the $29.20 in additional family income for 40 hours of work at $1.50 per hour amounts to a value of only 73¢ an hour for working Working 40 hours a week at $2.00 per hour is worth only 90¢ per hour to the employee.

(4) Earnings from any employment (as well as child support payments), if reported, reduce the benefits received by the family.

TABLE 9.—WORK DISINCENTIVES UNDER THE HOUSE BILL: INCOME FOR FAMILY OF 4

	Employed by—	
	Private employer at $1.50 per hour	Private employer at $2.00 per hour
40 hours worked:		
Wages	$60.00	$80.00
Welfare	15.40	2.10
Total income	75.40	82.10
20 hours worked:		
Wages	30.00	40.00
Welfare	35.40	28.70
Total income	65.40	68.70
No hours worked:		
Wages	0	0
Welfare	46.20	46.20
Total income	46.20	46.20
Hourly value of working 40 hours	.73	.90

Eligibility to Participate

Except as noted below, eligibility to participate in the employment program would be open to all family heads who are U.S. citizens or aliens lawfully admitted for permanent residence with a child under age 18 (or under age 22 and attending school full time). Participation would be purely voluntary. Mothers with children under age 6 who were eligible for welfare would also be eligible to participate in the employment program if they so chose.

Participation in Work Program

Only one member of a family would be eligible to participate in the work program, the head of the household. This would be deemed to be the father unless he was dead, absent, or incapacitated, in which case it would be deemed to be the mother.

A head of a household would not be permitted to participate in the employment program as a $1.50-per-hour Government employee if he or she:

(1) is a substantially full time student;

(2) is a a striker, but this disqualification would *not* apply to any employee who is (1) not participating or directly interested in the labor dispute and (2) does not belong to a group of workers any of whom are participating in or financing or directly interested in the dispute. The disqualification also would not apply to employees of suppliers or other related businesses which are forced to shut down or lay-off work because of a labor dispute in which they are not directly involved. This disqualification, adapted from the unemployment insurance laws, is designed to prevent the government financing one side of a labor-management dispute.

(3) is receiving unemployment compensation;

(4) is a single person or is a member of a couple with no child under 18 (or under age 22 and attending school full time); or

(5) has left employment without good cause or been discharged for cause or malicious misconduct during the prior 60 days. The Work Administration would be authorized to extend the disqualification to as much as six months for individuals who are discharged because of malicious misconduct or for the commission of a crime against their employer.

In addition:

(6) a family would be ineligible if it has unearned income in excess of $300 monthly or if total family income exceeds $5,600 annually; and

(7) if an individual is able to find regular employment on a part-time basis, he or she will be assured an opportunity for sufficient additional employment as a Government employee to result in a combined total of 40 hours work per week. If an individual working substantially full time in private employment wishes to work up to 20 hours in addition for the Government, the local office of the Work Administration (if it has work available) may provide him or her such an employment opportunity. Similarly, an individual working full time for the Government under the

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employment program could work an additional 20 hours with no reduction in the number of hours of Government employment he or she is provided.

Kinds of Employment

Three kinds of employment are provided:

1. Regular employment in the private sector or in jobs in public or nonprofit private agencies, with no subsidy;
2. Partially subsidized private or public employment; and
3. Newly developed jobs, with the Federal Government bearing the full cost of the salary.

Placement in Regular Employment

Some participants with little or no preparation could be placed immediately in regular employment involving no Government subsidy. These jobs would all pay at least $2.00 per hour.

Subsidized Public or Private Employment

In this category would be jobs not covered by the Federal minimum wage law, in which the employer paid less than $2.00 per hour but at least $1.50 per hour. No supplement would be paid if the employer reduced pay for the job because of the supplement. Thus no jobs presently paying the minimum wage would be downgraded under the Committee bill, and the minimum wage itself would not be affected. Rather, the supplement relates solely to those jobs not covered today under the minimum wage law. Some of these include:

Small retail stores:
- Sales clerk
- Cashier
- Cleanup man

Small service establishments:
- Beautician assistant
- Waiter
- Waitress
- Busboy
- Cashier
- Cook
- Porter
- Chambermaid
- Counterman

Domestic service:
- Gardener
- Handyman
- Cook
- Household aide
- Child attendant
- Attendant for aged or disabled person

Outside salesmen in any industry.

Public sector:
- Recreation aide
- Swimming pool attendant
- Park service worker
- Environmental control aide
- Ecology aide
- Sanitation aide
- Library assistant
- Police aide
- Fire department assistant
- Social welfare service aide
- Family planning aide
- Child care assistant
- Consumer protection aide
- Caretaker
- Home for the aged employee

Agricultural labor:
- Jobs picking, grading, sorting, and grading crops; spraying, fertilizing, and other preparatory work; milking cows; caring for livestock

For these jobs, the Federal Government would make a payment to any employee who is the head of a household equal to three quarters of the difference between what the employer pays him and $2.00 per hour, for up to 40 hours a week. Thus if an employer paid $1.50 an hour the Federal subsidy would amount to 38 cents an hour (three-quarters of the 50-cent difference between $1.50 and $2.00). This wage supplement would be administered by the local office of the Work Administration.

Federally Funded Jobs

For persons who could not be placed in either regular or subsidized public or private employment, jobs would be created which would pay at the rate of $1.50 per hour. An individual could work up to 32 hours a week (an annual rate of about $2,400), and would be paid on the basis of hours worked just as in any other job. There would be no pay for hours not worked.

However, a woman with school-age children would not be required to be away from home during hours that the children are not in school (unless child care is provided), although she may be asked, in order to earn her wage, to provide after-school care to children other than her own during these hours.

If an individual is able to find regular employment on a part-time basis, he or she will be assured an opportunity for sufficient additional employment as a Government employee to result in a combined total of 40 hours work per week. If an individual working substantially full time in private employment wishes to work up to 20 hours in addition for the Government, the local office of the Work Administration (if it has work available) may provide him or her such an employment opportunity. Similarly, an individual working full time for the Government under the employment program could work an additional 20 hours in private employment with no reduction in the number of hours of Government employment he or she is provided.

Participants would not be considered Federal employees, nor would they be covered by social security, unemployment compensation or workmen's compensation. The 10 percent special work-bonus would not apply to their salary.

For these individuals who cannot be placed immediately in regular employment at a rate of pay at least equal to the minimum wage, or in subsidized private employment, the major emphasis would be on having them perform useful work which can contribute to the betterment of the community. A large number of such activities are currently going undone because of the lack of individuals or funds to do them. With a large body of participants for whom useful work will have to be arranged, many of these community improvement activities could now be done. At the same time, safeguards are provided so that the program meets the goal of opening up new job opportunities and does not simply replace existing employees, whether in the public or private sector.

Any job in the regular economy paying $1.50 per hour or more, even a part-time job, would yield a greater income than $1.50 per-hour Government employment and it is anticipated that this will serve as an incentive for participants to seek regular employment. In addition,

the cost to the Government would be substantially less for an individual in regular employment.

Work Bonus for Low-Income Workers

Low-income workers in regular employment who head families would be eligible for a work bonus equal to 10 percent of their wages taxed under the social security (or railroad retirement) program, if the wage income of the husband and wife is $4,000 or less. For families where the husband's and wife's wage income exceeds $4,000, the work bonus would be equal to $400 minus one-quarter of the amount by which this income exceeds $4,000. Thus there would be no work bonus once income reached $5,600 ($5,600 exceeds $4,000 by $1,600; one-quarter of $1,600 is $400, which subtracted from $400 equals zero).

The size of the work bonus is shown on the table below for selected examples:

Annual earnings of family taxed under social security	*Work bonus*
$2,000	$200
3,000	300
4,000	400
5,000	150
5,600	0

The plan incorporates the features of (1) not varying benefits by family size, but only by income, providing no economic incentive for having additional children; and (2) having a gradual phaseout of the amount of the payment as income rises above $4,000 so as not to create a work disincentive. The plan would cost an estimated $1.2 billion and would provide work bonus payments to 5½ million families.

There are certain types of work which are covered under social security but only when the amount of wages earned from a single employer exceeds $50 in a quarter. This limitation applies to the employment of domestics, yardmen and other similar non-business employees. Such employees, if they are the heads of a family, would get the work bonus with respect to all of their wages including those not covered by social security because of the $50 quarterly limitation. In order to qualify for the work bonus on these wages, however, the individual would have to arrange to perform the work as an employee of the Work Administration which would pay him the prevailing wage for the job and bill the private employer for the wages and other costs associated with making his services available. If the employment would ordinarily be covered by social security, then it will be covered under social security when arranged on this basis by the Work Administration. If the employment is not covered by social security, then the employer will not have to pay social security taxes. However, the Work Administration will have a record of all such wages which would have been subject to social security taxes but for the requirement that at least $50 be paid by a private employer during a quarter.

The 10 percent work bonus would be administered by the Internal Revenue Service.

Transportation Assistance

In recognition of the fact that a major reason for low-skilled jobs going unfilled in metropolitan areas is the difficulty an individual faces getting to the potential job, the Work Administration would be authorized to arrange for transportation assistance where this is necessary to place its employees in regular jobs. For example, the Work Administration might determine the upper limit of transportation time to get to a job—say, 45 minutes or one hour, depending on the average commuting time in the area. If the individual can get to the job within that amount of time through ordinary public transportation or other arrangements, then he would be expected to do so. If this could not be done, however, then the Work Administration would be authorized to provide transportation directly to employees who could be placed in regular jobs in order to cut the transportation time down to the standard. The Work Administration could only do this where it was necessary in order to increase employment opportunities. In any case, the cost would ordinarily not be borne by the Government—the employee would pay the Work Administration, and perhaps be reimbursed by the employer if this is customary in the area for the type of job involved. The Work Administration would have the flexibility to absorb some of the costs involved in unusual circumstances.

Training

Participants in the employment program would be eligible to volunteer for training to improve their skills under the training program administered by the Work Administration. The individual would be accepted for enrollment to the extent funds are available and only if they are satisfied that the individual is:

1. Capable of completing training; and
2. Able to become independent through employment at the end of the training and as a result of the training.

Employees under the employment program who wished to participate in training would be strongly motivated, for they would be paid only $1.30 rather than $1.50 for each hour of training. Following the successful completion of training (which could not exceed 1 year in duration), the trainee would receive a lump-sum bonus for having completed training.

Services

Since the purpose of the proposal is to improve the quality of life for children and their families, any member of a family whose head participates in the work program could be provided services to strengthen family life or reduce dependency, to the extent funds are available to pay for the services. Open-ended funding would be provided for family planning and child care services. The agency administering the employment program would refer family members to other agencies in arranging for the provision of social and other services which they do not provide directly. For example, a disabled family member might be referred to the vocational rehabilitation agency, or a 16-year-old out-of-school youth might be referred to an appropriate work or training program, even though the cost of the services themselves would not be borne by the employment program.

Former participants in the work program would have access to free family planning services and to child care on a wholly or partly subsidized basis, depending on family income. Other services needed to continue in employment, including minor medical needs, could be provided by the agency administering the program.

State Supplementation

In order to prevent the State welfare program from undermining the objectives of the Federal employment program the State would have to assume that individuals eligible for the State supplement who are also eligible to participate in the employment program are actually participating full time and thus receiving $200 per month. A similar rule would apply to mothers with children under age 6 who volunteer.

Furthermore, the State would be required to disregard any earnings between $200 a month and $375 a month (the amount an employee would earn working 40 hours a week at $2.00 per hour) to ensure that the incentive system of the alternative plan is preserved. These earnings disregards would be a flat requirement; States would not be required to take into account work expenses. The effect of this requirement would be to give a participant in the work program a strong incentive to work full time (since earnings of $200 will be attributed to him in any case), and it would not interfere with the strong incentives he would have to seek regular employment rather than working for the Government at $1.50 per hour.

Food Stamps

Individuals participating in the employment program would not be eligible to participate in the food stamp program. However, States would be reimbursed the full cost of adjusting any supplementary benefits they might decide to give to participants so as to make up for the loss of food stamp eligibility. In order to avoid having States provide assistance to an entirely new category of recipient not now eligible for federally-shared Aid to Families with Dependent Children, the Committee provided that the Work Administration would pay families headed by an able-bodied father the amount equal to the value of food stamps (but only to the extent that the State provides cash instead of food stamps for families which are now in the Aid to Families with Dependent Children category).

Children of Mothers Refusing to Participate in the Employment Program

Under the employment program, mothers in families with no children under age six would generally be ineligible to receive their basic income from the Aid to Families with Dependent Children program. If it comes to the attention of a welfare agency, however, that children are suffering neglect because a mother who is ineligible for basic income under AFDC also refuses to participate in or is disqualified from the employment program, the Work Administration would be authorized to make payment to the family for up to one month if the mother is provided counseling and other services aimed at persuading

her to participate in the employment program. Following this, the mother would either have to be found to be incapacitated under the Federal definition (that is, unable to engage in substantial gainful employment), with mandatory referral to vocational rehabilitation agency; or, if she is not found to be incapacitated, the State could arrange for protective payments to a third party to ensure that the needs of the children are provided for.

Administration of the Employment Program

The employment program would be administered by a newly created Work Administration headed by a 3-man board appointed by the President with the advice and consent of the Senate. The actual operations of the program would be carried out by local offices of the Work Administration.

The local office would hire individuals applying to participate, develop employability plans for participants, attempt to expand job opportunities in the community, arrange for supportive services needed for persons to participate (utilizing the Work Administration's Bureau of Child Care to arrange for child care services), and operate programs utilizing participants which are designed to improve the quality of life for the children of participants in the employment program.

Employment Program in Puerto Rico

Certain provisions relating to the employment program in Puerto Rico were made. These modifications are necessary because of the fact that Puerto Rico has a different minimum wage structure than the rest of the United States, has substantially lower per capita income, and has a high rate of unemployment. Under the Committee bill the wages paid to Government employees would be equal to three-quarters of the lowest minimum wage applicable to a significant percentage of the population. This would result in a lower wage for Government employees than in the rest of the United States, but it would be significantly higher than current welfare payments in Puerto Rico. The wage supplement program for persons in regular employment at less than the minimum wage would not be applicable to Puerto Rico, but the 10 percent work bonus for low-income earners in jobs covered by social security would apply.

Tax Credit to Develop Jobs in the Private Sector

The provision of the present tax law under which an employer hiring a participant in the Work Incentive Program is eligible for a tax credit equal to 20 percent of the employee's wages during the first 12 months of employment, with a recapture of the credit if the employer does not retain the employee for at least one additional year (unless the employee voluntarily leaves or is terminated for good cause), will be continued under the new guaranteed employment program.

Because the guaranteed job opportunity program, unlike the Work Incentive Program, would be open to the head of any family with children, the following limitations would be added to the provisions of the tax credit to ensure that the credit meets the primary aim of expanding employment opportunities for participants in the Committee's work program:

1. The credit would apply only with respect to individuals who have been participating in the guaranteed job program for at least one month;
2. The credit would not be applicable with respect to more than 15 percent of all employes of the employer in any one year (though the employer would always be permitted to take the credit for at least one employee);
3. The credit would not be available in cases where an employee is discharged and replaced by another employee who formerly worked for the Work Administration; and
4. The credit could not exceed $800 in the case of any one employee (20 percent of $4,000, approximately the amount of annual earnings at $2 an hour).

In order to create additional employment opportunities for participants in the guaranteed job program, the Committee bill would extend the credit to private employers hiring participants in addition to businesses. A private employer taking the credit would not be eligible at the same time for the income tax child care or household expense deduction.

Effective Dates

The effective date for the basic job opportunity program is January 1974. As of that date, families which include an employable adult (including a mother with no child under age 6) will no longer be eligible for welfare as their basic income. If unable to find a regular job, however, the family head will be assured of Government employment paying $1.50 an hour for 32 hours weekly, producing $2,400 of income annually, the same amount which would have been payable to a family of 4 under the House-passed family assistance plan.

The 10 percent work bonus and the wage supplement payment would become payable even before the full guaranteed employment program is operative. Specifically, the work bonus which will be paid quarterly to low-income workers will become effective starting in January 1973. The wage supplement for family heads in regular jobs not covered under the minimum wage law and paying less than $2.00 per hour will be effective July 1973, utilizing the services of the local employment service offices to make the payments until the Work Administration mechanism is functioning.

GENERAL WELFARE PROVISIONS, CHILD WELFARE SERVICES, SOCIAL SERVICES, AND OTHER PROVISIONS

1. GENERAL WELFARE PROVISIONS

The following amendments approved by the Committee apply to both the adult categories (Aged, Blind and Disabled) and to the Aid to Families with Dependent Children category. Other provisions for each category are specified in separate sections of this release relating to each program.

Welfare as a Statutory Right

A number of court cases in recent years have been based on the view that welfare is a property right rather than a gratuity provided for under a statute. The Committee agreed to make clear in the statute that welfare is a statutory right granted under law which can be extended, restricted, altered, amended or repealed by law. It is distinct from a property right or any right considered inviolate under the Constitution.

Declaration Method of Determining Eligibility

Generally speaking, the usual method of determining eligibility for public assistance has involved the verification of information provided by the applicant for assistance through a visit to the applicant's home and from other sources. For persons found eligible for assistance, redetermination of eligibility is required at least annually, and similar procedures are followed.

The Department of Health, Education, and Welfare has required States to use a simplified or "declaration method" for aid to aged, blind, and disabled, and has strongly urged that this method be used in the program of Aid to Families with Dependent Children. The simplified or "declaration method" provides for eligibility determinations to be based to the maximum extent possible on the information furnished by the applicant, without routine interviewing of the applicant and without routine verification and investigation by the caseworker. The Committee bill precludes the use of the declaration method by law. It also explicitly authorizes the States in the statute to examine the application or current circumstances and promptly make any verification from independent or collateral sources necessary to insure that eligibility exists. The Secretary could not, by regulation, limit the State's authority to verify income or other eligibility factors.

Denial of Welfare for Refusal to Allow Caseworker in Home

In 1969 a Federal District Court ruled on constitutional grounds that a State could not terminate welfare payments to a recipient who

refused to allow a caseworker in her home. In 1971, the Supreme Court reversed the lower court's decision. The Committee agreed to codify the Supreme Court's decision in the statute by amending the Act to permit a State to require as a condition of eligibility for welfare that a recipient allow a caseworker to visit the home at a reasonable time and with reasonable advance notice.

Furnishing Manuals and Other Policy Issuances

Regulations issued by the Department of Health, Education, and Welfare in October, 1970, require States to make available current copies of program manuals and other policy issuances without charge to public or university libraries, the local or district offices of the Bureau of Indian Affairs, and welfare or legal services offices or organizations. The material may also be made available, with or without charge, to other groups and to individuals. The Committee approved an amendment under which States would be permitted to be reimbursed for the cost (but no more than the cost) of making this information available.

Requirement of Statewideness for Social Services

The Social Security Act requires that social services (including child care and family planning services) under the welfare programs be in effect in all political subdivisions of a State in order for the State to obtain Federal matching funds. This requirement of statewideness has sometimes delayed the provision of these services. The Committee agreed to permit the Secretary to waive the requirement of statewideness for services.

Use of Social Security Numbers and Other Means of Identification

The Committee bill would require the use of social security numbers in the administration of assistance programs. States would use social security numbers for case file identification, for cross-checking purposes and as an aid in the compilation of statistical data with respect to the welfare programs. In addition, States would be authorized to use photographs and such other means of identification as they desire in administering the welfare programs, as well as setting penalties for misuse of these means of identification.

Duration of Residency

The Committee agreed to require States to establish a three-month duration of residence requirement in order to be eligible for welfare. If a welfare recipient in one State moves to another State, the State of origin would continue making the welfare payments for three months; however, no State would be required to make welfare payments more than 90 days after an individual has left the State.

The Committee also agreed with the provision in the House-passed version of H.R. 1 that would make an individual ineligible for welfare payments during any month in which the person is outside the United States the entire month; once an individual has been outside

the United States for at least 30 consecutive days, he must remain in the United States for 30 consecutive days before he may again become eligible for welfare.

In addition, to become eligible for welfare, an individual must be a resident of the United States and either a citizen or alien lawfully admitted for permanent residence or a person who is a resident under color of law.

Welfare Payments for Rent

Under existing law welfare payments are ordinarily made directly to the recipients. Some States have indicated that they could effect substantial administrative savings if they were permitted to make a single payment directly to public housing authorities of the rent portion of welfare payments for recipients in public housing. The Committee bill would permit States to do this. It would also permit State welfare agencies to make a vendor payment for rent directly to a landlord provided that (a) the welfare recipient has failed to make rent payments (whether or not to the same landlord) for two consecutive months, and (b) the landlord agrees to accept the amount actually allowed by the State to the recipient for shelter as total payment for the rent. The Committee also agreed to repeal a welfare amendment in Public Law 92–213 which would require welfare agencies in some circumstances to pay as a rental allowance more than the actual cost of rent.

Alcoholics and Addicts

The Committee was concerned over the fact that many thousands of recipients on welfare who have been determined to be alcoholics and addicts are not being provided necessary rehabilitative care and treatment. For explanation of committee amendments related to care and treatment of these persons, see the end of the section on Medicare and Medicaid provisions.

Sharing the Cost of Prosecuting Welfare Fraud

Under present law, the Federal Government pays 50 percent of the cost of administration of the welfare programs, as these costs are incurred by the State welfare agency. The Committee bill extends an amendment providing 50 percent Federal matching also for the cost of State and local prosecuting attorney efforts to prosecute welfare fraud.

Recent Disposal of Assets

Under present law, an individual with assets whose value exceeds the welfare eligibility level in the State, may dispose of those assets in order to qualify for assistance. For example, an elderly widow may give her assets to her children to qualify for assistance even though the children continue to make the assets available to her.

The Committee bill deals with this situation by providing that anyone who has voluntarily assigned or transfered property to a relative within one year prior to applying for public assistance and who has received less than fair market value for the property, will be ineligible for public assistance for one year period commencing with the date of transfer.

Recouping Overpayments

The Committee agreed to provide statutorily that overpayments constitute an obligation of an individual to be withheld from any future assistance payments or any amounts (other than Social Security death benefits) owed by the Federal Government to the individual; in addition, overpayments could be collected through ordinary collection procedures.

Ineligibility for Food Stamps

Under the Committee bill (as under the House version), individuals in the welfare programs will not be eligible for food stamps or surplus commodities. States would be assured that there would be no additional expenses to them if they adjust their welfare payment levels to take into account loss of entitlement for food stamps, so that recipients would suffer no loss of income as a result of losing entitlement to food stamps.

Appeals Process

Present law requires that a State plan must provide for granting an opportunity for a fair hearing before the State agency to any individual whose claims for aid is denied or not acted upon with reasonable promptness.

On March 23, 1970, the Supreme Court ruled in two cases (*Goldberg* v. *Kelly* (397 U.S. 254) and *Wheeler* v. *Montgomery* (397 U.S. 280)) that assistance payments could not be terminated before a recipient is afforded an evidentiary hearing. The decision was made on the constitutional grounds that termination of payments before such a hearing would violate the due process clause. The Court argued that welfare payments are a matter of statutory entitlement for persons qualified to receive them, and that "it may be realistic today to regard welfare entitlements as more like 'property' than a 'gratuity.' * * * The constitutional challenge cannot be answered by an argument that public assistance benefits are 'a "privilege" and not a "right."'"

The HEW regulations based on the court's decision (45 CFR 205.10) go much further than the court in spelling out the requirements for fair hearings. The tone and emphasis of the regulations is shown in these excerpts: "Agency emphasis must be on helping the claimant to submit and process his request, and in preparing his case, if needed. The welfare agency must not only notify the recipient of his right to appeal, it must also notify him that his assistance will be continued during the appeal period if he decides to appeal." The regulation continues: "prompt, definitive, and final administrative action will be taken within 60 days from the date of the request for a fair hearing, *except where the claimant requests a delay in the hearing*" (emphasis added).

The Committee bill deals with this situation by requiring State Welfare agencies to reach a final decision on the appeal of a welfare recipient within 30 days following the day the recipient was notified of the agency's intention to reduce or terminate assistance. The bill would also require the repayment to the agency of amounts which a recipient received during the period of the appeal if it was

determined that the recipient was not entitled to them. Any amounts not repaid would be considered an obligation of the recipient and would be recouped in the same manner as other overpayments. In addition, the Committee bill would stipulate that the recipient has a right to appeal at a higher administrative level but that payments need not be continued once an initial adverse determination has been made on the local level at a hearing at which evidence can be presented.

The Committee provision was designed to assure that the appeals procedures would be handled expeditiously by the State and also to assure that appeals would not be made frivolously.

Safeguarding Information

The statutes in all of the welfare programs under the Social Security Act provide safeguards which restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of each welfare program. Regulations issued by the Department of Health, Education, and Welfare state that the same policies apply to requests for information from a governmental authority, the courts or law enforcement officials as from any other outside source.

The Committee bill re-enacts these statutory provisions but includes features making it clear that this requirement may not be used to prevent a court, prosecuting attorney, tax authority, law enforcement official, legislative body or other public official from obtaining information in connection with his official duties including the collection of support payments or prosecuting fraud or other criminal or civil violations.

Separation of Services and Eligibility Determination

A further example of legislation through regulation involves the separation of social services from the welfare payment process. On March 1, 1972, the Department of HEW issued a regulation requiring States to have completely separate administrative units handling the provision of social services and handling the determination of eligibility for welfare. The issuing of this regulation was justified on the grounds that the Family Assistance Plan in the House-passed bill would soon be enacted and it would require a separation of the State-administered services program from the Federal welfare payment programs. Under the Committee bill States would not be required to separate the provision of social services from the determination of eligibility for welfare.

Quality of Work Performed by Welfare Personnel

In an effort to try to upgrade the quality of work performed by welfare personnel, the Committee bill directs the Secretary of the Department of Health, Education, and Welfare to study and report to the Congress by January 1, 1974, on ways of enhancing the quality of welfare work, whether by fixing standards of performance or otherwise. In making this study, the Secretary could draw on the knowledge and expertise of persons talented in the field of welfare adminis-

tration, including those having direct contact with recipients. He should also benefit from suggestions made by recipients themselves as to how the level of performance in the administration of the welfare system might be improved, with a view toward ending the wide variations in employee conduct which characterize today's system, and moderating the extremes to which some social workers go in performing their duties.

Offenses by Welfare Employees

Under present Federal law there is no provision particularly directed to the question of employee conduct in the administration of the welfare program. On the other hand, the Internal Revenue Code (Sec. 7214) contains a list of offenses the commission of any of which, by a tax employee, would bring into effect discharge from employment and penalties of (a) fines not to exceed $10,000, or (b) imprisonment for not more than five years, or both. The provision in the Internal Revenue Code also authorizes a court to award out of any fines imposed an amount up to one-half of the fine to be paid to the informer whose information resulted in the detection of the criminal offense. This law has contributed to the high quality of performance of Internal Revenue employees and has been a factor in assuring relatively uniform standards of conduct.

Under the Committee bill similar rules would apply under the welfare laws that could relate to an upgrading of the quality of performance by welfare workers in general and serve as the basis for standards of conduct which hopefully might narrow the wide variations in employee conduct which exist today.

Specifically, under the Committee bill it would be a crime punishable by a fine of up to $10,000 or imprisonment of up to 5 years, or both, in the case of a welfare employee who is found guilty of:

(1) extortion or willful oppression under color of law; or

(2) knowingly allowing the disbursement of greater sums than are authorized by law, or receiving any fee, compensation, or reward, except as prescribed, for the performance of any duty; or

(3) failing to perform any of the duties of his office or employment with intent to defeat the application of any provision of the welfare statute; or

(4) conspiring or colluding with any other person to defraud the United States or any local, county or State government; or

(5) knowingly making opportunity for any person to defraud the United States; or

(6) doing or omitting to do any act with intent to enable any other person to defraud the United States or any local, county or State government; or

(7) making or signing any fraudulent entry in any book, or making or signing any application, form or statement, knowing it to be fraudulent; or

(8) having knowledge or information of the violation of any provision of the welfare statute which constitutes fraud against the welfare system, and failing to report such knowledge or information to the appropriate official; or

(9) demanding, or accepting, or attempting to collect, directly or indirectly as payment or gift, or otherwise, any sum of money or other thing of value for the compromise, adjustment, or settlement of any charge or complaint for any violation or alleged violation of law, except as expressly authorized by law.

In addition to these penalties the employee involved shall be dismissed from office or discharged from employment.

Limiting HEW Regulatory Authority in Welfare Programs

The Social Security Act permits the Secretary of Health, Education, and Welfare to "Make and publish such rules and regulations, not inconsistent with this Act, as may be necessary to the efficient administration of the functions" with which he is charged under the Act. Similar authority is provided under each of the welfare programs. Particularly since January, 1969, regulations have been issued under this general authority with little basis in law and which sometimes have run directly counter to legislative history. Many States have attributed at least a part of the growth of the welfare caseload in recent years to these regulations of the Department of HEW.

A number of Committee decisions deal with problems raised by specific HEW regulations. In addition, the Committee agreed to modify the statutory language quoted above by limiting the Secretary's regulatory authority under the welfare programs so that he may issue regulations only, with respect to specific provisions of the Act and even in these cases the regulations may not be inconsistent with these provisions.

Demonstration Projects to Reduce Dependency on Welfare

The Social Security Act currently authorizes appropriations for research and demonstration projects in the area of public assistance and social services. The authority has been used to fund several guaranteed minimum income experiments and also a large number of projects related to providing social services to welfare recipients. The Committete agreed to place emphasis on those programs helping persons to become economically independent by requiring that one-half of the funds spent under these two sections be spent on projects relating to the prevention and reduction of dependency on welfare, rather than welfare expansion.

2. CHILD WELFARE SERVICES

Grants to States for Child Welfare Services (Including Foster Care and Adoptions)

The Committee adopted an amendment increasing the annual authorization for Federal grants to the States for child welfare services to $200 million in fiscal year 1973, rising to $270 million in 1977 and thereafter. For fiscal year 1973, this is $154 million more than the $46 million which has been appropriated every year since 1967. The Committee anticipates that a substantial part of any increased appropriation under this higher authorization will go towards meeting the costs

of providing foster care which now represents the largest single item of child welfare expenditure on the county level. The Committee, however, avoided earmarking amounts specifically for foster care so that wherever possible the State and counties could use the additional funds to expand preventive child welfare services with the aim of helping families stay together and thus avoiding the need for foster care. The additional funds can also be used for adoption services, including action to increase adoptions of hard-to-place children.

National Adoption Information Exchange System

The Committee bill would authorize $1 million for the first fiscal year and such sums as may be necessary for succeeding fiscal years for a Federal program to help find adoptive homes for hard-to-place children. The amendment would authorize the Secretary of Health, Education, and Welfare to "provide information, utilizing computers and modern data processing methods, through a national adoption information exchange system, to assist in the placement of children awaiting adoption and in the location of children for persons who wish to adopt children, including cooperative efforts with any similar programs operated by or within foreign countries, and such other related activities as would further or facilitate adoption."

3. SOCIAL SERVICES

Federal Matching for Social Services

The Committee also approved an amendment clarifying the types of social services for which Federal funding may be provided and bringing such funding within the limitations of the appropriations process. Under current law, each State determines what kinds and amounts of social services it will provide to welfare recipients (and other low-income persons who are classified as potential recipients). Whatever services the State provides are matched on a 75 percent Federal, 25 percent non-Federal basis.

Because this matching is completely open-ended and not subject to the ordinary limitations of the appropriation process, Federal costs for social services have soared in the past few years from $354 million in 1969 to $692 million in 1971, and to an estimated $1,363 million in 1972.

The Committee amendment would specifically list the services for which Federal matching may be provided. For families, the services would be:

(a) services to unmarried women who are pregnant or already have children, for the purpose of arranging for prenatal and postnatal care of the mother and child, developing appropriate living arrangements for the child, and assisting the mother to complete school through the secondary level or secure training so that she may become self-sufficient;

(b) protective services for children who are (or are in danger of being abused, neglected, or exploited;

(c) homemaker services when the usual homemaker becomes ill or incapacitated or is otherwise unable to care for the children in the family, and services to educate appropriate family members about household and related financial management and matters pertaining to consumer protection;

(d) nutrition services;

(e) services to assist the needy families with children in dealing with problems of locating suitable housing arrangements and other problems of inadequate housing, and to educate them in practices of home management and maintenance;

(f) emergency services made available in connection with a crisis or urgent need of the family. Fires, floods, accidents, desertions and illnesses can all be disasters to people which may lead to institutionalization and dependency unless immediate response can be brought to bear on the problem;

(g) services to assist appropriate family members to engage in training or secure or retain employment; and

(h) informational and referral services for individuals in need of services from other agencies (such as the health, education, or vocational rehabilitation agency, or private social agencies) and follow-up activities to assure that individuals referred to and eligible for available services from such other agencies received such services.

For the aged, blind, and disabled, the services would include:

(a) protective services for individuals who are (or are in danger of being abused, neglected, or exploited, such as institutional services for those aged or physically or mentally disabled who are unable to maintain their own place of residence;

(b) homemaker services, including education in household and related financial management and matters of consumer protection, and services to assist aged, blind, or disabled adults to remain in or return to their own homes or other residential situations and to avoid institutionalization or to assist in making appropriate living arrangements at the lowest cost in light of the care needed;

(c) nutrition services, including the provision, in appropriate case, of adequate meals, and education in matters of nutrition and the preparation of foods;

(d) services to assist individuals to deal with problems of locating suitable housing arrangements and other problems of inadequate housing, and to educate them in practices of home maintenance and management;

(e) emergency services made available in connection with a crisis or urgent need of an individual;

(f) services to assist individuals to engage in training or securing or retaining employment; and

(g) informational and referral services for individuals in need of services from other agencies (such as the health, education, or vocational rehabilitation agency, or private social agencies) and follow-up activities to assure that individuals referred to and eligible for available services from such other agencies received such services.

Under the Committee amendment, Federal matching for social services beginning January 1973 would be the same as Federal matching for Medicaid (which ranges from 50 percent to 83 percent, depending on State per capita income), with two differences: (1) Federal matching would not exceed 75 percent, and (2) for the 12 months of

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calendar year 1973, the Federal matching percent would not be below 65 percent even if the Medicaid matching rate is below 65 percent. Child care and family planning services would continue to be matched on an open-ended basis, and child welfare services would continue to be a separate Federal grant program; with these exceptions, Federal funds for all other social services in both the adult and AFDC categories (excluding child care, family planning, and child welfare services) would be limited to not more than $1 billion annually beginning in fiscal year 1973. The Federal funds appropriated for social services would be allocated among the States on the basis of the total State population. Any funds which are allotted but not used by one State may be reallotted among the other States.

Family Planning Services

The Committee approved payment by the Federal Government of 100 percent of the cost of Family Planning Services as compared with 75 percent under present law.

Eliminate Statutory Requirement of Individual Program of Services for Each Family

Present law requires States to develop an individual program of services for each family receiving AFDC. This has proven to be an unnecessary administrative burden. The Committee agreed to delete this statutory requirement.

Supportive Services for Participants in the WIN Program

Until the Government Employment Program begins on January 1, 1974, the Committee bill would continue 90 percent Federal matching for supportive services other than family planning services to enable AFDC recipients to participate in the Work Incentive Program.

4. OTHER PROVISIONS

Evaluation of Programs Under the Social Security Act

The Committee bill assigns to the General Accounting Office the basic role of evaluating programs under the Social Security Act. In addition, the amendment would not permit any Federal agency to enter into a contract to evaluate any program under the Social Security Act (if an expenditure of more than $25,000 is involved) unless the Comptroller General approves the study in advance. His approval would be conditioned on his determination that:

(a) The conduct of such study or evaluation of such program is justified;

(b) The department or agency cannot effectively conduct the study or evaluation through utilization of regular full-time employees; and

(c) The study or evaluation will not be duplicative of any study or evaluation which is being conducted, or will be conducted within the next twelve months, by the General Accounting Office.

Use of Federal Funds to Undermine Federal Programs

Another amendment approved by the Committee would prohibit the use of Federal funds to pay, directly or indirectly, the compensation or expenses of any individual who in any way participates in action relating to litigation which is designed to nullify Congressional statutes or policy under the Social Security Act. This prohibition may, however, be waived by the Attorney General 60 days after he has provided the Committee on Finance and the Committee on Ways and Means with notice of his intent to waive the prohibition. This will allow the Committees time to take legislative action if appropriate. This amendment is similar to one approved by the Committee in 1970 as part of the Social Security-Welfare bill of that year—a bill which was not finally enacted.

Appointment and Confirmation of Administrator of Social and Rehabilitation Services

The Social and Rehabilitation Service was established in 1967 by a reorganization within the Department of Health, Education, and Welfare. Its responsibilities at present are broad, encompassing the federally aided welfare programs, medicaid, and programs in the areas of vocational rehabilitation, aging, and juvenile delinquency. The sums involved are huge; the bulk of the $14-billion 1972 budget for the agency is spent on the public assistance and medicaid programs. The Committee agreed to upgrade the stature of the Administrator of the Social and Rehabilitation Service by having the President select him and by having him confirmed by the Senate as his colleagues with equivalent positions in the Department (the Commissioner of Social Security, the Commissioner of Education, and the Surgeon General) now enjoy.

CHILD CARE

At the present time, the lack of availability of adequate child care today represents perhaps the greatest single obstacle in the efforts of poor families, especially those headed by a mother, to work their way out of poverty. It also represents a hindrance to those mothers in families above the poverty line who wish to seek employment for their own self-fulfillment or for the improvement of their family's economic status.

The Committee on Finance has long been involved in issues relating to child care. The committee has been dealing with child care as a segment of the child welfare program under the Social Security Act since the original enactment of the legislation in 1935. Over the years, authorizations for child welfare funds were increased in legislation acted on by the committee.

As part of its continuing concern for the welfare of families with children who are in need, and in order to provide for the expansion of child care required to enable the new employment program to meet its goal of making present AFDC recipients independent, the Committee is proposing a new approach to the problem of expanding the supply of child care services and improving the quality of these services. The Committee bill thus establishes within the new Work Administration a Bureau of Child Care with the eventual goal of making child care services available throughout the Nation to the extent they are needed, but are not supplied under other programs.

Bureau of Child Care

The Bureau of Child Care would have as its first priority making available child care services to participants in the employment program. Next in order of priority would be the provisions of child care to low-income working mothers and to other mothers desiring child care services.

Where child development services are available under any other legislation approved by the Congress, the Bureau would attempt to place children in those services.

To the maximum extent possible, the Bureau would attempt to utilize mothers participating in the employment program in providing child care services.

Initially, the Bureau would train persons to provide family day care and would contract with existing public, private non-profit, and proprietary facilities to serve as child care providers. To expand services, the Bureau would also give technical assistance and advice to organizations interested in establishing facilities under contract with the Bureau. In addition, the Bureau could provide child care services in its own facilities.

Federal child care standards are specified in the amendment to assure that adequate space, staff and health requirements are met. In

addition, facilities used by the Bureau will have to meet the Life Safety Code of the National Fire Protection Association. Any facility in which child care is provided by the Bureau, either directly or by contract, will have to meet the Federal standards, but will not be subject to any licensing or other requirements imposed by States or localities. This provision will make it possible for many groups and organizations to establish child care facilities under contract with the Bureau where they cannot now do so because of overly rigid State and local requirements.

Subsidization of child care for low-income working mothers will depend on the availability of appropriations. Mothers able to pay will be charged the full cost of services.

In addition to appropriations to subsidize child care costs for low-income working mothers, fees would be charged for services provided or arranged for by the Bureau. They would be set at a level which would cover the unsubsidized costs of arranging for child care. The fees would go into the revolving fund to provide capital for further expansion of services.

The child care amendment also includes provision to authorize the Bureau to issue bonds for construction if, after the first two years of operation, the Bureau feels that additional funds for capital construction of child care facilities are needed. Up to $50 million in bonds could be issued each year, with an overall limit of $250 million on bonds outstanding.

Authorization

The Committee agreed to authorize $800 million in fiscal year 1973 (and such sums as the Congress might appropriate thereafter) to arrange for and to pay for part or all of the cost of child care for the children of participants in the employment program and to other low income working mothers. (The House bill would provide $750 million for substantially the same purposes.)

Grants to States for Establishment of Model Day Care

The Committee expects that much of the child care offered by the Bureau of Child Care will be similar to that provided by mothers in their own home, since experience has shown that most working mothers prefer family day care because of its convenience and its informality. However, the Committee has also provided a 3-year program of grants to States to permit them to develop model child care. Appropriations would be authorized to permit each State in fiscal years 1973, 1974 and 1975 to receive a grant of up to $400,000 per year to pay all or part of the cost of model care, whether through the establishment of one child care center or a child care system. Special emphasis would be placed on utilizing the model child care for training persons in the field of child care.

AID TO FAMILIES WITH DEPENDENT CHILDREN

Persons Eligible for Aid to Families With Dependent Children

The Committee bill, when the Guaranteed Employment program goes into effect on January 1, 1974, will require that States:

1. Make eligible for AFDC only the following classes of families:
   a. Family headed by mother with child under age 6;
   b. Family headed by incapacitated father where mother is not in the home or is caring for father;
   c. Family headed by mother who is ill, incapacitated, or of advanced age;
   d. Families headed by mother too remote from an employment program to be able to participate;
   e. Family headed by mother attending school fulltime even if there is no child under 6; and
   f. Child living with neither parent, together with his caretaker relative(s), providing his mother is not also receiving welfare; and
2. Do not reduce payment levels to AFDC recipients below $1,600 for a two-member family, $2,000 for a three-member family and $2,400 for a family of four or more; or, if payment levels are already below these amounts, they could not be reduced at all.

This requirement is not intended to act as a limitation on the right of a State to make other persons eligible at its own expense for benefits under its AFDC program. Indeed, in many States with benefit levels higher than those provided under the guaranteed employment program, AFDC-type families participating in the work program would receive supplemental payments under the State program sufficient to bring their incomes up to the payment standards generally applicable in the State. Specifically, the families not required to be covered by the State program (although it can be anticipated that many States will continue to supplement them) are families headed by an able-bodied male and families headed by an able-bodied female if all her children have reached age six.

Definition of "Incapacity" Under Aid to Families with Dependent Children

Under present law the Federal Government will match payments to families where the father is incapacitated. The definition of "incapacitated" is left up to the States. Under the Committee bill the term "incapacitated" would be defined as "inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment." This is the same definition as is used in determining disability under the social security disability insurance program, except that the definition suggested would also apply to

short term, temporary disability while social security benefits are available only to persons whose disability will last at least 12 months.

Ineligibility of Unborn Children

Regulations of the Department of Health, Education, and Welfare permit Aid to Families with Dependent Children payments for a child who has not yet been born. The Committee bill would make unborn children ineligible for AFDC.

Children Living in a Relative's Home

Under the present law an AFDC mother with more than one child can enable a relative to become eligible for welfare by lending the relative one of her children. The Committee bill would permit a State to deny welfare aid to the relative in such situation.

Cooperation of Mother in Identifying the Father and Seeking Support Payments

The Committee bill would require, as a condition of eligibility, that a mother cooperate in efforts to establish the paternity of a child born out of wedlock, cooperate in seeking support payments from the father, and assign the right to collect support payments on her behalf to the Government.

The provisions related to child support and establishing paternity are described in greater detail under the heading "Child Support."

Families Where There is a Continuing Parent-Child Relationship

The Committee has approved a provision which would clarify congressional intent with respect to the meaning of the term "parent" under the AFDC program. In most cases, AFDC families are eligible on the basis that the children in the family have been deprived of parental support by reason of the continued absence from the home of a parent. In 1968, the Supreme Court ruled that a State could not consider a child ineligible for AFDC when there is a substitute father with no legal obligation to support the child. This court decision was based on an interpretation that Congress did not intend that such a person would come within the meaning of the term "parent." The Committee bill would authorize States to determine whether a man is a "parent" on the basis of a total evaluation of his relationship with the child and not solely on the question of his obligation to support. The determination would have to consider the following indications of the existence of a parental relationship:

1. The individual and the child are frequently seen together in public;
2. The individual is the parent of a half-brother or half-sister of the child;
3. The individual exercises parental control over the child;
4. The individual makes substantial gifts to the child or to members of his family;
5. The individual claims the child as a dependent for income tax purposes;

6. The individual arranges for the care of the child when his mother is ill or absent from the home;
7. The individual assumes responsibility for the child when there occurs in the child's life a crisis such as illness or detention by public authorities;
8. The individual is listed as the parent or guardian of the child in school records which are designed to indicate the identity of the parents or guardians of children;
9. The individual makes frequent visits to the place of residence of the child; and
10. The individual gives or uses as his address the address of such place of residence in dealing with his employer, his creditors, postal authorities, other public authorities, or others with whom he may have dealings, relationships, or obligations.

The relationship between an adult individual and a child would be determined to exist in any case only after an evaluation of the factors as well as any evidence which may refute any inference supported by evidence related to such factors. Under the Committee bill any natural parent or step-parent would meet these criteria.

Under the Committee bill, the use of this provision would be optional with the States. If a State affirmatively exercised its option, however, it would have to comply with this method in determining the child-father relationship.

Income Disregard

Under present law States are required, in determining need for Aid to Families with Dependent Children, to disregard the first $30 earned monthly by an adult plus one-third of additional earnings. Costs related to work (such as transportation costs) are also deducted from earnings in calculating the amount of the welfare benefit.

Two problems have been raised concerning the earned income disregard under present law. First, Federal law neither defines nor limits what may be considered a work-related expense, and this has led to great variation among States and to some cases of abuse. Secondly, some States have complained that the lack of an upper limit on the earned income disregard has the effect of keeping people on welfare even after they are working full time at wages well above the poverty line.

Until the Committee's new employment program becomes effective in January, 1974, the earnings disregard formula would be modified by allowing only day care as a separate deductible work expense (with reasonable limitations on the amount allowable for day care expenses). States would be required to disregard the first $60 earned monthly by an individual working full time ($30 for an individual working part time) plus one-third of the next $300 earned plus one-fifth of amounts earned above this. This differential between full time and part time employment is designed to encourage those who are able to move into full time jobs.

Once the employment program under the Committee bill becomes effective, however, these earned income exemptions under the residual welfare program would be replaced by a flat monthly exemption of $20, applicable to all kinds of income (with a separate $20 disregard

applicable to child support payments). It would be expected that mothers interested in working would receive their work incentives through participating in the employment program rather than by remaining on welfare.

In order to prevent the State welfare program from undermining the objectives of the Federal employment program, the States would have to assume for purposes of supplemental payments provided under AFDC or any welfare program that individuals, who are eligible to participate in the employment program (but no longer eligible to receive their basic income from AFDC), are actually participating full time in the employment program and thus receiving $200 per month. A similar rule would apply to mothers with children under age 6 who volunteer.

Futhermore, the State would be required to disregard any earnings between $200 a month and $375 a month (the amount an employee would earn working 40 hours a week at $2.00 per hour) to ensure that the incentive system of the workfare program is preserved. These earnings disregards would be a flat requirement; States would not be required to take into account work expenses. The effect of this requirement would be to give a participant in the work program a strong incentive to work full time (since earnings of $200 will be attributed to him in any case), and it would not interfere with the strong incentives he would have to seek regular employment rather than working for the Government at $1.50 per hour.

The table below shows how wages under the employment program would be treated for State welfare purposes:

Hours worked per week	None	20	32	40
Hourly wage		$1.50	$1.50	$2.00
Approximate actual monthly income	0	$130	$200	$375
Income deemed available for State welfare purposes	$200	$200	$200	$200

Assistance Levels

Under existing law, each State decides the level of assistance it will provide for AFDC families. The Committee bill generally reaffirms the right of the State to make this determination. In moving to a block grant approach which involves substantial fiscal relief, however, the Committee feels it is appropriate to require that States could not reduce payments levels to AFDC recipients below $1,600 for a two-member family, $2,000 for a three-member family, and $2,400 for a family of four or more; or, if payment levels are already below these amounts, they could not be reduced at all.

Right to Apply For Aid to Receive it With Reasonable Promptness

The present law requires that:

> All individuals wishing to make application for Aid to Families with Dependent Children shall have opportunity to do so, and that Aid to Families with Dependent Children shall be furnished with reasonable promptness to all eligible individuals.

The Committee bill would reiterate this provision, but would make clear the requirement that aid be furnished "with reasonable promptness" could not be so construed as to interfere with other requirements of the law such as seeking a mother's cooperation in establishing paternity and seeking support payments, or verifying information on income, resources and other eligibility factors.

Community Work and Training Programs

Prior to the enactment of the Work Incentive Program as part of the 1967 Social Security Amendments, the Federal statute permitted Federal matching of AFDC payments made to recipients participating in a community work training program. Since the enactment of the Work Incentive Program, however, the Department of Health, Education, and Welfare has taken the position that the Federal Government will not share in AFDC payments to recipients who are required by State law to participate in an employment program—unless the program is part of the Work Incentive Program. The Committee bill provides that during the period between enactment of the House bill and the effective date of the new Federal employment program, the community work training provisions in the law prior to the 1967 amendments would be applied so that States wishing to have such programs in the interim could do so.

Protective Payments for Children

The Committee bill requires States under the AFDC program to take certain actions to assure that welfare payments are being used in the best interests of children. Existing law provides that when the welfare agency has reason to believe that the AFDC payments are not used in the best interests of the child, it "may" provide counseling and guidance services so that the mother will use the payments in the best interests of the child. This failing, the agency "may" resort to protective payments to a third party who will use the funds for the best interest of the child. The Committee bill makes these procedures mandatory in such cases.

Emergency Assistance—Migrant Workers

Under existing law, emergency assistance may, at the option of the States, be provided to needy families in crisis situations, and it may be provided either statewide or in part of the State. Emergency assistance programs have been adopted in about half of the States, and they receive 50 percent Federal matching. Under the law, assistance may be furnished for a period not in excess of 30 days in any 12-month period in cases in which a child is without available resources and the payments, care, or services involved are necessary to avoid destitution of the child or to provide living arrangements for the child. The Committee bill (1) requires that all States have a program of emergency assistance to migrant families with children; (2) requires that the program be statewide in application; and (3) provides 75 percent Federal matching for emergency assistance to migrant families.

Making Establishment of Advisory Committee Optional

Regulations issued by the Department of Health, Education, and Welfare in 1969 require States to establish a welfare advisory committee for AFDC and child welfare programs "at the State level and at local levels where the programs are locally administered," with the cost of the advisory committees and their staffs borne by the States (with Federal matching) as part of the cost of administering the welfare programs. The Committee bill makes the establishment of such committees optional with the States.

Administrative Costs

The Committee agreed that the Federal Government would continue to pay 50 percent of the cost of administration of the AFDC program including administrative costs related to the provision of Social Services.

Federal Financial Participation in Welfare Payments

The Committee bill would make a major change in the basic method of Federal funding for AFDC by providing a block Federal grant with substantially more Federal funds than are now provided under present law. This approach is described in detail under the heading "Fiscal Relief for States."

TABLE 10.—RECIPIENTS OF AID TO FAMILIES WITH DEPENDENT CHILDREN, DECEMBER OF SELECTED YEARS

Year	Number of recipients	Percent increase since 1960
1940	1,222,000	.....
1945	943,000	.....
1950	2,233,000	.....
1955	2,192,000	.....
1960	3,073,000	.....
1961	3,566,000	+16
1962	3,789,000	+24
1963	3,990,000	+28
1964	4,219,000	+38
1965	4,396,000	+44
1966	4,666,000	+52
1967	5,309,000	+73
1968	6,086,000	+98
1969	7,313,000	+138
1970	9,659,000	+215
1971	10,651,000	+247
1972 [1]	12,573,000	+311
1973: [1]		
Current law	13,800,000	+349
Committee bill	[2] 13,800,000	+349
1974: [1]		
Current law	14,900,000	+385
Committee bill: persons eligible to receive basic income from AFDC	[3] 8,940,000	+191

[1] Estimated.
[2] Some reduction of caseload may be anticipated because of committee amendments related to eligibility rules and administration; the extent of the reduction will largely depend upon State action.
[3] Reflects estimate that about 40 percent of current caseload will no longer be eligible to get basic income from AFDC.

Source: Department of Health, Education, and Welfare.

Statistical Material

TABLE 11.—**AID TO FAMILIES WITH DEPENDENT CHILDREN:** INCOME ELIGIBILITY LEVEL FOR PAYMENTS AND LARGEST AMOUNT PAID TO **FAMILY OF 4,** BY STATE, DECEMBER 1971

	Income eligibility level for payments	Largest amount paid for basic needs
Alabama	$81	$81
Alaska	400	300
Arizona	266	173
Arkansas	210	106
California	314	261
Colorado	235	235
Connecticut	335	335
Delaware	287	158
District of Columbia	245	245
Florida	223	134
Georgia	158	149
Hawaii	268	268
Idaho	241	241
Illinois	273	273
Indiana	355	175
Iowa	243	243
Kansas	290	226
Kentucky	193	193
Louisiana	104	104
Maine	349	168
Maryland	311	200
Massachusetts	283	283
Michigan	293	293
Minnesota	309	309
Mississippi	277	60
Missouri	338	130
Montana	225	206
Nebraska	275	226
Nevada	176	176
New Hampshire	314	314
New Jersey	324	324
New Mexico	203	179
New York	313	313
North Carolina	172	172
North Dakota	300	300

TABLE 11.—**AID TO FAMILIES WITH DEPENDENT CHILDREN:** INCOME ELIGIBILITY LEVEL FOR PAYMENTS AND LARGEST AMOUNT PAID TO **FAMILY OF 4,** BY STATE, DECEMBER 1971—Continued

	Income eligibility level for payments	Largest amount paid for basic needs
Ohio	$258	$200
Oklahoma	189	189
Oregon	224	224
Pennsylvania	301	301
Rhode Island	255	255
South Carolina	198	103
South Dakota	270	270
Tennessee	217	129
Texas	148	148
Utah	224	224
Vermont	319	319
Virginia	261	261
Washington	282	270
West Virginia	138	138
Wisconsin	217	217
Wyoming	260	227

Source: Department of Health, Education, and Welfare.

CHILD SUPPORT

The Committee has long been aware of the impact of deserting fathers on the rapid and uncontrolled growth of families on AFDC. As early as 1950, the Congress provided for the prompt notice to law enforcement officials of the furnishing of AFDC with respect to a child that had been deserted or abandoned. In 1967, the Committee instituted what it believed would be an effective program of enforcement of child support and determination of paternity. Due to a total lack of leadership by the Department of HEW, most States have not implemented these provisions in a meaningful way. The Committee believes, therefore, that a new legislative thrust is required in this area which will create a mechanism to obtain compliance with the law. The major elements of this proposal have been adapted from those States who have been the most successful in establishing effective programs of child support and determination of paternity. Some of the modes of assistance which are created by the Committee plan will be available to deserted families generally, regardless of welfare status. It is hoped that making these provisions available to all deserted families will prevent further expansion of the welfare rolls.

Present law requires that the State welfare agency establish a separate, identified unit whose purpose is to undertake to determine the paternity of each child receiving welfare who was born out of wedlock, and to secure support for him; if the child has been deserted or abandoned by his parent, the welfare agency is required to secure support for him from the deserting parent, utilizing any reciprocal arrangements adopted with other States to obtain or enforce court orders for support. The State welfare agency is further required to enter into cooperative arrangements with the courts and with law enforcement officials to carry out this program. Access is authorized to both Social Security and (if there is a court order) to Internal Revenue Service records in locating deserting parents. The effectiveness of the provisions of present law have varied widely among the States.

Assignment of Right to Collection of Support Payments

In some instances, mothers may have personal reasons for fearing to cooperate in identifying and securing support payments from the father of the child. To protect the mother, and also to allow for a more systematic approach for the collection of support payments, the Committee approved an amendment requiring a mother, as a condition of eligibility for welfare, to assign her right to support payments to the Government and to require her cooperation in indentifying and locating the father and in obtaining any money or property due the family or Government. The assignment of family support rights would be to the Federal Government, and the Department of Justice would

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be authorized to delegate these rights to those States which have effective programs of determining paternity and obtaining child support. The Attorney General would also be authorized to delegate such collection rights to counties that have effective programs, but only if the State as a whole did not.

If the Attorney General found that a State did not have an effective program, the collection rights would remain with the Federal Government and would be enforced by Federal attorneys in either State or Federal Courts. OEO lawyers would be made available to assist Justice Department attorneys in carrying out their responsibility. In this situation the Federal Government would retain the full amount not payable to the family.

The House bill provided that the Federal share for State expenses for establishing paternity and securing support should be increased from 50 to 75 percent. The Committee adopted this provision, but with a proviso that there be no Federal participation in such State programs which do not meet the Attorney General's standards of effectiveness.

Locating a Deserting Parent; Access to Information

Under the Committee bill, the State or local Government would proceed to locate the absent parent, using any information available to it, such as the records of the Internal Revenue Service and the Social Security Administration. The Committee bill extends access to these Federal records to any parent seeking support from a deserting spouse regardless of whether the family was on welfare. Non-welfare families desiring to use this means of finding the absent parent would make the necessary application at local welfare offices. The Federal Government would have to be reimbursed for the cost of these services by the welfare agency or the individual if a welfare case was not involved.

As a further aid in location efforts, welfare information now withheld from public officials, under regulations concerning confidentiality, would be made available by the Committee bill; this information would also be available for other official purposes.

Incentives for States and Localities to Collect Support Payments

Under present law, when a State or locality collects support payments owed by a father, the Federal Government is reimbursed for its share of the cost of welfare payments to the family of the father; the Federal share currently ranges between 50 percent and 83 percent, depending on State per capita income. In a State with 50 percent Federal matching, for example, the Federal Government is reimbursed $50 for each $100 collected, while in a State with 75 percent Federal matching the Federal Government is reimbursed $75 for each $100 collected.

Consistent with the Committee's block-grant approach for AFDC, and as an incentive for the development of effective State and local programs, the Committee bill provides that the entire amount of welfare payments from support collections would remain with the State.

If, however, the actual collection and determination of paternity mechanism is carried out by local authority, the State would pay 25 percent of the governmental share of the support collections to such authority.

In the situation where the location of runaway parents and the enforcement of support orders is carried out by a State other than that in which the deserted family resides, the State or local authority which actually carries out the location and enforcement functions will be paid the 25 percent bonus.

The Committee bill provides, that the Federal Government would have to be reimbursed for any Federal costs incurred by the States and localities in their collection and determination of paternity efforts.

Voluntary Approach Stressed

Once located, the parent would be requested to enter voluntarily into an arrangement for making regular support payments. Primary reliance would be placed on such voluntary agreements as the most effective and efficient means of collecting support, avoiding the need for court action and formal collection procedures. The record of the State of Washington in collecting support payments voluntarily was highlighted in a recent study by the General Accounting Office as a key element in their highly successful support collection program; hopefully, the experience of Washington State can serve as a model for all States.

Civil Action To Obtain Support Payments—Residual Monetary Obligation

In the event that the voluntary approach is not successful, the Committee's bill provides for strong legal remedies. The States, as agents of the Federal Government, in enforcing the support rights assigned to them by welfare applicants would have available to them all the enforcement and collection mechanisms available to the Federal Government, including the use of the Internal Revenue Service to garnish the wages of the absent parent. As stated previously, if these mechanisms are utilized the Federal Government would have to be reimbursed on a cost basis. Support monies received would be distributed according to the formula described under "Incentives for States."

The welfare payment would serve as the basis of a continuing monetary obligation of the deserting parent to the United States. The obligation would be the lesser of the welfare assistance paid to the family, or 50 percent of the deserting spouse's income but not less than $50 a month.

A waiver of all or part of the Federal obligation might be allowed upon a showing of good cause.

Criminal Action

The Committee bill has provided for Federal criminal penalties for an absent parent who has not fulfilled his obligation to support his family and the family receives welfare payments in which the Federal

Government participates. His obligation to support would be determined by applying State civil and/or criminal law. The sanctions for failure to support could include a penalty of 50 percent of the amount owed or a fine of up to $1,000 or imprisonment for up to 1 year or a combination of these.

Determining Paternity

The Committee believes that an AFDC child has a right to have its paternity ascertained in a fair and efficient manner. Although this may in some cases conflict with the mother's short-term interests, the Committee feels that the child's right to support, inheritance, and his right to know who his father is deserves the higher social priority. In 1967, Congress enacted legislation requiring the States to establish programs to establish the paternity of AFDC children born out of wedlock so that support could be sought. The effectiveness of this provision was greatly curtailed both by the failure of the Department of Health, Education, and Welfare to exercise any leadership role and also by Court interpretations of Federal law in decisions which prevented State welfare agencies from requiring that a mother cooperate in identifying the father of a child born out of wedlock.

1. Cooperation of Mother

As noted earlier, the Committee has made cooperation in identifying the absent parent a condition for AFDC eligibility. As a further incentive for cooperation, the first $20 a month in support collections would be paid to the family and disregarded for purposes of determining the amounts of welfare payments to the family. Thus, the family would always be better off if support payments were made by the absent parent.

2. Blood Grouping Laboratories

The Committee has also taken additional steps to provide for a more effective system of determining paternity.

First, a father not married to the mother of his child would be required to sign an affidavit of paternity if he agreed to make support payments voluntarily in order to avoid court action. Most States do not permit initiation of paternity actions more than two or three years after the child's birth; the affidavit would serve as legal evidence of paternity in the event that court action for support should later become necessary.

Second, there is evidence that blood typing techniques have developed to such an extent that they may be used to establish evidence of paternity at a level of probability acceptable for legal determinations.

Moreover, if blood grouping is conducted expertly, the possibility of error can all but be eliminated. Therefore, the Committee adopted a provision to authorize and direct the Department of Health, Education, and Welfare to establish or arrange for regional laboratories that can do blood typing for purposes of establishing paternity, so that the State agencies and the courts would have this expert evidence available to them in paternity suits. No requirement would be made in Federal law that blood tests be made mandatory. The services of the laboratories would be available with respect to any paternity proceeding, not just a proceeding brought by, or for, a welfare recipient.

Leadership Role of Justice Department

To coordinate and lead efforts to obtain child support payments, the Committee action would require each U.S. Attorney to designate an assistant who would be responsible for child support. This Assistant U.S. Attorney would assist and maintain liaison with the States in their support collection efforts and would undertake Federal action as necessary. The Attorney General would be required to submit a quarterly report to Congress concerning child support activities.

The Committee bill requires that records be maintained of the amounts of support collected and of the administrative expenditures incurred in the collection effort. Amounts collected but not otherwise distributed would be deposited in a separate account which would finance the expenses of the Federal collection efforts. An authorization for an appropriation would be included for the contingency of a deficit in this fund in order to reimburse the Departments of Justice and Treasury for their expenses in this area.

Attachment of Federal Wages

State officials have recommended that legislation be enacted permitting assignment and attachment of Federal wages and other obligations (such as income tax refunds) where a support order or judgment exists. At the present time, the pay of Federal employees, including military personnel is not subject to attachment for purposes of enforcing court orders, including orders for child support or alimony. The basis for this exemption is apparently a finding by the courts that the attachment procedure involves the immunity of the United States from suits to which it has not consented.

The Committee bill would specifically provide that the wages of Federal employees be subject to garnishment in support and alimony cases. This Committee amendment would be applicable whether or not the family bringing the garnishment proceeding is on the welfare rolls.

Child Support Under Workfare

A deserted parent participating in the workfare program could take advantage of the support collection and, where applicable, the paternity determination mechanism provided in the Committee bill. The cost of collection, however, would be deducted from the amounts recovered and the balance would be turned over to the deserted family.

Effective Dates

Unless otherwise indicated in the bill, new features added by the collection of support and determination of paternity provision would be effective January 1, 1973.

Statistical Material

TABLE 12.—AFDC FAMILIES BY PARENTAGE OF CHILDREN, 1971

Parentage	Number	Percent
Total	2,523,900	100.0
Same mother and same father	1,800,200	71.3
Same mother, but 2 or more different fathers	638,400	25.3
Same father, but 2 or more different mothers	5,200	.2
2 or more different mothers and 2 or more different fathers	53,400	2.1
Unknown	26,700	1.1

Source: Department of Health, Education, and Welfare.

TABLE 13.—AFDC FAMILIES WITH SPECIFIED NUMBER OF ILLEGITIMATE RECIPIENT CHILDREN, 1971

Number of children	Number	Percent
Total	2,523,900	100.0
None	1,426,000	56.5
1	559,600	22.2
2	262,400	10.4
3	129,600	5.1
4	71,700	2.8
5	37,300	1.5
6 or more	37,300	1.5

Source: Department of Health, Education, and Welfare.

TABLE 14.—AFDC FAMILIES BY STATUS OF FATHER, 1961, 1967, 1969, AND 1971

Status	Percent of families in—			
	1961	1967	1969	1971
Total	100.0	100.0	100.0	100.0
Dead	7.7	5.5	5.5	4.3
Incapacitated	18.1	12.0	11.5	9.8
Unemployed	5.2	5.1	4.8	6.1
Absent from the home:				
Divorced	13.7	12.6	13.7	14.2
Legally separated		2.7	2.8	2.9
Separated without court decree	8.2	9.7	10.9	12.9
Deserted	18.6	18.1	15.9	15.2
Not married to mother	21.3	26.8	27.9	27.7
In prison	4.2	3.0	2.6	2.1
Absent for another reason	.6	1.4	1.6	1.2
Subtotal	66.7	74.2	75.4	76.2
Other status:				
Stepfather case	2.2	1.9	1.9	2.6
Children not deprived of support or care of father, but of mother		1.3	.9	.9
Not reported			(1)	.1

[1] Less than 0.05.

Source: Department of Health, Education, and Welfare.

TABLE 15.—AFDC FAMILIES BY WHEREABOUTS OF FATHER, 1971

Whereabouts	Number	Percent
Total	2,523,900	100.0
In the home	472,900	18.7
In an institution:		
Mental institution	8,000	.3
Other medical institution	11,200	.4
Prison or reformatory	75,300	3.0
Not in the home or an institution; he is residing in:		
Same county	469,200	18.6
Different county; same State	156,300	6.2
Different State and in the United States	230,900	9.1
A foreign country	27,100	1.1
Whereabouts unknown	959,600	38.2
Inapplicable (father deceased)	113,400	4.3

Source: Department of Health, Education, and Welfare.

FISCAL RELIEF FOR STATES

The Committee is well aware that the growth of the welfare rolls since 1967 has been one of the significant factors in bringing about the fiscal crisis currently facing state and local governments. Much of this growth has been due to increased Federal intervention in the control of the welfare programs by the State. The Committee feels that having the Federal Government take over the control of the welfare program is not now a step that should be taken. It believes that the correct approach is in the opposite direction. Accordingly, the Committee carefully designed many parts of this bill so that the State's control of welfare programs would be strengthened rather than weakened. The Committee recognizes, however, that this represents a long-range solution and that many States feel an acute need for immediate relief from the pressures of swollen welfare budgets. Under the Committee bill therefore, the fiscal burden on the States will be substantially decreased through increases in the Federal funding of assistance payments as well as through indirect fiscal relief resulting from improvements which the Committee bill makes in the general structure of the welfare programs.

Over the next 2½ years, the bill provides $5 billion in fiscal relief to the States. Of this, $2.6 billion represents fiscal relief in 1974, the first year the new employment programs are fully effective. The table below shows the detail for each of the years 1972–74.

[Dollars in billions]

	1972	1973	1974	Tota
Aid to the aged, blind, and disabled	$0.2	$1.0	$1.2	$2.4
Aid to families with dependent children	.4	.8	1.4	2.6
Total	.6	1.8	2.6	5.0

The estimated fiscal relief provided for each State in calendar year 1974, with respect to cash public assistance payments is shown in the table below.

TABLE 16

STATE SAVINGS IN WELFARE PAYMENT COSTS, 1974 [1]

[In millions of dollars]

State	Committee proposal			Estimated savings under H.R. 1
	Adult categories	Family welfare benefits	Total	
	(1)	(2)	(3)	(4)
Total	1,230.4	1,378.9	2,609.3	1,859.2
Alabama	27.1	12.9	40.0	31.1
Alaska	2.6	2.9	5.5	3.5
Arizona	10.6	32.0	42.6	40.5
Arkansas	14.0	7.5	21.5	21.5
California	298.9	163.3	462.2	180.9
Colorado	15.9	15.3	31.2	16.5
Connecticut	10.4	11.5	21.9	16.7
Delaware	4.5	3.7	8.2	4.7
District of Columbia	10.4	45.4	55.8	50.8
Florida	32.6	90.3	122.9	135.3
Georgia	24.9	36.5	61.4	58.9
Hawaii	3.6	8.7	12.3	9.4
Idaho	1.7	1.8	3.5	2.0
Illinois	45.4	100.6	146.0	167.0
Indiana	9.2	29.2	38.4	28.2
Iowa	19.4	10.1	29.5	22.7
Kansas	7.0	13.2	20.2	12.1
Kentucky	15.4	10.8	26.2	15.3
Louisiana	32.8	39.5	72.3	68.8
Maine	4.4	3.2	7.6	2.5
Maryland	17.1	52.8	69.9	72.3
Massachusetts	51.5	39.9	91.4	64.8
Michigan	45.3	94.9	140.2	97.4
Minnesota	13.1	14.5	27.6	17.5
Mississippi	14.6	5.5	20.1	20.8
Missouri	34.3	15.0	49.3	10.8
Montana	1.8	1.7	3.5	1.7
Nebraska	2.4	4.4	6.8	7.1
Nevada	.8	1.9	2.7	1.7
New Hampshire	4.0	1.2	5.2	2.2
New Jersey	20.1	30.0	50.1	48.5
New Mexico	4.0	3.6	7.6	3.7
New York	168.5	135.8	304.3	168.3
North Carolina	19.9	16.7	36.6	31.2
North Dakota	2.1	2.2	4.3	1.2
Ohio	29.9	94.0	123.9	103.0
Oklahoma	33.5	14.1	47.6	39.0
Oregon	6.7	14.9	21.6	15.4
Pennsylvania	46.8	57.1	103.9	70.0
Rhode Island	4.4	9.4	13.8	7.1

See footnote at end of table.

STATE SAVINGS IN WELFARE PAYMENT COSTS, 1974 [1]—Continued

[In millions of dollars]

State	Committee proposal			Estimated savings under H.R. 1
	Adult categories	Family welfare benefits	Total	
	(1)	(2)	(3)	(4)
South Carolina	5.9	7.0	12.9	12.9
South Dakota	.7	1.4	2.1	1.4
Tennessee	13.2	16.3	29.5	26.8
Texas	42.4	32.5	74.9	44.8
Utah	2.5	5.6	8.1	5.2
Vermont	2.3	1.6	3.9	3.7
Virginia	9.5	12.1	21.6	20.8
Washington	15.4	14.6	30.0	12.0
West Virginia	8.5	7.0	15.5	14.4
Wisconsin	17.9	32.0	49.9	44.6
Wyoming	.5	.8	1.3	.5

[1] Based on fiscal year 1974 data.

Federal Funding of Aid to the Aged, Blind, and Disabled

The Committee bill establishes minimum Federal standards for assistance to the aged, blind, and disabled, but leaves to the States the administration of the program under State eligibility rules. To give the States both substantial fiscal relief and a fiscal stake in good administration, the cost of making assistance payments meeting the Federal payment level requirements would be borne entirely by the Federal Government up to a specified base amount under the following formula:

> Federal funding would be provided for the costs of assistance to the aged, blind, and disabled up to the standards required by the bill ($130 for an individual, $190 for a couple with a $50 disregard of all income and additional disregards of earned income). These costs would be fully Federal up to the higher of (1) the cost of meeting these standards for a State's existing caseload; or (2) the State's share of $5 billion distributed among the States in proportion to the number of aged individuals with income below $1,750 and aged couples with income below $2,200 in 1969. If State costs involved in meeting the Federally required payment levels exceeded the higher of these amounts, the Federal Government would also pay 90 percent of the excess. There would be no Federal funding with respect to assistance provided at levels above those required by the Committee decision.

Under this formula most States would be required to pay a relatively small proportion of the costs involved in the Committee decision. A number of States, however, would have no costs at all for 1974; but these States would be required to pay small amounts in future years when their caseload grows to the point that the fully Federal base amount is no longer sufficient to cover the payments required by the Federal standards. As a result, all States would be relieved of all but a very small amount of responsibility for the funding of aid to the aged, blind, and disabled and would enjoy the savings shown in column 1 of the preceding table. However, there would be an incentive for the States to exercise control over caseload growth since they would be required to pay a part of the costs related to all additional recipients once the Federal base amount is exceeded.

In 1974, it is estimated that this formula would result in Federal payments to the aged, blind, and disabled of $4.2 billion (compared with $2.0 billion under existing law). State costs under the bill would be $0.2 billion compared with $1.4 billion under existing law, yielding fiscal relief for the States of $1.2 billion. The same formulas would apply with respect to assistance for the aged, blind, and disabled in the remaining months of 1972 and in 1973. It is estimated that this will result in State savings of $0.2 billion this year and $1.0 billion in 1973.

Federal Funding of Aid to Families with Dependent Children

In the Aid to Families with Dependent Children program, the Committee bill changes the funding mechanism from the present formula matching to a block grant approach. This new method of providing Federal funds for AFDC results in substantial immediate fiscal relief and is also consistent with the Committee's desire to return to the States a greater measure of control over their welfare programs. For the last 6 months of calendar year 1972 and for 1973 the block grant would be based on the funding for calendar year 1972 under current law. Starting in 1974 the grant would be adjusted to take into account

the effects of the work program. The following formula would be used:

The grant for 1973 would equal the 1972 Federal share, plus an additional amount equal to one-half of the 1972 State share, or if less the amount needed in 1972 to bring family income up to $1,600, $2,000 or $2,400 for families with two, three, or four or more members, respectively. In no case, however, would the Federal block grant be less than 110 percent of the Federal share in 1972. For the last 6 months of calendar year 1972, the grant would be one-half of the 1973 grant.

After the employment program becomes effective in January 1974, the Federal grant for AFDC would be reduced somewhat in recognition of the fact that families with no children under age 6 would no longer be eligible for AFDC. This reduced grant would remain the same in future years, except that it would be increased or decreased to reflect changes in total State population.

For example, it is estimated that the Federal block grant for AFDC in California would be $689.4 million in 1973. After the employment program becomes effective, this would be reduced to $526.7 million. The $526.7 million would remain as the annual amount of the Federal grant to California for AFDC except that it would be adjusted each year to reflect any percentage increase or decrease in the State's population.

The table below shows the State savings under AFDC over the next 2½ years.

TABLE 17.—STATE SAVINGS IN AFDC COSTS UNDER COMMITTEE BILL

(In billions)

Year	Current law		Committee bill		
	Federal	Non-Federal	Federal	Non-Federal	Fiscal relief to States
1972 [1]	$2.2	$1.8	$2.6	$1.4	$0.4
1973	4.4	3.6	5.2	2.8	.8
1974 [2]	4.8	3.9	3.7	2.5	1.4

[1] Last 6 months only.

[2] Total AFDC costs are reduced under Committee bill because many current law recipients would no longer be eligible to receive their basic income from AFDC.

Federal Funding Costs of Public Assistance Administration

The Committee bill would retain the present financing arrangement with respect to the costs of administration of the AFDC program. Under this arrangement, such costs are shared on a 50 percent Federal—50 percent State basis.

In the programs of aid to the aged, blind, and disabled, the Committee bill would provide Federal funding equal to 100 percent of the administration costs in calendar year 1972 plus 50 percent of any costs above this base. The additional Federal funding would be needed because several States may have substantially greater administrative costs due to the new Federal assistance standards for the aged, blind, and disabled.

Internal Revenue Amendments

Retirement Income Credit

Under present law, a retirement income credit of up to $1,524 multiplied by 15 percent ($229) is allowed for single persons age 65 or over having "retirement income"—that is, income from pensions, dividends, interest, rents, and other passive income. The income eligible for this credit is reduced, however, by social security, railroad retirement, or other tax-exempt pension income. It is also reduced by 50 percent of earnings between $1,200 and $1,700 and on a dollar-for-dollar basis as income rises above $1,700. For most married couples, the limitation on the credit is $2,286, one and one-half times the amount allowed a single person, and the maximum benefit is $342.90.

In addition, under present law, the retirement income credit, determined substantially as indicated above, is available for retirement income received from governmental units where the individual is under age 65, except that if he is also under age 62, earnings in excess of $900 reduce the $1,524 limitation on a dollar-for-dollar basis.

The Committee bill includes, with minor modification, the liberalized and simplified retirement income credit contained in the House bill. As adopted by the Committee, the limitation would be raised to $2,500 for a single person and $3,750 for a couple. Thus, the maximum credit will be $375 for a single person and $562.50 for a couple. The Finance Committee did not include in its bill the feature of the House provision which would have extended the credit to persons who have not yet retired.

Social Security and Unemployment Tax of Affiliated Corporations

The Social Security tax is based on the wages paid an employee, with a limitation on the amount subject to tax. Under present law, the limitation is $9,000 ($10,200 under the Committee bill). In some instances, an employee on the payroll of one member of an affiliated group of corporations may perform services for other members of the group; in these cases, he may be treated as a separate employee of each member of the group for which he performs services and the remuneration he receives may be attributed to them. As a result, the $9,000 limitation on wages subject to social security is applied to the remuneration attributed to each company separately, rather than to the total remuneration received by such employee, and the FICA tax collected with respect to his employment may be based on compensation considerably in excess of the statutory limit. While the employee may obtain a refund of any excess social security tax paid, the related employers may not.

The Committee approved an amendment to eliminate duplication of FICA tax in the situation described. The amendment also applies to

eliminate the duplication of the Federal unemployment taxes which may occur under similar circumstances. Under the amendment, an individual who performs services for more than one member of an affiliated group of corporations would be treated as an employee only of the member or members of the group by which he is employed and from which he receives his compensation. Under the committee action the present practice of attributing payments of compensation to other members of an affiliated group would no longer prevail.

Analysis of Cost of Committee Bill

(119)

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Chart 1

Cost Increases in H.R. 1 and Committee Bill

The chart shows the net increase in cost over current law for calendar years 1973 and 1974 for H.R. 1 and the Committee bill. Details for each of the program categories are shown in the succeeding charts and text.

The estimated costs for H.R. 1 are those prepared by the Department of Health, Education, and Welfare. As discussed in the text accompanying chart 5, some of these costs are believed to be significantly understated.

The cost estimate for the tax credit provisions relates to the retirement income credit provision in the House bill plus the credit added by the Committee for employers hiring persons who have been in the Committee's employment program. This estimate was prepared by the staff of the Joint Committee on Internal Revenue Taxation.

In summary, the Committee bill would cost $5.7 billion more than the House bill in 1973 and $6.3 billion more in 1974. Of the 1974 increase, $3.9 billion represents increased social security benefits and $2.4 billion represents increased general fund costs (principally payments to low-income working persons).

The Committee bill would cost $17.6 billion more than existing law in 1974, as shown below:

[In billions of dollars]

	Present law	Committee bill	Increase
Social security cash benefits	$43.2	$50.6	+$7.4
Medicare Part A	8.3	10.7	+2.4
Medicare Part B	3.3	3.9	+.6
Medicaid	6.1	6.1	.....
Aid to the aged, blind, and disabled	2.7	4.9	+2.2
Programs for families	7.0	11.5	+4.5
Increase in tax credits			+.5
Total			+17.6

Chart 1

Cost Increases in H.R.1 and Committee Bill

(in billions)

	1973		1974	
	H.R.1	Committee bill	H.R.1	Committee bill
General Funds				
Medicare Part B	$0.4	$0.3	$0.4	$0.6
Medicaid	-0.5	---	-0.5	---
Aged, blind, disabled	1.1	2.0	2.6	2.2
Programs for families	1.3[1]	2.7	2.5[1]	4.5
Tax credit provisions	0.4	0.4	0.4	0.5
SUBTOTAL	2.7	5.4	5.4	7.8
Increase in Committee bill		(+2.7)		(+2.4)
Trust Funds				
Social security cash benefits	3.9	7.0	4.3	7.4
Medicare Part A	1.5	1.4	1.6	2.4
SUBTOTAL	5.4	8.4	5.9	9.8
Increase in Committee bill		(+3.0)		(+3.9)
TOTAL	8.1	13.8	11.3	17.6
Increase in Committee bill		(+5.7)		(+6.3)

1/ Based on HEW estimate; Committee estimate is $2.0 billion higher in 1974.

Chart 2

Social Security Cash Benefits

H.R. 1 as passed by the House of Representatives provided for a first year increase in the cost of social security cash benefits of $3.9 billion. A 5 percent general benefit increase accounted for $2.1 billion of this total. Under the Committee bill, there would be an additional increase in social security cash benefit costs of $3.1 billion for a total increase over existing law of $7.0 billion. The 10 percent general benefit increase in the Committee bill represents a cost of $2.2 billion over the 5 percent increase in the House bill.

Chart 2

Social Security Cash Benefits

(First full year costs, in billions)

Increases in House Bill	
5 percent benefit increase	$2.1
Widow's benefits	0.9
Increase in earnings limit	0.6
Other changes	0.3
SUBTOTAL	3.9
Increases in Committee Bill	
Benefit increase of 10% rather than 5%	2.2
Special minimum up to $200	0.3
Credit for delayed retirement	0.2
Other changes	0.4
SUBTOTAL	3.1
TOTAL INCREASE IN COMMITTEE BILL OVER PRESENT LAW	7.0

Chart 3

Medicare and Medicaid

Medicare Part B

The principal increased cost in the committee bill is attributable to covering the disabled under Medicare on a basis similar to that approved by the House.

The Committee also approved adding coverage of chiropractors under Medicare and limiting the percentage by which the Medicare Part B premium paid by older people could be raised from one year to the next.

In addition, other changes were approved that were designed to smooth Medicare operation.

Medicaid

The Committee bill would for the first time cover eligible mentally ill children under age 21 receiving treatment in an accredited medical institution.

The Committee also provided that workfare participants otherwise ineligible for Medicaid would have the opportunity to "buy in" by paying premiums, with Federal subsidy for any remaining costs of benefits.

The principal change resulting in a decrease in Medicaid costs was the Committee's repeal of Section 1902 (d) which presently prohibits States from moderating their programs.

Medicare Part A

Extension of hospital insurance for the disabled accounts for the major cost increase shown on the chart.

A new benefit was added by the Committee covering a limited number of drugs appropriate for use in treating the chronically ill.

The definition of eligibility for services in an extended care facility was liberalized in the committee bill so as to simplify administration and improve availability of benefits.

Chart 3

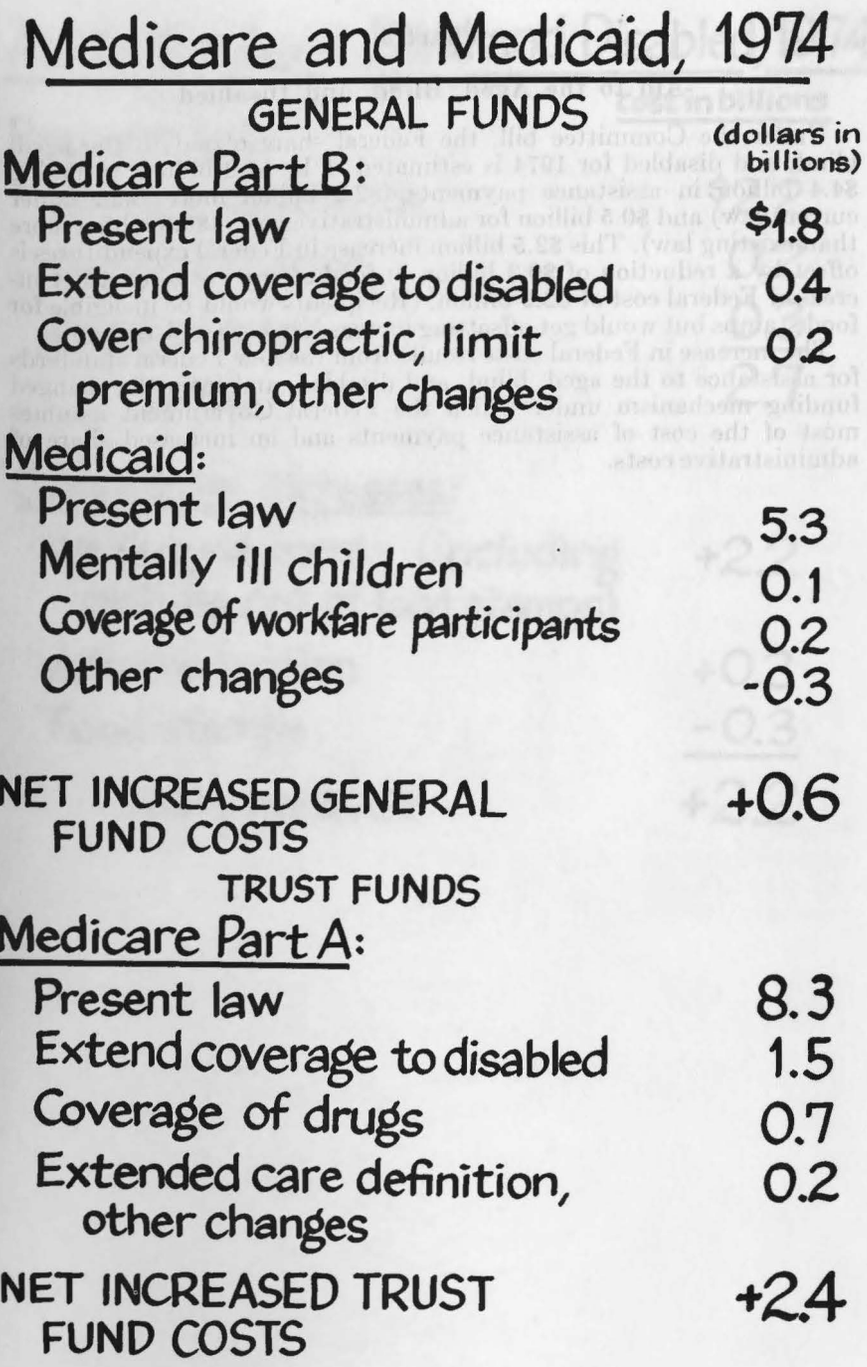

Chart 4

Aid to the Aged, Blind, and Disabled

Under the Committee bill, the Federal share of aid to the aged, blind, and disabled for 1974 is estimated to be $4.9 billion, including $4.4 billion in assistance payments ($2.2 billion more than under current law) and $0.5 billion for administrative costs ($0.3 billion more than existing law). This $2.5 billion increase in Federal expenditures is offset by a reduction of $0.3 billion in food stamp costs for a net increased Federal cost of $2.2 billion. (Recipients would be ineligible for food stamps but would get offsetting increases in cash assistance.)

The increase in Federal costs results from the new Federal standards for assistance to the aged, blind, and disabled, and from the changed funding mechanism under which the Federal Government assumes most of the cost of assistance payments and an increased share of administrative costs.

Chart 4

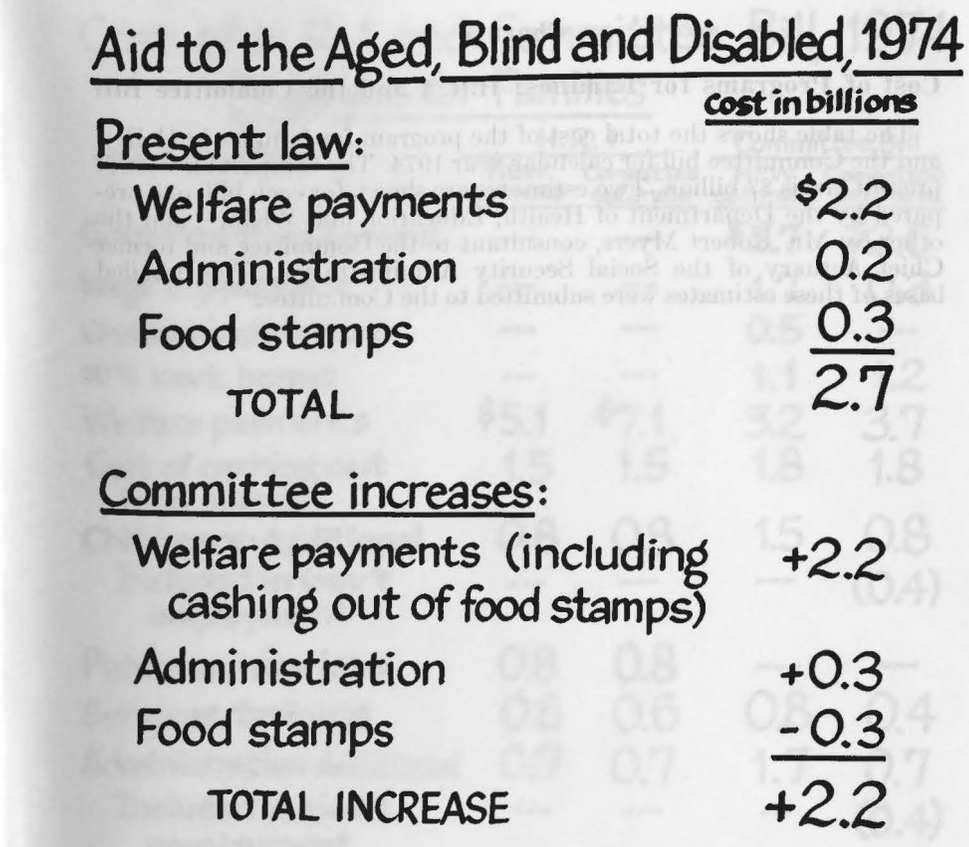

Chart 5

Cost of Programs for Families: H.R. 1 and the Committee Bill

The table shows the total cost of the program for families in H.R. 1 and the Committee bill for calendar year 1974. The comparable cost of present law is $7 billion. Two estimates are shown for each bill, one prepared by the Department of Health, Education and Welfare, and the other by Mr. Robert Myers, consultant to the Committee and former Chief Actuary of the Social Security Administration. The detailed bases of these estimates were submitted to the Committee.

Chart 5

Cost of H.R. 1 and Committee Bill, 1974: Programs for Families

(dollars in billions)	H.R. 1		Committee Bill	
	HEW estimate	Committee estimate	HEW estimate	Committee estimate
Government employment	---	---	$5.7	$2.6
Wage supplement	---	---	1.7	0.3
Children's allowance	---	---	0.5	---
10% work bonus	---	---	1.1	1.2
Welfare payments	$5.1	$7.1	3.2	3.7
Cost of cashing out food stamps	1.5	1.5	1.8	1.8
Child care: Additional	0.8	0.8	1.5	0.8
Included in Gov't employment	---	---	---	(0.4)
Public service jobs	0.8	0.8	---	---
Services, training	0.6	0.6	0.8	0.4
Administration: Additional	0.7	0.7	1.7	0.7
Included in Gov't employment	---	---	---	(0.4)
TOTAL	9.5	11.5	18.0	11.5
Present law	7.0	7.0	7.0	7.0
NET INCREASED COST	2.5	4.5	11.0	4.5

to benefits under both the social security and railroad retirement systems.

A living individual with entitlement to both social security and railroad retirement benefits may receive benefits separately under both systems. If he dies, however, his survivors may receive benefits from only one system, based on his combined earnings under both systems. Thus, upon his death a recomputation is necessary. The language of the law has been interpreted as preventing the Social Security Administration from automatically recomputing survivor benefits based on combined social security and railroad retirement earnings where the deceased person retired before 1966 and had no earnings after 1965. A specific provision in the law is needed to make it clear that survivor's benefits will continue to be based on the worker's combined social security and railroad earnings.

The bill would provide that a deceased individual who during his lifetime was entitled to social security benefits and railroad compensation and whose railroad remuneration and earnings under social security are, upon his death, to be combined for social security purposes would have his primary insurance amount recomputed on the basis of his combined earnings, whether or not he had earnings after 1965.

Retroactive payment of disability benefits

Under a 1967 amendment certain disabled people were allowed to establish a period of disability—the so-called disability freeze—even though the period provided in the law for filing effective applications had terminated. This 1967 provision was designed to protect a limited number of people who, when the disability program was new, had been so severely disabled that they did not have the opportunity or ability to file an application.

Your committee has been informed that these people also lost benefits which would otherwise have been paid. Therefore, your committee's bill would provide for the payment of cash disability benefits for periods of disability prior to 1968 that have been established by those persons under the 1967 amendment.

B. PROVISIONS RELATING TO MEDICARE, MEDICAID, AND MATERNAL AND CHILD HEALTH PROGRAMS

1. Eligibility and payment for benefits

(*a*) *Coverage for disability beneficiaries under medicare.*—Over the years your committee has given extensive consideration to proposals to provide health insurance protection under title XVIII for persons entitled as a result of disability to monthly cash benefits under the social security and railroad retirement programs. While your committee has always believed that there are compelling reasons for extending the protection of medicare to disability beneficiaries, it has in past years regretfully concluded that considerations of cost precluded recommending such an extension of coverage. Your committee believes, however, that the present unmet need for health insurance protection among the disabled of our Nation is so great that appropriate legislative action should no longer be deferred.

In an effort to ascertain the dimensions of the health insurance problem confronting the disabled and to evaluate all the possible approaches to providing or assuring adequate health insurance for such

people, your committee has in recent years directed a number of Advisory councils to study this question and to report their findings and recommendations to the Congress. In each case, the council charged with responsibility for examining the issue has recommended the extension of medicare coverage to the disabled. Moreover, your committee believes that the findings on which these councils based their recommendations are too impressive to be ignored or minimized. It is clear, for example, that a major unmet need for health insurance protection exists among the disabled. Use of health services by people who are severely disabled is substantially higher than that by the nondisabled. Disabled workers receiving cash benefits under the social security program use about seven times as much hospital care, and about three times as much physicians' services as does the nondisabled population. These facts account both for the great need for and the substantial costs of covering the disabled under medicare. Yet the disabled have limited incomes in comparison to those who are not disabled, and most disabled persons are unable financially to purchase adequate private health insurance protection, or to obtain such insurance at all.

Accordingly, your committee's bill would extend medicare protection to social security disability beneficiaries. Those covered would include disabled workers, disabled widows and disabled dependent widowers between the ages of 50 and 65, people aged 18 and over who receive social security benefits because they became disabled before reaching age 22, and disabled qualified railroad retirement annuitants.

While your committee has concluded that considerations of public policy dictate the extension of medicare protection to the disabled, your committee also believes, given the cost and financing considerations involved in such coverage, that it is imperative to proceed on a conservative basis. Consequently, your committee's bill would provide health insurance protection only after the disabled beneficiary has been entitled to social security disability benefits for not less than 24 consecutive months. Such an approach would help to keep program costs within reasonable bounds, avoid overlapping private health insurance protection, particularly in those cases where a disabled worker may continue his membership in a group insurance plan for a period of time following the onset of his disability, and minimize certain administrative problems that might otherwise arise in cases in which entitlement to disability benefits is not determined until some time after application is made because of delays due to the appellate process.

Moreover, this approach would provide assurance that the protection will be available to those whose disabilities have proven to be severe and long lasting.

Under this provision of your committee's bill, medicare protection would begin with the later of (a) July 1972, or (b) the 25th consecutive month of the individual's entitlement to social security disability benefits.

(*b*) *Hospital insurance benefits for uninsured individuals not eligible under transitional provision.*—Present law provides hospital insurance protection under the "special transitional provision" for people who are not qualified for cash benefits under the social security or railroad retirement program. (The provision excludes an active or retired Federal employee, or the spouse of such an employee, who is covered or could have been covered under the provisions of the Federal Em-

ployees Health Benefits Act of 1959; aliens residing in the United States for less than 5 years; and people who have been convicted of a crime against the security of the United States, including sabotage, espionage, treason, etc.) The "special transitional provision" covers people who are not qualified for cash benefits under the social security or railroad retirement program and who reached age 65 before 1968 even though they had no work under social security (or in the railroad industry). Those who attained or will attain age 65 after 1967 must have had specified amounts of work under these programs in order to be eligible for hospital insurance protection. The transitional provision will phase out as of 1974 as persons attaining age 65 in that year must be insured for cash benefits under one of the two programs in order to be eligible for hospital insurance protection.

Since the transitional provision is designed to provide hospital insurance coverage for only a part (though a large part) of the uninsured aged and to eventually phase out, a portion of the aged, though small in number (as of July 1, 1971, it is estimated that this portion will number approximately 344,000 or 1¼ percent of the aged population), are and will be, for one reason or another, excluded from hospital insurance coverage. (The 344,000 people include 50,000 recent immigrants, who would continue to be excluded from coverage; 150,000 active or retired Federal employees, who are not eligible for the transitional provisions; and 144,000 others.) Although these ineligibles include a substantial number of people who were eligible for social security coverage but who did not elect (or whose employers did not elect) to be covered (including employees of State and local governments), they also include several other groups: (1) wives who have never worked under covered employment and whose husbands are eligible for hospital insurance under the transitional provision, (2) women who are not insured on their own account and who cannot qualify for dependent's benefits (such as dependent aged sisters of insured workers and the dependents of uninsured workers), and (3) workers, such as agricultural and domestic workers, whose earnings may have been so low or sporadic they were unable to acquire insured status.

Further, it has become very difficult for many in this group to obtain private hospital insurance comparable to coverage under medicare. Since the passage of the medicare law, private insurance companies have generally changed their hospital insurance plans available to people age 65 and over to make their coverage complementary to medicare. While there is generally some type of hospital insurance available to persons age 65 and over, most of that which is offered is in the form of specified cash payment insurance, paying from $25 to $200 per week for limited periods of hospitalization. Few private health insurance companies offer their regular hospital expense plans to the aged.

Your committee's bill would make available hospital insurance coverage under medicare on a voluntary basis to persons age 65 and over, including Federal civil service employees or annuitants and their spouses, who are not entitled to such coverage under existing law. A State or any other public or private organization would be permitted to purchase such protection on a group basis for its retired or active employees age 65 and over. The intent is that the cost of such coverage would be fully financed by those who elect to enroll for this protection. Enrollees would pay a monthly premium based on the cost of hospital insurance protection for the uninsured group. The premium would be $31 a month beginning with January 1972 and up to and including

June 1972, and would be recomputed each fiscal year and increased in the same proportion as the inpatient hospital deductible. The same restrictions on enrollment and reenrollment (including a 10-percent-per-year charge for late enrollment) would apply as now apply to enrollment for supplementary medical insurance (including the changes in such enrollment provisions made by other provisions in the bill).

Your committee's bill would provide that whenever a person enrolled for voluntary hospital insurance becomes eligible for such coverage as a result of becoming eligible for monthly cash social security or railroad retirement benefits or under the special transitional provision, his coverage under the provision would be terminated; and to insure that his hospital insurance coverage continued uninterrupted he would be deemed to have filed the application required for establishing hospital insurance under the other provision in the month he becomes eligible under the other provision.

The effective date for coverage provided under this provision would be January 1, 1972.

(c) *Amount of supplementary medical insurance premium.*—Under present law, the Secretary of Health, Education, and Welfare is directed to determine and promulgate a premium in December of each year for individuals enrolled in the supplementary medical insurance program. The dollar amount of the premium is the amount the Secretary estimates to be necessary so that the aggregate premiums for the 12-month period commencing July 1 in the succeeding year will equal one-half of the total supplementary medical insurance program costs that will be payable during that fiscal year. (The Federal Government pays the other half of the costs by matching the premium amount paid by each enrollee.) During the first five years of the program it has been necessary to increase the premium almost 87 percent—from $3 in July 1966 to a scheduled $5.60 rate as of July 1971.

Your committee is concerned about the increasingly severe financial burden that the premium amount, established under this method, will come to represent in future years. The premium is not only likely to continue to rise significantly but will do so without regard to the ability of beneficiaries living on reduced retirement incomes to bear the increased financial burden.

Accordingly, under your committee's bill, the supplementary medical insurance premium generally would increase in any given year only if monthly cash social security benefits had been increased in the interval since the premium was last increased. Moreover, the premium would rise by no more than the percentage by which cash benefits had been increased across the board (whether by act of Congress or automatically under the provision in the bill which provides automatic increases in cash benefits under certain cirumstances). Thus, enrollment in the supplementary medical insurance program would remain voluntary and premium payments by enrollees would still be required, but premiums would be increased only at times and by amounts that would be related to the beneficiary's ability to meet the cost.

The revised procedure for establishing the medical insurance premium would operate as follows. The medical insurance premium would be allowed to rise to $5.60 on July 1, 1971, as presently scheduled. During December of 1971, and each year thereafter, the Secretary would be required, as he is under present law, to determine and promulgate the monthly premium amount for the 12-month period beginning the following July. As one step in determining the premium

amount, however, he would determine a monthly actuarial rate for aged enrollees representing the dollar amount he estimates will equal, in the aggregate over the 12-month period, one-half of the total benefit and administrative costs (plus a small contingency reserve) that the program will incur with respect to enrollees age 65 and over. The premium for all enrollees (including disability beneficiaries) would then be set to equal the lesser of (a) the actuarial rate described above or (b) the most recently promulgated premium rate, increased by the total percentage by which monthly cash benefits have increased or are scheduled to increase during the fiscal year to which such recently promulgated rate applies. When he promulgates the premium the Secretary would be required to issue a public statement setting forth the actuarial assumptions and bases used in arriving at the actuarial rate, and the drivation of the premium amount.

Your committee's bill would also authorize the appropriation from the general revenues of sufficient funds to meet all supplementary medical insurance program costs above those met by the aggregate premium amounts paid by aged and disabled enrollees.

(d) Change in supplementary medical insurance deductible.—Under present law, a deductible is applied to the first $50 of expenses incurred by a beneficiary for services of the type covered under the supplementary medical insurance program.

Recognizing that medical costs have risen considerably since the beginning of the medicare program, your committee has concluded that it would be appropriate to increase the supplementary medical insurance deductible to $60 as of January 1, 1972. Thus, beneficiaries would continue to bear a reasonably representative portion of their medical insurance costs. The $60 figure is below the amount ($70) that would be necessary to maintain the same relationship between the deductible and program costs as existed between $50 and program costs when the program began.

(e) Increase in lifetime reserve days and change in hospital insurance coinsurance amount under medicare.—Under present law, payment may be made for up to 90 days of inpatient hospital services furnished during a benefit period (spell of illness), with the beneficiary being responsible for an inpatient hospital deductible (currently $60) and, beginning with the 61st day of his stay, a daily coinsurance amount equal to one-fourth of the inpatient hospital deductible (now $15). In addition, present law provides each beneficiary with a nonrenewable lifetime reserve of 60 days of inpatient hospital coverage upon which he may draw after having exhausted the 90 days of covered care regularly available to him in a benefit period; a coinsurance amount equal to one-half of the inpatient hospital deductible is applicable to each lifetime reserve day used.

Your committee believes there is a need to more fully protect medicare beneficiaries against the very high costs associated with those illnesses that require prolonged use of inpatient hospital services; it has also been mindful of the need to promote the most effective possible utilization of such services and to maintain an awareness of the cost of hospital care among the beneficiaries of the program. To further the objective of the medicare program to protect the aged against the very heavy expenses of major illness, your committee's bill would provide for an increase from 60 to 120 in the number of "lifetime reserve" days for which inpatient hospital benefits may be paid. Thus, each medicare beneficiary would have available to him at least 210 days of covered

pitalization, even if he had only one benefit period. As under esent law, to guard against any possible unnecessary utilization of rvices, the beneficiary would be responsible for a coinsurance amount ual to one-half of the inpatient hospital deductible for each lifetime serve day used. Your committee believes that this increase in the time reserve would sufficiently protect the large majority of neficiaries against the most expensive illnesses without, however, rupting the intended effect of the benefit period provision, which is provide some objective means for discontinuing benefit payments those cases where the individual is more or less permanently stitutionalized.

Your committee has also examined the cost-sharing requirements t were established at the time of medicare's enactment in order to termine whether they were accomplishing their intended purposes. sed on its examination, your committee has concluded that cost-aring beginning at an earlier point in the benefit period than is quired under present law would serve to increase the incentive for th beneficiaries and their physicians to participate in efforts to bring bout more effective control of the utilization and cost of inhospital rvices. Your committee's bill provides for the application of a daily insurance amount equal to one-eighth of the inpatient hospital ductible for each day of inpatient hospital coverage during a benefit riod beginning with the 31st day and through the 60th day. The insurance amount for the 61st through the 90th day would remain, under present law, equal to one-fourth of the inpatient hospital ductible. Present experience indicates that about 10 percent of the spitalized aged use more than 30 days of hospital care during a nefit period and it may very well be that in some of those cases are beyond 30 days is really not needed.

These amendments would be effective with respect to inpatient spital services furnished during hospital stays beginning after December 31, 1971.

(f) Automatic enrollment for supplementary medical insurance.—nder present law an individual eligible for supplementary medical surance must take the positive action of enrolling to obtain coverage r such insurance. If he does not act within the time imposed by law, he stands to lose several months of medical insurance verage. In recognition of the importance of timely enrollment, a ncerted effort is made to notify people of their opportunity to enroll medical insurance as they become eligible and, in fact, nearly 96 rcent of eligible individuals are enrolled. Some few, however, fail enroll at their first opportunity due, for example, to inattention, or cause they are incapable of managing their own affairs.

Your committee believes, therefore, that it would be good public olicy to assure that individuals are enrolled for supplementary medical surance when they are first eligible, unless they elect not to have the verage. Accordingly, under your committee's bill, the aged and the sabled would be automatically enrolled for supplementary medical in-rance as they become entitled to hospital insurance. Persons already ceiving monthly social security or railroad retirement benefits would deemed to have enrolled in the month before the month for which ey become entitled to hospital insurance, so that their medical and spital insurance coverage will start at the same time. Others, not ady on the cash benefit rolls, would be deemed to have enrolled r supplementary medical insurance in the month in which they file

an application establishing their entitlement to hospital insurance, and their coverage under medical insurance would begin at the time specified by existing law for people enrolling in that month.

Your committee expects that persons eligible for automatic enrollment will, to the extent possible, be fully informed and given an opportunity to decline the coverage. They would be deemed to have enrolled if they do not decline coverage before it is scheduled to begin. Once their coverage has begun they would of course be free to disenroll if they wish in accordance with existing law.

The automatic enrollment provisions would be applicable only to persons who become entitled to hospital insurance after 1971, because of the practical difficulties that would be involved in locating nonenrollees whose eligibility for medical insurance was established prior to 1972 and giving them an opportunity to decline the coverage.

(g) *Establishment of incentives for States to emphasize comprehensive health care under medicaid programs.*—Your committee has been concerned about the need to improve the utilization of services under the medicaid program and to encourage more effective lower cost patterns of service. The present law has a uniform Federal matching percentage applied to all forms of health services covered under the State medicaid plan. In order to encourage the States to make more efficient use of health services, your committee's bill would create incentives for States to contract with health maintenance organizations or similar organizations and disincentives to discourage prolonged stays in institutional settings. Specifically, the bill would provide for (1) an increase of 25% (up to a maximum of 95%) in the Federal medicaid assistance matching for amounts paid by States under contracts with health maintenance organizations or other comprehensive health care facilities; (2) a decrease in the Federal medical assistance percentage by one-third after the first 60 days of care (in a fiscal year) in a general or tuberculosis hospital; (3) a reduction in the Federal percentage by one-third after the first 60 days of care (in a fiscal year) in a skilled nursing home unless the State makes a showing satisfactory to the Secretary that there is in the State an effective program of controls over utilization of such institutional care, (4) a decrease in Federal matching by one-third after 90 days of care except that an additional 30 days care would be allowed if the State shows that the patient will benefit from such additional period of hospitalization in a mental hospital and provision for no Federal matching after a total of 365 days of such care during an individual's lifetime, and (5) authority for the Secretary to compute a reasonable cost differential for reimbursement purposes between skilled nursing homes and intermediate care facilities.

These changes would be effective with respect to services furnished after June 30, 1971, except that the provision relating to the computation of a reasonable cost differential between skilled nursing homes and intermediate care facilities would be effective for any calendar quarter beginning after December 31, 1971.

The proposal to increase by 25 percent, up to a maximum of 95 percent, Federal matching on premiums paid by states under contracts with health maintenance organizations, neighborhood and community health centers and similar organizations is intended to encourage states to contract with such organizations. Organized plans, particularly those on a pre-paid basis, have been shown in some cases to discourage overutilization of expensive inpatient care.

The limitations on care in general and tuberculosis hospitals are designed to encourage transfer of patients to less expensive facilities. They reflect the assumption that treatment in acute institutions is generally of short duration, rarely exceeding 60 days.

The proposed limitations on length of stay in mental institutions reflect the assumption that for patients over 65 medical treatment of mental disease inpatients generally does not exceed three months and rarely continues beyond a year. However, in those cases where the State agency demonstrates that the patient is continuing to receive active treatment and the prognosis is for further improvement the medicaid percentage would not be reduced until 120 days. This will provide needed flexbility under the basic provision.

The reduction in matching for skilled nursing homes is directed toward early transfer of patients to alternative facilities (such as intermediate care facilities). There is a good deal of evidence found by the General Accounting Office and by the HEW audit agency that patients now in skilled nursing homes in many States do not belong there. A lower level of care than skilled nursing care would suit the needs of a large number of these patients. In the 1967 Social Security Amendments, the Congress attempted to meet these kinds of problems by funding intermediate care facilities at the medicaid matching rate (so as to avoid any financial incentive to use the higher level of care) and by requiring regular professional independent medical audit of the needs of nursing home patients. Some States have used the intermediate care facility as the less expensive option it was intended to be. Others have not used it all or have not used it effectively. Some few States have set up the required professional medical audits.

Your committee recommends a reduction in the Federal medicaid matching rate by one third after the 60th day of stay in a skilled nursing facility unless the State can show that it is carrying out an effective program under requirements for effective utilization review procedures and for regular professional medical audits. A State could maintain its full Federal share by complying with these necessary requirements. If it did not, the matching rate would be reduced with respect to stays. The 60 day period would provide an adequate period of time for the necessary review and certification requirements to be carried out.

The provision granting authority to the Secretary to compute (for reimbursement purposes) a reasonable cost differential between the cost of skilled nursing home services and the cost of intermediate care facilities is designed to assure that supporting care in these alternate institutions actually does result in decreased costs to the program.

(*h*) *Cost-sharing under medicaid.*—Your committee has been concerned that costs of the medicaid program have been escalating much more rapidly than anticipated and believes that an element of cost consciousness on the part of patients and their physicians should be introduced into the program primarily as a cost control device. Your committee bill would, therefore, require that States participating in the medicaid program impose on the medically indigent (those not eligible for cash assistance) under the program a premium enrollment fee graduated by income in accordance with standards prescribed by the Secretary. No other premium or enrollment fee could be imposed on the medically needy under the State plan. In the case of cash

assistance recipients, nominal deductible and cost-sharing charges, while prohibited with respect to mandatory services required under the plan, would be permitted with respect to optional services.

States could, at their option, impose deductibles and copayment features on the medically indigent (in addition to the required graduated premiums) which would not have to vary by level of income. Your committee recommends these provisions in order to discourage possible unnecessary overutilization and to encourage cost-consciousness on the part of those covered under medicaid.

(*i*) *Elimination of medicaid work disincentive.*—Your committee bill would amend title XIX to assure that medicaid eligibility requirements for families with children are structured in a way which relates them to family income and medical expenses, removes work disincentives, and concentrates medical assistance resources on those families most in need.

The medicaid statute has from the beginning required those States which elect to have a medicaid program to cover everyone who was eligible for cash assistance payments. With the introduction of the earnings disregard provisions under the 1967 amendments, and the consequent gradual loss of cash benefits as earned income increased, families on the assistance rolls can have a substantial total income, and still receive full medicaid protection. The medicaid program has, therefore, a work disincentive effect at some point in the earnings scale—the earning of an extra dollar can mean the phaseout of cash assistance, and the abrupt and complete loss of medicaid.

In the 24 States which had made no provision for covering the medically needy (the groups related to the welfare categories but with income in excess of the standard for public assistance), the loss of medicaid was complete. The family could not re-establish eligibility for medical assistance without dropping back on the public assistance rolls. In the 28 States and jurisdictions with programs for the medically needy, the situation was only slightly better. Since the maximum eligibility level for the medically needy was one hundred thirty-three and one-third percent of the payment level (and the payment level was often below the cash assistance standard), this standard is in some of these States several thousand dollars below the income level where cash assistance phased out under the earnings disregard provisions. This meant that the family which had lost medicaid coverage with their loss of cash assistance could re-establish their eligibility for medicaid only after incurring substantial medical expenses (equal to the amount by which their income exceeded the medically needy standard for families of that size).

Your committee proposes to correct these deficiencies by providing complete medicaid coverage to cash assistance families with children only if their income falls below the eligibility level established for medical assistance. In determining income for this purpose, the first $720 of earned income would be disregarded (this amount is allowed for work related expenses under the family program provisions in the bill).

The medical assistance eligibility level would be defined by the State in the range between the payment level for an eligible family of given size without income up to one-hundred thirty-three and one-third percent of that payment level. Cash assistance families with incomes above the eligibility level would receive medicaid coverage only after incurring medical expenses equal to the amount by which

their total income (including cash assistance payments) exceeded the medicaid standard; they would be required to "spend-down" by this amount to establish their eligibility for medicaid. In effect, this amount would be a deductible, increasing in amount as earnings rise and, therefore, avoiding the situation where one dollar of earnings can result in the loss of protection worth several hundred dollars. Medical expenses for this purpose would be defined as those in section 213 of the Internal Revenue Code.

Your committee does not propose to change medicaid eligibility for the adult categories except to allow a uniform amount of earnings in the amount of $720 ($1,020 for the blind and disabled) to be disregarded as work related expenses in determining income for purposes of medicaid eligibility. States would continue to have the option of operating programs for the medically needy for the aged, the blind, the disabled, foster children, families as defined in section 405(b), and all needy children under 21 who are not recipients of cash assistance.

Eligibility standards for the medically needy would be tied to the payment level for families under title XXI plus the supplementary payment, if any, provided by the State, with appropriate adjustments to account for family size. States with medical assistance eligibility levels higher than the payment level, but less than 133⅓ percent of that level, would be required to provide medical assistance to all individuals, whether recipients of cash assistance or not, whose income, after deducting medical expenses falls below the medical assistance level. These latter changes are essentially those necessary to preserve the effects of present law.

The proposed amendment is estimated to result in a saving of approximately $140 million in Federal medicaid funds in the family category. This saving results from the elimination of some of the medical costs of cash assistance recipients who have earnings in excess of $720 (the amount allowed for work expenses).

The estimate was prepared on the assumption that States without current programs for the medically needy would set the eligibility level at their current payment standard or $2400, whichever was higher; and States with a current program for the medically needy would maintain the medicaid eligibility level at the current medically needy standard.

(j) *Payment under the medicare program to individuals covered by Federal employees health benefits program.*—Under present law, Federal employees and retirees age 65 and over who are enrolled for Federal employees health benefits (FEHB) are also covered under the medicare hospital insurance plan (part A) if they have worked in employment covered by social security or railroad retirement and are eligible for monthly cash benefits under these programs. In addition, Federal employees, whether or not eligible for part A benefits, may enroll in the medicare voluntary supplementary medical insurance plan (part B) which is available to essentially all persons age 65 and over.

Part A hospital insurance protection under medicare is earned during a person's working years through a separate tax on his earnings and no payments are made by those entitled to benefits after they have stopped working. In contrast, persons who are eligible for health insurance protection under a FEHB plan continue to pay the same premium rates for their coverage after retirement as they did when they were active employees (although the coverage may be more valuable since older people use more medical services). The Federal Government currently pays about 40 percent of the overall cost of FEHB protection.

When the medicare program was enacted in 1965, it was intended that it would provide basic health insurance protection for people age 65 and over and that it would pay its benefits in full without regard to any other benefits that might be payable under an employee health benefits plan. At the same time, it was expected that such plans would adjust their benefit policies to complement the protection provided under medicare rather than to duplicate the benefits.

Unlike most employers, the Federal Government has not arranged the health insurance protection it makes available to its employees age 65 and over (active or retired) so that such protection would be supplementary to medicare benefits. It is true, however, that some individual plans have afforded more protection to those enrollees with medicare coverage than those without such coverage.

Although most Federal employment covered by a Federal staff retirement system is excluded from social security coverage, many Federal employees become insured under social security on the basis of other employment. About 50 percent of retired and active Federal employees age 65 and over are entitled to hospital insurance benefits under medicare.

Several problems arise under the present situation. The FEHB plans cover many of the same health care expenses that are covered under medicare. In cases where health care expenses are covered under both medicare and a Federal employee plan, the medicare benefits are paid first, and the Federal employee plan then pays its benefits in an amount which, when added to the benefits payable under medicare, may not exceed 100 percent of the expenses allowable under the FEHB plan.

A Federal employee who is covered under a high-option FEHB plan as well as the medicare plans has somewhat better protection than is afforded under the FEHB plan alone. But, because of the nonduplication clauses in the FEHB contracts, he does not derive the full value of the protection of the FEHB contracts. If a Federal retiree entitled under medicare cancels his enrollment under a FEHB plan because of the high total cost of his health care protection, he will lose the high level of protection he previously enjoyed under the FEHB program at an age where his health care costs can be expected to increase substantially.

Federal retirees and employees who are covered under an FEHB plan generally do not find it advantageous to enroll in the medicare voluntary supplementary medical insurance plan, because of the overlapping of FEHB benefits and benefits under the supplementary plan. Thus, Federal retirees and employees do not receive the advantage, available to virtually all other persons age 65 and over, of the 50-percent Government contribution toward the cost of the protection under the supplementary medical insurance program.

In order to assure a better coordinated relationship between the FEHB program and medicare and to assure that Federal employees and retirees age 65 and over will eventually have the full value of the protection offered under medicare and FEHB, your committee's bill would provide that effective January 1, 1975, the medicare program (both parts A and B) would not pay for any otherwise covered service if such service is covered under the FEHB plan in which the beneficiary to whom the service was provided is enrolled. This provision would not go into effect (or would be suspended, if already in effect) if the Secretary of Health, Education, and Welfare certifies that the the FEHB program has been so modified as to assure (1) that there is available to Federal employees or retirees age 65 and over one or

more Federal health benefit plans which offer protection supplementing the combined protection of parts A and B of medicare, and the protection of part B alone, and (2) that the Government is making a contribution toward the health insurance of all Federal employees or retirees age 65 and over which is at least equal to the contribution it makes for high option coverage under Governmentwide FEHB plans. Nor would this provision apply with respect to an individual plan if the Secretary of Health, Education, and Welfare certifies that such plan (1) has made available to its enrollees age 65 and over protection supplementing the combined protection of parts A and B of medicare, and the protection of part B alone, and (2) is making a contribution toward the health insurance of its enrollees age 65 and over which is at least equal to the contribution made by the Federal Government for high option coverage under Governmentwide FEHB plans. The contribution, whether by the Federal Government or by the individual plan, could be in the form of a contribution toward the supplementary FEHB protection or a payment to or on behalf of the individual employee or retiree to offset the cost of his purchase of medicare protection, or a combination of the two. The Secretary would, of course, prepare his certification on the basis of information he obtains from the Civil Service Commission about the characteristics and operations of each of the various plans as well as the Federal program as a whole. It is the hope and the intent of your committee that the Secretary will be able to make this certification for each of the plans under the FEHB program before January 1975.

(*k*) *Payment under medicare for certain inpatient hospital and related physicians' services furnished outside the United States.*—Under present law, services furnished outside the United States are excluded from coverage, with the single exception that hospital insurance benefits are payable for emergency inpatient services provided in nearby foreign hospitals if the beneficiary is physically present within the United States when the emergency arises and the foreign hospital to which he is admitted is closer to the place where the emergency arose or more accessible than the nearest United States hospital that is adequately equipped and available for his treatment. Your committee is concerned that under present law border residents who find that the nearest hospital suited to their inpatient care needs is located outside the United States may not receive protection against the health costs they incur in using these nearest hospitals except in the indicated emergency situations.

Your committee's bill would include a provision which would expand medicare coverage of services outside the United States to take account of the special problems of border residents. Medicare benefits would be payable for inpatient hospital services furnished outside the United States if the beneficiary is a resident of the United States and the foreign hospital was closer to, or substantially more accessible from his residence than the nearest hospital in the United States which was suitable and available for his treatment. For such beneficiaries, benefits would be payable without regard to whether an emergency existed or where the illness or accident occurred. Only inpatient services furnished by a hospital which has been accredited by the Joint Commission on Accreditation of Hospitals or by a hospital approval program having essentially comparable standards would be covered.

The present provisions covering emergency inpatient hospital services outside the United States would be retained.

Payment for all covered hospital services furnished outside the United States would be made on essentially the same basis as payment for emergency services furnished by a nonparticipating hospital within the United States. Where the hospital elected to bill the medicare program it would be reimbursed on the basis of the reasonable cost of the covered services furnished the beneficiary, as is now done with respect to emergency services furnished by a nonparticipating hospital which furnishes actual cost data. Where payment could not be made solely because the hospital did not elect to bill the program, benefits would be payable directly to the beneficiary on the basis of an itemized bill if he filed an acceptable application for reimbursement. Subject to the appropriate deductibles and coinsurance, the beneficiary would be reimbursed in an amount equal to 60 percent of the hospital's reasonable charges for "routine services" in the room occupied by him or in semiprivate accommodations, whichever is less, plus 80 percent of the hospital's reasonable charges for "ancillary services," or, if separate charges for routine and ancillary services are not made by the hospital, two-thirds of the hospital's total charges.

To assure that medicare beneficiaries would be adequately protected against other medically necessary health care costs they may incur while receiving covered foreign inpatient hospital care, your committee's bill would also provide for coverage under the medical insurance program of medically necessary physicians' services and ambulance services furnished in conjunction with covered foreign inpatient hospital services.

Payment for physicians' services would be limited to the period of time during which the individual is eligible to have payment made for the foreign hospital services he receives. Further, the Secretary would be authorized to establish, by regulations, reasonable limitations upon the amount of a foreign physician's charge that would be accepted as reimbursable under the medical insurance program. In recognition of the administrative difficulties that would arise in applying the assignment method of reimbursement to medical services furnished in other countries, your committee's bill would provide that benefits for foreign physicians' and ambulance services would be payable only in accordance with the itemized bill method of reimbursement provided for under present law.

These provisions would apply to services furnished with respect to hospital admissions occurring after December 31, 1971.

2. Improvements in operating effectiveness

(a) *Limitation on Federal participation for capital expenditures.*—Under title XVIII depreciation on buildings and equipment, and interest on loans used to acquire them, are reimbursable as part of the cost of providing services to medicare beneficiaries. Such reimbursement is paid without regard to whether the items were constructed or purchased in conformity with any type of health facility planning requirement. Similarly, reimbursement on a cost basis for inpatient hospital services provided under titles V (maternal and child health) and XIX (medicaid) of the Social Security Act includes a recognition of certain capital costs without regard to conformance to planning requirements.

There are few aspects of the health care system in the United States which have been so thoroughly explored as the need for comprehensive areawide planning for the development and utilization of all types of

ealth care facilities. But the acceptance of the purposes of State and areawide health facility planning has not always been matched by purposeful application of the incentives required to achieve the end result of such planning. Thus, while a significant amount of Federal money is currently being expended under the comprehensive health planning provisions of the Public Health Service Act in the interest of furthering health facility planning at the State and local levels, Federal funds are being expended for health services provided under medicare, medicaid, and the maternal and child health programs without regard to whether the facilities providing the services are cooperating in such health facility planning. Your committee believes that the connection between sound health facility planning and the prudent use of capital funds must be recognized if any significant gains in controlling health costs are to be made. Thus, your committee believes it is necessary to assure that medicare, medicaid, and the maternal and child health programs are consistent with State and local health facility planning efforts, in order to avoid paying higher costs unnecessarily in the future where these costs result from duplication or irrational growth of health care facilities.

At present, efforts are being made on the Federal, State, and local levels to assure that the need for the expansion and modernization of health facilities is evaluated, coordinated, and planned on a rational and controlled basis. At the Federal level, comprehensive health planning legislation provides for Federal grants for the establishment and funding of areawide and comprehensive State health care planning agencies. Currently, all 50 States, the District of Columbia, and five territories have State comprehensive health care planning agencies. On the areawide level, 125 planning agencies are receiving Federal grants: 72 of such agencies are operational. It is estimated that 140 areawide planning agencies will be receiving grants by the end of June 1971 and that more than 90 such agencies will be operational.

To avoid the use of Federal funds to support unjustified capital expenditures and to support health facility and health services planning activities in the various States, your committee's bill authorizes the Secretary of Health, Education, and Welfare to withhold or reduce reimbursement amounts to providers of services and health maintenance organizations under title XVIII for depreciation, interest, and, in the case of proprietary providers, a return on equity capital, related to certain capital expenditures that are determined to be inconsistent with State or local health facility plans. (Similar authority would be provided with respect to the Federal share of payment for inpatient hospital care under titles V and XIX.) Capital expenditures for the purposes of this provision include expenditures (1) for plant and equipment in excess of $100,000; (2) which change the bed capacity of the institution; or (3) which substantially change the services provided by the institution. The Secretary would take such action on the basis of findings and recommendations submitted to him by various qualified planning agencies. If he determines, however, after consultation with an appropriate national advisory council, that a disallowance of capital expenses would be inconsistent with effective organization and delivery of health services or effective administration of titles V, XVIII, or XIX, he would be authorized to allow such expenses.

The Secretary would be authorized to enter into agreements with the States under which designated planning agencies would submit

their findings and recommendations (along with those of other qualified planning agencies) with respect to proposed capital expenditures that are inconsistent with the plans developed by such agencies. (All such health facility and health services planning agencies must have governing bodies or advisory bodies at least half of whose members represent consumer interests.) An adverse decision by a State planning agency may be appealed to an appropriate agency or individual at the State level. The Secretary would be authorized to pay from the Federal Hospital Insurance Trust Fund the reasonable costs incurred by the planning agencies in preparing and forwarding findings and recommendations. The bill would in no way change the autonomy or authority of existing State or local planning agencies, or the relationships between such agencies, either within States or across State lines.

These limitations would be effective with respect to obligations for capital expenditures incurred after June 30, 1972, or earlier, if requested by the State.

(*b*) *Report on plan for prospective reimbursement; experiments and demonstration projects to develop incentives for economy in the provision of health services.*—Under present law, institutional providers furnishing covered services to medicare beneficiaries are paid on the basis of the reasonable cost of such services. Payment on this basis, with retroactive corrective adjustments, is consistent with the long history of public and private third party agency reimbursement for institutional health care on a cost basis. However, as experience under the medicare, medicaid, maternal and child health, and other third party programs has clearly demonstrated there is little incentive to contain costs or to produce the services in the most efficient and effective manner.

Your committee believes that payment determined on a prospective basis offers the promise of encouraging institutional policymakers and managers, through positive financial incentives, as well as the risk of possible loss inherent in that method, to plan, innovate and generally to manage effectively in order to achieve greater financial reward for the provider as well as a lower total cost to the programs involved. Prospective reimbursement differs from the present method of reimbursement in that a rate of payment is set in advance of the period over which the rate is to apply. The theory is that once the rate is set, a provider will institute cost saving measures which will maximize the difference between its actual costs and the higher prospective rate. This difference could be expressed as the "profit." Of course, if the provider's costs turned out to be higher than the prospective rate there would be a loss. Theoretically, this approach to reimbursement introduces incentives not present under the existing reimbursement method which, since it tends to pay whatever the costs turn out to be, provides no incentives for efficiency.

However, your committee is well aware that in considering such a fundamental change in the present reimbursement method, possible disadvantages as well as the potential advantages must be taken into account. While it is clear for example, that prospective rate setting will provide incentives for health care institutions to keep costs at a level no higher than the rates set, it is not clear that the rates set would result in government reimbursement at levels lower than, or even as low as, that which would result under the present retroactive cost finding approach. Providers could be expected to press for a rate that

would cover all the costs, including research costs and bad debts, as well as margins of safety in the prospective rates that might result in reimbursement—if their requests were met—in excess of the costs that would have been reimbursed under the present approach. Moreover, any excess of reimbursement over costs to voluntary providers would probably be used to expand services, and the new level of expenditures might be reflected in setting higher prospective rates for future years.

Also to be considered is the fact that under prospective reimbursement it will be necessary to take steps to assure that providers do not cut back on services necessary to quality care in order to keep actual costs down and thus increase the difference between costs and the prospective rate established. The development of adequate and widely-agreed-upon measures of quality of care will clearly be needed to provide that assurance and should be immediately developed by the Department.

In view of the far-ranging implications of such a change in the approach to reimbursement, your committee's bill provides for a period of experimentation under titles XVIII, XIX and V with various alternative methods and techniques of prospective reimbursement. It is the intent of your committee that experimentation be conducted with a view to developing and evaluating methods and techniques that will stimulate providers through positive financial incentives to use their facilities and personnel more efficiently, thereby reducing their own as well as program costs while maintaining or enhancing the quality of the health care provided.

The experiments and demonstration projects directed to be carried out under this provision are to be of sufficient scope and on a wide enough scale to give assurance that the results would obtain generally (but not so large or comprehensive as to commit the programs to any prospective payment system either locally or nationally). No experiment or demonstration project is to be undertaken by the Secretary until he consults with and takes into consideration the advice and recommendations of recognized specialists in the health care field who are qualified and competent to evaluate the feasibility of any given experiment or demonstration project.

Under your committee's bill, the Secretary would be required to submit to the Congress no later than July 1, 1973, a full report of the results of the experiments and demonstration projects, as well as an evaluation of the experience of other programs with respect to prospective reimbursement. The report is to include detailed recommendations with respect to the specific methods that might be used in the full implementation of a prospective reimbursement system.

Although recognizing the promise and potential offered by prospective reimbursement your committee does not wish to preclude experimentation with other forms of reimbursement. Your committee believes that a solid foundation of experience is required with all possible alternative forms of reimbursement before permanent changes can be made. The bill therefore includes authorization for the Secretary of Health, Education, and Welfare to engage in experiments and demonstration projects involving negotiated rates, the use of rates established by a State for administration of one or more of its laws for payment or reimbursement to health facilities located in such State, and alternative methods of reimbursement with respect to the services of residents, interns, and supervisory physicians in teach-

ing settings. Authority is also provided to make payments, on an experimental or demonstration project basis, to organizations and institutions which have the capability of providing comprehensive health care, mental health care, and ambulatory health care, for services which are not currently covered under titles V, XVIII, XIX, and which are incidental to services covered under the programs, if the inclusion of the additional services would, in the judgment of the Secretary, offer some prospect of resulting in more economical provision and more effective utilization of services for which payment may be made under such programs.

The bill would authorize experimentation with the use of areawide or communitywide peer review, utilization review, and medical review mechanisms to determine whether they would help to assure that health services provided to beneficiaries conform to appropriate professional standards and that payment will be made only for medically necessary services that in each case are rendered in the most economical setting that is consistent with professionally recognized standards. Authority is also provided to experiment with the use of fixed price or performance incentive contracts to determine whether they would have the effect of inducing more effective, efficient, and economical performance by medicare intermediaries and carriers.

It is intended that benefit costs and administrative costs incurred under this section would be paid out of the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in reasonable proportion to the participation of medicare in the project. Medicaid and private funds would also be used proportionately when medicaid and private programs participate in the project. These provisions will be effective upon enactment of the bill.

Your committee is concerned about the difficulties some beneficiaries who need extended care and their physicians face as a result of the present title XVIII provision under which payment may be made for services funished in an extended care facility only if the beneficiary was transferred from a hospital after a stay of at least three days. Therefore, in addition to the other experiments the Secretary will be undertaking, your committee expects him to conduct studies and engage in experiments to determine the effects of eliminating the three-day prior hospitalization requirement, which he has authority to waive for the purpose of such experimentation, and report to your committee his findings together with any recommendations he may have for changes in this provision of existing law.

(c) *Limitations on coverage of costs under medicare.*—Your committee is mindful of the fact that costs can and do vary from one institution to another as a result of differences in size, in the nature and scope of services provided, the type of patient treated, the location of the institution and various other factors affecting the efficient delivery of needed health services. Your committee is also aware, however, that costs can vary from one institution to another as a result of variations in efficiency of operation, or the provision of amenities in plush surroundings. Your committee believes that it is undesirable from the standpoint of those who support Government mechanisms for financing health care to reimburse health care institutions for costs that flow from marked inefficiency in operation or conditions of excessive service.

To the extent that differences in provider costs can be expected to result from such factors as the size of the institution, patient mix, scope of services offered or other economic factors, wide, but not unlimited recognition should be given to the variations in costs accepted as reasonable. However, data frequently reveals wide variations in costs among institutions that can only be attributable to those elements of cost that would ordinarily not be expected to vary substantially from one institution to another.

Where the high costs do in fact flow from the provision of services in excess of or more expensive than generally considered necessary to the efficient provision of appropriate patient care, patients may nevertheless desire such services. It is not the committee's view that if patients desire unusually expensive service they should be denied the service. However, it is unreasonable for medicare or medicaid (which are financed by almost all people in the country rather than the patient or community that wants the expensive services) to pay for it.

Similarly when the high costs flow from inefficiency in the delivery of needed health care services the institution should not be shielded from the economic consequences of its inefficiency. Health care institutions, like other entities in our economy should be encouraged to perform efficiently and when they fail to do so should expect to suffer the financial consequences. Unfortunately a reimbursement mechanism that responds to whatever costs a particular institution incurs presents obstacles to the achievement of these objectives. It is believed that they can only be accomplished by reimbursement mechanisms that limit reimbursement to the costs that would be incurred by a reasonably prudent and cost-conscious management.

Present law provides authority to disallow incurred costs that are not reasonable. However, there are a number of problems that inhibit effective exercise of this authority. The disallowance of costs that are substantially out of line with those of comparable providers after such costs have been incurred creates financial uncertainty for the provider, since, as the system now operates, the provider has no way of knowing until sometime after it incurs expenses whether or not they will be in line with expenses incurred by comparable providers in the same period. Furthermore, present law generally limits exercise of the authority to disallow costs to instances that can be specifically proved on a case-by-case basis. Clear demonstration of the specific reason that a cost is high is generally very difficult. And, since a provider cannot charge a beneficiary more than the program's deductible and coinsurance amounts for covered services, exercise of either type of authority can leave the provider without reimbursement for some costs of items or services it has already incurred for patients treated some time ago. Under these circumstances the provider would have to obtain funds from some other source to make up for its deficit.

The proposed new authority to set limits on costs recognized for certain classes of providers in various service areas differs from existing authority in several ways and meets these problems. First, it would be exercised on a prospective, rather than retrospective, basis so that the provider would know in advance the limits to Government recognition of incurred costs and have the opportunity to act to avoid having costs that are not reimbursable. Second, the evaluation of the costs necessary in delivering covered services to beneficiaries would be exercised on a class and a presumptive basis—relatively high costs

that cannot be justified by the provider as reasonable for the results obtained would not be reimbursable—so that implementation of the proposed authority would appear more feasible than present authority. Third, since the limits would be defined in advance, provision would be made for a provider to charge the beneficiary for the costs of items or services in excess of or more expensive than those that are determined to be necessary in the efficient delivery of needed health services. Public notice would be provided where such charges are imposed by the institution and the beneficiary would be specifically advised of the nature and amount of such charges prior to admission so that there is opportunity for the public, doctors, and their medicare patients to know what additional payment would have to be made. Your committee expects that the provision will not be applicable where there is only one hospital in a community—that is, where, if the provision were applied, additional charges could be imposed on beneficiaries who have no real opportunity to use a less expensive, non-luxury institution, and where the provision would be difficult to apply because comparative cost data for the area are lacking.

Your committee recognizes that the initial ceilings imposed will of necessity be imprecise in defining the actual cost of efficiently delivering needed health care. And your committee recognizes that these provisions will apply to a relatively quite small number of institutions. The data that are available for this purpose will often be less than perfectly reliable—for example, it may be necessary to use unaudited cost reports or survey or sampling techniques in estimating the costs necessary to the efficient delivery of care. Under medicare's administrative system, however, cost reports prepared by the providers are now being submitted more promptly after the close of the accounting period and should be available for analysis in the next year and for the establishment of limits in the second following year. Also, the precision of the limits determined from these data will vary with the degree to which excessive costs can be distinguished from the provision of higher quality or intensity of care.

For costs that would not generally be expected to vary with essential quality ingredients and intensity of medical care—for example, the costs of the "hotel" services (food and room costs) provided by hospitals—the Secretary might set limits sufficiently above the average costs per patient day previously experienced by a class of hospitals to make allowance for differing circumstances and short-term economic fluctuations. Hotel services may be easiest to establish limits for and be among the first for which work can be completed. Attention might be given as well to laundry costs, medical record costs, and administration costs within the reasonably near future.

Setting limits on overall costs per patient day and specific costs that vary with the quality and intensity of care would be more difficult, but the Secretary might be able to set reasonable limits sufficiently above average costs per patient day previously experienced by a class of institutions so that only cases with extraordinary expenses would be subject to any limits. In addition, special limits could be established on cost elements found subject to abuse. For example, the Secretary might establish limits on the level of standby costs that would be recognized as reasonable under the program to prevent Government programs from picking up the cost of excessive amounts of idle capacity—particularly relatively high personnel costs in relati

to patient loads where occupancy rates are low—in reimbursing for services to covered patients.

Providers would, of course, have the right to obtain reconsideration of their classification for purposes of cost limits applied to them and to obtain relief from the effect of the cost limits on the basis of evidence of the need for such an exception.

Providers will be permitted to collect costs in excess of the medicare ceilings from the beneficiary (except in the case of admission by a physician who has a direct or indirect financial interest in a facility) where these costs flow from items or services in excess of or more expensive than those necessary for the effective delivery of needed services, provided all patients are so charged and the beneficiary is informed of his liability in advance. Information on additional charges assessed would also be made available generally in the community. Your committee is also requesting that the Secretary submit annually to it a report identifying the providers that make such additional charges to beneficiaries and furnishing information on the amounts being charged by such providers.

The determination of the cost of the excess items or services for which the beneficiary may be charged will be made on the basis of costs previously experienced by the provider. For example, if costs for food services experienced in 1969 among a group of hospitals in an area ranged from $4 to $9 a day with a median cost of $5 a day and the limit for food services set by the Secretary for 1971 was $7.20 a day, the hospital previously experiencing costs of $9 a day could charge patients $1.80 a day for food services. However, should total reimbursement for covered services from the program plus charges billed for such services exceed actual costs in any year, the excess will be deducted from payments to the provider. Thus, the provider would not profit from charges to beneficiaries based on excess costs in the prior year.

In addition it should be noted that the fact that a provider's costs are below the ceilings established under this provision will not exempt it from application of the ceiling of customary charges where such charges are less than cost under another provision in the committee bill.

The provision would be effective with respect to accounting periods beginning after June 30, 1972.

(*d*) *Limits on prevailing charge levels.*—Under present administrative polices under medicare, the prevailing limit on the reasonable charge for a service is intended, over the long run, to be set at a level no higher than is necessary to embrace the 75th percentile of customary charges for that service in the physicians' locality. To illustrate, if customary charges for an appendectomy in a locality were at five levels, with 10 percent of the services rendered by physicians whose customary charge was $150, 40 percent rendered by physicians who charge $200, 40 percent rendered by physicians who charge $250 and 5 percent rendered by physicians who charge $300 and with the remaining 5 percent rendered by physicians charging in excess of $300, the prevailing limit would be $250, since this is the level that would cover at least 75 percent of the cases.

Customary charges for services that are within the prevailing fee limit are generally recognized in full. (In a relatively small number of situations additional rules are used to judge the reasonableness of charges.)

Your committee believes that it is necessary to move in the direction of an approach to reasonable charge reimbursement that ties recognition of fee increases to appropriate economic indexes so that the program will not merely recognize whatever increases in charges are established in a locality but would limit recognition of charge increases to rates that economic data indicate would be fair to all concerned.

Under your committee's bill, the prevailing charges recognized for a locality could be increased in fiscal year 1973 and in later years only to the extent justified by indexes reflecting changes in the operating expenses of physicians and in earnings levels. What the bill provides is a limit on the increases that would be recognized on the basis of the other reasonable charge criteria. Increases in the customary charges of individual physicians and in the charges prevailing among physicians in a locality would continue to be recognized only on the basis of adequate evidence that such increases had been in effect for a period of time. The new ceiling on recognition of increases in prevailing charge limits that is provided would come into play only when the adjustments necessary to meet increases in the actual charges prevailing in a locality exceeded, in the aggregate, the level of increase justified by other changes in the economy.

The Secretary would establish the statistical methods that would be used to make the calculations to establish the limit on the increases allowed by this provision.

The base for the proposed economic indexes would be calendar year 1970. The increase in the indexes that occurs in a succeeding calendar year would constitute the maximum allowable aggregate increase in prevailing charges that would be recognized in the fiscal year beginning after the end of that calendar year.

Initially, the Secretary would be expected to base the proposed economic indexes on presently available information on changes in expenses of practice and general earnings levels combined in a manner consistent with available data on the ratio of the expenses of practice to income from practice occurring among self-employed physicians as a group. If, for example, available data indicated that for self-employed physicians as a group, expenses of practice absorbed approximately 40 percent of gross receipts of practice (the proportion indicated by data compiled by IRS from tax returns), the Secretary could determine that the maximum aggregate increase in prevailing charge levels that could be recognized would be 40 percent of the increase in expenses of practice indicated by IRS data plus 60 percent of the increase in earnings levels indicated by social security data. Thus, if during calendar year 1971 the area increase in expenses of practice was 3 percent and the area increase in earnings was 5 percent, the allowable aggregate increase in prevailing charges recognized by the carrier in each locality during fiscal year 1973 would be 4.2. percent:

$$(.40\times.03)+(.60\times.05)=.042$$

The carrier would apply the prevailing charge criteria now in the law to data on charges in calendar year 1971 to determine the increase in prevailing charges that it would be appropriate to recognize during fiscal year 1973. If the aggregate increase in prevailing charges determined was less than 4.2 percent, the adjustments would be permitted and the portion of the allowable aggregate increase not used

in that fiscal year could be carried forward and used in future fiscal years. However, if the aggregate increase in prevailing charges found otherwise appropriate exceeded 4.2 percent, such increases would be reduced to the extent necessary to bring the aggregate of all increases within the 4.2 ceiling—that is, if the new prevailing charge limits that were indicated for fiscal year 1973 by the 75th percentile of calendar year 1971 charges weighted in proportion to the representation of the related services in aggregate services in calendar year 1971 exceeded, in total, the prevailing charge limits indicated for fiscal year 1972 by the 75th percentile of calendar 1970 charges weighted in proportion to the representation of the related services in aggregate services in calendar year 1970 by 8.4 percent, then each of the prevailing charge increases indicated for fiscal year 1973 by the 75th percentile of calendar year 1971 charges would be reduced by one-half so that the aggregate increase allowed would be within the 4.2 ceiling.

It is, of course, contemplated under the bill that the Secretary would use, both initially and over the long run, the most refined indexes that can be developed. However, your committee believes that the viability of the proposal does not depend on a great deal of further refinement. The objectives of the proposal could be attained with equity through the use of an approach such as that described above. This is so because the indexes are not to be applied on a procedure-by-procedure basis that would raise serious questions of equity in absence of refinements to take account of variations in the mix of factors of production among various types of medical services and to take account of changes in productivity with respect to various services. Rather, the indexes will operate as overall ceilings on prevailing fee level increases recognized in a carrier area under which adjustments permitted by the present customary and prevailing charge criteria could be made to take account of the shifting patterns and levels and actual charges in each locality. Thus, whether the new limit on prevailing charges will actually affect the determination of reasonable charges depends on the degree to which physicians' fees rise in the future. If the rise in fees in the aggregate was no more than the rise in operating expenses of physicians and in earnings, the rise in fees would be allowed in full.

Your committee believes it desirable to embody in the statute the limitations on medical charges recognized as prevailing now set forth in medicare regulations under which no charge may be determined to be reasonable if it exceeds the prevailing charge recognized by the carrier and found acceptable to the Secretary for similar services in the same locality on December 31, 1970, or the prevailing charge level that, on the basis of statistical data and methodology acceptable to the Secretary, would cover 75 percent of the customary charges made for similar services in the same locality during the last preceding calendar year elapsing prior to the start of the fiscal year.

While tying the allowability of future increases in prevailing charges to general economic indicators is an appropriate method for reasonable charge determinations with respect to the services of physicians, your committee believes it would be inappropriate for reasonable charge determinations with respect to medical supplies, equipment, and services that do not generally vary in quality from one supplier to another.

This is so because no program purpose would be served by allowing charges in excess of the lowest levels at which supplies, equipment, or services can be readily obtained in a locality. For this reason, the com-

mittee bill permits deviation from generally applicable reasonable charge criteria where it is determined that medical supplies, equipment, and services do not generally vary in quality from one supplier to another.

Your committee recognizes that it will not be possible for the Secretary to immediately establish special charge or cost limits for every item or service not materially affected in quality by the supplier who actually furnishes it to the patient. However, the committee believes that it is important to make explicit the Secretary's authority and it is expected that he will assert such authority to impose rules for determining reasonable charges when, after due consideration, he determines that a particular item or service does not vary in quality from one supplier to another and devises special rules for reasonable charge determinations that he considers equitable and administratively feasible. Until the Secretary designates an item or service as falling within the scope of this provision and establishes rules for determining reasonable charges for that item, the presently applicable rules, including any special rules imposed by the carrier, would generally remain in effect.

The effect of the new limits established under this provision would be extended to the medicaid and child health programs by providing that payments under these programs in fiscal year 1972 and thereafter may not be made with respect to any amount paid for items and services that exceeds these new limits. This would be consistent with the situation in the present medicaid program.

The medicaid provisions of the Social Security Amendments of 1965 contained nothing which attempted to limit the charges by physicians that States could pay under their medicaid programs. States could and usually did set some type of limits of their own, typically less than usual or customary charges. The Social Security Amendments of 1967 added a new medicaid provision which required that a State plan must provide assurances that "payments (including payment for any drugs under the plan) are not in excess of reasonable charges consistent with efficiency, economy, and quality of care." On June 30, 1969, HEW issued an interim regulation which limited fees paid to physicians, dentists, and other individual providers of medical services under medicaid. The HEW regulation stipulated that payments to providers would be limited to those received in January 1969, unless payments were below the 75th percentile of customary charges. States whose payment structures provided fees above the 75th percentile of customary charges were required to adjust their payments so that they did not exceed reasonable charges as determined under medicare. The regulation also stipulates that after July 1, 1970, States may request permission to increase fees paid to individual practitioners only if two conditions are met:

(1) The average percentage increase requested above the 75th percentile of customary charges on January 1, 1969, may not exceed the percentage increase in the all-services component of the Consumer Price Index (adjusted to exclude the medical component) or an alternative designed by the Secretary; and

(2) Evidence is clear that providers and the States have cooperatively established effective utilization review and quality control systems.

The proposed amendment is substantially along the lines of the present regulation.

(e) *Limits on payment for skilled nursing home and intermediate care facility services.*—Your committee is concerned that costs for skilled nursing homes and intermediate care facilities have been escalating at a rate which is undesirable from the standpoint of Federal, State and local governments and the private sector. Your committee therefore recommends that limits be placed on Federal financial participation for costs of such facilities with a view toward exerting pressure on both the public and private sectors to limit further cost increases. The bill would provide that for any calendar quarter beginning after December 31, 1971, the average per diem cost for skilled nursing homes and intermediate care facilities countable for Federal financial participation be limited to 105 percent of such cost for the same quarter of the preceding year. However, in computing the per diem costs any amounts ascribable to increases in the Federal minimum wage, or other Federal law enacted after the enactment of the bill, would be disregarded.

(f) *Payments to health maintenance organizations.*—Under present law, organizations providing comprehensive health services on a per capita prepayment basis cannot be reimbursed by medicare through a single capitation payment encompassing all covered services provided to medicare enrollees. Instead, medicare reimbursement to group practice prepayment plans, whether it is made on a cost or charge basis, must be related to the costs to the organization of providing specific services to beneficiaries, so that the financial incentives that such organizations have in their regular business to keep costs low and to control utilization of services do not carry over to their relationship with medicare.

Your committee believes that a serious problem in the present approach to payment for services in the health field, either by private patients, private insurance, or the Government, is that, in effect, payment is made to the provider for each individual service performed, so that other things being equal, there is an economic incentive on the part of those who make the decisions on what services are needed to provide more services, services that may not be essential, and even unnecessary services. A second major problem is that, ordinarily, the individual must largely find his own way among various types and levels of services with only partial help from a single hospital, a nursing home, a home health agency, various specialists, and so on. No one takes responsibility, in a large proportion of the cases, for determining the appropriate level of care in total and for seeing that such care, but no more, is supplied. The pattern of operation of health maintenance organizations that provide services on a per capita prepayment basis lends itself to a solution of both these problems with respect to the care of individuals enrolled with them. Because the organization receives a fixed annual payment from enrollees regardless of the volume of services rendered, there is a financial incentive to control costs and to provide only the least expensive service that is appropriate and adequate for the enrollee's needs. Moreover, such organizations take responsibility for deciding which services the patient should receive and then seeing that those are the services he gets.

Your committee believes it would be desirable for medicare to relate itself to health maintenance organizations in a way that conforms more

nearly to their usual way of doing business. The objective is to provide, in the case of medicare beneficiaries, the same kind of financial incentives that health maintenance organizations have with respect to their other enrollees.

Accordingly, your committee's bill provides for medicare payment to such an organization with respect to beneficiaries enrolled with it to be made on a prospective per capita basis, encompassing all medicare-covered services for which its enrollees are eligible to receive payment. (Group practice prepayment plans could, of course, choose to continue to be reimbursed under the provisions of existing law if they wished.) The payment would be determined annually in accordance with regulations of the Secretary, at a rate equal to 95 percent of the estimated amount(with appropriate adjustments—such as age and morbidity differentials—to assure actuarial equivalence) that would be payable if such covered services were furnished outside of the framework of a health maintenance organization. For beneficiaries who are covered by both the hospital and medical insurance plans, payments to health maintenance organizations would be made from both the hospital insurance and supplementary medical insurance trust funds, with the portion from the supplementary medical insurance trust fund being the product of the total monthly premium (beneficiary and Federal Government amounts combined) times the number of medicare beneficiaries enrolled in the organization. The remainder of the payment would be made from the hospital insurance trust fund.

The 95 percent payment rate for any health maintenance organization would be based upon the reimbursement amount per capita for services furnished by other than health maintenance organizations, adjusted for variations in unit benefit cost due to service areas, reasonable availability of services, and underwriting rules. The service area concept encompasses the geographical locality where the health maintenance organization is providing the service, and in which there is a reasonable cross section of different types of institutions and practitioners and utilization rates. Where there is an abnormal scarcity of services or excessive services for persons not in the health maintenance organization in a particular locality, but the needs of health maintenance organization members are fully met, the actuarial equivalent cost would be determined by established actuarial methods which include the consideration of costs in comparable locations where the covered services are reasonably available. The actuarial determinations should be performed by qualified actuaries experienced in health care program costing. This expertise also would be needed to appraise whether enrollment of poorer risks, such as institutionalized persons or persons of low income, were less than in proportion to the population in the service area and to determine the effects on costs. Similarly, special limitations of the health maintenance organization on access of members to care, and limitations on the provision of teaching and community services should also be taken into account in considering cost equivalence.

To guard against potentially excessive profits from the medicare payment, your committee has included a provision to assure that the rate of retention (gross revenues less costs) for medicare enrollees would not be permitted to exceed the rate for other beneficiaries of the health maintenance organization. Since an acceptable rate of retention cannot be prospectively assured, the provision calls for an

examination by the Secretary of the actual rates of retention experienced by the organization. The health maintenance organization would be required to submit to the Secretary, following each accounting period, a public accounting report which identifies (by amount and rate) the retention for all medicare beneficiaries, considered as a group, and the retention for all other enrollees of the organization, considered as a group. Any report showing a positive rate of retention for medicare enrollees which exceeds 90 percent of its rate for other enrollees would be subject to full audit. Where an excessive rate of retention is verified, the organization would be required to utilize such excess for additional benefits or reductions in premiums charged to medicare beneficiaries or to refund the excess to the trust funds.

For purposes of this provision, an "excessive rate of retention" would ordinarily be any positive rate of retention for medicare enrollees which exceeds the organization's rate of retention for enrollees under age 65. However, if persons over age 65 comprise more than one-half of the health maintenance organization's enrollment, an excessive rate of retention would be any rate with respect to its medicare enrollees which exceeds the rate of retention generally experienced by comparable types of organizations for enrollees under age 65. This latter provision is intended to assure that those organizations which are temporarily exempted from the requirement that one-half of the membership be under age 65 are nevertheless subject to a retention limit which accurately reflects the retention experienced by prepayment organizations which operate primarily in a true market situation.

Under this payment formula, the program is assured of saving for at least 5 percent over average payments made on behalf of medicare beneficiaries who are not enrolled in health maintenance organizations. More importantly, the payment mechanism rewards the health maintenance organization with earnings proportional to its efficiency relative to the traditional system and permits the especially efficient organization an opportunity to provide special incentives (in the form of additional benefits or premium reductions) for medicare beneficaries to enroll and thus to maximize its returns.

The individuals with respect to whom such payment would be made are medicare beneficiaries who are entitled to both hospital insurance and supplementary medical insurance or to medical insurance only and who are enrolled with a health maintenance organization. They would receive medicare-covered services only through the health maintenance organization, except for those emergency services as are furnished by other physicians and providers of services. The health maintenance organization would be responsible for paying the costs of such emergency services. If an enrolled individual received nonemergency care through some other means than the health maintenance organization, he would have to meet the entire expense of such care, except in the case where a determination has been made that the individual received care outside the health maintenance organization which should have been furnished by the HMO.

To qualify to receive payment in this way, a health maintenance organization would have to be one which provides: (1) either directly or through arrangements with others, health services on a prospective per capita prepayment basis; (2) all the services and benefits of both the hospital and medical insurance parts of the program; (3) physician's services, either directly by physicians who are employees or

partners of the organization, or under an arrangement with an organized group of physicians under which the group is reimbursed for its services primarily on the basis of an aggregate fixed sum or on a per capita basis. Since physicians play the major role in determining utilization of all covered services, such payment arrangement should contain an element of incentive for such physicians to assure that medicare patients are provided needed services in the most efficient and economical manner. (The group of physicians which has the arrangement with the health maintenance organization could, in turn, pay its physician members on any other basis, including fee-for-service.)

A health maintenance organization must have at least half of its enrolled membership under age 65 or be expected to meet this requirement within a period not exceeding 3 years with evidence of positive and continuing efforts to achieve the required enrollment distribution. The organization must also hold an annual open enrollment period during which it accepts enrollees on a nondiscriminatory basis up to the limits of its capacity. Additional requirements are: (1) that the organization furnish to the Secretary proof of its financial responsibility and its capacity to provide comprehensive health services, including institutional services, effectively and economically; (2) that the organization assure that the health services required by its enrollees are received promptly and appropriately and that they measure up to quality standards. The various elements of a health maintenance organization, such as the hospital, the extended care facility or clinical laboratory, would each continue to have to meet the conditions of participation or other quality standards which apply to such organizations under present law.

The Secretary would execute an individual contractual agreement with each qualified organization desiring to function as a health maintenance organization. Such contracts would be automatically renewed annually in the absence of reasonable advance notice by either party of intention to terminate at the end of the current term, except that the Secretary could terminate the contract at any time (after reasonable notice and opportunity for hearing) if he finds that the organization has failed substantially to carry out the contract, is carrying it out in a manner inconsistent with efficient, effective, and economical administration or no longer meets all requirements to qualify for payment as a health maintenance organization. Such contracts will include provisions giving the Secretary appropriate access to organization records to evaluate the quality of its performance with respect to provision of services as well as to determine compliance with fiscal requirements. In negotiating the contracts, the Secretary may disregard other laws and regulations which impose conditions or restraints on the contractual process, but only where such conditions or restraints are inconsistent with the purposes of the medicare program.

Under this provision, your committee expects that the Secretary will issue regulations establishing means for effective implementation of an ongoing review program to assure that the health maintenance organization effectively fulfills beneficiary service needs by adhering to specified minimum requirements for full-time qualified medical staff, keeping beneficiaries fully informed on the extent of coverage of services received outside the organization, taking positive actions to assure that beneficiaries are not deprived of benefits through devices

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such as scheduling appointments at inconvenient times or unwarranted delay in scheduling of elective surgery, and avoiding discrimination against poor health risks through selective enrollment or poor service aimed at encouraging disenrollment of high users of services. The Secretary is also expected to take precautions against possible fiscal abuse of the program by examining (and, where required, taking exception to) any arrangement the health maintenance organization may have with providers, including related organizations, which appear to result in an unwarranted increase in costs or to overstate the value of any added coverage or reduction of premiums.

If the health maintenance organization provides only the services covered by the medicare program to its enrollees, the premiums it may charge its enrollees cannot exceed the actuarial value of the cost-sharing provisions of the hospital and supplementary medical insurance parts of the medicare program. If, however, the organization provides its enrollees services in addition to those covered under medicare, it must inform enrollees of the portion of the premium applicable to such additional services, and the portion applicable to medicare-covered services may not exceed the actuarial value of the cost-sharing provisions of the medicare program These requirements are intended to assure that beneficiaries enrolled with health maintenance organizations benefit fully from their medicare coverage and are, in effect, charged no more than the deductible and coinsurance amounts. This provision will also assure that they are made aware of the exact cost of any coverage included in the benefits provided by the health maintenance organizations which is in addition to medicare coverage.

Beneficiaries enrolled with a health maintenance organization who are dissatisfied with decisions of the organizations on benefit coverage would have the right to a hearing before the Secretary, in which the health maintenance organization would be an interested party, and to judicial review with respect to disputes involving amounts exceeding specified limits.

Beneficiaries could terminate their enrollment with a health maintenance organization and revert to regular coverage under the program in accordance with regulations. It is expected that, generally, disenrollment would take effect the same time after the disenrollment request as is the case now with respect to disenrollment under the supplementary medical insurance program.

Your committee also notes that some potentially qualified health maintenance organizations currently have enrollees who may desire to continue membership in the organization but who do not wish to agree to receive covered services only from that organization. Since it would seem inequitable to require such individuals to either disenroll immediately or involuntarily accept a limitation on their access to covered services, your committee has added a provision under which a health maintenance organization could continue through December 1974 to be reimbursed for covered care provided to beneficiaries who were members prior to January 1972 but who do not elect the option. Program payments in such cases would be determined on a per capita basis similar to that used for enrollees who elect the option, with appropriate payment reductions for out-of-plan use of covered services by such enrollees.

The health maintenance organization provisions in the bill would be effective with respect to services furnished on or after January 1, 1972.

(g) Payment under medicare for services of physicians rendered at a teaching hospital.—When medicare was enacted, the general expectation was that physicians' services to patients (but not intern or resident services) would generally be paid for on a fee-for-service basis. However, the issue of how medicare should reimburse for the services of a physician when he supervised interns and residents in the care of patients was not specifically detailed. Nevertheless, it was clear that charges paid for a physician's services under medicare should be reasonable in terms of both the patient care services that a particular physician provided as well as the charges made for similar services to other patients—that is, if a physician merely took legal responsibility for care, no fee for service was intended to be paid. Or, if the physician performed the services differently than is usually done when a patient engages his own private physician, the differences were to be reflected in the charge paid by medicare.

Under present law, hospitals are reimbursed under the hospital insurance part (part A) of the medicare program for the costs they incur in compensating physicians for teaching and supervisory activities and in paying the salaries of residents and interns under approved teaching programs. In addition, reasonable charges are paid under the medical insurance program (part B) for teaching physicians' services to patients.

There is a wide variety of teaching arrangements. At one extreme there is the large teaching hospital with an almost exclusively charity clientele in which the treatment of medicare beneficiaries may, in fact, though not in law, be turned over to the house staff; in such hospitals many teaching physicians have had the roles exclusively of teachers and supervisors and have not acted as any one patient's physician. Since in these cases the services of the teaching physicians are primarily for the benefit of the hospital teaching program and hospital administration rather than being focused on the relationship between doctor and patient, the services of these physicians should be reimbursed as a hospital cost rather than on a fee-for-service basis under the supplementary medical insurance program.

At the other extreme, there is the community hospital with a residency program which relies in large part for teaching purposes on the private patients of teaching physicians whose primary activities are in private practice. The private patients contract for the services of the physician whom they expect to pay and on whom they rely to provide all needed services. The resident or intern normally acts as a subordinate to the attending physician, and the attending physician personally renders the major identifiable portion of the care and directs in detail the totality of the care. Moreover, there are teaching hospitals in which a teaching physician may be responsible both for private patients whom he has admitted and for patients who have presented themselves to the hospital for treatment at no cost and who have been assigned by the hospital to his care.

It has proved to be difficult to achieve effective and uniform application of present policies to the large number of widely varying teaching settings. In some cases, charges have been billed and paid for services rendered in teaching hospitals which clearly did not involve any degree of teaching physician participation. In some cases charges were billed for the services that residents and interns rendered in every case where a supervising physician had overall responsibility for their actions.

even though he may not actually have become involved in the patient's care. In other cases, charges for covered services were billed in amounts that were out of all proportion to the covered service or the charges billed to other patients.

Your committee does not question the appropriateness of fee-for-service payment for physicians' services in the typical community hospital and other teaching settings where patients are expected to pay fees for these services. For example, payment for the services a community physician provides to his private patient is clearly in accord with the usual practices of other health insurance programs and patients who pay their bills out of pocket.

On the other hand, in the case of all the ward or other accommodations in many large hospitals and the service wards of other teaching institutions where patients are not expected to pay any fees for physicians' services or only reduced fees are normally paid, the payment of full charges represents an expense to the program that is not necessary to give medicare patients access to the care they receive. Also, the payments tend to support the maintenance of two classes of patients in some cases.

Therefore, your committee's bill would provide that reimbursement for services of teaching physicians to a nonprivate medicare patient should be included under part A, on an actual cost or "equivalent cost" basis. A mechanism for computing payment for services of supervisory physicians on the unpaid voluntary medical staff of a hospital would be developed on a reasonable "salary equivalency" basis of the average salary (exclusive of fringe benefits) for all full-time physicians (other than house staff) at the hospital or, where the number of full-time salaried physicians is minimal, at like institutions in the area. Your committee expects that any determination with respect to whether the size of a particular hospital's salaried staff is sufficient to provide the proper basis for reimbursement of donated services would take into account the ratio of salaried to voluntary nonpaid staff members as well as the absolute number of salaried staff. The average salary equivalent, which would be distilled into a single hourly rate covering all physicians regardless of specialty, would be applied to the actual time contributed by the teaching physician in direct patient care or supervisory voluntary service on a regularly scheduled basis to nonprivate patients. Such services would be billed for by the organized medical staff of the hospital and reimbursed to a fund designated by the organized medical staff.

Medicare would pick up its proportionate share of such costs on a basis comparable to the method by which reimbursement is presently made for the services of interns and residents. The salary-equivalent allowance would provide reasonable and not excessive payments for such services. The payment represents compensation for contributed medical staff time which would otherwise have to be obtained through employed staff on a reimbursable basis. Such funds would in general be made available on an appropriate legal basis to the organized medical staff for their disposition for purposes such as payment of stipends enhancing the hospital's capacity to attract house staff or to upgrade or to add necessary facilities or services, the support of continuing education programs in the hospital, and similar charitable or educational purposes. Contributions to the hospital made by the staff from such funds would not be recognized as a reimbursable cost when

expended by the hospital nor would depreciation expense be allowed with respect to equipment or facilities donated to the hospital by the staff.

There are also teaching physicians whose compensation is paid by a medical school. With respect to reimbursement for their direct or supervisory services for nonprivate medicare patients, payments should be made on the basis of actual or salary-equivalent costs. The funds so received may be assigned by such physicians to an appropriate fund designated by the medical school for use in compensating teacher physicians, or for educational purposes. Where States elect to compensate for services of teaching or supervisory physicians under medicaid, Federal matching should be limited to reimbursement not in excess of that allowable under medicare.

Fee-for-service would continue to be payable for medicare beneficiaries who are bona fide "private patients." This would ordinarily be a patient who was seen by the physician in his office prior to hospital admission; for whom he arranged admission to the hospital, whose principal physicians' service were provided by him, who was visited and treated by him during his hospital stay; who would ordinarily turn to him for followup care after discharge from the hospital; and who is legally obligated to pay the charges billed, including deductibles and coinsurance, and from whom collection of such charges is routinely and regularly sought by the physician. Of course, appropriate safeguards should be established to preclude fee-for-service payment on the basis of pro forma or token compliance with these private patient criteria.

Your committee recognizes, however, that this concept of a private patient is not a complete definition primarily because it does not take account of the customary arrangements for reimbursing consultants and specialists who are not serving as the patient's attending physician, but who may provide a service to the patient for which a fee-for-service payment is appropriate and for which services the patient is legally obligated and which he expects to pay. For example, where a general practitioner refers his patient to a surgeon for necessary operative work and where the surgeon ordinarily charges and collects from all referred patients for his services. Furthermore, in some cases hospitals that normally do not bill for physician service have special centers,s uch as a center for severely burned people, where patients able to pay are regularly admitted and pay charges. It would be intended that medicare follow the pattern of the private patient in such centers.

The second exception to the cost-reimbursement coverage of teaching physician services is intended to permit the continuation of fee-for-service reimbursement for professional services provided to medicare patients in institutions which traditionally billed all patients (and the majority of whom paid) on a fee or package charge basis for professional services. This exception would apply if, for the years 1966, 1967, and each year thereafter for which part B charges are being claimed: all of the institution's patients were regularly billed for professional services; reasonable efforts were made to collect these billed charges and a majority of all patients actually paid the charges in whole or in substantial part. The hospital would have to provide evidence that it meets these tests for fee-for-service reimbursement before the payments could be made.

A hospital eligible for fee-for-service reimbursement on the basis of the requirement described in the above exception could, if it chose, elect to be reimbursed on the cost basis provided for by the bill if the election would be advantageous to the program in that it might reduce billing difficulties and costs. Similarly, where it would be advantageous to the program and would not be expected to increase the program's liability, the cost reimbursement provisions of the bill could serve as the basis for payment for teaching physicians' services furnished in the past where procedural difficulties have prevented a determination of the amount of fee-for-service that is appropriate.

Your committee expects that in any borderline or questionable areas concerning whether reimbursement for the services of teaching physicians in a given institution or setting should be on a costs or charges basis, reimbursement would be on the basis of costs.

An important effect of these various coverage and co-pay provisions would be that, where the cost-reimbursement approach is applicable, reimbursement for the physician's teaching activities and his related patient care activities would always be provided under the same provisions of the law. This would greatly simplify the administration of the program by making it unnecessary to distinguish, as required by present law, between a physician's teaching activities and patient care activities in submitting and paying bills.

Your committee's bill also provides that the law be amended so that a hospital could include the actual reasonable costs which an affiliated medical school incurs in paying physicians to provide patient care services to medicare patients in the hospital. The bill would also permit including in a hospital's reimbursable costs the reasonable cost to a medical school of providing services to the hospital which, if provided by the hospital, would have been covered as inpatient hospital services or outpatient hospital services. The hospital would be required to pay the reasonable cost of the services in question to the institution that bore the cost.

The above provisions would become effective with respect to accounting periods beginning on or after July 1, 1971.

(*h*) *Advance approval of extended care and home health coverage under medicare.*—Under present law, extended care benefits are payable only on behalf of patients who, following a hospital stay of at least 3 consecutive days, require skilled nursing care on a continuing basis for further treatment of the condition which required hospitalization. The post hospital home health benefit is payable on behalf of patients who, following hospitalization or an extended care facility stay, continue to require essentially the same type of nursing care on an intermittent basis, or physical or speech therapy. However, extended care facilities and home health agencies often care for patients who need less skilled and less medically oriented services in addition to patients requiring the level of care which is covered by the program.

Under current law, a determination of whether a patient requires the level of care that is necessary to qualify for extended care facility or home health benefits cannot generally be made until some time after the services have been furnished. Your committee is aware that in many cases such benefits are being denied retroactively, with the harsh result that the patient is faced with a large bill he expected would be paid or the facility or agency is faced with a patient who may not be able to pay his bill. The uncertainty about eligibility for these benefits

that exists until after the care has been given tends to encourage physicians to either delay discharge from the hospital, where coverage may less likely be questioned, or to recommend a less desirable, though financially predictable, course of treatment. The aggregate effect is to reduce the value of the post-hospital extended care and home health benefits as a continuation of hospital care in a less intensive—and less expensive—setting as soon as it is medically feasible for the patient to be moved.

Your committee believes that to the extent that valid criteria can be established posthospital extended care and home health benefits should be more positively identified by type of medical condition which ordinarily requires such care and that minimum coverage periods should be assured for such conditions. To achieve its purpose, your committee's bill authorizes the Secretary to establish, by medical conditions and length of stay or number of visits, periods for which a patient would be presumed to be eligible for benefits. These periods of presumed coverage would be limited to those conditions which program experience indicates are most appropriate for the extended care or home health level of services following hospitalization, taking into account such factors as length of hospital stay, degree of incapacity, medical history and other health factors affecting the type of services to be provided.

Your committee recognizes that, in order to avoid the risk of presuming coverage (by general medical category) in substantial numbers of cases where extended care or home health care may not be required, presumed coverage periods must necessarily be limited in duration and will not, in many cases, encompass the entire period that the patient will require covered care. Nevertheless, these minimum presumed periods will provide a dual advantage over the present system of coverage determination by (1) encouraging prompt transfer through assurance that the admission or start of care will be reimbursed and (2) identifying in advance the point at which further assessment should be made, on an individual case basis, of continuing need for extended or home health care. Where request for coverage beyond the initial presumed period, accompanied by appropriate supporting evidence, is submitted for timely advance consideration, it is expected that a decision to terminate extended care or home health coverage would ordinarily be effected on a prospective basis. For those conditions for which specific presumed periods cannot be established, current procedures for determining coverage would continue to apply; however, fiscal intermediaries should be able to make coverage determinations on a more timely basis for such admissions.

To prevent abuse of the advance approval procedure, intermediaries and facilities would be expected to monitor, through periodic review of a sample of paid stays, utilization review committee studies, and similar measures, the reliability of individual physicians in describing the patients' conditions or certifying patients' needs for posthospital extended care and home health services. The Secretary could suspend the applicability of the advance approval procedure for patients certified by physicians who are found to be unreliable in this respect.

This provision would be effective January 1, 1972.

(i) *Authority of Secretary to terminate payments to suppliers of services.*—Present law does not provide authority for the Secretary to withhold future payments for services furnished by an institutional

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provider of services, a physician, or any other supplier who either abuses the program or endangers the health of beneficiaries, although payment for past or current claims may be withheld on an individual basis where the services are not reasonable or necessary for treatment of illness or injury or where the supplier fails to provide the necessary payment information.

Your committee believes it important to protect the medicare, medicaid, and maternal and child health programs and their beneficiaries from those suppliers of services who have made a practice of furnishing inferior or harmful supplies or services, engaging in fraudulent activities, or consistently overcharging for their services. Such protection is not now provided under the law. For example, if a physician is found guilty of fraud in connection with the furnishing of services to a medicare beneficiary, there is no authority under present law to bar payment on his subsequent claims so long as the physician remains legally authorized to practice. States can, and some do, bar from medicaid providers who abuse the program, but they are not now required to do so.

Under your committee's bill, the Secretary would be given authority to terminate or suspend payments under the medicare program for services rendered by any supplier of health and medical services found to be guilty of program abuses. The Secretary would make the names of such persons or organizations public so that beneficiaries would be informed about which suppliers cannot participate in the program. The situations for which termination of payment could be made include overcharging, furnishing excessive, inferior, or harmful services, or making a false statement to obtain payment. Also, there would be no Federal financial participation in any expenditure under the medicaid and maternal and child health programs by the State with respect to services furnished by a supplier to whom the Secretary would not make medicare payments under this provision of the bill.

Program review teams would be established in each State by the Secretary, following consultation with groups representing consumers of health services, State and local professional societies, and the appropriate intermediaries and carriers utilized in the administration of title XVIII benefits. Both the professional and the nonprofessional members of the program review teams would be responsible for reviewing and reporting on statistical data on program utilization (which the Secretary would periodically provide). In addition, the entire program review team would review cases involving overcharging; however, only the professional members of the program review teams would review cases involving the furnishing of excessive, inferior, or harmful services in order to assure that only professionals will review other professionals under this provision.

It is not expected that any large number of suppliers of health services will be suspended from the medicare program because of abuse. However, the existence of the authority and its use in even a relatively few cases is expected to provide a substantial deterrent.

The provisions relating to title XVIII would be effective with respect to determinations made by the Secretary after enactment of the bill. The provisions relating to titles V and XIX would be effective with respect to items or services furnished after June 30, 1971.

Any person or organization dissatisfied with the Secretary's decision to terminate payments would be entitled to a hearing by the Secretary and to judicial review of the Secretary's final decision.

It is not intended that this provision would in any way change the Secretary's present right to withhold payment where necessary payment information is not provided. Nor would the supplier of services be entitled to a hearing or judicial review with respect to payments withheld under such existing authority.

(*j*) *Elimination of requirement that States move toward comprehensive medicaid programs.*—Section 1903(e) of the medicaid statute requires that each State make "a satisfactory showing that it is making efforts in the direction of broadening the scope of the care and services made available under the plan and in the direction of liberalizing the eligibility requirements for medical assistance." Under an amendment adopted by the Congress in 1969 (Public Law 91–56, enacted August 9, 1969), the operation of this provision was suspended for two years, until July 1, 1971, and the date by which the States were to have comprehensive medicaid programs (applying to everyone who meets their eligibility standards with respect to income and resources) was changed from 1975 to 1977.

Your committee has been concerned with the burden of the medicaid program on State finances and has included a provision in the bill which would remove section 1903(e) from the Act. When the operations of the State medicaid programs have been substantially improved and there is assurance that program extensions will not merely result in more medical costs inflation, the question of required expansion of the program could then be reconsidered.

(*k*) *Reductions in care and services under medicaid program.*—Under current law (section 1902(d) amended by P.L. 91–56) a State cannot reduce its expenditures for the State share of medicaid from one year to the next. If a State wishes to modify its State plan so as to reduce the extent of care and services provided or to terminate any of its programs, the Governor must certify to the Secretary that a) the State share of medicaid expenditures will not be reduced, b) the State is complying with the provisions in its plan relating to utilization and costs of services, and c) the modification is not made for the purpose of increasing the standard or other formula for determining payments.

Your committee is concerend with the effect of section 1902(d) on States which are faced with fiscal crises. Your committee is also concerned, however, that such crises should not operate to prevent the poor from receiving basic medical care and services, particularly the six specific services mandated by present law.

Your committee wishes to assure maintenance of effort with regard to the basic services—physician, inpatient hospital, outpatient hospital, laboratory, x-ray and home health services, as well as nursing home care for those over 21 and early and periodic screening, diagnosis, treatment for those under 21. The bill would, therefore, amend section 1902(d) by restricting the maintenance of effort requirement to these basic services. The State would be able to modify the scope and extent of optional services provided, such as drugs, dental care and eyeglasses. This would enable the States experiencing fiscal crises to respond to such crises without reducing their expenditures for those services most urgently needed by the poor.

(*l*) *Determination of reasonable cost of inpatient hospital services under medicaid and maternal and child health programs.*—Under present law, as defined in earlier regulations issued by the Secretary, States are

required to reimburse hospitals for inpatient care under medicaid on the basis of the reasonable cost formula set forth in medicare. Several States have objected to this requirement, asserting that use of the medicare formula for medicaid reimbursement can result in their paying more than the actual cost of providing inpatient care to those eligible for medicaid. There is nothing in the legislative history which requires that reasonable costs should be defined precisely the same way for both programs, and there are reasons why they should not, such as the differing characteristics of the two populations served.

Your committee's bill would allow States to develop their own methods and standards for reimbursement, thereby giving them flexibility in working out satisfactory payment arrangements with their hospitals. The Secretary could disapprove a State's plan if it were shown to his satisfaction that the method developed by the State would not pay the actual and direct cost of providing care to medicaid eligibles. Reimbursement by the States would in no case exceed reasonable cost reimbursement as provided for under medicare.

Your committee bill wishes to make clear that it is not the intention of this section to shift the burden of costs from medicaid recipients to non-medicaid recipients. However, the States should not be unduly restricted in the methods with which they might experiment for payment of inpatient hospital services.

The bill would apply the same determination of reasonable costs to maternal and child health programs. The provision would be effective July 1, 1972, or earlier if the State plan so provides.

(*m*) *Amount of payments where customary charges for services furnished are less than reasonable cost.*—Under present law, reimbursement under the medicare program is based on the reasonable costs incurred by providers of services (but only for inpatient hospital services under medicaid and the maternal and child health programs) in providing services to individuals covered by these programs. This results, in some cases, in these programs paying higher amounts for services received by covered individuals than such individuals would be charged if they were not covered by these programs, because, in some cases, a provider's customary charges to the general public are set at a level which does not reflect the provider's full costs.

Your committee believes that it is inequitable for the medicare, medicaid, and the child health programs to pay more for services than the provider charges to the general public. To the extent that a provider's costs are not reflected in charges to the public generally, such costs are expected to be met from income other than revenues from patient care—for example, from endowment or investment income. The bill would provide, therefore, that reimbursement for services under the medicare, medicaid, and child health programs could not exceed the lesser of the reasonable cost of such services as determined under section 1861(v) of the Social Security Act, or the customary charges to the general public for such services.

However, your committee believes that it would be undesirable to apply this provision in the case of services furnished by public providers of services free of charge or at a nominal fee. The bill would provide, therefore, that where services are furnished by a public provider of services free of charge or at a nominal charge, the Secretary shall specify by regulation reimbursement based on those elements of costs generally allowed in the determination of reasonable cost that he

finds will result in fair compensation for such services. In such cases fair compensation for a service could not exceed, but could be less than the amount that would be paid under present law.

Your committee recognizes that a provider's charges may be lower than its costs in a given period as a result of miscalculation or special circumstances of limited duration, and it is not intended that providers should be penalized by such short-range discrepancies between costs and charges. Nor does the committee want to introduce any incentive for providers to set charges for the general public at a level substantially higher than estimated costs merely to avoid being penalized by this provision. Thus, your committee recognizes the desirability of permitting a provider that was reimbursed under the medicare, medicaid and child health programs on the basis of charges in a fiscal period to carry unreimbursed allowable costs for that period forward for perhaps two succeeding fiscal periods. Should charges exceed costs in such succeeding fiscal periods, the unreimbursed allowable costs carried forward could be reimbursed to the provider along with current allowable costs up to the limit of current charges.

Your committee intends that for purposes of administering this provision, "customary charges" shall mean (1) the charges listed in an established charge schedule (if the institution has only a single set of charges applied to all patients), or (2) the most frequent or typical charges imposed (if the institution uses more than one charge for a single service). However, in order to be considered to be the "customary charge," a charge would have to be one that was actually collected from a substantial number of individuals. A charge set up in name only, perhaps primarily to avoid the effect of this provision, is not intended to determine medicare reimbursement.

The provisions relating to medicare would be effective with respect to services furnished by hospitals, extended care facilities and home health agencies in accounting periods beginning after June 30, 1971. Provisions relating to medicaid and maternal and child health would be effective for accounting periods beginning after June 30, 1971.

(*n*) *Institutional planning under medicare.*—Under present medicare law, there is no requirement for providers of services to develop fiscal plans such as operating and capital budgets. However, your committee is aware of the fact that health care facilities have come under increasing criticism on the grounds that they fail to follow sound business practices in their operations. The Advisory Committee on Hospital Effectiveness established by the Secretary of HEW in its report stated, "* * * the fact must be faced that deficiencies in hospital management owe something, at least, to inattention, indifference, or lack of information on the part of some hospital boards, and some trustees with the best intentions and energy have not been adequately informed by administrations on what the functions of a hospital trustee, or a hospital should be." In recommending the requirement contained in the bill, the Secretary's committee stated, "The requirement that detailed budgets and operating plans be prepared annually as a condition of approval for participation in Federal programs can be expected to disclose management inefficiencies in such health care institutions as a necessary first step toward bringing about needed improvements. Especially, the committee believes this requirement will compel the attention of many hospital trustees to lapses in management that would not be permitted in their own businesses."

Under your committee's bill, providers of services (including hospitals accredited by the Joint Commission on Accreditation of Hospitals) would be required, as a condition of participation under the medicare program, to have a written overall plan and budget reflecting an operating budget and a capital expenditures plan. The overall plan would be expected to contain information outlining the services to be provided in the future, the estimated costs of providing such services (including proposed capital expenditures in excess of $100,000 for acquisition of land, buildings, and equipment and replacement, modernization, and expansion of the buildings and equipment), and the proposed methods of financing such costs. It would have to be prepared under the direction of the governing body of the institution, by a committee consisting of representatives of that body, the administrative staff and the medical staff. The required annual operating budgets may be prepared by groupings of cost or income rather than a detailed itemization for each type of cost or income. The plan would cover the immediately following year and the immediately following 3-year accounting period and would be reviewed and updated annually to assure that it is consistent with the budgetary program of the provider.

The plan would not be reviewed for substance by the Government or any of its agents. The purpose of the provision is to assure that such institutions carry on budgeting and planning on their own. It is not intended that the Government will play any role in that process.

The new condition of participation would have to be met with respect to any provider of services for fiscal years of the provider beginning after the fifth month after the month of enactment.

(o) *Payments to States under medicaid programs for installation and operation of claims processing and information retrieval systems.*—Under present law, States are required to use methods of administration deemed necessary by the Secretary for efficient operation of the program. Federal matching is now set at 50 percent for administrative costs and 75 percent for compensation of professional medical personnel. Despite this requirement, many States do not have effective claims administration or well-designed information storage and retrieval systems; nor do they possess the financial and technical resources to develop them if required to do so by the Secretary.

Your committee proposes to aid the States in meeting their responsibilities by authorizing 90 percent Federal matching for the cost necessary to design, develop, and install mechanized claims processing and information retrieval systems deemed necessary by the Secretary. The Federal Government acknowledges the obligation to provide technical assistance, including the development of model systems, to each State operating a medicaid program. It is expected that this financial and technical support will aid the States in realizing efficient and effective administration of the program, and that it will reduce program costs.

Your committee also recognizes the importance of this activity by providing in the bill for Federal matching funds at the 75 percent rate for the operation of the system approved by the Secretary.

States would not be eligible to receive this increased Federal support until they have developed the capacity to provide basic information to recipients on services paid for by the program, including the names of the providers, the dates on which services were furnished, and the amount of payment made. Experience with the medicare program indicates that beneficiary complaints about discrepancies

between the "explanation of benefits" form they receive, and the care actually provided, has been the largest single source of information on possible abuse and fraud. It is appropriate to combine the requirement that States provide such explanations with the increased Federal matching which would support such an activity. Savings resulting from improved administrative efficiency would more than offset the cost of this provision.

This provision of the bill would be effective July 1, 1971.

(*p*) *Prohibition against reassignment of claims to benefits.*—Under present law, payment for services furnished by a physician or other person under the supplementary medical insurance program is made: (1) to the beneficiary on the basis of an itemized bill, or (2) to the physician or other person who provided the services on the basis of an assignment under the terms of which the reasonable charge is the full charge for the service. Present law also provides that payment for such services under the medicaid program is made to the physician or other person providing the services. The law is silent with respect to reassignment by physicians or others who provide services of their right to receive payment under these programs The Department of HEW makes such reassigned payments under medicare without specific legislative authority.

Experience with this practice under these programs shows that some physicians and other persons providing services reassign their rights to other organizations or groups under conditions whereby the organization or group submits claims and receives payment in its own name. Such reassignments have been a source of incorrect and inflated claims for services and have created administrative problems with respect to determinations of reasonable charges and recovery of overpayments. Fraudulent operations of collection agencies have been identified in medicaid. Substantial overpayments to many such organizations have been identified in the medicare program, one involving over a million dollars.

Your committee's bill seeks to overcome these difficulties by prohibiting payment under these programs to anyone other than the patient, his physician, or other person who provided the service, unless the physician or other person is required as a condition of his employment to turn his fees over to his employer, or unless the physician or other person has an arrangement with the facility in which the services were provided under which the facility bills for the services. It is not the intent of your committee that this provision apply to payments to providers of services that are based on the reasonable cost of the services.

Your committee's bill would not preclude a physician or other person who provided the services and accepted an assignment from having the payment mailed to anyone or any organization he wishes, but the payment would be to him in his name.

The provision would in no way interfere with the fiscal relationships between physician and hospitals, in the case of hospital-based pathologists and radiologists, for example.

This provision as it applies to medicare would be effective with respect to bills submitted after the enactment date. For medicaid the provision would be effective July 1, 1972, or earlier if the State plan so provides.

(q) *Utilization review requirements for hospitals and skilled nursing homes under medicaid and maternal and child health programs.*—Under present medicare law, each hospital and extended care facility is required to have a utilization review committee to review all long-stay cases as well as review, on a sample or other basis, admissions, durations of stay and professional services. The reasons for requiring hospitals and extended care facilities to have utilization review committees for medicare cases apply with equal force to review of medicaid cases, but there is now no such requirement in the medicaid law.

Your committee's proposal would require hospitals and skilled nursing homes participating in the medicaid or maternal and child health program to have cases reviewed by the same utilization review committee already reviewing medicare cases or, if one does not exist, by a committee which meets the standards established under medicare. States could, if they wish, impose more stringent requirements, e.g., they might request that the committee review medicaid patient stays earlier than medicare cases since the medicaid population is generally younger than that covered under medicare.

This provision would be effective July 1, 1972.

(r) *Notification of unnecessary admission to a hospital or extended care facility under medicare.*—Under present law, the utilization review committee required to function in each hospital and extended care facility must review all long-stay cases and at least a sample of admissions. When in the review of a long-stay case the utilization review committee determines that further stay in the institution is not medically necessary, the committee is required to notify promptly the physician, the patient, and the institution of its finding. No medicare payment is made for any services furnished after the third day following such notification.

Your committee's bill would require a similar notification, and a similar payment cut-off after 3 days, to be made where the utilization review committee in its sample or other review of admissions finds a case where hospitalization or extended care is no longer necessary (or never was necessary). Thus, your committee's bill would remove the anomaly of continuing payment in a case where the utilization review committee determined in the course of sample or other review that admission to the institution or further stay was not necessary and would make parallel the treatment accorded long-stay cases and cases reviewed on a sample basis.

This provision would be effective with respect to services furnished after the second month following enactment of the bill.

(s) *Use of State health agency or other appropriate medical agency to perform certain functions under medicaid and maternal and child health programs.*—Under present law, one State agency may have the responsibility for certifying health facilities for participation in the medicare program and another agency for certifying health facilities for participation in medicaid and maternal and child health programs. Your committee believes that this duplication of effort in the verification of and in the establishment and maintenance of health standards is unnecessary and inefficient and should be limited to the extent feasible. Your committee's bill would require the State to provide that the State health agency (or the State medical agency which licenses health facilities) shall perform these functions for medicare, medicaid, and the maternal and child health programs. Your committee would

authorize the use of the appropriate State medical agency rather than limiting the designation to "State health agency."

Your committee also believes that the effectiveness and economy of the medicaid program would be enhanced through development of capability in each State to perform utilization reviews, to establish standards relating to the quality of health care furnished to medicaid recipients, and to review the quality of the services provided. Activities such as these would provide information on the under-or over-utilization of resources and the quality and appropriateness of care.

To encourage the development of the capabilities upon which these improvements would be based, your committee bill would provide that Federal participation in medicaid payments be contingent upon the establishment of a plan, acceptable to the Secretary, for utilization review, the establishment of standards relating to the quality of care furnished to medicaid recipients, and review of the quality of services provided. Federal matching at the 75-percent rate is available for the costs of the health professionals and their supporting staff found necessary in carrying out such functions.

This provision would be effective July 1, 1972.

(t) *Relationship between medicaid and comprehensive health care programs.*—Present law provides that under Title XIX all eligible recipients should receive the same scope of services; that those services should be available throughout the States; and that recipients should have freedom of choice to determine where they shall receive their care. The law also provides that recipients may choose to obtain medical services from organizations providing them (or arranging for their availability on a prepayment basis).

These requirements for State plans, called "comparability and "statewideness", have limited states in their ability to contract with organizations such as neighborhood health centers or pre-paid group practices to provide services to medicaid recipients. These organizations provide services which are often broader in scope than the services received under the medicaid plan, and, therefore, are not available throughout the State. Under current law States are able to contract with such organizations only a) through a waiver under a provision in present law that the particular contract is a demonstration project, or (b) through establishing a separate premium rate for the particular set of services offered under the State plan.

Organized plans, primarily those on a prepaid basis, have been shown to discourage overutilization of expensive inpatient care and to encourage less costly ambulatory care and preventive health measures.

Your committee bill would enable States to waive Federal statewideness and comparability requirements, if a State contracts with an organization which has agreed to provide health care and services in excess of the State plan to eligible people who reside in the geographic area served by such an organization, and who elect to obtain such care and services from such an organization. Payments to such organizations could not be higher on a per capita basis than per capita payments expended for medicaid eligibles in the same general geographic area not under the proposed arrangement.

The amendment would be effective upon enactment.

(u) *Program for determining qualifications for certain health care personnel.*—Under present law, the Secretary establishes various

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health and safety criteria as conditions for the participation of providers of service in the medicare program. In setting these standards it is necessary to establish criteria for judging the professional competency and qualifications of key personnel in these health facilities. Medicare and medicaid regulations have relied heavily on formal training courses and professional society membership in judging professional competency.

Your committee agrees with the Secretary that appropriate criteria as prima facie evidence of competence are necessary. However, your committee is concerned that reliance solely on specific formal education or training, or membership in private professional organizations might serve to disqualify people whose work experience and training might make them equally or better qualified than those who meet the existing requirements. Your committee believes that failure to make the fullest use of competent health personnel is of particular concern because of the shortage of such personnel.

Your committee's bill, therefore, requires the Secretary to explore, develop, and apply appropriate means of determining the proficiency of health personnel disqualified or limited in responsibility under present regulations. A proficiency testing program would help to make greater use of otherwise qualified health personnel and technicians who do not now meet medicare's formal criteria for judging professional competency and qualifications. Appropriate methods and procedures are capable of being promptly developed and applied to determine qualifications and to upgrade skills to qualifying levels.

Your committee obtained agreement from the Department last year to institute such a program with respect to clinical laboratory personnel and asked for a report on the matter by July 1, 1971. Your committee is looking forward to receiving that report.

The amendment would be effective upon enactment.

(v) *Penalties for fraudulent acts and false reporting under medicare and medicaid.*—Under present law, a false statement or representation of a material fact in any application for payment under social security programs is defined as a misdemeanor and carries a penalty of up to one year of imprisonment, a fine of $1,000, or both.

Your committee believes that a specific provision defining acts subject to penalty under the medicare and medicaid programs should be included to provide penalties for certain practices which have long been regarded by professional organizations as unethical, as well as unlawful in some jurisdictions, and which contribute appreciably to the cost of the medicare and medicaid programs. Thus, under the committee bill, the criminal penalty provision would include such practices as the soliciting, offering, or accepting of kickbacks or bribes, including the rebating of a portion of a fee or charge for a patient referral, involving providers of health care services. In addition, the provision would include penalties for concealing or failing to disclose knowledge of any event affecting a person's right to any benefit payment with the intent to defraud, or for knowingly and willfully converting benefits or payments to improper use. Under the bill, the penalty for such acts, as well as false statements or representations of material facts in any application for payment under the medicare and medicaid programs, would be a fine of $10,000, 1 year of imprisonment, or both.

Continuing investigation and review of reports by the General Accounting Office have indicated that false statements may have been made by individuals and institutions with respect to health and safety conditions and operating conditions in health care facilities in order to secure approval for participation in the medicare and medicaid programs. While the numbers of different individuals and institutions involved in such fraud may not be large in relation to the number participating in the program, your committee believes that a specific penalty for such acts should be provided to deter the making or inducing of such statements. Thus, your committee's bill includes specific provisions under title XVIII (medicare) and under title XIX (medicaid) of the Social Security Act whereby anyone who knowingly and willfully makes, or induces or seeks to induce the making of, a false statement of material fact with respect to the conditions and operation of a health care facility or agency in order to secure certification or approval to participate in the medicare and medicaid programs would be subject to imprisonment for up to 6 months, a fine not to exceed $2,000, or both.

These provisions would be in addition to and not in lieu of any other penalty provisions in State or Federal law.

The amendment is effective upon enactment.

(*w*) *Provider reimbursement review board.*—Under present law there is no specific provision for an appeal by a provider of services of a fiscal intermediary's final reasonable cost determination. Although the HEW has developed administrative procedures to assist providers and intermediaries to reach reasonable and mutually satisfactory settlements of disputed reimbursement items, your committee believes that it is desirable to prescribe in law a specific procedure for settling disputed final determinations applying to the amount of program reimbursement. This procedure would not apply to questions of coverage or disputes involving individual beneficiary claims.

Your committee's bill, therefore, provides for the establishment of a Provider Reimbursement Review Board. The Board would be composed of 5 members, knowledgeable in the field of cost reimbursement, appointed by the Secretary of Health, Education, and Welfare. At least one member of the Board would have to be a certified public accountant, and two members would be representative of providers of services.

Any provider of services which has filed a timely cost report may appeal an adverse final decision of the fiscal intermediary with respect to the period covered by such a report to the Board where the amount in controversy is $10,000 or more. The appeal must be filed within 180 days after notice of the fiscal intermediary's final determination. Implementation of the intermediary determinations would not be held in abeyance pending the Board's decision.

The provider would have the right to reasonable notice as to the time and place of hearing and reasonable opportunity to appear at the hearing; to be represented by counsel; to introduce reasonable and pertinent evidence to supplement or contradict the evidence considered by the fiscal intermediary; and to examine and cross-examine witnesses. Under your committee's bill, all decisions by the Board would have to be based upon the record made at such hearing, which may include any evidence submitted by the Department. Such evidence would include the evidence or record considered by the intermediary. Based upon examination of all of the evidence, the Provider Reim-

bursement Review Board may find in whole or in part for the provider or the Government (including a finding based upon the evidence before it that the provider owes sums in addition to the amount raised in the appeal).

A decision of the Provider Reimbursement Review Board would be final unless the Secretary, on his own motion, and within 60 days after the provider of services is notified of the Board's decision, reverses or modifies the Board's decision adversely to the provider. In any case where such reversal or modification occurs, the provider of services would have the right to obtain a review of such a decision by the United States District Court for the district in which it is located or in the United States District Court for the District of Columbia, as an aggrieved party under the Administrative Procedure Act, notwithstanding any other provision in section 205 of the Social Security Act.

The amendments made by this section would be effective with respect to accounting periods beginning after June 30, 1971.

3. Miscellaneous and technical provisions

(*a*) *Physical therapy services and other therapy services under medicare.*—Under present law, physical therapy is covered as an inpatient hospital service, an inpatient extended care service, a home health service, and a service incident to physicians' services. Physical therapy is also covered when furnished under prescribed conditions by a participating hospital, extended care facility, home health agency, clinic, rehabilitation agency, or public health agency to its outpatients. The physical therapist may be either an employee of the participating facility or he may be self-employed and furnish his services under arrangements with and under the supervision of the facility.

The limitations imposed under present law on the coverage of physical therapy have been a source of some difficulty. For example, it has been difficult to explain why physical therapy services cannot be furnished in the therapist's office, especially in cases where the latter is more accessible than the facility to which the beneficiary must travel to obtain the service.

Your committee's bill would include as covered services under the supplementary medical insurance program the services of a physical therapist in independent practice, when furnished in his office or in the patient's home (including a place of residence used as his home other than an institution which is primarily engaged in furnishing skilled health care services). These services would be furnished under such licensing and other conditions relating to health and safety as the Secretary may find necessary, such as requiring that the services be furnished pursuant to a written plan of treatment established by a physician which prescribes the amount, type, and duration of services to be furnished, and setting out professional qualifications in addition to State licensure for the physical therapists participating under this provision. The bill would provide that the Secretary establish regulations governing other conditions under which the proposed services would be furnished. Your committee expects the Secretary to be guided by the conditions now in effect for providers of outpatient physical therapy services, taking into account the less elaborate facilities generally present in the office setting, but assuring that the regulations provide for the availability of an adequate program of physical therapy services in the therapist's office.

. With respect to present law as it covers physical therapy services furnished to an inpatient of a hospital or an extended care facility there are a few cases where an inpatient exhausts his inpatient benefits and can continue to receive payment for the physical therapy treatment (as a covered expense under the supplementary medical insurance program) only if the hospital or extended care facility is able to arrange for another participating facility to furnish the physical therapy treatment as an outpatient service. Your committee's bill would authorize a hospital or extended care facility to furnish outpatient physical therapy services to its inpatients. This would permit an inpatient of a participating hospital or extended care facility to continue to receive covered physical therapy services under the supplementary medical insurance program in those cases where he had exhausted his inpatient benefits through which physical therapy services were covered under the hospital insurance program or where he is otherwise ineligible for hospital insurance inpatient benefits.

Your committee is concerned over the increasing costs of physical therapy services and other therapy services furnished in hospitals and extended care facilities. Accordingly, the committee bill includes two provisions for controlling program expenditures for therapy services and services of other health related personnel and for preventing abuse:

(1) Total charges on which payment may be made in a calendar year with respect to an individual for physical therapy services furnished to him in practitioners' offices or in his home by independently practicing physical therapists may not exceed $100 (such payment would be subject to the deductible and coinsurance provisions of the supplementary medical insurance program). Program reimbursement for the reasonable charges for the covered services would be made either to the beneficiary or, on assignment, directly to the physical therapist.

(2) With respect to physical, occupational, and speech therapy services, or the services of other health specialists, furnished by a provider of services, a clinic, rehabilitation agency, or a public health agency or by others under arrangements with such providers or other organizations, payment for the reasonable cost of such services may not exceed an amount equal to the salary which would have been payable if the services had been performed in an employment relationship, plus the cost of such other expenses an individual not working as an employee might have, such as maintaining an office, travel-time and expense, and similar costs. Your committee expects that the Secretary will, in establishing the criteria for determining the reasonable cost of such services, consult with the professions directly affected and give thorough consideration to procedures used in other public and private plans that may be local, regional, or national in scope.

The provisions for covering additional physical therapy services under supplementary medical insurance would be effective for services furnished on or after January 1, 1972. The provision relating to the coverage of outpatient physical therapy services furnished to inpatients of hospitals or extended care facilities would be effective on enactment of the bill. The provision relating to determining the reasonable cost of services of therapists and other health specialists would be effective with respect to accounting periods beginning on or after January 1, 1972.

(b) *Coverage of supplies related to colostomies.*—Payment under medicare for the bags and straps used in conjunction with some colostomies (an artificial opening of the bowel to the abdominal wall which is often necessary in surgical treatment of cancer of the bowel) is not specifically authorized by the law. Medicare pays for these as surgical dressings, but does not pay for the irrigation equipment and supplies used in treating a colostomy condition. The provision would correct this inequity by providing specific coverage for colostomy bags and supplies directly related to colostomy care, as prosthetic devices.

This provision would be effective on enactment.

(c) *Coverage of ptosis bars.*—Under medicare's supplementary medical insurance program, specific provision is made for the coverage of leg, arm, back, and neck braces, which includes a variety of devices used to support weak or deformed body members or to restrict motion in a diseased or injured part of the body. However, medicare does not pay for ptosis bars used to support the drooping eyelids of patients suffering from paralysis or atrophy of the muscles of the upper eyelid. Your committee's bill would cover these devices in the same way as other supportive devices or appliances. No payment would be made, of course, for eyeglasses to which such devices may be attached.

This provision would be effective on enactment.

(d) *Inclusion under medicaid of care in intermediate care facilities.*—In order to provide a less costly institutional alternative to skilled nursing home care, the Congress approved in 1967 an amendment to Title XI of the Social Security Act which authorized Federal matching for a new classification of care provided in "intermediate care facilities." The provision was intended to provide a means for appropriate placement of patients professionally determined to be in need of institutional care but not care at the skilled nursing home level.

The intermediate care benefit was not intended to cover care which was essentially residential or boarding home in nature. It was not intended to provide a refuge for substandard nursing homes which would not or could not meet medical standards. It was not intended as a placement device whereby States could reduce costs through wholesale and indiscriminate transfer of patients from skilled nursing homes to intermediate care without careful and independent medical review of each patient's health care needs.

Many thousands of patients are in skilled nursing homes who do not need that level of care, according to recent General Accounting Office and HEW audit reports. Thousands of those people are in skilled nursing homes because their States have not as yet established intermediate care programs.

Your committee has, therefore, included an amendment to clarify congressional intent with respect to intermediate care and to make such care, where appropriate, more generally available as an alternative to costlier skilled nursing home or hospital care.

Your committee's amendment is designed to make it clear that intermediate care coverage is for persons who require care in the entire range from just above simple boarding home arrangements up to, but not including, the skilled nursing home level.

Your committee amendment would require an intermediate care facility to meet such standards, prescribed by the Secretary, as are deemed necessary to assist in meeting the needs of the types of patients

expected to be placed in such institutions. The Secretary could establish several levels of standards depending upon the type of care involved. As indicated, the term intermediate care is a broad one encompassing institutions which are just above the boarding home level up to the institution which has a level of health care just below that of the skilled nursing home.

The amendment would provide for the transfer of the intermediate care provisions from Title XI of the Social Security Act to Title XIX (Medicaid). This action will enable the medically indigent, presently ineligible for intermediate care, to receive such care, when a State has a medically needy program and when such care has been determined as appropriate to their health care needs. This change should also serve to end the practice in some States of keeping medically indigent patients in skilled nursing homes when they could more appropriately be cared for in intermediate care facilities. Such States may do so because, under present law, Federal matching funds are available toward the costs of skilled nursing home care provided medically indigent persons but not for care of such people in intermediate care facilities.

Your committee's amendment would also authorize Federal matching under medicaid for care of the mentally retarded in public institutions which have a primary purpose of providing health or rehabilitation services and which are classified as intermediate care facilities. Matching would be available only in a properly qualified institution meeting standards (in addition to those required of an intermediate care facility) established by the Department for mentally retarded persons receiving an active program of health-related treatment or rehabilitation. States would not be eligible for the additional Federal matching funds unless they maintained present levels of State and local funds expended for care of the mentally retarded. The purpose here is to improve medical care and treatment of the needy mentally retarded rather than to simply substitute Federal dollars for State dollars. The provision would not provide Federal participation in payments to institutions that are primarily residential or custodial in character even though these may provide some health or rehabilitation services.

Intermediate care would, under another provision in the bill by definition be less expensive than skilled nursing home care; therefore, the cost of intermediate care should generally be significantly less than skilled nursing home care in the same area.

In view of the rapidly increasing expenditures for intermediate care and in view of the extension of intermediate care to the medically indigent, your committee has added another provision to its amendment requiring regular independent professional review of patients in those intermediate care facilities which have a significant health content. Teams headed by either a physician or a registered nurse would regularly review, on site, the nature of the care required and provided to each such intermediate care recipient. That review would be undertaken on a patient-by-patient basis and may not be performed at a distance or without reference to the specific circumstances of the individual patient. The Secretary of HEW would be expected to establish two or more levels of care encompassed under the intermediate care concept and then vary his regulations for such reviews based on the characteristics of the patients in the various levels of care.

The amendment would be effective January 1, 1972.

(e) *Coverage prior to application for medical assistance.*—Under present law, a State may, at its own option cover the cost of health care provided to an otherwise qualified recipient for the three months prior to his application for medicaid. Thirty-one States have elected to provide this coverage, thereby protecting persons who are eligible for medicaid but do not apply for assistance until after they have received care, either because they did not know about the medicaid eligibility requirements, or because the sudden nature of their illness prevented their applying.

Your committee believes such coverage is reasonable and desirable. Your committee's bill would therefore require States to provide coverage for care and services furnished in or after the third month prior to application for those individuals who were otherwise eligible when services were received.

This provision would be effective July 1, 1972.

(f) *Hospital admissions for dental services under medicare.*—Under present medicare procedures, when a patient is hospitalized in connection with the performance of noncovered dental procedures, payment may be made for inpatient hospital services if the patient has other impairments so severe that hospitalization is necessary. In some cases, intermediaries require that a physician certify to the medical necessity of dental admissions, since hospitalization is ordinarily not necessary for the provision of dental services. Where such a certification is required, the dentist who will be performing the dental procedures must arrange for a physician to make the necessary certification.

Your committee's bill would authorize the dentist who is caring for the patient to make the certification of the necessity for inpatient hospital admission for noncovered dental services under the above circumstances without requiring a corroborating certification by a physician. Your committee believes that in these kinds of cases the dentist is in a better position to make the necessary evaluation of the patient's condition and probable reaction to dental surgery than is a physician who may not be familiar either with the patient or the nature of the dental procedures to be performed.

This provision would be effective with respect to admissions occurring after the second month following enactment of the bill.

(g) *Extension of grace period for termination of supplementary medical insurance coverage where failure to pay premiums is due to good cause.*—Under present law, an individual's coverage under the supplementary medical insurance part of medicare is terminated for nonpayment of premiums. The termination is effective on a date determined under regulations which may be established so as to provide a grace period (not in excess of 90 days) during which overdue premiums may be paid and coverage continued.

Several types of cases have arisen in which termination of an individual's supplementary medical insurance protection for failure to pay all premiums due within 90 days is clearly inequitable. For example, there have been cases where for reasons of physical or mental incapacity the enrollee was unable to make the premium payment within the allowed time limit and there was no one acting on his behalf to protect his interests. In other cases, coverage has been terminated because the enrollee mistakenly believed that payment had been made when actually it had not.

Your committee's bill would extend the 90-day grace period for an additional 90 days where the Secretary finds that there was good cause for failure to pay the premium before the expiration of the initial 90-day grace period.

This provision would apply to such cases of nonpayment of premiums due within the 90-day period preceding the date of enactment.

(*h*) *Extension of time for filing claim for supplementary medical insurance benefits where delay is due to administrative error.*—Under present law, a claim for benefits under the supplementary medical insurance program must be filed by December 31 of the year following the year in which the services were provided. (For this purpose, services furnished in the last 3 months of a year are deemed to have been furnished in the following year.) The present time limit is adequate for the vast majority of supplementary medical insurance claims. In some few cases, however, beneficiaries have failed to file a timely claim due to a mistake or other action on the part of the Government or one of its agents. For example, misinformation from an official source or delay in establishing supplementary medical insurance entitlement has resulted in late filing of claims.

Your committee's bill would provide that where a claim under supplementary medical insurance is not filed timely due to error of the Government or one of its agents, the claim may nevertheless be honored if filed as soon as possible after the facts in the case have been established. This provision would assure that claimants would not be treated inequitably because of such an error.

This amendment would apply with respect to bills submitted and requests for payment made after March 1968.

(*i*) *Waiver of enrollment period requirements where individual's rights were prejudiced by administrative error or inaction.*—Under present law, an individual can enroll in the supplementary medical insurance program during his initial 7-month enrollment period, beginning with the third month before the month he attains age 65, or during any general enrollment period (during the first 3 months of each year), which begins within 3 years after the end of his initial enrollment period. (The committee's bill includes a provision which would eliminate the 3-year limit on enrollment. That provision is discussed immediately following discussion of this provision.)

There have been some relatively rare cases in which it has been discovered that due to an action, inaction, or error on the part of the Government an individual is in fact enrolled, or is in fact not enrolled, under supplementary medical insurance when both the individual and the Government had until then believed that the reverse was true.

Although rare, such cases may be a cause of considerable hardship and distress to the individuals involved, and present law permits no relief to be given. Your committee recognizes that enactment of the provision (discussed above) under which supplementary medical insurance enrollment would be automatic for individuals who are entitled to hospital insurance would in all likelihood result in a lesser number of problem cases involving supplementary medical insurance enrollment than are encountered under present law. However, since not all supplementary medical insurance enrollees will be entitled to hospital insurance and therefore will not be automatically enrolled for supplementary medical insurance, it is reasonable to expect there will continue to be such problem situations. It can also be expected

that some problem cases involving enrollment status may result from the automatic enrollment of eligible persons.

Your committee believes that where an individual's enrollment rights under supplementary medical insurance have been prejudiced because of the action, inaction or error on the part of the Government, he should not be penalized or caused hardship. The bill, therefore, authorizes the Secretary to provide such equitable relief as may be necessary to correct or eliminate the effects of these situations, including (but not limited to) the establishment of a special initial or subsequent enrollment period, with a coverage period determined on the basis thereof and with appropriate adjustments of premiums.

This provision would apply to all cases which have arisen since the beginning of the program.

(*j*) *Elimination of provisions preventing enrollment in supplementary medical insurance program more than 3 years after first opportunity.*—Under present law, an individual can enroll for the first time in the supplementary medical insurance program during his initial 7-month enrollment period, beginning with the third month before the month he attains age 65, or during any general enrollment period (during the first 3 months of each year) which begins within 3 years after the end of his initial enrollment period. A person whose enrollment has terminated may not enroll for the second time in supplementary medical insurance unless he does so in a general enrollment period which begins within 3 years after the effective date of such termination. An individual may reenroll only once.

The 3-year enrollment limit was included in the law (as are other limitations on enrollment in the supplementary medical insurance program) in the interest of avoiding antiselection in case the enrollment under the program was not a very substantial proportion of people eligible to enroll. For example, substantial numbers of people who are relatively healthy might delay enrollment until they are well past age 65 and have become sick, at which point they would enroll and receive substantial benefits without having paid much in premiums. However, since there is now a 95-percent rate of participation in the program and since the vast majority of enrollees enroll at the earliest possible time, there would seem to be no reason to retain the 3-year limit on enrollment. Further, present law provides that premiums for late enrollees are increased 10 percent for each full 12 months elapsed between the time they could have enrolled and actually do enroll and this provision would be retained. Such late-enrollment charges serve to prevent antiselection and to meet the higher costs associated with those who enroll at older ages. It is not intended, of course, that the months for which the law itself precluded individuals from enrolling or reenrolling would apply in determining the late-enrollment charges.

Your committee's bill would eliminate the 3-year limit with respect to both initial enrollment and reenrollment after an initial termination. Enrollment periods would remain as presently defined and the restriction limiting individuals who terminate enrollment to reenroll only once would be retained.

This provision would apply to all those who are ineligible to enroll because of the 3-year limit in effect under present law.

(*k*) *Waiver of recovery of incorrect payments from survivor who is without fault under medicare.*—Under present law, an individual to whom (or on behalf of whom) a medicare overpayment is made is

subjected to recovery action with respect to such overpayment, except that the recovery action may be waived if the individual is without fault and if recovery would defeat the purposes of the cash social security title (title II) of the Social Security Act or would be against equity and good conscience. If such individual dies, recovery action is initiated as necessary against any other individual who is receiving cash social security benefits on the same earnings record as the deceased overpaid beneficiary. In the latter situation, however, waiver of recovery action is not permitted even though the surviving beneficiary—a widow, for example—is without fault with respect to the overpayment.

The Social Security Amendments of 1967 included a provision which permitted recovery to be waived in the case of cash benefits if the individual from whom recovery is being considered is without fault, even though the overpaid individual was at fault. However, the comparable change with respect to medicare overpayments was not made. As a result, there are situations in which, for example, an overpayment made to a deceased beneficiary is the responsibility of his widow even though she was without fault in causing the overpayment, whereas if the overpayment had been made to or on behalf of the widow herself, the waiver provision would apply if she were not at fault.

Your committee's bill would rectify this anomaly by permitting any individual who is liable for repayment of a medicare overpayment to qualify for waiver of recovery of the overpaid amount if he is without fault and if such recovery would defeat the purposes of title II or would be against equity and good conscience.

The provision would be effective upon enactment for overpayments outstanding at that time.

(*l*) *Requirement of minimum amount of claim to establish entitlement to hearing under supplementary medical insurance program.*—Under present law, people enrolled in the supplementary medical insurance program are assured an opportunity for a fair hearing by the carrier when requests for payment under supplementary medical insurance are denied or are not acted upon with reasonable promptness, or when the amount of the payment is in controversy, regardless of the dollar amount at issue. Experience under the program indicates that the holding of a full fair hearing is unwarranted in cases where the amount in controversy is relatively small. Carriers have reported cases involving $5 and $10 claims for which the cost of holding a fair hearing has exceeded $100. Approximately 45 percent of the hearings held since the beginning of the program have involved an amount less than $100. Further, regulations require carriers to have a reconsideration review of all denied claims. Such review involves different claims personnel than those who acted on the original claim and should be sufficient protection in small claims cases.

Your committee's bill would require that a minimum amount of $100 be at issue before an enrollee in the supplementary medical insurance program will be granted a fair hearing by the carrier.

The provision would be effective with respect to hearings requested after the enactment of the bill.

(*m*) *Collection of supplementary medical insurance premiums from individuals entitled to both social security and railroad retirement benefits.*—Under present law, the responsibility for collecting supple-

mentary medical insurance premiums for enrollees entitled to both railroad retirement benefits and social security benefits is vested in either the Social Security Administration or the Railroad Retirement Board, depending upon the circumstances of entitlement at the time of enrollment. This arrangement requires an administrative procedure under which persons so entitled can enroll in the supplementary medical insurance program with either agency. The result has been that some individuals (because all the facts are not made known at the time of enrollment) are enrolled twice and have two different identifying numbers; others are enrolled by the Social Security Administration and not enrolled by the Railroad Retirement Board, or vice versa, and thus may have two medicare cards—one showing entitlement to benefits under part A only and the other showing entitlement to benefits under both parts A and B. Such discrepancies, even though ultimately corrected, are a source of confusion to beneficiaries and a cause of unnecessary administrative expense.

Also, the processing of medical insurance claims is established so as to require that all claims submitted by or on behalf of railroad beneficiaries be handled by a single carrier, presently the Travelers Insurance Company. Because the account numbers assigned to railroad beneficiaries who enroll with the Social Security Administration are not identified as applying to railroad beneficiaries (because the beneficiary does not make this known), many railroad beneficiary claims are submitted to other carriers and require rerouting to Travelers Insurance Company. This is expensive and a cause of delay in making payments.

Your committee's bill provides that the Railroad Retirement Board shall be responsible for collection of supplementary medical insurance premiums for all enrollees who are entitled under that program. This change will eliminate the confusion, payment delay, and administrative expense deriving from the related provisions of present law. Your committee's bill also provides that the Railroad Retirement Board shall contract with a carrier or carriers for purposes of servicing its beneficiaries with respect to part B benefits, an arrangement presently in effect as a result of the Commissioner of Social Security having delegated his authority to do this to the Railroad Retirement Board. Your committee expects the Railroad Retirement Board to make continuing efforts to assure that there is conformity between reasonable charges for covered services as these are determined by the carrier or carriers under contract with the Board and reasonable charges for comparable services in the same locality as these are determined by carriers acting for the Social Security Administration.

This provision would be effective for premiums becoming due and payable after the fourth month after the month of enactment.

(*n*) *Prosthetic lenses furnished by optometrists under supplementary medical insurance program.*—Under present law, optometric services are not covered except with respect to services incidental to the fitting and supplying of prosthetic lenses ordered by a physician. Your committee's bill does not provide for any change in the present limitation on coverage of optometric services.

The committee believes, however, that the medicare requirement that a physician's prescription or order accompany requests for payment for covered prosthetic lenses when such lenses are furnished by

an optometrist unduly limits both patient and optometrist and should be eliminated. The patient's freedom to choose either an ophthalmologist or an optometrist to furnish him with prosthetic lenses should no longer be restricted by this requirement.

The committee bill would recognize the ability of an optometrist to determine a beneficiary's need for prosthetic lenses by amending the definition of the term "physician" in title XVIII to include a doctor of optometry authorized to practice optometry by the State in which he furnishes services. An optometrist would be recognized as a "physician" only for the purpose of attesting to the patient's need for prosthetic lenses. This change would not provide for coverage of services performed by optometrists other than those covered under present law.

The amendment would become effective upon enactment.

(o) *Prohibition against requiring professional social workers in extended care facilities under medicare.*—In order to participate as an extended care facility under the medicare program, institutions are now required to engage the services of a professional social worker. This requirement is not specified in the statute but was promulgated by the Secretary under his authority to establish conditions deemed necessary for the health and safety of patients. The regulation requires an extended care facility to designate one staff member to be responsible for attending to medically related social problems of patients; if this staff member is not a qualified social worker (that is, one who was graduated from a school of social work accredited by the Council on Social Work Education), the facility must have effective arrangements with a public or private agency (which may be a local welfare department) to provide social service consultation. In addition, a qualified social worker must participate in staff training programs, case conferences, and arrangements for staff orientation to community services to meet patients' needs.

Your committee recognizes and appreciates the value of medical social services, particularly for the medicare patient receiving extended care, since these services promote emotional and social adjustment of the patient and his family, aid rehabilitation, and contribute to effective discharge planning. However, the need to make such specialized services generally available from or under the direction of professional social workers can, in some cases, represent a substantial cost to the extended care facility which cannot be justified by the value derived by its total patient population. Your committee also notes that, although conditions for participation by hospitals include standards for a medical social service department, a hospital which does not have such a department may, nevertheless, be certified to participate in the program. It seems inconsistent with the medicare concept of movement of patients to progressively lower levels of care that provision of such a specialized ancillary service as medical social services would be optional for a hospital but required of an extended care facility.

While agreeing that services of professional social workers are appropriate for medicare reimbursement to those extended care facilities which provide them to their patients, your committee believes that the individual facility should have greater latitude in determining whether the medical social needs of its patient population require availability of professional assistance. Therefore, your committee's amendment would specify that provision of medical social services

would not be required as a condition of participation as an extended care facility under the medicare program. Of course, where such services are being provided it is expected that they would conform to recognized standards.

(*p*) *Refunding of excess premiums under medicare.*—Under present law, where part B entitlement terminates due to the death of the enrollee, refund of any excess premiums is made, upon claim, to the legal representative of the enrollee's estate. If there is no legal representative and it is reasonably certain that none will be appointed, refund may be made, only upon claim, to a relative of the deceased on behalf of the estate.

It has come to the committee's attention that early in the program it was recognized that excess part B premiums paid by a deceased enrollee could be best disposed of, in those cases where there is no legal representative of the deceased's estate, by adding them to benefits subsequently payable on the same medicare claims number or to those relatives who would (except for age or dependency requirements) be eligible on the same record. However, the Office of General Counsel has advised that this could not be done in the absence of necessary authority in the law. Consequently, the much more cumbersome claims procedure has had to be used. Where there is no claim for the excess premium payments, no refund is made.

A similar problem is likely to exist with respect to premiums paid in advance under the provision of the bill which would provide, at a cost of $31 per month per enrollee, hospital insurance coverage for people who are age 65 and over and who are not eligible for such coverage under present law.

The committee bill, therefore, would provide authority for the Secretary to dispose of excess supplementary medical insurance premiums and excess hospital insurance premiums in the same manner as unpaid medical insurance benefits are treated. This provision would be effective upon enactment.

(*q*) *Waiver of requirement of registered professional nurses in skilled nursing homes in rural areas under medicaid program.*—Your committee is concerned that an undue hardship may be imposed on skilled nursing homes in rural areas through implementation of the medicaid requirement that all such facilities have an organized nursing service under the direction of a full-time professional registered nurse. In several rural areas such facilities would be unable to meet the medicaid requirements due to the scarce supply of nursing personnel in such areas.

Your committee bill would therefore authorize waivers (for up to one year at a time and ending no later than December 31, 1975) of the requirements for skilled nursing homes in rural areas providing such homes make certain showings to the Secretary. Waivers would only be granted in those cases where (1) the nursing home is located in a rural area and the supply of other skilled nursing home services in such area is not sufficient to meet patient needs, (2) the failure of such home to qualify would seriously reduce the availability of services to beneficiaries in the area, (3) the nursing home has and is continuing to make a good faith effort to comply with this requirement but such compliance is impeded by the lack of qualified nursing personnel in such area, and (4) the requirements were met for a regular daytime shift.

Your committee wishes to assure that in no case will this provision result in the encouragement of substandard nursing services and that every effort is being made by the facilities to comply with the nursing requirements.

(r) *Exemption of Christian Science sanatoriums from certain nursing home requirements under medicaid.*—Under present law, Christian Science sanatoriums are permitted to participate in the medicaid program as skilled nursing homes, and as such, are required to meet the general requirements established for skilled nursing homes.

Your committee believes that Christian Science sanatoriums, which do not actually provide medical care, should not be required to have a skilled nursing home administrator licensed by the State, to maintain an organized nursing service under the direction of a registered nurse, to maintain detailed medical records, or to have diagnostic and other service arrangements with general hospitals. The bill would therefore, exempt Christian Science sanatoriums from the requirements for a licensed nursing home administrator and other inappropriate medical requirements of the medicaid program. Such sanitoriums will be expected to continue to meet all applicable safety standards.

This provision would be effective upon enactment.

(s) *Requirements for nursing home administrators.*—Your committee is concerned that persons who have demonstrated their capability as nursing home administrators over a period of time should not be precluded from serving in this capacity because they fail to meet certain formal requirements imposed for purposes of the medicaid program. Your committee bill would, therefore, permit the States to establish a permanent waiver from such requirements for those persons who served as nursing home administrators for the three-year period preceding the year the State established a program for the licensing of nursing home administrators.

(t) *Termination of National Advisory Council on Nursing Home Administration.*—The 1967 Social Security Amendments required State licensure of nursing home administrators. The statute also established the National Advisory Council on Nursing Home Administration in order to study, develop, and advise the Secretary and the States concerning matters relating to the qualifications, training and other areas related to a proper program of licensure. The Council was scheduled to terminate on December 31, 1971.

Your committee has noted that the Council has essentially completed its work and has passed a resolution to that effect. Therefore your Committee bill would provide for the termination of the National Advisory Council on Nursing Home Administration thirty days after enactment of this bill. It is expected that the Medical Assistance Advisory Council would assume responsibility for any continuing need for advice and assistance with respect to licensing of nursing home administrators.

(u) *Increase in limitation on payments to Puerto Rico for medical assistance.*—Under present law, Federal matching funds for Puerto Rico's Medicaid expenditures are at the rate of 50 percent, except that the total amount of Federal funds may not exceed $20 million in any fiscal year.

Your committee believes that the $20 million Federal maximum on Medicaid payments to Puerto Rico should be adjusted to reflect the

rise in hospital and health care costs, as well as the number of people eligible for Medicaid since 1967, when the ceiling and matching rate were established.

Your committee recognizes the effective improvement in the delivery of health care to the poor which has characterized the Puerto Rico Medicaid program and the fact that the cost of health care has substantially increased since 1967 when the original ceiling was established.

Your committee's bill would therefore provide that the Federal ceiling on title XIX payments to Puerto Rico be increased to $30 million effective with the fiscal year 1972 and fiscal years thereafter. The 50 percent Federal matching rate would remain unchanged.

(v) *Study of chiropractic coverage.*—Your committee's bill would require the Secretary to conduct a study of chiropractic services covered under State plans approved under title XIX. The objectives of the study would be to determine whether and to what extent chiropractic services should be covered under the supplementary medical insurance program of title XVIII, giving particular attention to the limitations which should be placed on such coverage and on the amounts to be paid for whatever services might be provided. The study would include one or more demonstration projects designed to assist in providing (under controlled conditions) the information necessary to achieve the objectives of the study. The Secretary would be required to report the results of the study to the Congress within 2 years after the date of enactment of this bill, together with his findings and recommendations based on the study, and on the information he obtains concerning the experience of public and private plans which now or did cover chiropractic services.

C. Actuarial Cost Estimates Under the Bill

1. FINANCING

Consistent with the policy of maintaining the social security program on a sound financial basis, which has been followed in the past, the bill would make provision for meeting the cost of the expanded program. At the present time, the social security cash benefits program is in close actuarial balance, while the hospital insurance program has an actuarial deficiency; that is, it is expected that over the long-range future the income to the hospital insurance program will be considerably less than the costs of the program. To meet the cost of the expanded cash benefits and hospital insurance programs and to bring the hospital insurance program into actuarial balance, the schedule of contribution rates would be revised and the contribution and benefit base—the maximum amount of annual earnings subject to contributions and used in computing benefits—would be increased.

(a) *Increase in the contribution and benefit base.*—The proposed increase in the contribution and benefit base from $7,800 to $10,200 in 1972, rather than to $9,000 as provided in present law, would not only provide higher benefits at higher earnings levels, but also would help to finance the changes made by the bill. An increase in the base results in a reduction in the overall cost of the social security program as a percent of taxable payroll. This occurs because the benefits provided are a higher percentage of earnings at the lower levels than at the higher levels, while the contribution rate is a flat percentage of

CONDITIONS OF PARTICIPATION:
EXTENDED CARE FACILITIES

FEDERAL HEALTH INSURANCE FOR THE AGED

(CODE OF FEDERAL REGULATIONS,
TITLE 20, CHAPTER III, PART 405)

REGULATIONS

U. S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

HIR-11 (2-68)
REPRINT DATE (2-70)

SUBPART K

Conditions of Participation; Extended Care Facilities

NOTE: §§ 405.1101 to 405.1137 issued under sections 1102, 1861(j), 1864, and 1871, 49 Stat. 647, as amended, 79 Stat. 317, 79 Stat. 326, 79 Stat. 331; 42 U.S.C. 1302, 1395 et seq.

405.1101 General.—(*a*) In order to participate as an extended care facility in the health insurance program for the aged, an institution must be an "extended care facility" within the meaning of section 1861 (j) of the Social Security Act. This section of the law states a number of specific requirements which must be met by participating extended care facilities and authorizes the Secretary of Health, Education, and Welfare to prescribe other requirements considered necessary in the interest of health and safety of beneficiaries.

SEC. 1861. For purposes of this title—

* * * * *

(j) The term "extended care facility" means (except for purposes of subsection (a)(2)) an institution (or a distinct part of an institution) which has in effect a transfer agreement (meeting the requirements of subsection (l)) with one or more hospitals having agreements in effect under section 1866 and which—

(1) is primarily engaged in providing to inpatients (A) skilled nursing care and related services for patients who require medical or nursing care, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons;

(2) has policies, which are developed with the advice of (and with provision of review of such policies from time to time by) a group of professional personnel, including one or more physicians and one or more registered professional nurses, to govern the skilled nursing care and related medical or other services it provides;

(3) has a physician, a registered professional nurse, or a medical staff responsible for the execution of such policies;

(4)(A) has a requirement that the health care of every patient must be under the supervision of a physician, and (B) provides for having a physician available to furnish necessary medical care in case of emergency;

(5) maintains clinical records on all patients;

(6) provides 24-hour nursing service which is sufficient to meet nursing needs in accordance with the policies developed as provided in paragraph (2), and has at least one registered professional nurse employed full time;

(7) provides appropriate methods and procedures for the dispensing and administering of drugs and biologicals;

(8) has in effect a utilization review plan which meets the requirements of subsection (k);

(9) in the case of an institution in any State in which State or applicable local law provides for the licensing of institutions of this nature, (A) is licensed pursuant to such law, or (B) is approved, by the agency of such State or locality responsible for licensing institutions of this nature, as meeting the standards established for such licensing; and

(10) meets such other conditions relating to the health and safety of individuals who are furnished services in such institution or relating to the physical facilities thereof as the Secretary may find necessary (subject to the second sentence of section 1863);

except that such term shall not (other than for purposes of subsection (a)(2)) include any institution which is primarily for the care and treatment of mental diseases or tuberculosis. For purposes of subsection (a)(2), such term includes any institution which meets the requirements of paragraph (1) of this subsection. The term "extended care facility" also includes an institution described in paragraph (1) of subsection (y), to the extent and subject to the limitations provided in such subsection.

(*b*) The requirements included in the statute and the additional health and safety requirements prescribed by the Secretary are set forth in the Conditions of Participation for Extended Care Facilities. An institution which meets all of the specific statutory requirements and which is found to be in substantial compliance with the additional conditions prescribed by the Secretary may, if it so desires, agree to become a participating extended care facility.

(*c*) The Secretary may, at the request of a State, approve higher health and safety requirements for that State. Also, where a State or political subdivision imposes higher requirements on institutions as a condition for the purchase of services under a State plan approved under title I, XVI, or XIX of the Social Security Act, the Secretary is required to impose like requirements as a condition to the payment for services in such institutions in that State or subdivision.

(*d*)(1) The extended care benefit provided by the health insurance program for the aged is intended to be a benefit for those persons who, though they no longer require the level of intensive care

ordinarily furnished in a general hospital, continue to need for medical reasons a level of care entailing medically supervised skilled nursing and related services on a continuing basis in an institutional setting. The extended care benefit covers not only postacute hospitalization where the individual is convalescing or being rehabilitated but also those types of cases where the patient may continue to be severely ill and indeed have little or no prospect of recovery. (The physician's certification required by section 1814(a)(2)(D) of the Social Security Act is, in part, that the extended care facility services are required because the patient needs "skilled nursing care on a continuing basis" for any of the conditions for which he had just been previously hospitalized. Thus, a terminal cancer patient who may receive only palliative treatment but whose condition requires skilled nursing services available at all times would qualify for extended care benefits.) The underlying program purpose of the extended care benefit is to encourage the most effective and economical utilization of available medical care resources and facilities. Since it will be necessary for many aged patients who are hospitalized for intensive treatment of an acute phase of illness to undergo a period of medically supervised convalescence or care in a facility which is staffed and equipped to provide skilled nursing and other restorative services, the extended care benefit was provided to enable physicians to transfer patients (when the physician determines the transfer is medically appropriate), to such facilities rather than allowing patients to continue unnecessarily to occupy high-cost hospital beds.

(2) Accordingly, an extended care facility, whether it is a distinct part of an institution or a separate institution, is a facility which provides a level of care distinguishable from the level of intensive care ordinarily furnished by a general hospital. This level of care is reflected in the conditions of participation. While the conditions c ll for a wide range of specialized medical services and the employment by the facility in adequate numbers of a variety of paramedical and skilled nursing personnel, the emphasis is on the provision of skilled nursing and related care rather than the type of care and treatment required in the acute phase of an illness. Similarly, although the legislative language concerning rehabilitation services is the same with respect to hospitals and extended care facilities, the general concept of an extended care facility is that of an intermediate institution which provides post-hospital, subacute services. Hence, a rehabilitation hospital would be equipped and staffed to diagnose and evaluate the patient's disability and to initiate a rehabilitation regime. A rehabilitation extended care facility, on the other hand, would be staffed and equipped to continue and modify such a regime during the patient's convalescence.

(3) Thus, neither the title used by an institution, nor the statute under which it is licensed, necessarily identifies its function as being that of either a hospital or an extended care facility in the context of title XVIII. Its primary purpose and the way it carries out its program of services must be evaluated and determined. In the final analysis, the hospital is designed to initiate care, including diagnosis and treatment. The extended care facility is designed to continue care, with appropriate modifications as the patient's condition changes.

(e) Attention is invited to the requirements of Title VI of the Civil Rights Act of 1964 (78 Stat. 252; P.L. 88–352) which provides that no person in the United States shall, on the ground of race, color, or national origin be excluded from participation in, be denied the benefits of, or be subject to discrimination under any program or activity receiving Federal financial assistance (sec. 601), and to the implementing regulation issued by the Secretary of Health, Education, and Welfare with the approval of the President (Part 80 of this title).

405.1102 Conditions of Participation; General.—For an institution to be eligible for participation in the program, it must meet the statutory requirements of section 1861(j) and there must be a finding of substantial compliance on the part of the institution with all the other conditions. These conditions which include both the statutory requirements and the additional health and safety requirements prescribed by the Secretary are set forth in §§ 405.1120 through 405.1137. They are requirements relating to the quality of care and the adequacy of the services and facilities which the institution provides. Variations in the type and size of the institutions and the nature and scope of services offered will be reflected in differences in the details of organization, staffing, and facilities. However, the test is whether there is substantial compliance with the prescribed conditions of participation.

405.1103 Standards; General.—As a basis for a determination as to whether or not there is substantial compliance with the prescribed conditions in the case of any particular extended care facility, a series of standards, almost all interpreted by explanatory factors, are listed under each con-

dition. These standards represent a broad range and variety of activities which such facilities may undertake or be pursuing in order to carry out the functions embodied in the conditions. Reference to these standards will enable the State agency surveying a facility to document the activities of the institution, to establish the nature and extent of its deficiencies, if any, with respect to any particular function, and to assess the facility's need for improvement in relation to the prescribed conditions. In substance, the application of the standards, together with the explanatory factors, will indicate the extent and degree to which an extended care facility is complying with each condition.

405.1104 Certification by State Agency.—(*a*) The Health Insurance for the Aged Act provides that the services of State agencies, operating under agreements with the Secretary, will be used by the Secretary in determining whether institutions meet the conditions of participation. Pursuant to these agreements, State agencies will certify to the Secretary, extended care facilities which, are found to be in substantial compliance with the conditions. Such certifications shall include findings as to whether each of the conditions is substantially met. The Secretary, on the basis of such certification from the State agency, will determine whether or not an institution is an extended care facility eligible to participate in the health insurance program as a provider of services.

(*b*) The decisions of the State agency represent recommendations to the Secretary. Notice of determination of eligibility or noneligibility made by the Secretary on the basis of a State agency decision will be sent to the institution concerned by the Social Security Administration after such review and professional consultation with the Public Health Service as may be required. If it is determined that the institution does not comply with the conditions of participation, the institution may request that the determination be reviewed. For procedures relating to the appeals process, see Subpart O of this Part 405.

(Par. (*b*) amended 12–18–68.)

405.1105 Principles for the Evaluation of Extended Care Facilities to Determine Whether They Meet the Conditions of Participation.—Extended care facilities will be considered in substantial compliance with the conditions of participation upon acceptance by the Secretary of findings, adequately documented and certified to by the State agency, showing that:

(*a*) The facility meets the specific statutory requirements of section 1861(j) and is found to be operating in accordance with all other conditions of participation with no signfiicant deficiencies, or

(*b*) The facility meets the specific statutory requirements of section 1861(j) but is found to have deficiencies with respect to one or more other conditions of participation which:

(1) It is making reasonable plans and efforts to correct, and

(2) Notwithstanding the deficiencies, is rendering adequate care and is without hazard to the health and safety of individuals being served, taking into account special procedures or precautionary measures which have been or are being instituted.

405.1106 Time Limitations on Certifications of Substantial Compliance.—(*a*) All initial certifications by the State agency to the effect that an extended care facility is in substantial compliance with the conditions of participation will be for a period of 1 year, beginning with January 1, 1967, or if later, with the date on which the facility is first found to be in substantial compliance with the conditions. State agencies may visit or resurvey institutions where necessary to ascertain continued compliance or to accommodate to periodic or cyclical survey programs. A State finding and certification to the Secretary that an institution is no longer in compliance may occur within a 1-year or subsequent period of certification and will thereby terminate the State certification as to compliance.

(*b*) If an extended care facility is in substantial compliance under the provisions of § 405.1105(*b*), the following information will be incorporated in the Secretary's finding and into the notice of eligibility to the facility:

(1) A statement of the deficiencies which were found, and

(2) A description of progress which has been made and further action which is being taken to remove the deficiencies, and

(3) A scheduled time for a resurvey of the institution to be conducted not later than the ninth month (or earlier, depending on the nature of the deficiencies) of the period of certification.

(Par. (*b*) amended 12–18–68.)

405.1107 Certification of Noncompliance.—(*a*) The State agency will certify that an institution is not in compliance with the conditions of participation or, where a determination of eligibility has been made, that an institution is no longer in compliance where:

(1) The institution is not in compliance with one or more of the statutory requirements of section 1861(j), or

(2) The institution has deficiencies of such character as to seriously limit the capacity of the institution to render adequate care or to place health and safety of individuals in jeopardy, and consultation to the institution has demonstrated that there is no early prospect of such significant improvement as to establish substantial compliance as of a later beginning date, or

(3) After a previous period or part thereof for which the institution was certified under circumstances outlined in § 405.1105(b), there is a lack of progress toward a removal of deficiencies which the State agency finds are adverse to the health and safety of individuals being served.

(b) If, on the basis of a State agency certification, it is determined by the Secretary that the institution does not substantially meet, or no longer substantially meets, the conditions of participation, an agreement for participation may not be accepted for filing, or if filed, may be terminated. The institution may request that the determination be reviewed. For procedures relating to the appeals process, see Subpart O of this Part 405.

(Section heading and par. (b) amended 12-18-68.)

405.1108 Criteria for Determining Substantial Compliance.—Findings made by a State agency as to whether an extended care facility is in substantial compliance with the conditions of participation require a thorough evaluation of the degree to which operation of a facility demonstrates adequate performance of the functions which are embodied in the conditions. The State evaluation will take into consideration:

(a) The degree to which each standard, as well as the total set of standards relating to a condition of participation, is met;

(b) When there is a deficiency in meeting a standard, whether the deficiency is one concerning the statutory requirements which must be met by all extended care facilities (sec. 1861(j));

(c) Whether the deficiency creates a hazard to health and safety; and

(d) Whether the facility is making reasonable plans and efforts to correct the deficiency within a reasonable period.

405.1109 Documentation of Findings.—The findings of the State agency with respect to each of the conditions of participation should be adequately documented. Where the State agency certification to the Secretary is that an institution is not in compliance with the conditions of participation, such documentation should include a report of all consultation which has been undertaken in an effort to assist the institution to comply with the conditions, a report of the institution's responses with respect to the consultation, and the State agency's assessment of the prospects for such improvements as to enable the institution to achieve substantial compliance with the conditions.

405.1110 Authorization for Special Certification.—(a) Where, because of the absence of any participating extended care facility or hospital in an area, the denial of eligibility of an institution to participate in the program would result in beneficiaries not having access to needed services, an institution may, upon recommendation by the State agency, be approved by the Secretary as an extended care facility. Such approval will be granted only where there are no deficiencies of such character and seriousness as to place health and safety of individuals in jeopardy. An institution receiving this special approval shall furnish information showing the extent to which it is making the best use of its resources to improve its quality of care. Resurveys of such institutions will be made at least semiannually.

(b) Each case will have to be decided on its individual merits; and while the degree and extent of compliance will vary, the institution must, as a minimum, meet all of the statutory conditions in section 1861(j)(1)–(9), in addition to meeting such other requirements as the Secretary finds necessary under section 1861(j)(10).

405.1120 Condition of Participation—Compliance With State and Local Laws.—The extended care facility is in conformity with all applicable Federal, State, and local laws, regulations and similar requirements.

(a) *Standard; Licensing of Institution.*—In any State in which State or applicable local law provides for the licensing of extended care facilties, the institution (1) is licensed pursuant to such law, or (2) is approved by the agency of the State or locality responsible for licensing such institutions, as meeting the standards established for such licensing.

(b) *Standard; Licensing of Staff.*—Staff of the extended care facilty is currently licensed or registered in accordance with applicable laws.

(c) *Standard; Conformity With Laws.*—The extended care facility is in conformity with laws relating to fire and safety, communicable and reportable diseases, and other relevant matters.

405.1121 Condition of Participation—Administrative Management.—The extended care facility has an effective governing body legally responsible for the conduct of the facility, which designates an administrator and establishes administrative policies. However, if the extended care facility does not have an organized governing body, the persons legally responsible for the conduct of the extended care facility carry out or have carried out the functions herein pertaining to the governing body.

(*a*) *Standard; Governing Body.*—There is a governing body which assumes full legal responsibility for the overall conduct of the facility. The factors explaining the standard are as follows:

(1) The ownership of the facility is fully disclosed to the State agency. In the case of corporations, the corporate officers are made known.

(2) The governing body is responsible for compliance with the applicable laws and regulations of legally authorized agencies.

(*b*) *Standards; Full-Time Administrator.*—The governing body appoints a full-time administrator who is qualified by training and experience and delegates to him the internal operation of the facility in accordance with established policies. The factors explaining the standard are as follows:

(1) The administrator is at least 21 years old, capable of making mature judgments, and has no physical or mental disabilities or personality disturbances which interfere with carrying out his responsibilities.

(2) It is desirable for the administrator to have a minimum of a high school education, to have completed courses in administration or management and to have had at least 1 year of work experience including some administrative experience in an extended care facility or related health program.

(3) The administrator's responsibilities for procurement and direction of competent personnel are clearly defined.

(4) An individual competent and authorized to act in the absence of the administrator is designated.

(5) The administrator may be a member of the governing body.

(*c*) *Standard; Personnel Policies.* — There are written personnel policies, practices, and procedures that adequately support sound patient care. The factors explaining the standard are as follows:

(1) Current employee records are maintained and include a résumé of each employee's training and experience.

(2) Files contain evidence of adequate health supervision such as results of preemployment and periodic physical examination, including chest X-rays, and records of all illnesses and accidents occurring on duty.

(3) Work assignments are consistent with qualifications.

(*d*) *Standard; Notification of Changes in Patient Status.*—There are appropriate written policies and procedures relating to notification of responsible persons in the event of significant change in patient status, patient charges, billings, and other related administrative matters. The factors explaining the standard are as follows:

(1) Patients are not transferred or discharged without prior notification of next of kin or sponsor.

(2) Information describing the care and services provided by the facility is accurate and not misleading.

405.1122 Condition of Participation—Patient Care Policies.—There are policies to govern the skilled nursing care and related medical or other services provided, which are developed with the advice of professional personnel, including one or more physicians and one or more registered professional nurses. A physician, a registered professional nurse, or a medical staff is responsible for the execution of these policies.

(*a*) *Standard; Policies Regarding Nursing and Medical Care.*—(1) The extended care facility has written policies which are developed with the advice of (and with provision for review of such policy from time to time by) a group of professional personnel, including at least one or more physicians and one or more registered professional nurses, to govern the skilled nursing care and related medical or other services it provides. Policies reflect awareness of and provision for meeting the total needs of patients. These are reviewed at least annually and cover at least the following:

(i) Admission, transfer, and discharge policies including categories of patients accepted and not accepted by extended care facility.

(ii) Physician services.

(iii) Nursing services.

(iv) Dietary services.

(v) Restorative services.

(vi) Pharmaceutical services.

(vii) Diagnostic services.

(viii) Care of patients in an emergency, during a communicable disease episode, and when critically ill or mentally disturbed.

(ix) Dental services.

(x) Social services.

(xi) Patient activities.

(xii) Clinical records.

(xiii) Transfer agreement.

(xiv) Utilization review.

(2) The factors explaining the standard are as follows:

(i) It is desirable that the group of professional personnel responsible for patient care policies includes health personnel such as social workers, dietitians, pharmacists, speech pathologists and audiologists, physical and occupational therapists, and mental health personnel. Pharmacy policies and procedures are preferably developed with the advice of a subgroup of physicians and pharmacists, serving as a pharmacy and therapeutics committee.

(ii) Some members of this group are neither owners nor employees of the facility.

(iii) The group meets at regularly scheduled intervals and minutes of each meeting are recorded.

(iv) The group may serve one or more facilities.

(*b*) *Standard; Responsibilities; Execution of Patient Care Policies.*—The extended care facility has a physician, a registered professional nurse, or a medical staff responsible for the execution of patient care policies established by the professional group referred to in paragraph (*a*) (1) of this section. The factors explaining the standard are as follows:

(1) If the organized medical staff is responsible, an individual physician is designated to maintain compliance with overall patient care policies.

(2) If a registered professional nurse is responsible, the facility makes available an advisory physician from whom she receives medical guidance.

405.1123 Condition of Participation—Physician Services.—Patients in need of skilled nursing care are admitted only upon the recommendation of a physician; their health care continues under the supervision of a physician; and the facility has a physician available to furnish necessary medical care in case of emergency.

(*a*) *Standard; Medical Findings and Physicians' Orders.*—There is made available to the facility, prior to or at the time of admission, patient information which includes current medical findings, diagnoses, rehabilitation potential, a summary of the course of treatment followed in the hospital, and orders from a physician for the immediate care of the patient. The factors explaining the standard are as follows:

(1) If the above information is not available in the facility upon admission of the patient, it is obtained by the facility within 48 hours after admission.

(2) If medical orders for the immediate care of a patient are unobtainable at the time of admission, the physician with responsibility for emergency care gives temporary orders.

(3) A current hospital discharge summary containing the above information is acceptable.

(*b*) *Standards; Supervision by Physician.*—The facility has a requirement that the health care of every patient is under the supervision of a physician who, based on an evaluation of the patient's immediate and long-term needs, prescribes a planned regimen of medical care which covers indicated medications, treatments, restorative services, diet, special procedures recommended for the health and safety of the patient, activities, plans for continuing care and discharge. The factors explaining the standard are as follows:

(1) The medical evaluation of the patient is based on a physical examination done within 48 hours of admission unless such examination was performed within 5 days prior to admission.

(2) The charge nurse and other appropriate personnel involved in the care of the patient assist in planning his total program of care.

(3) The patient's total program of care is reviewed and revised at intervals appropriate to his needs. Attention is given to special needs of patients such as foot, sight, speech, and hearing problems.

(4) Orders concerning medications and treatments are in effect for the specified number of days indicated by the physician but in no case exceed a period of 30 days unless recorded in writing by the physician.

(5) Telephone orders are accepted only when necessary and only by licensed nurses. Telephone orders are written into the appropriate clinical record by the nurse receiving them and are countersigned by the physician within 48 hours.

(6) Patients are seen by a physician at least once overy 30 days. There is evidence in the clinical record of the physician's visits to the patient at appropriate intervals.

(7) There is evidence in the clinical record that the physician has made arrangements for the medical care of the patient in the physician's absence.

(8) To the extent feasible, each patient or his sponsor designates a personal physician.

(c) *Standard; Availability of Physicians for Emergency Care.*—The extended care facility provides for having one or more physicians available to furnish necessary medical care in case of emergency if the physician responsible for the care of the patient is not immediately available. A schedule listing the names and telephone numbers of these physicians and the specific days each is on call is posted in each nursing station. There are established procedures to be followed in an emergency, which cover immediate care of the patient, persons to be notified, and reports to be prepared.

405.1124 Condition of Participation—Nursing Services.—The extended care facility provides 24-hour nursing service which is sufficient to meet the nursing needs of all patients. There is at least one registered professional nurse employed full time and responsible for the total nursing service. There is a registered professional nurse or licensed practical nurse who is a graduate of a State approved school of practical nursing in charge of nursing activities during each tour of duty. The terms "licensed practical nurse(s)" and "practical nursing" as used in this section are synonymous with "licensed vocational nurse(s)" and "vocational nursing."

(a) *Standard; Full-Time Nurse.*—There is at least one registered professional nurse employed full time. If there is only one registered professional nurse, she serves as director of the nursing service, works full time during the day, and devotes full time to the nursing service of the facility. If the director of nursing has administrative responsibility for the facility, she has a professional nurse assistant so that there is the equivalent of a full-time director of nursing service. The director of nursing service is trained or experienced in areas such as nursing service administration, rehabilitation nursing, psychiatric or geriatric nursing.

(b) *Standard; Director of Nursing Service.*—The director of the nursing service is responsible for:

(1) Developing and/or maintaining nursing service objectives, standards of nursing practice, nursing procedure manuals, and written job descriptions for each level of nursing personnel;

(2) Recommending to the administrator the number and levels of nursing personnel to be employed, participating in their recruitment and selection, and recommending termination of employment when necessary;

(3) Assigning and supervising all levels of nursing personnel;

(4) Participating in planning and budgeting for nursing care;

(5) Participating in the development and implementation of patient care policies and bringing patient care problems requiring changes in policy to the attention of the professional policy advisory groups;

(6) Coordinating nursing services with other patient care services such as physician, physical therapy, occupational therapy, and dietary;

(7) Planning and conducting orientation programs for new nursing personnel, and continuing inservice education for all nursing personnel;

(8) Participating in the selection of prospective patients in terms of nursing services they need and nursing competencies available;

(9) Assuring that a nursing care plan is established for each patient and that his plan is reviewed and modified as necessary.

(c) *Standard; Supervising Nurse.*—Nursing care is provided by or under the supervision of a full-time registered professional nurse currently licensed to practice in the State. The factors explaining the standard are as follows:

(1) The supervising nurse is trained or experienced in areas such as nursing administration and supervision, rehabilitation nursing, psychiatric or geriatric nursing.

(2) The supervising nurse makes daily rounds to all nursing units performing such functions as visiting each patient, reviewing clinical records, medication cards, patient care plans and staff assignments, and to the greatest degree possible accompanying physicians when visiting patients.

(d) *Standard; Charge Nurse.*—There is at least one registered professional nurse or qualified licensed practical nurse who is a graduate of a State-approved school of practical nursing on duty at all times and in charge of the nursing activities during each tour of duty. The factors explaining the standard are as follows:

(1) A State-approved school of practical nursing is one whose standards of education meet those set by the appropriate State nurse licensing authority.

(2) Some State laws grant practical nurse li-

censure (nonwaivered) to certain individuals who have an educational background considered to be equivalent to graduation from a State-approved school of practical nursing. Such licensure determination is made by the appropriate State nurse licensing authority on the basis of evaluation of the individual's educational achievements, as well as on successful completion of the appropriate State licensing examination. Licensure under such conditions may be accepted as meeting the requirement of graduation from a State-approved school of practical nursing.

(3) It is desirable that the nurse in charge of each tour of duty be trained or experienced in areas such as nursing administration and supervision, rehabilitation nursing, psychiatric or geriatric nursing.

(4) The charge nurse has the ability to recognize significant changes in the condition of patients and to take necessary action.

(5) The charge nurse is responsible for the total nursing care of patients during her tour of duty.

(*e*) *Standard; 24-Hour Nursing Service.*—There is 24-hour nursing service with a sufficient number of nursing personnel on duty at all times to meet the total needs of patients. The factors explaining the standard are as follows:

(1) Nursing personnel include registered professional nurses, licensed practical nurses, aides and orderlies.

(2) The amount of nursing time available for patient care is exclusive of nonnursing duties.

(3) Sufficient nursing time is available to assure that each patient:

(i) Receives treatments, medications and diet as prescribed;

(ii) Receives proper care to prevent decubiti and is kept comfortable, clean, and well-groomed;

(iii) Is protected from accident and injury by the adoption of indicated safety measures;

(iv) Is treated with kindness and respect.

(4) Licensed practical nurses, nurses' aides, and orderlies are assigned duties consistent with their training. and experience.

(*f*) *Standard; Restorative Nursing Care.*—There is an active program of restorative nursing care directed toward assisting each patient to achieve and maintain his highest level of self care and independence. The factors explaining the standard are as follows:

(1) Restorative nursing care initiated in the hospital is continued immediately upon admission to the extended care facility.

(2) Nursing personnel are taught restorative nursing measures and practice them in their daily care of patients. These measures include:

(i) Maintaining good body alignment and proper positioning of bedfast patients;

(ii) Encouraging and assisting bedfast patients to change positions at least every 2 hours day and night to stimulate circulation, and prevent decubiti and deformities;

(iii) Making every effort to keep patients active and out of bed for reasonable periods of time, except when contraindicated by physicians' orders, and encouraging patients to achieve independence in activities of daily living by teaching self care, transfer and ambulation activities;

(iv) Assisting patients to adjust to their disabilities, to use their prosthetic devices, and to redirect their interests if necessary;

(v) Assisting patients to carry out prescribed physical therapy exercises between visits of the physical therapist.

(3) Consultation and instruction in restorative nursing available from State or local agencies are utilized.

(*g*) *Standard; Dietary Supervision.* — Nursing personnel are aware of the dietary needs and food and fluid intake of patients. The factors explaining the standard are as follows:

(1) Nursing personnel observe that patients are served diets as prescribed.

(2) Patients needing help in eating are assigned promptly upon receipt of meals.

(3) Adaptive self-help devices are provided to contribute to the patient's independence in eating.

(4) Food and fluid intake of patients is observed and deviations from normal are reported to the charge nurse. Persistent unresolved problems are reported to the physician.

(*h*) *Standard; Nursing Care Plan.*—There is a written nursing care plan for each patient based on the nature of illness, treatment prescribed, long- and short-term goals and other pertinent information. The factors explaining the standard are as follows:

(1) The nursing care plan is a personalized, daily plan for individual patients. It indicates what nursing care is needed, how it can best be accomplished for each patient, how the patient likes things done, what methods and approaches are most suc-

cessful, and what modifications are necessary to insure best results.

(2) Nursing care plans are available for use by all nursing personnel.

(3) Nursing care plans are reviewed and revised as needed.

(4) Relevant nursing information from the nursing care plan is included with other medical information when patients are tranferred.

(*i*) *Standard; Inservice Educational Program.*—There is a continuing inservice educational program in effect for all nursing personnel in addition to a thorough job orientation for new personnel. Skill training for nonprofessional nursing personnel begins during the orientation period. The factors explaining the standard are as follows:

(1) Planned inservice programs are conducted at regular intervals for all nursing personnel.

(2) All patient care personnel are instructed and supervised in the care of emotionally disturbed and confused patients, and are helped to understand the social aspects of patient care.

(3) Skill training includes demonstration, practice, and supervision of simple nursing procedures applicable in the individual facility. It also includes simple restorative nursing procedures.

(4) Orientation of new personnel includes a review of the procedures to be followed in emergencies.

(5) Opportunities are provided for nursing personnel to attend training courses in restorative nursing and other educational programs related to the care of long-term patients.

405.1125 Condition of Participation—Dietary Services.—The dietary service is directed by a qualified individual and meets the daily dietary needs of patients. An extended care facility which has a contract with an outside food management company may be found to meet this condition of participation provided the company has a dietitian who serves, as required by the scope and complexity of the service, on a full-time, part-time or consultant basis to the extended care facility, and provided the company maintains standards as listed herein and provides for continuing liason with the medical and nursing staff of the extended care facility for recommendations on dietetic policies affecting patient care.

(*a*) *Standard; Dietary Supervision.*—A person designated by the administrator is responsible for the total food service of the facility. If this person is not a professional dietitian, regularly scheduled consultation from a professional dietitian or other person with suitable training is obtained. The factors explaining the standard are as follows:

(1) A professional dietitian meets the American Dietetic Association's qualification standards.

(2) Other persons with suitable training are graduates of baccalaureate degree programs with major studies in food and nutrition.

(3) The person in charge of the dietary service participates in regular conferences with the administrator and other supervisors of patient services.

(4) This person makes recommendations concerning the quantity, quality and variety of food purchased.

(5) This person is responsible for the orientation, training and supervision of food service employees, and participates in their selection and in the formulation of pertinent personnel policies.

(6) Consultation obtained from self-employed dietitians or dietitians employed in voluntary or official agencies is acceptable if provided on a frequent and regularly scheduled basis.

(*b*) *Standard; Adequacy of Diet Staff.*—A sufficient number of food service personnel are employed and their working hours are scheduled to meet the dietary needs of the patients. The factors explaining the standard are as follows:

(1) There are food service employees on duty over a period of 12 or more hours.

(2) Food service employees are trained to perform assigned duties and participate in selected inservice education programs.

(3) In the event food service employees are assigned duties outside the dietary department, these duties do not interfere with the sanitation, safety, or time required for dietary work assignments.

(4) Work assignments and duty schedules are posted.

(*c*) *Standards; Hygiene of Diet Staff.*—Food service personnel are in good health and practice hygienic food handling techniques. The factors explaining the standards are as follows:

(1) Food service personnel wear clean washable garments, hairnets, or clean caps, and keep their hands and fingernails clean at all times.

(2) Routine health examinations at least meet local, State, or Federal codes for food service personnel. Where food handlers' permits are required, they are current.

(3) Personnel having symptoms of communicable diseases or open infected wounds are not permitted to work.

(*d*) *Standard; Adequacy of Diet.*—The food and nutritional needs of patients are met in accordance with physicians' orders, and, to the extent medically possible, meet the dietary allowances of the Food and Nutrition Board of the National Research Council adjusted for age, sex and activity. A daily food guide for adults may be based on the following allowances:

(1) Milk: Two or more cups.

(2) Meat group: Two or more servings of beef, veal, pork, lamb, poultry, fish, eggs. Occasionally dry beans, nuts, or dry peas may be served as alternates.

(3) Vegetable and fruit group, four or more servings: A citrus fruit or other fruit and vegetable important for Vitamin C; a dark green or deep yellow vegetable for Vitamin A, at least every other day; other fruits and vegetables including potatoes.

(4) Bread and cereal group: Four or more servings of whole grain, enriched or restored.

(5) Other foods to round out meals and snacks, to satisfy individual appetites and provide additional calories.

(*e*) *Standard; Therapeutic Diets.*—Therapeutic diets are prepared and served as prescribed by the attending physician. The factors explaining the standard are as follows:

(1) Therapeutic diet orders are planned, prepared, and served with supervision or consultation from a qualified dietitian.

(2) A current diet manual recommended by the State licensure agency is readily available to food service personnel and supervisors of nursing service.

(3) Persons responsible for therapeutic diets have sufficient knowledge of food values to make appropriate substitutions when necessary.

(*f*) *Standard; Quality of Food.*—At least three meals or their equivalent are served daily, at regular times, with not more than a 14-hour span between a substantial evening meal and breakfast. Between-meal or bedtime snacks of nourishing quality are offered. If the "four or five meal a day" plan is in effect, meals and snacks provide nutritional value equivalent to the daily food guide previously described.

(*g*) *Standard; Planning of Menus.*—Menus are planned in advance and food sufficient to meet the nutrition needs of patients is prepared as planned for each meal. When changes in the menu are necessary, substitutions provide equal nutritive value. The factors explaining the standard are as follows:

(1) Menus are written at least 1 week in advance. The current week's menu is in one or more accessible places in the dietary department for easy use by workers purchasing, preparing, and serving foods.

(2) Menus provide a sufficient variety of foods served in adequate amounts at each meal. Menus are different for the same days of each week and are adjusted for seasonal changes.

(3) Records of menus as served are filed and maintained for 30 days.

(4) Supplies of staple foods for a minimum of a 1-week period and of perishable foods for a minimum of a 2-day period are maintained on the premises.

(5) Records of food purchased for preparation are on file.

(*h*) *Standard; Preparation of Food.*—Foods are prepared by methods that conserve nutritive value, flavor, and appearance, and are attractively served at the proper temperatures and in a form to meet individual needs. The factors explaining the standard are as follows:

(1) A file of tested recipes, adjusted to appropriate yield, is maintained.

(2) Food is cut, chopped or ground to meet individual needs.

(3) If a patient refuses food served, substitutes are offered.

(4) Effective equipment is provided and procedures established to maintain food at proper temperature during serving.

(5) Table service is provided for all who can and will eat at a table including wheelchair patients.

(6) Trays provided bedfast patients rest on firm supports such as overbed tables. Sturdy tray stands of proper height are provided patients able to be out of bed.

(*i*) *Standard; Maintenance of Sanitary Conditions.*—Sanitary conditions are maintained in the storage, preparation and distribution of food. The factors explaining the standard are as follows:

(1) Effective procedures for cleaning all equipment and work areas are followed consistently.

(2) Dishwashing procedures and techniques are well developed, understood and carried out in compliance with the State and local health codes.

(3) Written reports of inspections by State or local health authorities are on file at the facility with notation made of action taken by the facility to comply with any recommendations.

(4) Waste which is not disposed of by mechanical means is kept in leak-proof nonabsorbent containers with close-fitting covers and is disposed of daily in a manner that will prevent transmission of disease, a nuisance, a breeding place for flies, or a feeding place for rodents. Containers are thoroughly cleaned inside and out each time emptied.

(5) Dry or staple food items are stored off the floor in a ventilated room not subject to sewage or waste water backflow, or contamination by condensation, leakage, rodents, or vermin.

(6) Handwashing facilities including hot and cold water, soap, and individual towels, preferably paper towels, are provided in kitchen areas.

(Par. (*d*) (3) amended 12–18–68.)

405.1126 Condition of Participation—Restorative Services.—Restorative services are provided upon written order of the physician.

(*a*) *Standard; Medical Direction.*—Restorative services are provided only upon written order by the physician, who indicates anticipated goals and is responsible for general medical direction of such services as part of the total care of the patient. The physician prescribes specific modalities to be used and frequency of physical and occupational therapy services.

(*b*) *Standard; Maintenance of Patient's Functions.*—At a minimum, restorative nursing care designed to maintain function or improve the patient's ability to carry out the activities of daily living is provided by the extended care facility. (See § 405.1124(*f*).)

(*c*) *Standard; Therapy Services.*—If restorative services beyond restorative nursing care are offered, whether directly or through cooperative arrangements with appropriate agencies such as hospitals, rehabilitation centers, State or local health departments, or independently practicing therapists, these services are given or supervised by therapists meeting the qualification set out below. When supervision is less than full time it is provided on a planned basis and is frequent enough, in relation to the staff therapist's training and experience to assure sufficient review of individual treatment plans and progress. The factors explaining the standard are as follows:

(1) Physical therapy is given or supervised by a therapist who meets one of the following requirements:

(i) He has graduated from a physical therapy curriculum approved by—

(A) The American Physical Therapy Association; or

(B) The Council on Medical Education and Hospitals of the American Medical Association; or

(C) The Council on Medical Education of the American Medical Association in collaboration with the American Physical Therapy Association; or

(ii) Prior to January 1, 1966—

(A) Has been admitted to membership by the American Physical Therapy Association; or

(B) Has been admitted to registration by the American Registry of Physical Therapists; or

(C) Has graduated from a physical therapy curriculum in a four year college or university approved by a State department of education, is licensed or registered as a physical therapist, and where appropriate, has passed a State examination for licensure as a physical therapist; or

(iii) If trained outside the United States—

(A) Has graduated since 1928 from a physical therapy curriculum approved in the country in which the curriculum was located and in which there is a member organization of the World Confederation for Physical Therapy; and

(B) Is a member of a member organization of the World Confederation for Physical Therapy; and

(C) Has completed one year's experience under the supervision of an active member of the American Physical Therapy Association; and

(D) Has successfully completed a qualifying examination as prescribed by the American Physical Therapy Association.

(2) Physical therapy includes such services as:

(i) Assisting the physician in his evaluation of patients by applying muscle, nerve, joint, and functional ability tests;

(ii) Treating patients to relieve pain, develop or restore function, and maintain maximum performance, using physical means such as exercise, massage, heat, water, light, and electricity.

(3) Speech therapy is given or supervised by a therapist who meets one of the following requirements:

(i) Has been granted a Certificate of Clinical Competence in the appropriate area (Speech Pathology or Audiology) by the American Speech and Hearing Association; or

(ii) Meets the equivalent educational requirements and work experience necessary for such certificate; or

(iii) Has completed the academic and practicum requirements for certification and is in the process of accumulating the necessary supervised work experience required for certification; or

(iv) Until January 1, 1970, has a Basic Certificate or provisional basic certification and is in the process of acquiring 4 years of sponsored professional experience; or

(v) Had a Basic Certificate or sponsor privilege as of December 31, 1964, cannot complete 4 years of sponsored professional experience before January 1, 1970, but passes a special examination given by the American Speech and Hearing Association during 1969.

(4) Speech therapy is service in speech, pathology or audiology, and may include:

(i) Cooperation in the evaluation of patients with speech, hearing, or language disorders;

(ii) Determination and recommendation of appropriate speech and hearing services;

(iii) Provision of necessary rehabilitative services for patients with speech, hearing, and language disabilities.

(5) Occupational therapy is given or supervised by a therapist who is registered by the American Occupational Therapy Association or is a graduate of a program approved by the Council on Medical Education of the American Medical Association in collaboration with the American Occupational Therapy Association and is in the process of accumulating supervised clinical experience required for registration.

(6) Occupational therapy includes duties such as:

(i) Assisting the physician in his evaluation of the patient's level of function by applying diagnostic and prognostic tests;

(ii) Guiding the patient in his use of therapeutic creative and self-care activities for improving function.

(7) Other personnel providing restorative services are specially trained and work under professional supervision in accordance with accepted professional practices. For example, an occupational therapy assistant has successfully completed a training course approved by the American Occupational Therapy Association, is certified by that body as a certified occupational therapy assistant, and receives supervision from a qualified occupational therapist.

(8) In a facility with an organized rehabilitation service using a multidisciplinary team approach to all the needs of the patient, and where all therapists' services are administered under the direct supervision of a physician qualified in physical medicine who will determine the goals and limits of the therapists' work, and prescribe modalities and frequency of therapy, persons with qualifications other than those described in subparagraphs (1), (3), and (5) of this paragraph could be assigned duties appropriate to their training and experience.

(9) Therapists collaborate with the facility's medical and nursing staff in developing the patient's total plan of care.

(10) Therapists participate in the facility's in-service education programs.

(*d*) *Standard; Ambulation and Therapeutic Equipment.*—Commonly used ambulation and therapeutic equipment necessary for services offered is available for use in the facility. The factors explaining the standard are as follows:

(1) Recommended ambulation equipment includes such items as parallel bars, hand rails, wheel chairs, walkers, walkerettes, crutches and canes.

(2) The therapists advise the administrator concerning the purchase, rental, storage, and maintenance of equipment and supplies.

405.1127 Condition of Participation—Pharmaceutical Services.—Whether drugs are generally procured from community or institutional pharmacists or stocked by the facility, the extended care facility has methods and procedures for its pharmaceutical services that are in accord with accepted professional practices.

(*a*) *Standard; Procedures for Administration of Pharmaceutical Services.*—The extended care facility provides appropriate methods and procedures for the obtaining, dispensing and administering of drugs and biologicals, developed with the advice of a staff pharmacist, a consultant pharmacist, or a pharmaceutical advisory committee which includes one or more licensed pharmacists. The factors explaining the standard are as follows:

(1) If the extended care facility has a pharmacy department, a licensed pharmacist is employed to administer the pharmacy department.

(2) If the facility does not have a pharmacy department, it has provision for promptly and con-

veniently obtaining prescribed drugs and biologicals from community or institutional pharmacists.

(3) If the facility does not have a pharmacy department, but does maintain a supply of drugs:

(i) The consultant pharmacist is responsible for the control of all bulk drugs and maintains records of their receipt and disposition.

(ii) The consultant pharmacist dispenses drugs from the drug supply, properly labels them and makes them available to appropriate licensed nursing personnel. Wherever possible, the pharmacist in dispensing drugs works from the prescriber's original order or a direct copy.

(iii) Provision is made for emergency withdrawal of medications from the drug supply.

(4) An emergency medication kit approved by the facility's group of professional personnel is kept readily available.

(5) The extended care facility has written policies covering pharmaceutical services which are developed with the advice of a group of professional personnel and which are reviewed at least annually. Pharmacy policies and procedures are preferably developed with the advice of a subgroup of physicians and pharmacists serving as a pharmacy and therapeutics committee.

(*b*) *Standard; Conformance With Physicians' Orders.*—All medications administered to patients are ordered in writing by the patient's physician. Oral orders are given only to a licensed nurse, immediately reduced to writing, signed by the nurse and countersigned by the physician within 48 hours. Medications not specifically limited as to time or number of doses, when ordered, are automatically stopped in accordance with written policy approved by the physician or physicians responsible for advising the facility on its medical administrative policies. The factors explaining the standard are as follows:

(1) The charge nurse and the prescribing physician together review monthly each patient's medications.

(2) The patient's attending physician is notified of stop order policies and contacted promptly for renewal of such orders so that continuity of the patient's therapeutic regimen is not interrupted.

(3) Medications are released to patients on discharge only on the written authorization of the physician.

(*c*) *Standard; Administration of Medications.*—All medications are administered by licensed medical or nursing personnel in accordance with the Medical and Nurse Practice Acts of each State. Each dose administered is properly recorded in the clinical record. The factors explaining the standard are as follows:

(1) The nursing station has readily available items necessary for the proper administration of medication.

(2) In administering medications, medication cards or other State approved systems are used and checked against the physician's orders.

(3) Medications prescribed for one patient are not administered to any other patient.

(4) Self-administration of medications by patients is not permitted except for emergency drugs on special order of the patient's physician or in a predischarge program under the supervision of a licensed nurse.

(5) Medication errors and drug reactions are immediately reported to the patient's physician and an entry thereof made in the patient's clinical record as well as on an incident report.

(6) Up-to-date medication reference texts and sources of information are provided, such as the American Hospital Formulary Service of the American Society of Hospital Pharmacists or other suitable references.

(*d*) *Standard; Labeling and Storing Medications.*—Patients' medications are properly labeled and stored in a locked cabinet at the nurses' station. The factors explaining the standard are as follows:

(1) The label of each patient's individual medication container clearly indicates the patient's full name, physician's name, prescription number, name and strength of drug, date of issue, expiration date of all time-dated drugs, and name and address, and telephone number of pharmacy issuing the drug. It is advisable that the manufacturer's name and the lot or control number of the medication also appear on the label.

(2) Medication containers having soiled, damaged, incomplete, illegible, or makeshift labels are returned to the issuing pharmacist or pharmacy for relabeling or disposal. Containers having no labels are destroyed in accordance with State and Federal laws.

(3) The medications of each patient are kept and stored in their originally received containers and transferring between containers is forbidden.

(4) Separately locked, securely fastened boxes (or drawers) within the medicine cabinet are provided for storage of narcotics, barbiturates, am-

phetamines and other dangerous drugs subject to the Drug Abuse Control Amendments of 1965.

(5) Cabinets are well lighted and of sufficient size to permit storage without crowding.

(6) Medications requiring refrigeration are kept in a separate, locked box within a refrigerator at or near the nursing station.

(7) Poisons and medications for "external use only" are kept in a locked cabinet and separate from other medications.

(8) Medications no longer in use are disposed of or destroyed in accordance with Federal and State laws and regulations.

(9) Medications having an expiration date are removed from usage and properly disposed of after such date.

(*e*) *Standard; Control of Narcotics, etc.*—The extended care facility complies with all Federal and State laws and regulations relating to the procurement, storage, dispensing, administration and disposal of narcotics, those drugs subject to the Drug Abuse Control Amendments of 1965, and other legend drugs. The factor explaining the standard is as follows: A narcotic record is maintained which lists on separate sheets for each type and strength of narcotic the following information: date, time administered, name of patient, dose, physician's name, signature of person administering dose, and balance.

405.1128 Condition of Participation—Diagnostic Services.—The extended care facility has provision for obtaining required clinical laboratory, X-ray and other diagnostic services.

(*a*) Standard; provisions for diagnostic services: The extended care facility has provision for promptly and conveniently obtaining required clinical laboratory, X-ray and other diagnostic services. Such services may be obtained from a physician's office, a laboratory which is part of a hospital approved for participation in the Health Insurance for the Aged program or a laboratory which is approved to provide these services as an independent laboratory under the Supplementary Medical Insurance for the Aged program. If the facility provides its own diagnostic services, these meet the applicable conditions established for certification of hospitals that are contained in §§ 405.1028 and 405.1029.

(*b*) The factors explaining the standard are as follows:

(1) All diagnostic services are provided only on the request of a physician.

(2) The physician is notified promptly of the test results.

(3) Arrangements are made for the transportation of patients, if necessary to and from the source of service.

(4) Simple tests, such as those customarily done by nursing personnel for diabetic patients, may be done in the facility.

(5) All reports are included in the clinical record.

405.1129 Condition of Participation—Dental Services.—The extended care facility assists patients to obtain regular and emergency dental care. However, the services of dentists to individual patients are not included as a benefit in the basic hospital insurance program, and only certain oral surgery is included in the supplemental medical insurance program.

(*a*) Standard; provision for dental care: Patients are assisted to obtain regular and emergency dental care.

(*b*) The factors explaining the standard are as follows:

(1) An advisory dentist provides consultation, participates in in-service education, recommends policies concerning oral hygiene, and is available in case of emergency.

(2) The extended care facility, when necessary, arranges for the patient to be transported to the dentist's office.

(3) Nursing personnel assist the patient to carry out the dentist's recommendations.

405.1130 Condition of Participation—Social Services.—Services are provided to meet the medically related social needs of patients.

(*a*) *Standard; Provision for Medically Related Social Needs.*—The medically related social needs of the patient are identified, and services provided to meet them, in admission of the patient, during his treatment and care in the facility, and in planning for his discharge. The factors explaining the standard are as follows:

(1) As a part of the process of evaluating a patient's need for services in an extended care facility and whether the facility can offer appropriate care, emotional and social factors are considered in relation to medical and nursing requirements.

(2) As soon as possible after admission, there is evaluation, based on medical, nursing, and social factors, of the probable duration of the patient's

need for care and a plan is formulated and recorded for providing such care.

(3) Where there are indications that financial help will be needed arrangements are made promptly for referral to an appropriate agency.

(4) Social and emotional factors related to the patient's illness, to his response to treatment, and to his adjustment to care in the facility are recognized and appropriate action is taken when necessary to obtain casework services to assist in resolving problems in these areas.

(5) Knowledge of the patient's home situation, financial resources, community resources available to assist him, and pertinent information related to his medical and nursing requirements are used in making decisions regarding his discharge for the facility.

(*b*) *Standard; Staff Members Responsible for Social Services.*—There is a designated member of the staff of the facility who will take responsibility, when medically related social problems are recognized, for action necessary to solve them. The factors explaining the standard are as follows:

(1) There is a full-time or part-time social worker employed by the facility, or there is a person on the staff who is suited by training and/or experience in related fields to find community resources to deal with the social problems.

(2) The staff member responsible for this area of service has information promptly available on health and welfare resources in the community.

(3) If the facility does not have a qualified social worker on its staff, there is an effective arrangement with a public or private agency, which may include the local welfare department, to provide social service consultation.

(4) A qualified social worker is a graduate of a school of social work accredited by the Council on Social Work Education.

(*c*) *Standard; Social Services Training of Staff.*—There is provision for orientation and in-service training of staff directed toward understanding emotional problems and social needs of sick and infirm aged persons, and recognition of social problems of patients and the means of taking appropriate action in relation to them. Either a qualified social worker on the staff, or one from outside the facility, participates in training programs, case conferences, and arrangements for staff orientation to community services and patient needs.

(*d*) *Standard; Confidentiality of Social Data.*—Pertinent social data, and information about personal and family problems related to the patient's illness and care, are made available only to the attending physician, appropriate members of the nursing staff, and other key personnel who are directly involved in the patient's care, or to recognized health or welfare agencies. There are appropriate policies and procedures for assuring the confidentiality of such information. The factors explaining the standard are as follows:

(1) The staff member responsible for social services participates in clinical staff conferences and/or confers with the attending physician prior to admission of the patient, at intervals during the patient's stay in the facility, and prior to discharge of the patient, and there is evidence in the record of such conferences.

(2) The staff member and nurses responsible for the patient's care confer frequently and there is evidence of effective working relationships between them.

(3) Records of pertinent social information, and of action taken to meet social needs, are maintained for each patient; signed social service summaries are entered promptly in the patient's clinical record for the benefit of all staff involved in the care of the patient.

405.1131 Condition of Participation—Patient Activities.—Activities suited to the needs and interests of patients are provided as an important adjunct to the active treatment program and to encourage restoration to self-care and resumption of normal activities.

(*a*) Standard; provision for patient activity: Provision is made for purposeful activities which are suited to the needs and interests of patients.

(*b*) The factors explaining the standard are as follows:

(1) An individual is designated as being in charge of patient activities. This individual has experience and/or training in directing group activity, or has available consultation from a qualified recreational therapist or group activity leader.

(2) The activity leader uses, to the fullest possible extent, community, social and recreational opportunities.

(3) Patients are encouraged, but not forced, to participate in such activities. Suitable activities are provided for patients unable to leave their room.

(4) Patients who are able and who wish to do so are assisted to attend religious services.

(5) Patient's requests to see their clergymen are

honored and space is provided for privacy during visits.

(6) Visiting hours are flexible and posted to permit and encourage visiting by friends and relatives.

(7) The facility makes available a variety of supplies and equipment adequate to satisfy the individual interests of patients. Examples of such supplies and equipment are: Books and magazines, daily newspapers, games, stationery, radio and television, and the like.

405.1132 Condition of Participation—Clinical Records.—A clinical record is maintained for each patient admitted, in accordance with accepted professional principles.

(*a*) *Standard; Maintenance of Clinical Record.*—The extended care facility maintains a separate clinical record for each patient admitted with all entries kept current, dated, and signed. The record includes:

(1) Identification and summary sheet(s) including patient's name, social security number, marital status, age, sex, home address, and religion; names, addresses, and telephone numbers of referral agency (including hospital from which admitted), personal physician, dentist, and next of kin or other responsible person; admitting diagnosis; final diagnosis, condition on discharge, and disposition, and any other information needed to meet State requirements;

(2) Initial medical evaluation including medical history, physical examination, diagnosis, and estimation of restoration potential;

(3) Authentication of hospital diagnoses, in the form of a hospital summary discharge sheet, or a report from the physician who attended the patient in the hospital, or a transfer form used under a transfer agreement;

(4) Physician's orders, including all medications, treatments, diet, restorative and special medical procedures required for the safety and well-being of the patient;

(5) Physician's progress notes describing significant changes in the patient's condition, written at the time of each visit;

(6) Nurse's notes containing observations made by the nursing personnel;

(7) Medication and treatment record including all medications, treatments, and special procedures performed for the safety and well-being of the patient;

(8) Laboratory and X-ray reports;

(9) Consultation reports;

(10) Dental reports;

(11) Social service notes;

(12) Patient care referral reports.

(*b*) *Standard; Retention of Records.*—All clinical records of discharged patients are completed promptly and are filed and retained in accordance with State law or for 5 years in the absence of a State statute. The factors explaining the standard are as follows:

(1) The extended care facility has policies providing for the retention and safekeeping of patients' clinical records by the governing body for the required period of time in the event that the extended care facility discontinues operation.

(2) If the patient is transferred to another health care facility, a copy of the patient's clinical record or an abstract thereof accompanies the patient.

(*c*) *Standard; Confidentiality of Records.*—All information contained in the clinical records is treated as confidential and is disclosed only to authorized persons.

(*d*) *Standard; Staff Responsibility for Records.*—If the extended care facility does not have a full or part-time medical record librarian, an employee of the facility is assigned the responsibility for assuring that records are maintained, completed and preserved. The designated individual is trained by, and receives, regular consultation from a person skilled in record maintenance and preservation.

405.1133 Condition of Participation—Transfer Agreement.—The extended care facility has in effect a transfer agreement (meeting the requirements of section 1861(l) of the Social Security Act) with one or more hospitals which have entered into agreements with the Secretary to participate in the program. (*See* paragraph (*e*) of this section where facility attempted to enter into a transfer agreement.)

(*a*) *Standard; Patient Transfer.*—The transfer agreement provides reasonable assurance that transfer of patients will be effected between the hospital and the extended care facility whenever such transfer is medically appropriate as determined by the attending physician. The factors explaining the standard are as follows:

(1) The agreement is with a hospital close enough to the facility to make the transfer of patients feasible.

(2) The transfer agreement facilitates continuity

of patient care and expedites appropriate care for the patient.

(3) The agreement may be made on a one-to-one basis or on a community wide basis. The latter arrangement could provide for a master agreement to be signed by each hospital and extended care facility.

(4) When the transfer agreement is on a community wide basis it reflects the mutual planning and agreement of hospitals, extended care facilities and other related agencies.

(5) The institutions provide to each other information about their resources sufficient to determine whether the care needed by a patient is available.

(6) Where the transfer agreement specifies restrictions with respect to the types of services available in the hospital or the facility and/or the types of patients or health conditions that will not be accepted by the hospital or the facility, or includes any other criteria relating to the transfer of patients (such as priorities for persons on waiting lists), such restrictions or criteria are the same as those applied by the hospital or facility to all other potential inpatients of the hospital or facility.

(7) When a transfer agreement has been in effect over a period of time, a sufficient number of patient transfers between the two institutions have occurred to indicate that the transfer agreement is effective.

(*b*) *Standard; Interchanges of Information.*—The transfer agreement provides reasonable assurance that there will be interchange of medical and other information necessary or useful in the care and treatment of individuals transferred between the institutions, or in determining whether such individuals can be adequately cared for otherwise than in either of such institutions. The factors explaining the standard are as follows:

(1) The agreement establishes responsibility for the prompt exchange of patient information to enable each institution to determine whether it can adequately care for the patient and to assure continuity of patient care.

(2) Medical information transferred includes current medical findings, diagnosis, rehabilitation potential, a brief summary of the course of treatment followed in the hospital or extended care facility, nursing and dietary information useful in the care of the patient, ambulation status, and pertinent administrative and social information.

(3) The agreement provides for the transfer of personal effects, particularly money and valuables, and for the transfer of information related to these items.

(*c*) *Standard; Execution of Agreement.*—The transfer agreement is in writing and is signed by individuals authorized to execute such agreement on behalf of the institutions, or, in case the two institutions are under common control, there is a written policy or order signed by the person or body which controls them. The factors explaining the standard are as follows:

(1) When the hospital and extended care facility are not under common control, the terms of the transfer agreement are established jointly by both institutions.

(2) Each institution participating in the agreement maintains a copy of the agreement.

(*d*) *Standard; Specification of Responsibilities.*—The transfer agreement specifies the responsibilities each institution assumes in the transfer of patients and information between the hospital and the extended care facility. The agreement establishes responsibility for notifying the other institution promptly of the impending transfer of a patient; arranging for appropriate and safe transportation; and arranging for the care of patients during transfer.

(*e*) *Standard; Presumed Agreement Where Necessary for Provision of Services.*—An extended care facility which does not have a transfer agreement in effect but which is found by the State agency conducting the survey (or, in the case of a State in which there is no such agency, by the Secretary) to have attempted in good faith to enter into a transfer agreement with a hospital sufficiently close to the facility to make feasible the transfer between them of patients and medical and other information, shall be considered to have such an agreement in effect if and for so long as it is also found that to do so is in the public interest and essential to assuring extended care services for patients in the community eligible for benefits. The factors explaining the standard are as follows:

(1) If there is only one hospital in the community, the extended care facility has attempted in good faith to enter into a transfer agreement with that hospital.

(2) If there are several hospitals in the community, the extended care facility has exhausted all reasonable possibilities of entering into a transfer agreement with these hospitals.

(3) The extended care facility has copies of letters, records of conferences, and other evidence to support its claim that it has attempted in good faith to enter into a transfer agreement.

(4) The State agency has found that hospitals in the community have, in fact, refused to enter into a transfer agreement with the extended care facility in question.

(5) The State agency has taken into consideration the availability of extended care facilities in the community and the expected need of such services for eligible beneficiaries under the law.

405.1134 Condition of Participation—Physical Environment.—The extended care facility is constructed, equipped, and maintained to insure the safety of patients and provides a functional, sanitary, and comfortable environment. The following standards are guidelines to help State agencies to evaluate existing structures which do not meet Hill-Burton construction regulations in effect at the time of the survey, and to evaluate in all facilities those aspects of the physical environment which are not covered by such Hill-Burton regulations. They are to be applied to existing construction with discretion and in light of community need for service.

(*a*) *Standard; Safety of Patients.*—The extended care facility is constructed, equipped, and maintained to insure the safety of patients. It is structurally sound and satisfies the following conditions:

(1) The facility complies with all applicable State and local codes governing construction.

(2) Fire resistance and flamespread ratings of construction, materials, and finishes comply with current State and local fire protection codes and ordinances.

(3) Permanently attached automatic fire-extinguishing systems of adequate capacitv are installed in all areas considered to have special fire hazards including but not limited to boiler rooms, trash rooms, and nonfire resistant areas or buildings. In an extended care facility of two or more stories fire alarm systems providing complete coverage of the building are installed and inspected regularly. Fire extinguishers are conveniently located on each floor and in special hazard areas such as boiler rooms, kitchens, laundries, and storage rooms. Fire regulations are prominently posted and carefully observed.

(4) Doorways, passageways, and stairwells are wide enough for easy evacuation of patients and are kept free from obstruction at all times. Corridors are equipped with firmly secured handrails on each side. Stairwells, elevators, and all vertical shafts with openings have fire doors kept normally in closed position. Exit facilities comply with State and local codes and regulations.

(5) Unless the facility is of fire resistive construction, blind and nonambulatory or physically handicapped persons are not housed above the street level floor.

(6) Reports of periodic inspections of the structure by the fire control authority having jurisdiction in the area are on file in the facility.

(7) The building is maintained in good repair and kept free of hazards such as those created by any damaged or defective parts of the building.

(8) No occupancies or activities undesirable to the health and safety of patients are located in the building or buildings of the extended care facility.

(*b*) *Standard; Favorable Environment for Patients.*—The extended care facility is equipped and maintained to provide a functional, sanitary and comfortable environment. Its electrical and mechanical systems (including water supply and sewage disposal) are designed, constructed and maintained in accordance with recognized safety standards and comply with applicable State and local codes and regulations. The factors explaining the standard are as follows:

(1) Lighting levels in all areas of the facility are adequate and void of high brightness, glare, and reflecting surfaces that produce discomfort. Lighting levels are in accordance with recommendations of the Illuminating Engineering Society. The use of candles, kerosene oil lanterns, and other open flame methods of illumination is prohibited.

(2) An emergency electrical service, which may be battery operated if effective for 4 or more hours, covers lights at nursing stations, telephone switchboard, night lights, exit and corridor lights, boiler room, and the fire alarm system.

(3) The heating and air-conditioning systems are capable of maintaining adequate temperatures and providing freedom from drafts.

(4) An adequate supply of hot water for patient use is available at all times. Temperature of hot water at plumbing fixtures used by patients is automatically regulated by control valves and does not exceed 110° F. (110 degrees Fahrenheit).

(5) The facility is well-ventilated through the use of windows, mechanical ventilation, or a combination of both. Rooms and areas which do not have outside windows and which are used by patients or personnel are provided with functioning mechanical ventilation to change the air on a basis commensurate with the type of occupancy.

(6) All inside bathrooms and toilet rooms have forced ventilation to the outside.

(7) Laundry facilities (when applicable) are located in areas separate from patient units and are provided with the necessary washing, drying, and ironing equipment.

(c) *Standard; Elevators.*—Elevators are installed in the facility if patient bedrooms are located on floors above the street level. The factors explaining the standard are as follows:

(1) Installation of elevators and dumbwaiters complies with all applicable codes.

(2) Elevators are of sufficient size to accommodate a wheeled stretcher.

(d) *Standard; Nursing Unit.*—Each nursing unit has at least the following basic service areas: Nurses' station, medicine storage and preparation area, space for storage of linen, equipment and supplies, and a utility room. The factors explaining the standard are as follows:

(1) A nurses' call system registers calls at the nurses' station from each patient bed, patient toilet room, and each bathtub or shower.

(2) Equipment necessary for charting and recordkeeping is provided.

(3) The medication preparation area is well-illuminated and is provided with hot and cold running water.

(4) The utility room is located, designed and equipped to provide areas for the separate handling of clean and soiled linen, equipment and supplies.

(5) Toilet and handwashing facilities are provided.

(e) *Standard; Patients' Bedrooms and Toilet Facilities.*—Patients' bedrooms are designed and equipped for adequate nursing care and the comfort and privacy of patients. Each bedroom has or is conveniently located near adequate toilet and bathing facilities. Each bedroom has direct access to a corridor and outside exposure with the floor at or above grade level. The factors explaining the standard are as follows:

(1) Ordinarily rooms have no more than four beds with not less than 3 feet between beds.

(2) In addition to basic patient care equipment each patient unit has a nurses' call signal, an individual reading light, bedside cabinet, comfortable chair, and storage space for clothing and other possessions. In multiple bedrooms, each bed has flameproof cubicle curtains or their equivalent.

(3) It is desirable that each patient room have a lavatory with both hot and cold running water, unless provided in adjacent toilet or bathroom facilities.

(4) On floors where wheelchair patients are located, there is at least one toilet room large enough to accommodate wheelchairs.

(5) Each bathtub or shower is in a separate room or compartment which is large enough to accommodate wheelchair and attendant.

(6) At least one water closet, enclosed in a separate room or stall, is provided for each eight beds.

(7) Substantially secured grab bars are installed in all water closet and bathing fixture compartments.

(8) Doors to patient bedrooms are never locked.

(f) *Standard; Facilities for Isolation.*—Provision is made for isolating infectious patients in well-ventilated single bedrooms having separate toilet and bathing facilities. Such facilities are also available to provide for the special care of patients who develop acute illnesses while in the facility and patients in terminal phases of illness.

(g) *Standard; Examination Rooms.*—A special room (or rooms) is provided for examinations, treatments, and other therapeutic procedures. The factors explaining the standard are as follows:

(1) This room is of sufficient size and is equipped with a treatment table, lavatory or sink with other than hand controls, instrument sterilizer, instrument table, and necessary instruments and supplies.

(2) If the facility provides physical therapy, areas are of sufficient size to accommodate necessary equipment and facilitate the movement of disabled patients. Lavatories and toilets designed for the use of wheelchair patients are provided in such areas.

(h) *Standard; Dayroom and Dining Area.*—The extended care facility provides one or more attractively furnished multipurpose areas of adequate size for patient dining, diversional and social activities. The factors explaining the standard are as follows:

(1) At least one dayroom or lounge, centrally located, is provided to accommodate the diversional and social activities of the patients. In addition, several smaller dayrooms, convenient to patient bedrooms, are desirable.

(2) Dining areas are large enough to accommodate all patients able to eat out of their rooms. These areas are well-lighted and well-ventilated.

(3) If a multipurpose room is used for dining and diversional and social activities, there is suf-

ficient space to accommodate all activities and prevent their interference with each other.

(i) *Standard; Kitchen or Dietary Area.*—The extended care facility has a kitchen or dietary area adequate to meet food service needs and arranged and equipped for the refrigeration, storage, preparation, and serving of food as well as for dish and utensil cleaning and refuse storage and removal. Dietary areas comply with the local health or food handling codes. Food preparation space is arranged for the separation of functions and is located to permit efficient service to patients and is not used for nondietary functions.

405.1135 Condition of Participation—Housekeeping Services.—The extended care facility provides the housekeeping and maintenance services necessary to maintain a sanitary and comfortable environment.

(a) *Standard; Housekeeping Services.*—The facility provides sufficient housekeeping and maintenance personnel to maintain the interior and exterior of the facility in a safe, clean, orderly, and attractive manner. Nursing personnel are not assigned housekeeping duties. The factors explaining the standard are as follows:

(1) Housekeeping personnel, using accepted practices and procedures, keep the facility free from offensive odors, accumulations of dirt, rubbish, dust, and safety hazards.

(2) Floors are cleaned regularly. Polishes on floors provide a nonslip finish; throw or scatter rugs are not used except for nonslip entrance mats.

(3) Walls and ceilings are maintained free from cracks and falling plaster, and are cleaned and painted regularly.

(4) Deodorizers are not used to cover up odors caused by unsanitary conditions or poor housekeeping practices.

(5) Storage areas, attics, and cellars are kept safe and free from accumulations of extraneous materials such as refuse, discarded furniture, and old newspapers. Combustibles such as cleaning rags and compounds are kept in closed metal containers.

(6) The grounds are kept free from refuse and litter. Areas around buildings, sidewalks, gardens, and patios are kept clear of dense undergrowth.

(b) *Standard; Pest Control.*—The facility is maintained free from insects and rodents. The factors explaining the standard are as follows:

(1) A pest control program is in operation in the facility. Pest control services are provided by maintenance personnel of the facility or by contract with a pest control company. Care is taken to use the least toxic and least flammable effective insecticides and rodenticides. These compounds are stored in nonpatient areas and in nonfood preparation and storage areas. Poisons are under lock.

(2) Windows and doors are appropriately screened during the insect breeding season.

(3) Harborages and entrances for insects and rodents are eliminated.

(4) Garbage and trash are stored in areas separate from those used for the preparation and storage of food and are removed from the premises in conformity with State and local practices. Containers are cleaned regularly.

(c) *Standard; Linen.*—The facility has available at all times a quantity of linen essential for the proper care and comfort of patients. Linens are handled, stored, and processed so as to control the spread of infection. The factors explaining the standard are as follows:

(1) The linen supply is at least three times the usual occupancy.

(2) Clean linen and clothing are stored in clear, dry, dust-free areas easily accessible to the nurses' station.

(3) Soiled linen is stored in separate well-ventilated areas, and is not permitted to accumulate in the facility. Soiled linen and clothing are stored separately in suitable bags or containers.

(4) Soiled linen is not sorted, laundered, rinsed, or stored in bathrooms, patient rooms, kitchens or food storage areas.

405.1136 Condition of Participation—Disaster Plan.—The extended care facility has a written procedure to be followed in case of fire or other disaster.

(a) *Standard; Disaster Plan.*—The facility has a written procedure to be followed in case of fire, explosion or other emergency. It specifies persons to be notified, locations of alarm signals and fire extinguishers, evacuation routes, procedures for evacuating helpless patients, frequency of fire drills, and assignment of specific tasks and responsibilities to the personnel of each shift.

(b) The factors explaining the standard are as follows:

(1) The plan is developed with the assistance of qualified fire and safety experts.

(2) All personnel are trained to perform assigned tasks.

(3) Simulated drills testing the effectiveness of the plan are conducted on each shift at least three times a year.

(4) The plan is posted throughout the facility.

405.1137 Condition of Participation—Utilization Review Plan.—(*a*) *Condition.*—The extended care facility has in effect a plan for utilization review which applies at least to the services furnished by the facility to individuals entitled to benefits under title XVIII of the Act, and meets all other requirements of section 1861(k) of the Social Security Act. An acceptable utilization review plan provides for: (1) The review on a sample or other basis, of admissions, duration of stays, and professional services furnished; and (2) review of each case of continuous extended duration.

(*b*) *General.*—(1) There are many types of plans which can fulfill the requirements of title XVIII of the Act. Extended care facilities wishing to establish their eligibility to participate will be required to submit a written description of their utilization review plan and a certification that it is currently in effect or that it will be in effect no later than the first day on which the extended care facility expects to become a participating provider of services. Ordinarily, this will constitute sufficient evidence to support a finding that the utilization review plan of the extended care facility is or is not in conformity with the statutory requirements.

(2) The review plan of an extended care facility should have as its overall objectives the maintenance of high quality patient care, more effective utilization of extended care services (through the mechanism of an educational approach involving study of patterns of care), the encouragement of appropriate utilization, and the assurance of continuity of care upon discharge (through, among other things, the accumulation of appropriate data on the availability of other facilities and services).

(3) The review of professional services furnished might include study of such conditions as overuse or underuse of services, proper use of consultation, and whether the required nursing and related care is initiated and carried out promptly. While review of lengths of stay for purposes of determining whether continued inpatient stay in the extended care facility is medically necessary, must be based on medical factors, the plan should take into account the need to assure that assistance is available to the physician in arranging for discharge planning.

(4) Costs incurred in connection with the implementation of the utilization review plan are includable in reasonable costs and are reimbursable to the extent that such costs relate to health insurance program beneficiaries.

(*c*) *Standard; Responsibility for Plan.*—The operation of the utilization review plan is a responsibility of the medical profession. The plan for reviewing utilization in the facility is developed with the advice of the facility's group of professional personnel referred to in § 405.1122 and has the approval of the facility's medical staff, if any, and the facility's governing body.

(*d*) *Standard; Statement of Plan.*—The extended care facility has a currently applicable, written description of its utilization review plan. Such description includes:

(1) The organization and composition of the committee(s) which will be responsible for the utilization review functions;

(2) Frequency of meetings;

(3) The type of records to be kept;

(4) The method to be used in selecting cases on a sample or other basis;

(5) The definition of what constitutes the period or periods of extended duration;

(6) The relationship of the utilization review plan to claims administration by a third party;

(7) Arrangements for committee reports and their dissemination;

(8) Responsibilities of the facility's administrative staff in support of utilization review.

(*e*) *Standard; Conduct of Review.* — (1) The utilization review function is conducted by one or a combination of the following (except that with respect to facilities lacking an organized medical staff, review is conducted only as in subdivision (ii) or (iii) of this subparagraph):

(i) By a staff committee of the facility, which is composed of two or more physicians, with or without the inclusion of other professional personnel; or

(ii) By a committee(s) or group(s) outside the facility composed as in subdivision (i) of this subparagraph which is established by the local medical society and some or all of the hospitals and extended care facilities in the locality; or

(iii) Where a committee(s) or group(s) as described in subdivision (i) or (ii) of this subparagraph has not been established to carry out all the utilization review functions prescribed by the Act,

by a committee(s) or group(s) composed as in subdivision (i) of this subparagraph, and sponsored and organized in such manner as approved by the Secretary.

(2) The factors explaining the standard are as follows:

(i) The medical care appraisal and educational aspects of review on a sample or other basis, and the review of long-stay cases need not be done by the same committee or group.

(ii) In a facility with an organized medical staff, all of the review functions may be carried out in the facility by a committee of the whole or a medical care appraisal committee.

(iii) The committee(s) include at least one physician member who does not have a direct financial interest in the institution.

(iv) Under subparagraph (1)(iii) of this paragraph, any sponsorship of a utilization committee or group is ordinarily acceptable if it is composed as in subparagraph (1)(i) of this paragraph.

(*f*) *Standard; Basis for Review.*—(1) Reviews are made, on a simple or other basis, of admissions, duration of stays, and professional services (including drugs and biologicals) furnished, with respect to the medical necessity of the services, and for the purpose of promoting the most efficient use of available health facilities and services. Such reviews emphasize identification and analysis of patterns of patient care in order to maintain consistent high quality. The review is accomplished by considering the data obtained by any one or any combination of the following:

(i) By use of services and facilities of external organizations which compile statistics, design profiles, and produce other comparative data; or

(ii) By cooperative endeavor with the fiscal intermediary or State agency; or

(iii) By studies of medical records of patients of the institution.

(2) The factors explaining the standard are as follows:

(i) Some review functions are carried out on a continuing basis.

(ii) Reviews include a sample of physician recertifications of medical necessity for extended care facility services, as made for purposes of the Health Insurance for the Aged program.

(*g*) *Standard; Extended Duration Cases.*—(1) Reviews are made of each beneficiary case of continuous extended duration. The definition of such extended duration is reasonable and consonant with the intent of the benefit. The extended care facility's utilization review plan specifies the number of continuous days of stay in the extended care facility following which a review is made to determine whether further inpatient extended care services are medically necessary. The plan may specify a different number of days for different classes of cases.

(2) Reviews for such purpose are made no later than the seventh day following the last day of the period of extended duration specified in the plan. No physician has review responsibility for any case of continuous extended duration in which he was professionally involved.

(3) If physician members of the committee decide, after opportunity for consultation is given the attending physician by the committee, that further inpatient stay is not medically necessary, there is to be prompt notification (within 48 hours) in writing to the facility, the physician responsible for the patient's care, and the patient or his representative. Because there are significant divergencies in opinion among individual physicians with respect to evaluation of medical necessity for posthospital extended care services, the judgment of the attending physician in an extended stay case is given great weight, and is not rejected except under unusual circumstances.

(*h*) *Standard; Maintenance of Records of Review.*—Records are kept of the activities of the committee; and reports are regularly made by the committee to the executive committee of the medical staff (if any) or to the facilities, institutions, and organizations sponsoring the utilization review plan, and relevant information and recommendations are reported through usual channels to the entire medical staff and the governing body of the facility, and the sponsor of the plan. The factors explaining the standard are as follows:

(1) The extended care facility administration studies and acts upon Administrative recommendations made by the utilization review committee.

(2) A summary of the number and types of cases reviewed, and the findings, are part of the records of the committee and the participating facilities and institutions.

(3) Minutes of each committee meeting are maintained.

(4) Committee action in extended stay cases is recorded, with cases identified only by case number when possible.

(*i*) *Standard; Staff Cooperation With Review*

Committee.—The committee(s) having responsibility for utilization review functions have the support and assistance of the facility's administrative staff in assembling information, facilitating chart reviews, conducting studies, exploring ways to improve procedures, maintaining committee records, promoting the most efficient use of available health services and facilities, and in planning for the patient's continuity of care upon discharge. The factors explaining the standard are as follows:

(1) With respect to each of these activities, an individual or department is designated as being responsible for the particular service.

(2) In order to encourage the most efficient use of available health services and facilities, assistance to the physician in timely planning for care following extended facility care is initiated as promptly as possible, either by the facility's staff, or by arrangement with other agencies. For this purpose, the facility makes available to the attending physician current information on resources available for continued noninstitutional or custodial care of patients and arranges for prompt transfer of appropriate medical and nursing information in order to assure continuity of care upon discharge of a patient.

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

HEW NEWS

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FOR IMMEDIATE RELEASE
Friday, June 30, 1972

A massive Federal effort to upgrade long term care facilities will reach a milestone on Saturday, July 1, the deadline announced last November 30 by HEW Secretary Elliot L. Richardson for cutoff of Federal support to substandard nursing homes.

As of that date, established as part of a multi-pronged program to upgrade long term care facilities ordered by President Nixon last August 6, each State must have completed certification of all skilled nursing homes providing care to Medicaid patients.

Those States that are determined by HEW to have failed to complete the inspection and certification of all skilled nursing homes may face formal compliance hearings. All States will lose Federal Financial Participation (FFP) for the homes they have not yet certified. If valid certification of these homes is achieved at a later date, FFP will resume on the first day of the month in which certification occurs.

Those homes failing to meet Federal Medicaid standards for patient care and safety will no longer be eligible to participate in the Medicaid program. States will no longer receive Federal funds for them.

Summary reports on the progress of State certification programs and on the number of nursing homes properly certified by July 1 will be sent to HEW in Washington by the Department's ten Regional Offices by July 6.

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The reports will be analyzed by the Department and the results made public in mid-July.

At that time the Department will announce which States have not met the July objective and what further action will be taken. Information will also be released in Washington and HEW's Regional Offices about other results of the certification program.

HEW is recommending to State Medicaid agencies that in mid-July they release or make available to the public the results of survey reports of individual homes they have inspected.

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HEW NEWS

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
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HEW-B76

FOR RELEASE IN A.M. PAPERS
Tuesday, May 23, 1972

The Department of Health, Education and Welfare today announced a $139,000 contract with the American Nursing Home Association to train 10,000 personnel in ways to expand, develop, and enrich the lives of the Nation's nursing home patients.

Marie Callender, Special Assistant for Nursing Home Affairs, said that each of those in the program would receive about 36 hours of continuing education over a period of three months.

According to Mrs. Callender, the program is an outgrowth of recommendations made last year in a report of a joint government-American Hospital Association conference on activity programs for long-term care institutions.

Under the program, directors of nursing home patient activities will be trained through a series of workshops in every State. It is sponsored under the Division of Health Resources, Community Health Service, a component of the Department of HEW's Health Services and Mental Health Administration.

Mrs. Callender said the program is part of HEW's overall drive to upgrade the Nation's nursing homes and cited "President Nixon's determination that the nursing homes of America should be shining symbols of comfort and concern," and called it an example of joined sponsorship between HEW and nursing home groups.

"Nursing homes must stress personal as well as medical care," she said. "One of our goals is to make it possible for patients to pursue

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independently those activities which will enrich their lives. This contract is aimed at training the directors of patient activities at nursing homes to help patients fulfill their non-medical needs."

The project includes evaluation of the patients' improved independent development as a result of the training program.

First phase of the contract will be a regional two-day orientation program for State planning teams. These teams later will hold three to five day training sessions for the local instructors who will teach patient activities personnel in each State.

State planning teams will include ANHA and State official agency personnel, as well as representatives of the occupational therapy, therapeutic recreation, and social work professions.

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HEW NEWS

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GEREMIA--(202) 962-2548

FOR RELEASE IN A.M. PAPERS
Thursday, October 7, 1971

HEW Secretary Elliot L. Richardson today asked the Governors of all 50 States to assist in an immediate upgrading of the Nation's nursing homes through strict enforcement of standards established under Medicaid.

Secretary Richardson cited President Nixon's call on August 6 for "increased Federal attention to the problems of aged citizens confined to nursing homes." Richardson told the Governors that Federal efforts to carry out the Presidential mandate "will place greater demands upon your State personnel, and we hope that you can give them the administrative support and encouragement they will need to respond quickly and effectively."

The Secretary promised Federal assistance to State enforcement officials to back up the Presidential order, including training materials and courses for State nursing home inspectors, and "a request for Congressional authorization to pay for 100 percent of these costs in the Medicaid program."

Such costs already are reimbursed for the Federally administered Medicare program. Medicaid programs, however, are State administered. Under Medicaid, States enforce nursing homes standards similar to those under Medicare, and administer payments to certified establishments.

In writing his letter, Secretary Richardson, in effect, called on the Governors to assist the Federal Government in policing those nursing homes under Medicaid for which the States have primary enforcement responsibility.

The Secretary told the Governors that "substantially increased State efforts are requested to insure that acceptable standards of care are provided

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in nursing homes" in their respective States. Toward this end he asked that each Governor appoint a representative to work with Dr. Merlin K. DuVal, HEW's Assistant Secretary for Health and Scientific Affairs, "to work to insure coordinated and effective enforcement of regulations governing all levels of care in the nursing homes in your State."

# # #

HEW NEWS

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FOR RELEASE IN A.M. PAPERS
Thursday, September 9, 1971

HEW-A97

A move to strengthen the hand of States in raising and enforcing nursing home standards was announced today by John D. Twiname, Administrator of HEW's Social and Rehabilitation Service.

Mr. Twiname issued a proposed regulation, tied to the Medicaid program, which would prohibit a State board responsible for licensing nursing home administrators from having a majority of its members made up of representatives of nursing homes, such as administrators, operators, or investors. Neither could members of single professions, such as physicians or nurses, constitute a majority on licensing boards.

The regulation also brings institutions such as large State, county, and municipal long term care institutions serving Medicaid patients under the requirements for supervision by licensed nursing home administrators.

"Secretary Richardson is determined to fulfill the President's commitment to raise the standards of care in all nursing homes receiving Federal money," Mr. Twiname stated.

"A number of senior citizen organizations have complained to me that in some States, the licensing board is controlled by a single group that may stand to profit personally from nursing home operations. This new regulation should help to build public confidence in the procedures by which nursing home administrators are licensed under the Medicaid program, while allowing time for legislatures, where necessary, to make conforming amendments to State licensing laws."

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Skilled nursing facilities and extended care units that are integral parts of hospitals, and thus not separately licensed or formally approved as nursing homes by States, are exempt from the nursing home administrator licensing requirement.

The proposed regulations would broaden the definition of a "Provisional license" to provide for such an emergency as a facility being unexpectedly without a licensed administrator.

Approval procedures for Federal financial participation in the training of nursing home administrators now serving with provisional rather than full licensure are spelled out in detail in the proposed regulations.

Comments and suggestions on the proposed regulation may be sent within the next 30 days to the Administrator, Social and Rehabilitation Service, Department of HEW. Comments received will be available for public inspection in Room 5121 of the Department's offices at 301 C Street, S.W., Washington, D.C. on Monday through Friday of each week from 8:30 a.m., to 5:00 p.m.

The notice of Proposed Rule Making appears in today's Federal Register. Copies may be obtained from the Medicaid Public Information Office, Room 4609, HEW South Building, 330 C. Street, Washington, D.C. 20201.

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EMBARGOED FOR RELEASE ON DELIVERY AUGUST 6, 1971
(Estimated at 3:30 p.m. EDT)

Office of the White House Press Secretary
(Nashua, New Hampshire)

THE WHITE HOUSE

STATEMENT BY THE PRESIDENT

The vast majority of Americans over 65 years of age are eager and able to play a continuing role as active, independent participants in the life of our country. Encouraging them to play this role -- and providing greater opportunities for them to do so -- is a cornerstone of this administration's policy concerning older Americans.

For almost one million of our 20 million senior citizens, however, a dignified and humane existence requires a degree of care from others that can usually be found only in a nursing home or extended care facility. For those who need them, the nursing homes of America should be shining symbols of comfort and concern.

Many of our nursing homes meet this standard most admirably. Day after day and year after year they demonstrate the capacity of our society to care for even the most dependent of its elderly citizens in a decent and compassionate manner. It is the goal of this administration to see that all of our nursing homes provide care of this same high quality.

Unfortunately, many facilities now fall woefully short of this standard. Unsanitary and unsafe, overcrowded and understaffed, the substandard nursing home can be a terribly depressing institution. To live one's later years in such a place is to live in an atmosphere of neglect and degradation.

In my speech to the regional convention of the National Retired Teachers Association and the American Association of Retired Persons in Chicago on June 25th, I pledged action to meet this challenge. Members of my administration have been vigorous in their development of specific plans to carry out that pledge. Today I am announcing certain decisions which we have already made in this important area.

A Plan For Action

Nursing homes presently receive over $1 billion or 40 percent of their total income from the Federal Government -- most of it through Medicare and Medicaid payments. (An additional $700 million comes from the States and localities and $900 million comes from private sources.) As I emphasized in my Chicago speech, "I do not believe that Medicaid and Medicare funds should go to substandard nursing homes in this country and subsidize them." This is not only a matter of personal belief, it is also the law of the land -- and has been since 1965.

The reason that many substandard facilities have often continued to receive such payments are many and complex. It has been difficult to enforce the law that requires participant homes to meet certain standards. In the final analysis, however, there can be no excuse for lax law enforcement -- and I therefore am taking a number of steps to improve enforcement efforts.

(MORE)

1. I am ordering that the Federal program for training State nursing home inspectors be expanded so that an additional 2,000 inspectors will be trained over the next 18-month period. The major responsibility for surveillance and regulation in the field is now carried out by State governments and this action will enable them to increase their effectiveness most significantly.

One of three places in the country where such training is now provided is the W. K. Kellogg Center for Continuing Education at the University of New Hampshire in Durham. This program trains people not only to inspect nursing homes but also to provide technical assistance and consultative services which can help improve these facilities. This New Hampshire program is funded through a grant from Department of Health, Education and Welfare and it is our intention to establish similar programs in other areas of the country. This expansion effort will cost approximately $3 million.

2. Toward this same end, I am asking theCongress to authorize the Federal Government to assume 100% of the necessary costs of these State inspection teams under the Medicaid program. This will bring the Medicaid law, which now requires the States to pay from 25 to 50 percent of these costs, into line with the Medicare law, under which the Federal Government pays the entire cost for such inspections. Again, State enforcement efforts would be significantly enhanced by this procedure.

3. I am ordering that all activities relating to the enforcement of such standards -- activities which are now scattered in various branches of the Department of Health, Education and Welfare -- be consolidated within the Department into a single, highly efficient program. This means that all enforcement responsibility will be focused at a single point -- that a single official will be accountable for success or failure in this endeavor. I am confident that this step alone will enormously improve the efficiency and the consistency of our enforcement activities.

4. I am requesting funds to enlarge our Federal enforcement program by creating 150 additional positions. This will enable the Federal Government more effectively to meet its own responsibilities under the law and to support State enforcement efforts.

5. I have directed the Department of Health, Education and Welfare to institute a new program of short-term courses for physicians, nurses, dieticians, social workers and others who are regularly involved in furnishing services to nursing home patients. Appropriate professional organizations will be involved in developing plans and course materials for this program and the latest research findings in this complex field will also be utilized. In too many cases, those who provide nursing home care -- though they be generally well prepared for their profession -- have not been adequately trained to meet the special needs of the elderly. Our new program will help correct this deficiency.

6. I have also directed the Department of Health, Education and Welfare to assist the States in establishing investigative units which will respond in a responsible and constructive way to complaints made by or on behalf of individual patients. The individual who is confined to an institution and dependent upon it is often powerless to make his voice heard. This new program will help him deal with concerns such as accounting for his funds and other personal property, protecting himself against involuntary transfers from one nursing home to another or to a mental hospital, and gaining a fair hearing for reports of physical and psychological abuse.

7. I am also directing the Secretary of Health, Education and Welfare to undertake a comprehensive review of the use of long-term care facilities as well as the standards and practices of nursing homes and to recommend any further remedial measures that may be appropriate. Such a review is badly needed. Study after study tells us -- compellingly -- that many things are wrong with certain nursing home facilities, but there is not yet a clear enough understanding of all the steps that must be taken to correct this picture.

Of course, I am also looking to the White House Conference on Aging, which meets this December, to offer specific recommendations regarding this same difficult question.

8. Finally, I would emphasize my earnest hope that all these efforts will bring about the improvement of existing substandard homes rather than their abolition. The interests of the elderly are far better served when a home is reformed and renewed than when a home is eliminated. But let there be no mistaking the fact that when facilities fail to meet reasonable standards, we will not hesitate to cut off their Medicare and Medicaid funds.

We are particularly hopeful that our efforts will bring reform, since any reasonable expenses incurred as a result of improving care can often be financed under the existing Medicare and Medicaid programs. We are fully prepared to budget the necessary funds to meet reasonable cost increases which result from such improvements.

The Federal Government stands ready to help in this great reform effort in other ways as well. Under the Hill Burton Act, for example, we are able to provide loan guarantees and direct loans for the modernization of old nursing home facilities and the construction of new ones. The Federal Housing Administration also provides help in this field by insuring mortages to finance construction or rehabilitation of nursing homes and intermediate care facilities. And the Small Business Administration also guarantees loans and makes direct loans to assist proprietary nursing homes in constructing, expanding or converting their facilities, in purchasing equipment or materials, and in assembling working capital.

In addition to all of these efforts, the administration is working in a number of other ways to improve the life of all older Americans -- whatever their place of residence. Some of our strongest initiatives to help older people -- including major reforms in both the welfare and social security systems -- are contained in the legislation designated H. R. 1 which is now pending in the Senate. I would emphasize again the passage of this legislation could make a major impact for good in the lives of older Americans, including those who need to live in nursing homes and extended care facilities.

As we work to improve the quality of life for the elderly -- and especially for those who must rely on the care provided in the nursing homes of our country-- we should not expect overnight miracles. The problems we face have developed in too many places over too long a time. But we can expect that our efforts will result in significant and continuing progress. With the cooperation of the Congress, the State governments, and the nursing home industry, we can truly transform substandard nursing homes so that the very best nursing homes of today will be the typical nursing homes of tomorrow.

# # #

Friday, February 4, 1972

STATEMENT
BY
JOHN G. VENEMAN
UNDER SECRETARY
DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Last November HEW established February 1 as the date by which all States must have in place and ready to operate a mechanism for surveying and certifying skilled nursing home providers.

All but one State has met this objective, and even that State -- Pennsylvania -- is substantially in accord with regulations.

We are pleased that all States were able to make such exceptional progress in just two months.

On November 30, we had identified 105 items requiring correction in the certification process in the 38 states we identified then as having "substantial deficiencies" and another 16 in the other 9 States with skilled nursing home programs.

As of February 1, there was only one such deficiency.

Secretary Richardson has asked Mrs. Marie Callender, Special Assistant for Nursing Home Affairs and Mr. John D. Twiname,

Administrator of the Social and Rehabilitation Service, to move with all possible speed to resolve the remaining deficiency.

While SRS will initiate the action necessary to call a hearing for Pennsylvania, we hope the State will quickly correct the remaining deficiency and make the hearing unnecessary.

I want to point out that although we consider the elimination of deficiencies in the certification process a significant achievement, it is only the first essential step in carrying out President Nixon's directive to upgrade the Nation's nursing homes.

The States, with our help, must turn attention now to the program for certifying that all skilled nursing homes participating in Medicaid comply with Federal regulations.

This must be done by July 1, 1972.

This is a massive task but it must be done if we are to improve the quality of life for those who must depend on nursing home care.

I want to point out that we are not interested in simply decertifying a lot of homes, although we will do this if we find it necessary.

Our goal is rather to do everything humanly possible to assure that nursing home care is upgraded wherever necessary. This

is an entirely different effort, and a much more difficult one, but it is the only one that will make a real difference in the lives of nursing home patients. In this matter, we are determined to take the high road of excellence instead of the low road of expediency.

If the States respond to this effort with the same interest and support that enabled them to eliminate their deficiencies in certification procedures, I feel confident the certification program will be completed successfully and on time.

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U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

HEW NEWS

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FOR IMMEDIATE RELEASE
Friday, February 4, 1972

HEW Secretary Elliot L. Richardson announced today that 48 States out of 49 which provide skilled nursing home care under the Medicaid program have met a February 1 deadline for installing systems for surveying and certifying skilled nursing homes.

He said even that State - Pennsylvania - had only one deficiency and that was readily correctable.

On November 30, the Secretary announced that 38 States had "substantial deficiencies" in their nursing home certification processes and that Federal hearings would be initiated for those who were not meeting Federal certification requirements by February 1. Nine other States had deficiencies of a less significant nature. Two States had no defects.

"It is particularly gratifying that so many States were able to make this exceptional progress in just two months" the Secretary said. "On November 30, there were 105 items requiring correction in the certification process in the 38 States we identified as having 'substantial deficiencies' and another 16 in the other nine States with deficiencies.

"Today, there is only one such deficiency remaining in the Nation."

Secretary Richardson said that he had asked Mrs. Marie Callender, Special Assistant for Nursing Home Affairs, and Mr. John D. Twiname, Administrator, Social and Rehabilitation Service (SRS) to move with all possible speed to resolve the remaining deficiency in Pennsylvania. He said that SRS would initiate at once the procedures necessary to call hearings but that he hoped the State would act speedily to install fully certification processes and thus make a hearing unnecessary.

The Secretary said he is sending messages today complimenting the Governors of the States that have installed acceptable certification processes.

Mr. Richardson pointed out that while elimination of deficiencies in the certification process was a significant achievement, it was only the essential first step in carrying out President Nixon's directive to upgrade the Nation's nursing homes.

"The States, with our help, must turn attention now to the next major step in the program -- the actual certifying that each skilled nursing home participating in Medicaid complies with Federal standards. This is a massive task that involves detailed inspection of all such homes and, where necessary, assuring that they are upgraded or de-certified."

This must be done by July 1, 1972, the Secretary said.

"HEW people in the regional offices and in Washington are available to help States meet this target," Mr. Richardson said. "In addition, I have assigned an additional 142 positions for SRS to augment their capability to provide assistance to the States."

"If the States respond to this effort with the same interest and support that enabled them to eliminate deficiencies in their certification procedures, I feel confident the certification program will be completed successfully and on time. The beneficiaries will be the Nation's nursing home patients."

In Pennsylvania, the State has a newly revised fire and panic code which is now being reviewed in HEW to determine whether it agrees with the Title XIX standards. The problem is that the new code does not apply to Philadelphia, Pittsburgh or Scranton which use their own local fire codes, not approved by HEW. Although the State has indicated its intention to apply the fire and panic code to the three cities, this has not yet happened and the State code is, therefore, not applicable State-wide as is required.

As of today, February 4 at 10:00 A.M., only Pennsylvania does not have in place a completely acceptable procedure for certifying skilled nursing homes.

The problem is that the newly revised fire and panic code that is now being reviewed in HEW does not apply to Philadelphia, Pittsburgh, or Scranton which apply local ordinances.

SELECTED AREAS REQUIRING SIGNIFICANT IMPROVEMENT IN THE CERTIFICATION OF SKILLED NURSING HOMES FOR PARTICIPATING IN THE TITLE XIX PROGRAM AS OF

November 30, 1971

	FAILURE OF STATES TO:				
STATES	A. Have agreements for facility surveys	B. Use Medicaid standards in surveys	C. Have written agreements with skilled nursing homes	D. Place required time-limits on agreements	E. Have other required survey procedures
TOTAL	14	20	13	30	44
Alabama		X		X	
Arkansas				X	X
California				X	X
Colorado	X			X	X
Connecticut	X	X	X		X
D.C.	X			X	X
Delaware	X	X	X	X	X
Florida					X
Georgia			X		X
Hawaii	X	X		X	X
Idaho	X		X		X
Illinois				X	X
Indiana				X	X
Iowa	X			X	X
Kansas		X	X		X
Kentucky		X	X	X	X
Louisiana		X		X	X
Maine		X		X	X
Maryland	X	X	X	X	X
Massachusetts	X				X
Michigan			X		X
Minnesota			X		X
Mississippi		X			X
Missouri				X	X
Montana		X		X	X
Nebraska					X
Nevada	X	X	X		X
New Hampshire				X	
New Jersey					
New Mexico				X	X
New York		X			X
North Carolina		X			X
North Dakota		X		X	X
Ohio				X	X
Oklahoma		X		X	X
Oregon				X	X
Pennsylvania	X	X		X	X
Rhode Island					
South Carolina				X	X
South Dakota				X	X
Tennessee	X			X	X
Texas	X			X	
Utah				X	X
Vermont		X	X		X
Virginia				X	X
Washington				X	X
Wisconsin			X		X
West Virginia	X	X	X		X
Wyoming		X			X

EXPLANATION OF COLUMNS:

A. Agreements for Facility Surveys
Written agreement or memorandum of understanding between the State Medicaid agency and the survey agency (which performs on-site reviews of skilled nursing homes). The agreement should delineate the responsibilities of each agency and provide for the exchange of pertinent information. 45 CFR 205.190(a)(3) & 45 CFR 249.33(a)(2)(i).

B. Medicaid Standards in Surveys
The application by the survey agency of Federal Medicaid standards relating to: (1) health, (2) sanitation, (3) construction, (4) physical plant including fire safety, (5) patient records, (6) admission policies and procedures, and (7) administrative and fiscal records as prescribed by regulations 45 CFR 249.10(b)(4)(i) & 45 CFR 249.33.

C. Written Agreements with Skilled Nursing Homes
Formal written agreement between the State Medicaid agency and the skilled nursing home which receive Medicaid payments. These agreements should conform with the applicable requirements of Federal regulations 45 CFR 249.10(b)(4)(h); 45 CFR 249.33; and 45 CFR 250.21.

D. Time Limits on Agreements
One year agreements with skilled nursing homes which meet all Medicaid requirements. Six month agreements with skilled nursing homes which have "correctable deficiencies," or deficiencies which the Medicaid agency can waive in accordance with regulations 45 CFR 249.33(a)(2)(iv).

E. Other Required Survey Procedures
These include review of survey agency reports by the Medicaid agency to determine whether a facility meets Medicaid standards, appropriate follow-up with facilities which have correctable deficiencies obtaining and reviewing staffing reports on a quarterly basis; and ascertaining that facilities are licensed by the State licensing authority 45 CFR 249.10(b)(4)(i) & 45 CFR 249.33.

NOTE: The information in this chart is based on recent findings by the Regional Office survey teams and is not necessarily complete. The States have been advised of the deficiencies and have been asked to submit plans for correction. The degree of deficiency in each area varies from State to State.

Alaska and Arizona do not participate in the title XIX program. Guam and the Virgin Islands do not have any skilled nursing homes. In Puerto Rico no nursing home facilities have been certified for title XIX participation.

HEW NEWS

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Office of the Secretary
Washington, D.C. 20201

Office of Public Affairs

KELSO--(202) 963-4241
(Home)--(202) 833-2012

FOR RELEASE AT 12:15 P.M.
Tuesday, November 30, 1971

HEW Secretary Elliot L. Richardson told the White House Conference on Aging today that 38 states have "substantial deficiencies" in their nursing home certification process under Medicaid and called for rapid corrections.

The Secretary said that "appropriate officials in all 38 of these states are being notified today" of the results of a recent survey of certification procedures "and advised that they have until February 1 to significantly improve their Medicaid processes."

Under the Federal-State Medicaid program, Federal regulations require states to certify that nursing homes meet Federal, State and local standards covering fire, sanitation, and safety, and for medical, nursing and general care services for patients.

In his address to conference delegates meeting here through December 8, Secretary Richardson said "the States also have been informed that HEW stands ready to assist them, in any way the Department can, in upgrading their procedures.

"And they have been further informed," he said, "that unless such improvements are validated by the February 1 target date, HEW intends to initiate a non-compliance procedure that could ultimately result in witholding all Federal Medicaid funds from any or every one of the 38 States."

Secretary Richardson said, "Finally, all States and territories receiving Federal Medicaid funds have been given until July 1 of next year to inspect every participating skilled nursing home to insure that such homes are in

(more)

compliance or in substantial compliance with the Medicaid certification procedure that the State must have in place by February 1."

The deficiencies in certification procedures in the 38 States were found during a special survey of State Medicaid inspection and enforcement efforts undertaken at President Nixon's request and completed November 15.

Secretary Richardson told the conference that "I am sure we can expect that some will accuse the Federal government of exhibiting too much muscle in this matter.

"But I am hopeful," he said, "that strong Federal action will, in the end, prove unnecessary. I believe that none of the 38 States face insurmountable difficulties in meeting the February 1 target date.

"But let there be no mistake about it," he said, "the President has said Federal funds will no longer be used to subsidize nursing homes that are little more than 'warehouses for the elderly. . . dumping grounds for the dying'- - - and I mean to enforce that Presidential directive."

In letters sent Monday to State officials responsible for the Medicaid program in the 38 States, John D. Twiname, Administrator of HEW's Social and Rehabilitation Service, outlined steps States must take if they are to avoid loss of Medicaid funds.

By December 15, all States with deficiencies must submit to HEW Regional Offices written plans and timetables for correcting deficiencies.

Mr. Twiname emphasized that if the target dates announced by Secretary Richardson to the Conference delegates are not met, he would "have no alternative but to initiate" the non-compliance hearings process.

HEW acted to carry out the Presidential directive to upgrade nursing homes by developing plans to train 2000 additional State nursing home inspectors over

(more)

the next 18 months, planning short-term courses for those who regularly furnish services to patients, and helping States set up "ombudsman" units to check complaints by patients.

The Department has asked Congress to amend the Social Security Act so that the Federal Government can pay 100 percent of the cost of Medicaid inspections, and has asked for funds to add 150 Federal positions for enforcement of nursing home standards.

To expedite the job, Secretary Richardson mobilized task forces in each HEW region which, on October 18, began the survey of Medicaid certification standards in each State.

# # #

NOTE TO CORRESPONDENTS: List of 38 States, copy of the letter to State officials, and a background sheet are attached.

SELECTED AREAS REQUIRING SIGNIFICANT IMPROVEMENT IN THE CERTIFICATION OF SKILLED NURSING HOMES FOR PARTICIPATION IN THE TITLE XIX PROGRAM

	FAILURE OF STATES TO:				
STATES	A. Have agreements for facility surveys	B. Use Medicaid standards in surveys	C. Have written agreements with skilled nursing homes	D. Place required time limits on agreements	E. Have other required survey procedures
Total	11	19	13	24	38
Arkansas				X	X
California				X	X
Connecticut	X	X	X		X
D.C.	X			X	X
Delaware	X	X	X	X	X
Georgia			X		X
Hawaii	X	X		X	X
Idaho	X		X		X
Illinois				X	X
Indiana				X	X
Iowa	X			X	X
Kansas		X	X		X
Kentucky		X	X	X	X
Louisiana		X		X	X
Maine		X		X	X
Maryland	X	X	X	X	X
Michigan			X		X
Minnesota			X		X
Mississippi		X			X
Montana		X		X	X
Nevada	X	X	X		X
N. Carolina		X			X
N. Dakota		X		X	X
N. Mex.				X	X
New York		X			X
Ohio				X	X
Oklahoma		X		X	X
Oregon				X	X
Pa.	X	X		X	X
S. Carolina				X	X
S. Dakota				X	X
Tennessee	X			X	X
Utah				X	X
Vermont		X	X		X
Washington				X	X
Wisconsin			X		X
W. Virginia	X	X	X		X
Wyoming		X			X

EXPLANATION OF COLUMNS:

A. Agreements for Facility Surveys
Written agreement or memorandum of understanding between the State Medicaid agency and the survey agency (which performs on-site reviews of skilled nursing homes). The agreement should delineate the responsibilities of each agency and provide for the exchange of pertinent information. 45 CFR 205.190(a)(3) and 45 CFR 249.33(a)(2)(i).

B. Medicaid Standards in Surveys
The application by the survey agency of Federal Medicaid standards relating to: (1) health, (2) sanitation, (3) construction, (4) physical plant including fire safety, (5) patient records, (6) admission policies and procedures, and (7) administrative and fiscal records as prescribed by regulations 45 CFR 249.10(b)(4)(i) and 45 CFR 249.33.

C. Written Agreements with Skilled Nursing Homes
Formal written agreement between the State Medicaid agency and the skilled nursing homes which receive Medicaid payments. These agreements should conform with the applicable requirements of Federal regulations. 45 CFR 249.10(b)(4)(h); 45 CFR 249.33; and 45 CFR 250.21.

D. Time Limits on Agreements
One year agreements with skilled nursing homes which meet all Medicaid requirements. Six month agreements with skilled nursing homes which have "correctable deficiencies," or deficiencies which the Medicaid agency can waive in accordance with regulations. 45 CFR 249.33(a)(2)(iv).

E. Other Required Survey Procedures
These include review of survey agency reports by the Medicaid agency to determine whether a facility meets Medicaid standards; appropriate follow-up with facilities which have correctable deficiencies; obtaining and reviewing staffing reports on a quarterly basis; and ascertaining that facilities are licensed by the State licensing authority. 45 CFR 249.10(b)(4)(i) and 45 CFR 249.33.

NOTE: The information in this chart is based on recent findings by the Regional Office survey teams and is not necessarily complete. The States have been advised of the deficiencies and have been asked to submit plans for correction. The degree of deficiency in each area varies from State to State.

COPY

LETTER FROM THE ADMINISTRATOR, SOCIAL AND REHABILITATION SERVICE, DHEW, TO THE DIRECTORS OF TITLE XIX AGENCIES IN THE 38 STATES WHERE NEED FOR SIGNIFICANT IMPROVEMENT IN THE SKILLED NURSING HOME CERTIFICATION PROCESS HAS BEEN IDENTIFIED

Staff from the Department of Health, Education, and Welfare Regional Office have recently visited your State to survey the skilled nursing home certification process. The information they gathered has been transmitted to me by the Regional Office and has been subjected to an analysis by the staff of the Medical Services Administration in Washington. Review of this report indicates that there are substantial deficiencies in your skilled nursing home certification process which require significant corrective action. Thus, there is a question of compliance.

Social and Rehabilitation Service staff will assist any State where the need for significant improvement has been identified in upgrading its procedures. We hope and anticipate that it will not be necessary to institute compliance proceedings that would result in the withholding of Federal funds.

Where the Regional Office has not already received a written plan and timetable for correction of deficiencies from the State, the State must submit this by December 15, 1971. Where insufficient information has been obtained by the survey team regarding the certification process, they will be in touch with you to obtain this further information by December 6, 1971.

I am anxious to have all States come into compliance with title XIX regulations for certification of skilled nursing homes without the necessity of calling a conformity hearing.

To accomplish the certification goal, we have set the following target dates for full compliance in all States:

> February 1, 1972 -- all States must have in place and ready to operate a mechanism (including organization, procedures, and staff) for surveying and certifying skilled nursing home providers. Beginning on that date, each State will be expected to process all new provider applicants through that mechanism.
>
> July 1, 1972 -- all States will be expected to have examined all participating skilled nursing homes and to have established that they have valid provider agreements and that they are in compliance or substantial compliance with Federal standards.

As stated above, the Regional Commissioner is available to assist you in any way that he can to meet these deadlines. If, however, the target dates listed in the immediately preceding paragraph are not met, I will have no alternative but to initiate the conformity hearing process. Under Section 1904(a) of the Social

Security Act, the Secretary of Health, Education, and Welfare is required to provide opportunity to a State for a hearing to determine if there is failure to comply with Federal requirements. If the State is found to be out of compliance, all or part of the Federal funding for the title XIX program in the State must be withheld.

The above procedures and deadlines relate only to the certification process. We will shortly plan for the review of other aspects of the skilled nursing home program in your State that will cover utilization review, medical review, and other requirements of title XIX.

Sincerely yours,

John D. Twiname
Administrator

November 30, 1971

Background Paper
Certification of Skilled Nursing Homes

A skilled nursing home qualified to care for Medicaid patients and receive Medicaid payments is a facility, or distinct part of a facility, that has been surveyed and certified as meeting the conditions and standards set forth under Federal, State and local regulations. These regulations define standards for the physical attributes of the institution (fire, sanitation and safety rules) and for the medical, nursing, and general care and services to be provided for patients.

Since Medicaid is a Federal grant-in-aid program administered by the States in accordance with Federal regulations, State Medicaid agencies are responsible to the Department of Health, Education, and Welfare (SRS) for making sure that State programs operate in accordance with all Federal regulations as well as with State and local rules.

A State can give the Department of HEW assurance that this is so only if it demonstrates that homes are inspected, that standards are enforced, and that only homes that meet Federal, State, and local standards are "certified" to participate in the Medicaid program and receive Medicaid funds.

How does a State do this? The staff of a State Medicaid agency has neither the personnel or expertise to survey homes to find out whether they meet the standards for fire safety, or nursing care, or dietary planning. The Medicaid agency therefore arranges for the "survey" or inspection function to be done, usually employing the State licensing

authority or the State authority designated to survey for the Medicare program. This is accomplished thru an "interagency agreement." The agency responsible for surveying inspects homes, notes deficiencies, makes recommendations, and forwards its report to the Medicaid agency.

The next step is up to the Medicaid agency which must review the survey findings, inform the home of deficiencies, discuss the possibility of prompt remedial action, and decide whether or not the home meets all requirements for certification. If the home meets standards the Medicaid agency may enter into a "provider agreement" with it. The provider agreement will be in effect for a maximum of a year, and will specify the services to be made available to Medicaid patients and the rate at which the home will be reimbursed for these services.

If the Medicaid agency decides that the home is in substantial compliance with requirements except for some deficiencies which individually or collectively do not jeopardize patients' health and safety, the State agency may enter into a provider agreement with it for a maximum of six months, providing it is reasonable to believe that the deficiencies can be corrected within that period and the nursing home provides a written plan indicating how it will do so. No more than two successive 6-month agreements may be executed with any nursing home having deficiences. The second agreement may be signed only if the home can document its remedial effort and progress.

The reports of the regional survey teams that recently inspected State efforts to enforce nursing home standards noted deficiencies relating to interagency agreements, certification procedures, and provider agreements - deficiencies serious enough to have made us inform 38 States that "significant improvements are needed" in their enforcement programs.

Interagency agreements may have been ambiguous about the respective responsibilities of the agencies involved, or they may have failed to set standards for the professional qualifications of surveyors, or may have failed to call for recommendations for the correction of the deficiencies found, or may have been totally nonexistent.

Certification procedures were deficient in that they permitted the certification of homes which did not meet Federal standards. For example, in some cases States did not use Medicaid standards in surveying homes or the Medicaid agency did not review the survey agency's findings before approving Medicaid payments to a home.

Provider agreements were sometimes signed with homes although they did not meet the conditions for such agreements. Some agreements were issued for an indefinite period. Twelve-month agreements were sometimes signed when six-month agreements were called for. Or successive six-month agreements were signed when they could not be justified.

HEW NEWS

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Office of the Secretary
Washington, D.C. 20201

Office of Public Affairs

BROUDY--962-8897

FOR RELEASE IN A.M. PAPERS
Friday, October 29, 1971

Dr. Merlin K. DuVal, HEW's Assistant Secretary for Health and Scientific Affairs, today named Mrs. Marie Callender to serve as his Special Assistant for Nursing Home Affairs.

Mrs. Callender, 39, a member of the faculty of the University of Connecticut School of Medicine, has had a varied career in public health practice, teaching and research. Her research has included studies of patient progress in nursing homes, the organization of patient care in extended care facilities, and home-based chronically ill adults.

Dr. DuVal said that Mrs. Callender would serve as a focal point for HEW efforts in the area of nursing home affairs, starting in early November.

"We are extremely fortunate in having been able to enlist Mrs. Callender in this national effort to upgrade the quality of long term care," said Dr. DuVal, who has been given responsibility for over-seeing all nursing home enforcement activities. "She brings to this demanding assignment a rare understanding of the dimensions of the problem as well as the administrative ability to coordinate and develop, within the health structure of the Department, program activities related to nursing home initiatives. We will draw heavily on her talents and experience in carrying out the President's August 6 directive to take specific action to improve the standards and quality of nursing home care."

At the University of Connecticut School of Medicine Mrs. Callender was an assistant professor in the Department of Community Medicine and Health Care. She taught medical and dental students the organization and delivery of health care

(More)

and conducted courses in the epidemiology of medical care for doctoral candidates in sociology, psychology and anthropology. In addition, she was director of the Community Studies Unit.

A native of Rupert, Idaho, who now lives in Pine Orchard, Connecticut, Mrs. Callender holds the Bachelor of Science degree and Public Health Nursing Certificate from the University of California at Los Angeles and the Master of Public Health degree from the University of California at Berkeley. She is completing requirements at Yale University for the Ph.D. degree in Epidemiology: Medical Care.

Before coming to the University of Connecticut in 1970, she was a research associate in the Department of Epidemiology and Public Health at Yale University.

Mrs. Callender began her work in public health in 1954 as a staff nurse in the Alameda County, California, Health Department. From 1959 to 1961 she was an instructor in the School of Nursing at the University of California, San Francisco. In 1961 she became staff consultant for chronic diseases and adult health in the Westchester County, New York, Health Department, and from 1964 to 1966 was Associate Director of that Department's Division of Chronic Diseases and Adult Health.

During 1966 Mrs. Callender held a joint appointment as administrative assistant at the Yale-New Haven Hospital and Research Associate at the Yale University Medical School.

In addition to her studies of nursing homes, Mrs. Callender has conducted research and demonstration projects on health aides, neighborhood health centers, and prepaid group practice.

# # #

HEW NEWS

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Office of the Secretary
Washington, D.C. 20201

Office of Public Affairs

BROUDY--(202) 962-8897
(Home)--(301) 654-7120

FOR RELEASE
Sunday, October 24, 1971

The Department of Health, Education, and Welfare spelled out today some of the steps it will take to assist the States in carrying out their role in the national effort to improve the quality of nursing home care.

In a letter to the Governors of all 50 States Dr. Merlin K. DuVal, Assistant Secretary for Health and Scientific Affairs, promised Federal help on nursing home inspections, training of personnel, and establishment by the States of "ombudsman" units to check complaints by patients.

"We are most anxious to assist you, as well as to receive assistance from you and your staff in a joint effort to improve the performance of Federal and State responsibilities," he said.

President Nixon on August 6 called on HEW to take specific action to improve the standards and quality of nursing home care. Dr. DuVal has been given the responsibility for overseeing all nursing home enforcement activities.

In his letter, he said that State inspectors should be strongly urged to enforce Federal and State standards for nursing homes.

State personnel inspect nursing homes for Medicare under full Federal reimbursement and inspect for Medicaid on behalf of the State Medicaid program. HEW has asked Congress to amend the Social Security Act so that the Federal Government can pay 100 percent of the cost of Medicaid inspections.

"In the meantime," Dr. DuVal told the Governors, "we will provide you with as much short term help as possible in the form of teams of Federal personnel who are qualified to do inspections and who can provide technical assistance, advice and supplementation to your staff."

(More)

The letter also promised the Governors that the Federal Government would provide training for State nursing home surveyors and for professional and paraprofessional health workers who take care of nursing home patients.

Dr. DuVal also asked the Governors to implement another element in President Nixon's plan for nursing home improvement--the establishment of investigative units to review and follow up complaints made by or on behalf of nursing home patients. Governors are being requested to develop plans for such "ombudsman" units in their offices.

In States where homes have been decertified from participation in the Medicare program this year a list of these homes was sent to the Governor together with the letter. Dr. DuVal suggested an inspection of these homes for Medicaid compliance and requested a report by December 1.

# # #

NOTE TO CORRESPONDENTS: A list of these decertified homes and a copy of a letter to the Governors are attached.

FACILITIES TERMINATED BY THE SOCIAL SECURITY ADMINISTRATION
FROM PARTICIPATION IN MEDICARE

Arizona - 1971

Facility	Termination Date
Beverly Manor Phoenix, Arizona	2/1/71

California - 1971

Facility	Termination Date
Hyde Park Convalescent Home Los Angeles, California	3/10/71
Arrowood Conv. Hospital Ukiah, California	5/27/71
Convalescent Hospital - Valley Branch Van Nuys, California	5/1/71
Sherwood Conv. Hospital Van Nuys, California	5/1/71
*Ygnacio Convalescent Center Walnut Creek, California	10/25/71

*Governor Reagan received information about this termination earlier in a telegram from Dr. DuVal dated October 4, 1971.

Michigan - 1971

Facility	Termination Date
*Avonside Nursing Home Detroit, Michigan	10/25/71
*Fairlane Memorial ECF Detroit, Michigan	10/25/71
Longfellow Nursing Center Detroit, Michigan	4/30/71

*Governor Milliken received information about these terminations earlier in a telegram from Dr. DuVal dated October 4, 1971.

FACILITIES TERMINATED BY THE SOCIAL SECURITY ADMINISTRATION
FROM PARTICIPATION IN MEDICARE

Ohio - 1971

Facility	Termination Date
Pearlview, Inc. Brunswick, Ohio	9/15/71
Madeline Marie Nursing Home Cincinnati, Ohio	2/16/71
*Avon Convalescent Center Cincinnati, Ohio	10/25/71
*Curtis Nursing Home, Inc. Cleveland, Ohio	10/25/71

*Governor Gilligan received information about these terminations earlier in a telegram from Dr. DuVal dated October 4, 1971.

Pennsylvania - 1971

Facility	Termination Date
Norwood Nursing and Convalescent Home Philadelphia, Pennsylvania	2/12/71

Texas - 1971

Facility	Termination Date
Four Seasons Nursing Center of Brookhaven Dallas, Texas	7/21/71
Waldrop Sanitarium Houston, Texas	5/10/71
The Pavilion McKinney, Texas	4/16/71
LaCasa Canyon Nursing & Conv. Home Canyon, Texas	5/8/71
Victoria Conv. Center Victoria, Texas	2/4/71

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
OFFICE OF THE SECRETARY
WASHINGTON, D.C. 20201

Dear Governor

In early August the President announced a major new Federal effort to improve the quality of nursing home care. Secretary Richardson has already told you about some of our plans, but I would like to take this opportunity to give you some further details and enlist your support of our activities.

A major thrust of the new effort is enforcement of existing standards for nursing homes. This includes full enforcement of the Federal and State standards for extended care facilities under Medicare and for skilled nursing homes and intermediate care facilities under Medicaid. The effort will necessitate the termination of payments to substandard facilities under both of these programs in as expeditious a manner as possible unless standards of care are raised to meet the minimum requirements. To accomplish this, your State inspectors--both those who inspect for Medicare under full Federal reimbursement by that program, and those who inspect for Medicaid on behalf of your State Medicaid agency--must be encouraged to enforce the standards stringently through complete inspection of all homes, documentation of deficiencies, and consultation with providers to help them improve their facilities.

We are fully aware that this enforcement program may place even greater strains upon your State's personnel and financial resources. Consequently, we have asked Congress to amend Title XIX of the Social Security Act so that we can pay 100 percent of the costs of inspection for the Medicaid program. In the meantime, we will provide you with as much short term help as possible in the form of teams of Federal personnel who are qualified to do inspections and who can provide technical assistance, advice, and supplementation to your staff on an ad hoc basis. Arrangements for these teams will be made with your State agency through our HEW Regional Office.

Many of the nursing homes in your State participate in both Medicare and Medicaid. Since the standards for Medicare extended care facilities and Medicaid skilled nursing homes are nearly identical, the inspections and decisions made for one will often apply to the other. I would expect, therefore, that if a Federal decision to terminate Medicare payments is

made, Medicaid payments are also apt to be terminated by your State agency, unless adequate justification is presented for continuing the home in the Medicaid program. If any homes in your State have been decertified from participation in the Medicare program this year, a list of those homes is enclosed. I assume that you will want to inspect these homes as soon as possible for compliance with Medicaid standards, and I would appreciate a report from your designated representative on these homes as soon as inspections are completed, hopefully no later than December 1. Such a report may be sent to the Regional Director in the HEW Region serving your State. Should any home fail to take the necessary steps to comply with Federal and State regulations, and Medicaid payment termination is in order, we will, of course, work with your staff to assure that any patients in facilities terminated are placed in other facilities.

To enhance the capability of your staff to enforce standards, we will provide training for State nursing home surveyors under contracts we have with university training centers. Within 18 months, we hope that all of your staff conducting surveys and inspections under Medicare and Medicaid and your State licensure programs will have received this training. Although this training will take inspectors away from their jobs for 3-4 weeks, I solicit your complete support in encouraging their participation in this training because it represents a critical part of our joint enforcement activity. If your policies currently restrict out-of-State travel, or otherwise deter the possibility of staff participation, I would hope that you could reexamine these policies and support us in this effort.

Another element of the President's proposal envisions the establishment of investigative or "ombudsman" units in the States to review and follow-up complaints made by, or on behalf of, nursing home patients. I would appreciate your having plans developed for establishing such a unit in your office. Some modification of Federal regulations and some Federal support may be necessary in this area, and I look forward to working with you on this.

Finally, there are other actions we will be taking to improve nursing home care. A study of long-term care is under way through which we hope to reexamine our national policy. Also being developed are short-term training programs for health workers--both professional and para-professional--who work with nursing home patients.

We are most anxious to assist you, as well as to receive assistance from you and your staff in a joint effort to improve the performance of

Federal and State responsibilities. Please let me know if you have specific problems or suggestions. I look forward to hearing from you or your designee.

Sincerely yours,

Merlin K. DuVal, M.D.
Assistant Secretary for
Health and Scientific Affairs

FOR IMMEDIATE RELEASE JULY 19, 1972

Office of the White House Press Secretary

THE WHITE HOUSE

FACT SHEET

NURSING HOME PROGRAM

Background

At Nashua, New Hampshire, on August 6, 1971, in an announcement made at the Greenbriar Nursing Home, the President said that "for those who need them, the nursing homes of America should be shining symbols of comfort and concern."

Noting that "many facilities now fall woefully short of this standard," the President said that it is the goal of his Administration "to see that all of our nursing homes provide care of high quality."

Repeating a pledge for action made before the joint convention of the National Retired Teachers Association and the American Association of Retired Persons in Chicago on June 25, 1971, the President announced an eight-point plan aimed at upgrading long term care facilities throughout the nation and at developing new Federal initiatives in institutional and non-institutional long term care.

Progress on the President's Plan for Action

1. Cutoff of Federal funds to substandard nursing homes.

Action: The Department of Health, Education, and Welfare surveyed 47 States, Puerto Rico and District of Columbia Medicaid nursing home standard enforcement programs and found 39 States deficient as of November 30, 1971. States were given until February 1, 1972, to upgrade certification programs, and until July 1, 1972, to act on certification of all 7,000 Medicaid skilled nursing homes. As of this date, 579 facilities have been decertified or have withdrawn from the program in face of strict application of Federal standards; 4,766 have been certified with six-month timetables to correct deficiencies not affecting patient health and safety; 1,469 have been found in full conformity with all Federal standards; and 244 remain in process of certification with final action expected on or before July 31.

2. Consolidation of all activities related to enforcement of Federal nursing home standards into a single office.

Action: Creation of HEW Office of Nursing Home Affairs and appointment of Mrs. Marie Callender as Special Assistant for Nursing Home Affairs. New office was charged with coordinating enforcement programs of Social and Rehabilitation Service, Medical Services Administration, Social Security Administration and Health Services and Mental Health Administration.

3. Training of State nursing home inspectors.

Action: Four-week, university-based training provided for 700 of nation's 1,100 State health facility surveyors as of July 1. Remainder expected to be reached within the year.

(MORE)

4. Federal assumption of State Medicaid nursing home inspection cost.

Action: The President requested this legislation from the Congress on October 7, 1971. Upon enactment, this legislation would encourage States to further expand enforcement resources and upgrade health facility survey programs.

5. Expansion of Federal nursing home standards enforcement resources.

Action: A staff expansion was requested and authorized by Congress as part of a $9.6 million Nursing Home Supplemental Appropriation sent to the Congress on October 7, 1971 and signed by the President on December 28, 1971. The new funds enabled deployment of 227 additional enforcement personnel, with most distributed among 10 HEW regional offices to provide technical assistance to State inspection programs.

6. Training of medical and allied health professionals working in nursing homes.

Action: Federally-sponsored programs operated in conjunction with nationally professional associations and nursing home groups are programmed to reach 20,000 of nation's 500,000 long term care personnel this year, an additional 20,000 next year. Primary focus on physicians, nurses, nursing home administrators and patient activity directors.

7. Assistance to States in establishing nursing home patient "ombudsman" units.

Action: Five models developed for testing this year. Contracts with four States and a national organization to be announced shortly. Pending outcome of field tests, 885 Social Security District Offices were ordered to receive complaints from patients and relatives for forwarding to appropriate State agencies. More than 2,000 complaints acted on to date.

8. Comprehensive review of the use, standards and practices of long term care facilities and development of new Federal policy and program proposals.

Action: Office of Nursing Home Affairs has initiated exhaustive study of all modes of institutional and non-institutional long term care with focus on development of comprehensive Federal plan to encourage development of improved facilities and new alternatives to institutional care. Study and recommendations to be completed within one year.

Some Facts on Nursing Homes

Number of Institutions for the Aged	23,000
Type of Ownership:	
Proprietary-for profit	71%
Private Non-profit	20%
Governmental (State and Local)	9%
Average monthly charge per resident (1971)	
In skilled nursing homes	$420
In intermediate care facilities	$270

(MORE)

Number of persons 65 and over (1971) in long term care institutions	1,000,000
Federal support of nursing home patient care (1971)	$1.5 billion
State and local governments spend	$1.1 billion
Private sources spend over	$900 million
Nursing home "industry" is close to $3.5 billion of which public funds represent almost 75%	
Skilled nursing beds certified as Medicaid providers as of 7/17/72	430,997

# # #

TABLE 1

SUMMARY OF SKILLED NURSING HOME CERTIFICATION STATUS BY STATE, JULY 1, 1972

STATE	NUMBER				PERCENTAGE DISTRIBUTION		
	SNH Properly Certified as of 7/1/72	SNH Still in the Certification Process	SNH No Longer in Program		Certified	Still in Process	No Longer in Program
			Decertification	Withdrawn			
TOTAL	5704	869	187	248	81	12	7
Alabama	154	--	--	--	100	--	--
Arkansas	16	--	--	--	100	--	--
California	1206	--	4	33	97	--	3
Colorado	143	--	1	17	89	--	11
Connecticut	191	1	8	32	83	*	17
Delaware	12	--	--	1	92	--	8
Dist. of Col	4	--	--	1	80	--	20
Florida	238	--	2	--	99	--	1
Georgia	237	--	6	8	94	--	6
Hawaii	20	--	1	1	91	--	9
Idaho	43	12	--	--	78	22	--
Illinois	168	77	--	3	68	31	1
Indiana	93	--	--	4	96	--	4
Iowa	50	--	--	7	88	--	12
Kansas	63	--	--	3	95	--	5
Kentucky	81	--	--	--	100	--	--
Louisiana	140	--	--	1	99	--	1
Maine	21	--	--	--	100	--	--
Maryland	91	--	--	5	95	--	5
Massachusetts	173	51	--	1	77	23	*
Michigan	293	10	1	--	97	3	*
Minnesota	222	1	--	8	96	*	4
Mississippi	80	--	--	--	100	--	--
Missouri	97	5	8	16	77	4	19
Montana	64	--	--	1	98	--	2
Nebraska	45	--	3	4	87	--	13
Nevada	17	--	--	--	100	--	--
New Hampshire	14	--	--	--	100	--	--
New Jersey	221	--	1	4	98	--	2
New Mexico	19	--	--	1	95	--	5
New York	62	370	94	18	11	68	21
North Carolina	101	--	4	4	93	--	7
North Dakota	48	--	1	--	98	--	2
Ohio	121	125	39	1	42	44	14
Oklahoma	5	--	--	3	63	--	37
Oregon	17	50	4	10	21	62	17
Pennsylvania	4	65	1	1	6	92	2
Puerto Rico	7	--	--	--	100	--	--
Rhode Island	43	--	--	16	73	--	27
South Carolina	76	--	--	--	100	--	--
South Dakota	53	--	--	1	98	--	2
Tennessee	49	--	--	3	94	--	6
Texas	325	--	5	24	92	--	8
Utah	28	--	--	--	100	--	--
Vermont	22	--	--	--	100	--	--
Virginia	51	--	2	8	84	--	16
Washington	175	102	1	3	62	36	2
West Virginia	20	--	--	--	100	--	--
Wisconsin	263	--	1	5	98	--	2
Wyoming	18	--	--	--	100	--	--

*Less than 1%.

July 17, 1972

SUMMARY OF SKILLED NURSING HOME CERTIFICATION STATUS BY STATE, July 17, 1972

STATE	NUMBER				PERCENTAGE DISTRIBUTION		
	SNH Properly Certified as of 7/17/72	SNH Still in the Certification Process	SNH No Longer in Program		Certified	Still in Process	No Longer In Program
			Decertification	Withdrawn			
TOTAL	6,235	244	327	252	88	4	8
Alabama	154	--	--	--	100	--	--
Arkansas	16	--	--	--	100	--	--
California	1206	--	4	33	97	--	3
Colorado	143	--	1	17	89	--	11
Connecticut	191	1	8	32	83	*	17
Delaware	12	--	--	1	92	--	8
Dist. of Col.	4	--	--	1	80	--	20
Florida	238	--	2	--	99	--	1
Georgia	237	--	6	8	94	--	6
Hawaii	20	--	1	1	91	--	9
Idaho	55	--	--	--	100	--	--
Illinois	208	37	--	3	84	15	1
Indiana	93	--	--	4	96	--	4
Iowa	50	--	--	7	88	--	12
Kansas	63	--	--	3	95	--	5
Kentucky	81	--	--	--	100	--	--
Louisiana	140	--	--	1	99	--	1
Maine	21	--	--	--	100	--	--
Maryland	91	--	--	5	95	--	5
Massachusetts	190	19	11	5	84	8	8
Michigan	302	1	1	--	99	*	*
Minnesota	223	--	--	8	97	*	3
Mississippi	80	--	--	--	100	--	--
Missouri	102	--	8	16	81	0	19
Montana	64	--	--	1	98	--	2
Nebraska	45	--	3	4	87	--	13
Nevada	17	--	--	--	100	--	--
New Hampshire	14	--	--	--	100	--	--
New Jersey	221	--	1	4	98	--	2
New Mexico	19	--	--	1	95	--	5
New York	270	34	222	18	50	6	44
North Carolina	101	--	4	4	93	--	7
North Dakota	48	--	1	--	98	--	2
Ohio	156	90	39	1	55	31	14
Oklahoma	56	--	--	3	95	--	5
Oregon	67	--	4	10	83	0	17
Pennsylvania	6	62	2	1	9	87	4
Puerto Rico	7	--	--	--	100	--	--
Rhode Island	43	--	--	16	73	--	27
South Carolina	76	--	--	--	100	--	--
South Dakota	53	--	--	1	98	--	2
Tennessee	49	--	--	3	94	--	6
Texas	325	--	5	24	92	--	8
Utah	28	--	--	--	100	--	--
Vermont	22	--	--	--	100	--	--
Virginia	51	--	2	8	84	--	16
Washington	276	--	1	3	99	0	1
West Virginia	20	--	--	--	100	--	--
Wisconsin	263	--	1	5	98	--	2
Wyoming	18	--	--	--	100	--	--

* Less than 1%.

NUMBER AND PERCENT DISTRIBUTION OF PROVIDER AGREEMENTS BY DURATION IN CERTIFIED SKILLED NURSING HOMES BY STATE, JULY 1, 1972

State	Skilled Nursing Homes Properly Certified	Number		Percentage Distribution	
		6 Months	12 Months	6 Months	12 Months
Total	5,704	4,415	1,289	77	23
Alabama	154	50	104	32	64
Arkansas	16	16	0	100	--
California	1,206	989	217	82	18
Colorado	143	143	0	100	--
Connecticut	191	73	118	38	62
Delaware	12	0	12	100	--
Dist. of Col.	4	4	0	100	--
Florida	238	39	199	16	84
Georgia	237	165	72	70	30
Hawaii	20	17	3	85	15
Idaho	43	38	5	88	12
Illinois	168	133	35	79	21
Indiana	93	75	18	81	19
Iowa	50	49	1	98	2
Kansas	63	60	3	95	5
Kentucky	81	31	50	38	62
Louisiana	140	132	8	94	6
Maine	21	2	19	95	5
Maryland	91	87	4	95	5
Massachusetts	173	172	1	99	1
Michigan	293	187	106	64	36
Minnesota	222	219	3	99	1
Mississippi	80	57	23	71	29
Missouri	97	97	0	100	--
Montana	64	64	0	100	--
Nebraska	45	42	3	93	7
Nevada	17	15	2	88	22
New Hampshire	14	0	14	--	100
New Jersey	221	221	0	100	--
New Mexico	19	5	14	26	74
New York	62	34	28	59	61
North Carolina	101	42	59	42	58
North Dakota	48	48	0	100	--
Ohio	121	62	59	51	49
Oklahoma	5	0	5	--	100
Oregon	17	17	0	100	--
Pennsylvania	4	1	3	3	97
Puerto Rico	7	0	7	--	100
Rhode Island	43	23	20	54	46
South Carolina	76	66	10	87	13
South Dakota	53	53	0	100	--
Tennessee	49	9	40	18	82
Texas	325	325	0	100	--
Utah	28	15	13	54	46
Vermont	22	19	3	86	14
Virginia	51	51	0	100	--
Washington	175	174	1	91	1
West Virginia	20	13	7	65	35
Wisconsin	263	263	0	100	--
Wyoming	18	18	0	100	--

TABLE 2 A

NUMBER AND PERCENT DISTRIBUTION OF PROVIDER AGREEMENTS BY DURATION IN CERTIFIED SKILLED NURSING HOMES BY STATE, JULY 17, 1972

STATE	Skilled Nursing Homes Properly Certified	NUMBER		PERCENTAGE DISTRIBUTION	
		6 Months	12 Months	6 Months	12 Months
TOTAL	6,235	4,766	1,469	76	24
Alabama	154	50	104	32	64
Arkansas	16	16	0	100	--
California	1,206	989	217	82	18
Colorado	143	143	0	100	--
Connecticut	191	73	118	38	62
Delaware	12	0	12	100	--
Dist. of Col	4	4	0	100	--
Florida	238	39	199	16	84
Georgia	237	165	72	70	30
Hawaii	20	17	3	85	15
Idaho	55	50	5	91	9
Illinois	208	158	50	76	24
Indiana	93	75	18	81	19
Iowa	50	49	1	98	2
Kansas	63	60	3	95	5
Kentucky	81	31	50	38	62
Louisiana	140	132	8	94	6
Maine	21	2	19	95	5
Maryland	91	87	4	95	5
Massachusetts	190	189	1	99	1
Michigan	302	194	108	64	36
Minnesota	223	220	3	99	1
Mississippi	80	57	23	71	29
Missouri	102	102	0	100	--
Montana	64	64	0	100	--
Nebraska	45	42	3	93	7
Nevada	17	15	2	88	22
New Hampshire	14	0	14	--	100
New Jersey	221	221	0	100	--
New Mexico	19	5	14	26	74
New York	270	158	112	59	41
North Carolina	101	42	59	42	58
North Dakota	48	48	0	100	--
Ohio	156	80	76	51	49
Oklahoma	56	0	56	--	100
Oregon	67	67	0	100	--
Pennsylvania	6	2	4	33	67
Puerto Rico	7	0	7	--	100
Rhode Island	43	23	20	54	46
South Carolina	76	66	10	87	13
South Dakota	53	53	0	100	--
Tennessee	49	9	40	18	82
Texas	325	325	0	100	--
Utah	28	15	13	54	46
Vermont	22	19	3	86	14
Virginia	51	51	0	100	--
Washington	276	275	1	100	* --
West Virginia	20	13	7	65	35
Wisconsin	263	263	0	100	--
Wyoming	18	18	0	100	--

* Less than 1%

July 17, 1972

FIGURES SUPPLIED BY STATES--NOT VERIFIED BY REGIONAL OFFICES

TABLE 3

PATIENTS IN SKILLED NURSING HOMES DECERTIFIED AND/OR WITHDRAWN FROM THE PROGRAM BY STATE, JULY 17, 1972

STATE	Skilled Nursing Homes Decertified and Withdrew	Total Number of Patients	DISPOSITION OF PATIENTS					
			To Other SNHs	To Intermediate Care Facilities	To Residence	To Hospital	Cash Grant [a]	Other [b]
TOTAL	579	28,179 [c]	2,860	15,866	2	1	427	9,023
Alabama	--							
Arkansas	--							
California	37	1,272	52	3				1,217 [d]
Colorado	18	392	111	278				3
Connecticut	40	581			2			579 [e]
Delaware	1	19	19					
Dist. of Col.	1	320		320				
Florida	2	158	158					
Georgia	14	292	292					
Hawaii	2	82		31			51	
Idaho	--							
Illinois	3	*						
Indiana	4	6	1	2		1		2
Iowa	7	*						
Kansas	3	*						
Kentucky	--							
Louisiana	1	22	2	20				
Maine	--							
Maryland	5	17	1	16				
Massachusetts	16	NA	NA	NA	NA	NA	NA	NA
Michigan	1	13	13					
Minnesota	8	12	6				6	
Mississippi	--							
Missouri	24	577	91				200	286 [f]
Montana	1	1						
Nebraska	7	19						19
Nevada	--							
New Hampshire	--							
New Jersey	5	199	199					
New Mexico	1	*						
New York	240	23,433	1,633	15,000				6,800 [g]
North Carolina	8	98	55	41				2
North Dakota	1	25	25					
Ohio	40	60	30					30
Oklahoma	3	4						4
Oregon	14	42	42					
Pennsylvania	2	3					3	
Puerto Rico	--							
Rhode Island	16	NA	NA	NA	NA	NA	NA	NA
South Carolina	--							
South Dakota	1	26	3	23				
Tennessee	3	31		30				1
Texas	29	217	36	101				80 [h]
Utah	--							
Vermont	--							
Virginia	10	30	30					
Washington	4	60	60					
West Virginia	--							
Wisconsin	6	168	1				167	
Wyoming	--							

a/ Patients for whose care the State pays a direct cash grant to the patient rather than a vendor payment to the facility.

b/ Examples of other: Transferred to convalescent, rest or boarding homes; remaining in facility pending suitable alternate placement.

c/ Totals exclude information from Massachusetts and Rhode Island.

d/ Patients remaining in facilities pending certification determination upon change of ownership.

e/ 422 placed in convalescent homes; 140 to rest homes; and 17 to boarding homes.

f/ Remaining in facilities.

g/ Patients in homes under litigation.

h/ 62 remaining in facilities.

* No Medicaid patients in facilities.

July 17, 1972

FIGURES SUPPLIED BY STATES--NOT VERIFIED BY REGIONAL OFFICES

TABLE 4

NUMBER AND PERCENT DISTRIBUTION OF SKILLED NURSING HOME BEDS BY CERTIFICATION STATUS AND BY STATE, JULY 1, 1972

STATE	NUMBER						PERCENTAGE DISTRIBUTION		
	Number Certified SNH	Total Beds In SNH	Total XIX Beds	Total XIX Beds In Certified SNH	XIX Beds in SNH Still in Certification Process	XIX Beds In SNH No Longer In Program	Certified	Still In Process	No Longer In Program
TOTAL	5704	609,620	516,031	430,997	85,034	27,504	79	16	5 1/
Alabama	154	11,805	8,912	8,912	--	--	100	--	--
Arkansas	16	2,473	2,473	2,473	--	--	100	--	--
California	1206	100,509	96,417	96,417	--	2,337	98	--	2
Colorado	143	13,872	10,976	10,976	--	597	92	--	8
Connecticut	191	17,648	16,067	15,792	275	1,322	91	1	8
Delaware	12	913	913	913	--	39	96	--	4
Dist. of Col.	4	1,624	871	871	--	320	73	--	27
Florida	238	23,600	23,600	23,600	--	158	99	--	1
Georgia	237	21,718	2,491	2,491	--	440	87	--	13
Hawaii	20	1,680	1,680	1,680	--	82	95	--	5
Idaho	43	4,983	3,573	3,096	477	--	87	13	--
Illinois	168	24,220	24,220	20,695	3,525	119	85	14	1
Indiana	93	6,952	6,952	6,952	--	134	98	--	2
Iowa	50	3,280	1,786	1,786	--	309	86	--	14
Kansas	63	3,445	3,092	3,092	--	89	98	--	2
Kentucky	81	5,646	5,026	5,026	--	--	100	--	--
Louisiana	140	8,493	7,433	7,433	--	32	100	--	*
Maine	21	2,862	749	749	--	--	100	--	--
Maryland	91	10,362	7,626	7,626	--	274	97	--	3
Massachusetts	173	21,398	15,414	11,565	3,849	50	75	25	*
Michigan	293	23,892	23,892	23,705	187	25	99	1	*
Minnesota	222	16,637	16,637	16,497	140	246	98	*	2
Mississippi	80	4,881	4,881	4,881	--	--	100	--	--
Missouri	97	11,214	10,529	8,969	1,560	2,002	75	12	13
Montana	64	3,230	2,462	2,462	--	29	99	--	1
Nebraska	45	4,723	3,221	3,221	--	301	92	--	8
Nevada	17	912	912	912	--	--	100	--	--
New Hampshire	14	1,208	746	746	--	--	100	--	--
New Jersey	221	20,430	19,777	19,777	--	183	99	--	1
New Mexico	19	910	814	814	--	18	98	--	2
New York	62	61,575	46,321	8,157	38,164	11,102	14	67	19
North Carolina	101	6,489	5,523	5,523	--	166	97	--	3
North Dakota	48	3,451	3,451	3,451	--	25	99	--	1
Ohio	121	20,374	20,374	12,999	7,375	3,207	55	31	14
Oklahoma	5	884	674	674	--	107	86	--	14
Oregon	17	6,612	4,299	1,095	3,204	787	22	63	15
Pennsylvania	4	19,143	18,836	2,250	16,586	99	12	88	*
Puerto Rico	7	573	573	573	--	--	100	--	--
Rhode Island	43	2,988	1,433	1,433	--	449	76	--	24
South Carolina	76	5,592	4,653	4,653	--	--	100	--	--
South Dakota	53	3,393	3,137	3,137	--	34	99	--	1
Tennessee	49	13,576	2,164	2,164	--	350	86	--	14
Texas	325	17,751	14,529	14,529	--	1,263	92	--	8
Utah	28	2,375	1,925	1,925	--	--	100	--	--
Vermont	22	1,522	1,250	1,250	--	--	100	--	--
Virginia	51	4,942	2,745	2,745	--	436	86	--	14
Washington	175	27,262	24,404	14,712	9,692	129	60	40	*
West Virginia	20	1,156	1,156	1,156	--	--	100	--	--
Wisconsin	263	33,163	33,163	33,163	--	244	99	--	1
Wyoming	18	1,279	1,279	1,279	--	--	100	--	--

* Less than one percent.

1/ Represents 5% of the beds in the title XIX program as of February 1, 1972.

July 17, 1972

TABLE 5

HEW REGIONAL OFFICE VALIDATION BY TYPE OF ACTIVITY BY STATE, JULY 1, 1972

STATE	Number of Certified Homes	Provider Files Review		In-depth File Examination		Survey Report Review		SNH Validation On-site Surveys	
		Number	Percent	Number	Percent	Number	Percent	Number	Percent
TOTAL	5704	5203	91	2411	42	1785	31	281	5
Alabama	154	75	49	75	49	35	23	2	1
Arkansas	16	11	69	11	69	11	69	3	19
California	1206	1197	99	183	15	210	17	40	3
Colorado	143	143	100	143	100	35	25	0	0
Connecticut	191	151	79	40	21	54	28	1	*
Delaware	12	12	100	12	100	12	100	3	25
Dist. of Col	4	4	100	4	100	4	100	0	0
Florida	238	75	32	40	17	40	17	3	1
Georgia	237	46	19	46	19	46	19	5	2
Hawaii	20	10	50	10	50	10	50	10	50
Idaho	43	43	100	12	28	16	37	5	12
Illinois	168	168	100	35	21	35	21	8	5
Indiana	93	93	100	93	100	93	100	0	0
Iowa	50	50	100	50	100	50	100	2	4
Kansas	63	63	100	63	100	40	64	3	5
Kentucky	81	48	59	27	33	20	25	2	3
Louisiana	140	140	100	48	34	64	46	12	9
Maine	21	21	100	19	91	19	91	2	10
Maryland	91	88	97	40	44	40	44	8	9
Massachusetts	173	173	100	35	20	0	0	1	*
Michigan	293	293	100	57	20	10	3	3	1
Minnesota	222	223 1/	100+	45	22	32	15	2	1
Mississippi	80	50	63	20	25	20	25	2	3
Missouri	97	92	95	48	50	20	21	3	3
Montana	64	64	100	64	100	17	27	2	3
Nebraska	45	45	100	45	100	10	22	2	4
Nevada	17	17	100	17	100	8	47	8	47
New Hampshire	14	14	100	14	100	14	100	3	21
New Jersey	221	226 1/	100+	226	100	226	100	8	4
New Mexico	19	19	100	19	100	19	100	3	16
New York	62	62	100	125 1/	100+	20	32	20	32
North Carolina	101	75	74	25	25	30	30	2	2
North Dakota	48	48	100	30	63	23	48	0	0
Ohio	121	121	100	121	100	70	58	2	2
Oklahoma	5	5	100	5	100	9 1/	100+	3	60
Oregon	17	19 1/	100+	14	82	21 1/	100+	8	47
Pennsylvania	4	0	0	40 1/	100+	40 1/	100+	6 1/	100+
Puerto Rico	7	3	43	3	43	3	43	3	43
Rhode Island	43	35	81	35	81	12	28	1	2
South Carolina	76	76	100	61	80	26	34	5	7
South Dakota	53	53	100	14	26	20	38	3	6
Tennessee	49	49	100	30	61	10	20	3	6
Texas	325	325	100	80	25	103	32	23	7
Utah	28	28	100	28	100	28	100	0	0
Vermont	22	22	100	22	100	22	100	1	5
Virginia	51	51	100	40	78	3	6	6	12
Washington	175	276 1/	100+	54	31	25	14	43	25
West Virginia	20	20	100	20	100	2	10	2	10
Wisconsin	263	263	100	105	40	90	34	3	1
Wyoming	18	18	100	18	100	18	100	1	6

1/ Validation activity conducted prior to certification decision accounts for over 100% of certified homes.

* Less than 1%

July 17, 1972

NOTES ON STATES WITH CERTIFICATION ACTIONS PENDING ON JULY 1, 1972

Idaho

	No.	% Distrib.
Skilled nursing homes as of 2/1/72	55	100
Properly certified as of 7/1/72	43	78
Still in the certification process as of 7/1/72	12	22

Pending decisions on waiver criteria for the sprinkler requirement in the Life Safety Code, these surveys were delayed in the State. As a result, 12 out of 55 homes did not have signed provider agreements. However, all certification actions have been completed except for the return of the signed contract by the facility. All of the remaining 12 skilled nursing homes returned their signed provider agreements by July 14, 1972. Idaho has now completed all certification action.

Illinois

	No.	% Distrib.
Skilled nursing homes as of 2/1/72	248	100
Properly certified as of 7/1/72	168	68
Voluntarily withdrawn	3	1
Still in the certification process as of 7/1/72	77	31
(Certification still unfinished as of 7/17/72	37)	

Illinois is expected to have all title XIX skilled nursing homes certified by the end of July and has met all of the HEW requirements for surveying skilled nursing homes and issuing agreements for signature to nursing home operators.

Currently, there are 208 homes certified, 37 remain to be certified, and 3 have withdrawn. The 37 remaining homes will be certified by the end of the month.

Massachusetts

	No.	% Distrib.
Skilled nursing homes as of 2/1/72	225	100
Properly certified as of 7/1/72	173	77
Voluntarily withdrawn	1	--
Still in the certification process as of 7/1/72	51	23
(Still uncertified as of 7/17/72	19)	

Of the 51 homes still in the certification process as of July 1, 30 had surveyed and were awaiting review of the survey and issuance of the provider agreement. Twenty of these 30 required the return of a properly signed provider agreement by the home in order to complete the process. The other 10 required either waivers or acceptable plans of correction. These actions should be completed this month. The files for the balance of the homes (21) remained in the survey agency. These files required additional information from the nursing home before the processing of the provider agreement can continue.

Massachusetts' certification delays were due to: (1) lack of sufficient staff in the certification agency, and (2) the absence of proper documentation in fire safety surveys. Documentation of deficiencies is essential before the certification agency can decide whether a home is qualified to participate in the Medicaid program as a skilled nursing facility.

Michigan

	No.	% Distrib.
Skilled nursing homes as of 2/1/72	304	100
Properly certified as of 7/1/72	293	97
Decertified	1	-
Still in the the certification process as of 7/1/72	10	3
(Still uncertified as of 7/17/72	1)	

Michigan is expected to have all Medicaid nursing homes certified by the end of July. Only 1 agreement remains to be certified.

Missouri

	No.	% Distrib.
Skilled nursing homes as of 2/1/72	126	100
Properly certified as of 7/1/72	97	77
Decertified	8	6
Voluntarily withdrawn	16	13
Still in the certification process as of 7/1/72	5	4

Five of the 103 skilled nursing homes in the State lacked proper provider agreements as of July 1. Information as of July 14, indicates that all homes have now been certified.

New York

	No.	% Distrib.
Skilled nursing homes as of 2/1/72	544	100
Properly certified as of 7/1/72	62	11
Decertified	94	17
Voluntarily withdrawn	18	03
Still in the certification process as of 7/1/72	370	68
(Still uncertified as of 7/17/72	34)	

State has now certified 270 facilities and has moved to decertify a total of 222, including 189 which have entered court action to block final State decertification. State has mailed provider agreements to another 34 homes with request that these be returned by July 31. When all are returned, New York will have completed all certification activity. Delay in State's certification program was due to: late start by survey agency; inadequate staff in Title XIX agency; and diversion of survey agency personnel to planning for series of more than 100 hearings on individual facilities mandated under court order.

Ohio

	No.	% Distrib.
Skilled nursing homes as of 2/1/72	286	100
Properly certified as of 7/1/72	121	42
Decertified	39	14
Voluntarily withdrawn	1	-
Still in the certification process as of 7/1/72	125	44
(Still uncertified as of 7/17/72	90)	

Ohio has met the HEW requirements which call for surveying homes and issuing the agreements to nursing home operators. A court restraining order, obtained by the Ohio Nursing Home Association, had prevented 125 nursing homes from signing agreements and returning them to the State. Since that time, 35 homes have returned signed agreements. The remaining 90 homes are restrained from signing the agreement due to a preliminary injunction by the court. Certification process cannot be resumed until court action is complete.

Oregon

	No.	% Distrib.
Skilled nursing homes as of 2/1/72	81	100
Properly certified as of 7/1/72	17	21
Decertified	4	5
Voluntarily withdrawn	10	12
Still in certification process as of 7/1/72	50	62

Fire safety surveys were delayed in the State pending decisions on waiver criteria to the sprinkler requirement in the Life Safety Code. All 67 facilities had been surveyed by July 1 and of these 17 had signed and returned their provider agreements. All of the remaining 50 skilled nursing homes returned their signed provider agreements by July 17, 1972. Oregon has now completed all certification activities.

Pennsylvania

	No.	% Distrib.
Skilled nursing homes as of 2/1/72	71	100
Properly certified as of 7/1/72	4	6
Decertified	1	1
Voluntarily withdrawn	1	1
Still in certification process as of 7/1/72	65	92
(Still uncertified as of 7/17/72	62)	

In June, large portions of Pennsylvania were devastated by floods caused by tropical storm Agnes. As a result, most State staff were diverted to emergency assignments to provide food, shelter, and other assistance to persons dispossessed by the flood. The certification activity is only now beginning to resume.

Because the flood caused the certification effort to be completely halted, the Department has decided that Pennsylvania should be permitted an extension of 60 days from July 1 to complete the certification process.

Washington

	No.	% Distrib.
Skilled nursing homes as of 2/1/72	281	100
Properly certified as of 7/1/72	175	62
Decertified	1	-
Voluntarily withdrawn	3	1
Still in the certification process as of 7/1/72	102	37

The problem in Washington was that the State was slow in developing and applying the certification mechanism and in hiring and training necessary staff in the survey unit. Also, the State Fire Marshal was late in starting Life Safety Code surveys which were not completed until the last days of June. Of the 281 facilities in Washington, a total of 175 skilled nursing homes had valid provider agreements, 91 were complete except for the provider's signature, 4 were decertified or withdrawn,and of the balance only 4 facilities still had problems on July 1. All skilled nursing homes had signed provider agreements by 7/17/72. Washington has now completed all certification activities.

July 19, 1972

Background Paper

The Certification Process
Six-Month, 12-Month Provider Agreements and the Use of Waivers

A skilled nursing home qualified to care for Medicaid patients and receive Medicaid payments is a facility, or distinct part of a facility, that has been inspected and certified as meeting the conditions and standards set forth under Federal, State and local regulations. These regulations define standards for the physical environment of the institution (fire, sanitation and safety) and for the medical, nursing, dietary and general care and services to be provided.

Since Medicaid is a Federal grant-in-aid program administered by the States in accordance with Federal regulations, State Medicaid agencies are responsible to the Social and Rehabilitation Service in the Department of Health, Education, and Welfare for making sure that State programs operate in accordance with all Federal regulations as well as with State and local rules.

A State can assure HEW of this by demonstrating that homes are inspected, that standards are enforced, and that only homes that meet Federal, State, and local standards are "certified" to participate in the Medicaid program and receive Medicaid funds.

How does a State do this? The staff of a State Medicaid agency usually has neither the personnel nor expertise to survey homes to find out whether they meet standards. The Medicaid agency, therefore, usually delegates responsibility for the survey and inspection function to the State licensing authority or the State authority designated to survey for the Medicare program.

This is arranged through an "interagency agreement" or contract. The responsible agency inspects homes, notes deficiencies, obtains a plan of correction of deficiencies from the home, and then forwards reports and recommendations to the Medicaid agency.

The next move belongs to the Medicaid agency which must review the survey findings and recommendations, and decide whether or not the homes can be certified.

Certification is accomplished by the Medicaid agency's issuance of a "provider agreement" specifying the services to be made available to Medicaid patients and the rate at which the home will be reimbursed. The agreement may be issued for one year or for six month.

A one year agreement is issued if the Medicaid agency decides the home meets all Federal, State and local standards, as evidenced by survey reports.

A six-month agreement is issued if all the following conditions are met:

1. The home meets standards except for deficiencies which individually or collectively do not jeopardize patients' health and safety;

2. It is reasonable to believe that the deficiencies can be corrected within the six-month period; and

3. The nursing home provides a written plan indicating how and when correction will be made.

No more than two successive 6-month agreements may be issued to any nursing home. The second agreement may be issued only if the home documents its remedial effort and progress.

In issuing either a 6-or 12-month agreement to a nursing home, a State agency may waive one or more specific requirements related to environment and sanitation, and fire and safety requirements including the Life Safety Code if there is documented evidence that:

1. The waiver of specific requirements does not adversely affect patients' health and safety, and

2. The standards, if rigidly applied, would result in unreasonable hardship for the skilled nursing home; and

3. A written justification of such a finding is maintained on file.

The requirement regarding hospital agreements may be waived if the home's location is remote from a general hospital, or if the home unsuccessfully tried to enter into an agreement with one or more hospitals.

A waiver remains in effect only as long as the provider agreement to which it applies. It must be fully re-evaluated and re-justified whenever a new agreement is issued.

The DHEW set July 1 as the date by which States were to have surveyed all skilled nursing homes participating in the Medicaid program to be sure they were certified in accordance with the procedures described above. A previous effort completed on February 1 of this year corrected deficiencies in States' certification procedures.

THE OUTLOOK ON NURSING HOMES

MRS. MARIE CALLENDER
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DEPARTMENT OF HEALTH, EDUCATION AND WELFARE*

*TO BE PRESENTED AT THE VIRGINIA NURSING HOME ASSOCIATION MEETING, ARLINGTON, VIRGINIA ON WEDNESDAY, MAY 10, 1972.

THE OUTLOOK ON NURSING HOMES

It is with some humility that I approach a topic as broad as "The Outlook on Nursing Homes." For not only are you, of the Virginia Nursing Home Association involved in the immediate, personal job of caring for patients in nursing homes, but also as Virginians you are too close to Washington to harbor illusions about the wisdom or grandeur of Federal power. You can gaze across the Potomac and witness the legislative jungle through which a program must pass in Congress to become law, and you can observe the difficulty in translating an administrative policy conceived in the HEW North building into a reality in Arlington County. So you know that those of us who serve the Federal Government today do not come equipped with all the answers - ready to dispense the balm of great personal wisdom to heal all wounds afflicting a troubled society.

I come before you today then not to offer ready-made prescriptions or rock-hard certainties, but to describe to you some of the problems we see and the answers we have devised. And I want to enlist your aid in helping us find and realize solutions to the problems facing those who need or are receiving nursing home care.

The Federal Government has become increasingly involved in nursing home care over the last twenty years, particularly since the enactment of the Medicare and Medicaid programs in 1965. In 1970 the Federal Government spent over $2 billion in support of nursing home patients, while State and local government spent another $700 million.

THE DIFFICULTY WITH SUCH MASSIVE INVOLVEMENT IS IN ASSURING THAT DESIRED AND DESIRABLE IMPACT IS ACHIEVED. WITH RESPECT TO CONTINUITY OF CARE BETWEEN HOSPITAL AND ENTENDED CARE FACILITY, I BELIEVE THE FEDERAL ROLE HAS BEEN USEFUL AND IMPORTANT. THE PRESIDENT'S 8-POINT PLAN FOR ACTION TO IMPROVE NURSING HOMES, ANNOUNCED LAST AUGUST IN NEW HAMPSHIRE, IS DESIGNED TO STRENGTHEN AND IMPROVE THAT ROLE. THE IMPLEMENTATION OF THAT PLAN HAS ABSORBED MOST OF MY TIME SINCE I ASSUMED MY NURSING HOME RESPONSIBILITIES LAST DECEMBER - MORE OF MY TIME THAN I HAD IMAGINED, I MIGHT ADD - AND I WOULD LIKE TO DESCRIBE FOR YOU SOME OF THESE EFFORTS. BUT I WOULD ALSO LIKE TO DESCRIBE FOR YOU THE PROBLEMS AT THE OPPOSITE END OF THE SPECTRUM - CONTINUITY BETWEEN INSTITUTIONAL CARE AND THE HOME. I BELIEVE THAT THE FEDERAL ROLE HAS BEEN LESS CONSTRUCTIVE IN THAT AREA, WHICH REPRESENTS TOMORROW'S CHALLENGES. AND THESE CHALLENGES FACE US ALREADY IN WAYS I SHALL DESCRIBE.

THE EXTENDED CARE FACILITY PROGRAM UNDER MEDICARE WAS DESIGNED TO COVER THE EXTENSION OF CARE FOR A PATIENT WHO NO LONGER REQUIRES THE FULL MEDICAL RESOURCES OF A HOSPITAL, BUT STILL NEEDS RELATIVELY INTENSIVE MEDICAL SERVICES. THE SKILLED NURSING HOME PROGRAM UNDER MEDICAID, ALTHOUGH THE PHILOSOPHIC INTENT WAS SOMEWHAT DIFFERENT, ADOPTED VERY SIMILAR STANDARDS. ACUTE ILLNESS, IN WHICH THE PATIENT IS EXPECTED EVENTUALLY RECOVER, IS THE BASIC MODEL FOR WHICH THIS SYSTEM IS DESIGNED, AND THE EMPHASIS HAS BEEN ON MEDICAL RATHER THEN SOCIAL AND PERSONAL SERVICES. THIS APPROACH HAS LED TO VERY REAL PROBLEMS WHEN APPLIED TO PATIENTS WITH CHRONIC ILLNESS, WHO MAKE UP A LARGE PROPORTION OF THE ELDERLY NURSING HOME POPULATION - I SHALL DISCUSS THESE PROBLEMS LATER.

THE PRESIDENT'S PLAN FOR NURSING HOMES ACCEPTED THE RESPONSIBILITY TO ASSURE THAT NURSING HOMES DELIVER CARE AT LEAST AT THE LEVELS OF FEDERAL STANDARDS AND REGULATIONS. A MAJOR GOAL OF THE PLAN IS TO IMPROVE FEDERAL ENFORCEMENT OF NURSING HOME STANDARDS. AS YOU KNOW, THE TERM "NURSING HOME" IS APPLIED TO A WIDE RANGE OF FACILITIES, FROM THOSE PROVIDING PRIMARILY CUSTODIAL CARE TO THOSE DELIVERING HIGHLY SKILLED POST-HOSPITAL AND REHABILITATIVE SERVICES. THESE DIFFERENT TYPES OF FACILITIES ARE ACCREDITED THROUGH DIFFERENT MECHANISMS, AND FEDERAL LEVERAGE IN ENFORCING STANDARDS VARIES WIDELY. MEDICARE CERTIFICATION OF EXTENDED CARE FACILITIES IS A FEDERAL PROGRAM MEDIATED THROUGH STATE AGENCIES. MEDICAID IS A FEDERAL-STATE PROGRAM, FINANCED AND ADMINISTERED THROUGH BOTH FEDERAL AND STATE FUNDS AND ACTIVITIES. INTERMEDIATE CARE FACILITIES UNTIL RECENTLY WERE REQUIRED TO MEET ONLY STATE LICENSING REQUIREMENTS TO RECEIVE FEDERAL FUNDS. THESE DIFFERENCES HAVE COMPLICATED THE ENFORCEMENT OF STANDARDS. IF H.R. 1 AS CURRENTLY AMENDED BY THE SENATE FINANCE COMMITTEE IS PASSED, THEM SOME OF THESE DIFFERENCES WILL BE MINIMIZED AND MORE UNIFORM STANDARDS AND CERTIFICATION PROCEDURES WILL BE ADOPTED FOR MEDICARE AND MEDICAID. IN ANTICIPATION OF THESE CHANGES, A COMMON SET OF STANDARDS FOR BOTH PROGRAMS IS BEING DEVELOPED UNDER THE AUSPICES OF MY OFFICE. BUT THE STATE AGENCY WILL RETAIN ITS INSPECTION ROLE. AND THE FEDERAL GOVERNMENT, WHICH IS RESPONSIBLE FOR THE QUALITY OF CARE WHICH IT FINANCES, MUST AID IN ENHANCING THE CAPABILITY OF THE STATE AGENCIES TO REGULATE AND IMPROVE THE QUALITY OF NURSING HOME CARE. TO IMPROVE ENFORCEMENT OF NURSING HOME STANDARDS, THE PRESIDENT'S PLAN PLEDGED THE FOLLOWING STEPS:

1. Consolidation of responsibility for nursing home affairs

Nursing home activities have been scattered among several branches of the Department of HEW, including the Social Security Administration, the Social and Rehabilitation Service, and the Health Service and Mental Health Administration. The President ordered that all Federal enforcement responsibility be consolidated in a single office, and Dr. Merlin K. DuVal, the Assistant Secretary of Health and Scientific Affairs, was designated as the responsible official. Dr. DuVal appointed me to work with him on these activities and to function as a full-time coordinator of nursing home activities.

2. Enlargement of Federal staff for enforcement of nursing home standards.

The Social and Rehabilitation Service, which administers the Medicaid program, has been assigned 142 additional positions to carry out its increased responsibilities. One hundred ten of these positions were allocated to the Regional office of HEW. The Social Security Administration received thirty-four additional positions to increase their audits of nursing home operations. The National Center for Health Services Research and Development received seven new positions for efforts to improve nursing home data systems and to develop data in special fields relevant to nursing home care.

3. Federal support of 100% of the cost of State Medicaid Inspections.

We recognize that an increased level of enforcement activity involves additional costs to the States. Medicare inspection costs have always been fully paid for by the Federal government, but under the Medicaid program States have paid 25 to 50 percent of these costs. Secretary Richardson submitted to Congress in October, 1971,

AN AMENDMENT TO H.R. 1. AUTHORIZING THE FEDERAL GOVERNMENT TO ASSUME 100 PERCENT OF INSPECTION COSTS UNDER MEDICAID; THIS STEP WILL PLACE BOTH PROGRAMS ON AN EQUAL FOOTING AND LESSEN THE FINANCIAL BURDEN TO THE STATES.

4. Training State nursing home inspectors.

NURSING HOME SURVEYORS HAVE BEEN TRAINED IN SURVEY AND COUNSELLING TECHNIQUES UNDER A PROGRAM SPONSORED BY THE HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION SINCE MARCH, 1970. THESE FOUR-WEEK COURSES HAVE BEEN PRESENTED IN UNIVERSITY CENTERS IN NEW HAMPSHIRE, LOUISIANA, AND CALIFORNIA. IN HIS AUGUST SPEECH, THE PRESIDENT PLEDGED AN EXPANSION OF THIS PROGRAM SO THAT 2,000 SURVEYORS WOULD BE TRAINED IN THE ENSUING EIGHTEEN MONTH PERIOD. AS A RESULT OF THE PRESIDENT'S ORDER , THE PROGRAM HAS BEEN ACCELERATED SO THAT MORE THAN 700 SURVEYORS WILL HAVE BEEN TRAINED BY JULY 1. CONTRACT NEGOTIATIONS ARE IN PROCESS TO ESTABLISH THREE ADDITIONAL UNIVERSITY CENTERS. IN ADDITION, A STUDY WAS PERFORMED BY MACRO, SYSTEMS, INC., TO EVALUATE THE EFFECTIVENESS OF THE TRAINING COURSES, AND THESE HAVE NOW BEEN MODIFIED TO REFLECT THE RESULTS OF THAT STUDY.

THESE EFFORTS TO ACHIEVE COMPLIANCE WITH FEDERAL STANDARDS AND REGULATIONS ARE NOT DESIGNED TO ELIMINATE FACILITIES AND THUS TO DEPRIVE PATIENTS OF NEEDED NURSING HOME CARE. WE ARE WORKING RATHER TO COORDINATE FEDERAL AND STATE PROGRAMS AND STATE AGENCIES TO SHARE THEIR RESOURCES AND EXPERTISE SO THAT SUBSTANDARD FACILITIES CAN BE UPGRADED. THE FEDERAL PROGRAM TO TRAIN NURSING HOME SURVEYORS, FOR EXAMPLE, EMPHASIZES THE DEVELOPMENT OF SKILLS TO AID NURSING HOME ADMINISTRATORS IN MAKING NEEDED IMPROVEMENTS. FEDERAL FINANCIAL ASSISTANCE IS AVAILABLE FOR NURSING HOME MODERNIZATION AND NEW CONSTRUCTION FROM THE FEDERAL HOUSING

ADMINISTRATION AND SUCH PROGRAMS AS HILL BURTON. THE STANDARDS THEMSELVES ARE BEING REVISED AND STRENGTHENED. WE ARE DEVELOPING PROGRAMS TO IMPROVE NURSING HOMES DIRECTLY-I SHALL DESCRIBE THEM IN A FEW MOMENTS.

BUT AS THE PRESIDENT WARNED LAST AUGUST," ... LET THERE BE NO MISTAKING THE FACT THAT WHEN FACILITIES FAIL TO MEET REASONABLE STANDARDS, WE WILL NOT HESITATE TO CUT OFF THEIR MEDICARE AND MEDICAID FUNDS." BETWEEN AUGUST 6, 1971, AND FEBRUARY 11, 1972, 13 EXTENDED CARE FACILITIES WERE DECERTIFIED FOR MEDICARE PARTICIPATION. ON NOVEMBER 30, 1971, THIRTY-NINE STATES WERE DECLARED OUT OF COMPLIANCE WITH TITLE 19-MEDICAID--CERTIFICATION PROCEDURES. BY FEBRUARY 1, 1972, IN RESPONSE TO SECRETARY RICHARDSON'S DEADLINE, ALL BUT ONE OF THOSE STATES HAD MADE THE IMPROVEMENTS REQUIRED FOR COMPLIANCE. BY JULY 1, 1972, ALL TITLE 19 FACILITIES IN ALL STATES ARE TO HAVE BEEN INSPECTED AND CERTIFIED THROUGH THE CORRECT PROCEDURES. THE FEDERAL GOVERNMENT IS PLEDGED TO MEET ITS RESPONSIBILITY TO ASSURE THAT FEDERAL DOLLARS DO NOT FINANCE SUBSTANDARD CARE.

IN ADDITION TO IMPROVED ENFORCEMENT OF NURSING HOME STANDARDS, TWO OTHER POINTS IN THE PRESIDENT'S PLAN INITIATED MORE DIRECT STEPS TO IMPROVE NURSING HOME CARE. THE PRESIDENT DIRECTED THE DEPARTMENT OF HEW "TO INSTITUTE A NEW PROGRAM OF SHORT-TERM COURSES FOR PHYSICIANS, NURSES, DIETICIANS, SOCIAL WORKERS AND OTHERS WHO ARE REGULARLY INVOLVED IN FURNISHING SERVICES TO NURSING HOME PATIENTS." HEW HAS SUPPORTED SUCH TRAINING FOR SEVERAL YEARS, AND HAS DEVELOPED CLOSE WORKING RELATIONSHIPS WITH PROFESSIONAL ASSOCIATIONS AND WITH TRAINING CENTERS. IN RESPONSE TO THE PRESIDENTS' DIRECTIVE, SUCH PROGRAMS HAVE BEEN EXPANDED UNDER THE LEADERSHIP OF THE COMMUNITY HEALTH SERVICE, HEALTH SERVICE AND MENTAL HEALTH ADMINISTRATION, AND IT IS ANTICIPATED THAT APPROXIMATELY 20,000 PERSONS

WILL BE TRAINED IN FISCAL YEAR 1972 AT A COST OF $2.5 MILLION. TRAINING PROGRAMS WILL FOCUS INITIALLY ON FOUR MANPOWER AREAS SELECTED BECAUSE OF THEIR DIRECT DAY-TO-DAY RELATIONS WITH NURSING HOME PATIENTS: NURSING HOME ADMINISTRATORS, PHYSICIANS, NURSES, AND PATIENT ACTIVITIES DIRECTORS. MANY OF THESE TRAINING PROGRAMS WILL BE OPERATED UNDER CONTRACTS WITH PROFESSIONAL GROUPS. APPROACHES TO MENTAL HEALTH PROBLEMS OF NURSING HOME PATIENTS WILL BE DEVELOPED BY NATIONAL INSTITUTE OF MENTAL HEALTH STAFF WORKING WITH THE GERONTOLOGICAL SOCIETY. OTHER TRAINING MECHANISMS WILL ALSO BE EXPLORED, SUCH AS PROGRAMS SPONSORED BY STATE HEALTH DEPARTMENTS AND STATE AGENCIES. THESE PROGRAMS WILL BE DIRECTED TOWARD MAKING NURSING HOME STAFF-BOTH PROFESSIONAL AND ALLIED HEALTH-MORE SENSITIVE AND EXPERT IN THE SPECIAL PROBLEMS OF CARE FOR GERIATRIC PATIENTS AND THE CHRONICALLY ILL. THEY ARE INTENDED TO BE THE BEGINNING OF A SYSTEM FOR NATIONWIDE, CONTINUOUS TRAINING FOR NURSING HOME PERSONNEL WHICH WILL BECOME STANDARD PRACTICE IN THE NURSING HOME INDUSTRY OF THE FUTURE.

AS THE SEVENTH POINT IN HIS PLAN, THE PRESIDENT DIRECTED THE DEPARTMENT OF HEW "TO ASSIST THE STATES IN ESTABLISHING INVESTI-GATIVE UNITS WHICH WILL RESPOND IN A RESPONSIBLE AND CONSTRUCTIVE WAY TO COMPLAINTS MADE BY OR ON BEHALF OF INDIVIDUAL PATIENTS." SINCE I ASSUMED MY NURSING HOME RESPONSIBILITIES, I HAVE RECEIVED MANY LETTERS FROM NURSING HOME PATIENTS-TOUCHING IN THEIR APPEAL FOR CARE OFFERING SIMPLE DIGNITY AND RIGHTS OF PRIVACY, HARROWING SOMETIMES IN THEIR DESCRIPTIONS OF PHYSICAL OR PSYCHOLOGICAL ABUSE. THESE PATIENTS ARE OFTEN HELPLESS IN THEIR DEPENDENCE ON THE IN-STITUTION IN WHICH THEY LIVE. THEY DESERVE A FAIR HEARING, AND AN ADVOCATE WHEN THEY ARE POWERLESS. THE HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION HAS DEVELOPED FIVE MODELS FOR OMBUDSMAN

UNITS TO FILL THIS ROLE, PLACED AT VARIOUS LEVELS WITHIN THE STATES AND DEMONSTRATING DIFFERENT MECHANISMS FOR ACTION. CONTRACT PROPOSALS TO TEST THESE MODELS ARE BEING SOLICITED, AND $600,000 HAS BEEN BUDGETED FOR FISCAY YEAR 1972 FOR THIS ACTIVITY.

IT WILL TAKE TIME TO TEST AND DEVELOP SUCH AN OMBUDSMAN SYSTEM, TIME INAPPROPRIATE TO THE URGENCY OF THE PROBLEM. SO AN INTERIM OMBUDSMAN MECHANISM HAS BEEN ESTABLISHED WITH THE 855 SOCIAL SECURITY ADMINISTRATION DISTRICT OFFICES DESIGNATED TO RECEIVE AND INVESTIGATE COMPLAINTS. THIS MECHANISM IS CURRENTLY IN EFFECT, AND HAS RECEIVED OVER A THOUSAND RESPONSES.

FOR THESE NURSING HOME INITIATIVES, A SUPPLEMENTAL APPROPRIATION OF $9,572,000 HAS BEEN REQUESTED FOR FISCAL YEAR, 1972. WE FEEL THAT BY MEANS OF THESE PROGRAMS A SIGNIFICANT IMPROVEMENT IN NURSING HOME CARE CAN BE ACHIEVED IN A RELATIVELY SHORT PERIOD OF TIME.

I WOULD LIKE TO EXAMINE NURSING HOMES NOW IN A DIFFERENT PERSPECTIVE. I HAVE MENTIONED THAT MEDICARE FINANCES NURSING HOME CARE AS AN EXTENSION OF HOSPITAL CARE - THE PRIOR HOSPITALIZATION REQUIREMENT AND THE TIME LIMITATIONS PER SPELL OF ILLNESS ARE MANIFESTATIONS OF THIS PRINCIPLE. MEDICAID REQUIREMENTS FOR SKILLED NURSING HOMES, WHILE THEY ARE NOT BASED ON THE SAME CONCEPT OF EXTENDED CARE TEND TO EMPHASIZE AND PROVIDE COVERAGE FOR MEDICAL SERVICES AS OPPOSED TO SOCIAL AND PERSONAL CARE.

THE ELDERLY OF COURSE SUFFER FROM ACUTE DISEASE, BUT THEY ARE MUCH MORE SUBJECT THAN YOUNGER PEOPLE TO THE DEPENDENCY OF CHRONIC ILLNESS. THE TERM "SPELL OF ILLNESS" MAKES LITTLE SENSE WHEN APPLIED TO A DISEASE PROCESS WHICH WILL NEVER BE CURED. MOREOVER, ALTHOUGH THE CHRONICALLY - ILL PATIENT MAY BENEFIT FROM INTENSIVE MEDICAL SERVICES, HE IS MORE LIKELY TO REQIRE LESS INTENSIVE BUT CONTINUOUS MEDICAL CARE IN COMBINATION WITH SOCIAL AND PERSONAL SERVICES TO HELP HIM LIVE WITH HIS CHRONIC DISABILITY. SO THE HEALTH FACILITY WHICH CAN BEST SERVE HIM MAY BE VERY DIFFERENT FROM THE EXTENDED CARE FACILITY WHICH IS IDEALLY SUITED TO A PATIENT RECUPERATING FROM A MYOCARDIAL INFARCTION OR A BROKEN HIP. OR HE MIGHT NOT REQUIRE INSTITUTIONAL CARE AT ALL - HE MIGHT BE PERFECTLY ABLE TO LIVE IN HIS OWN HOME WITH THE AID OF HOMEMAKING AND HOME HEALTH SERVICES.

THESE PATIENTS WITH CHRONIC ILLNESSES - WHICH INCLUDE A DISPROPORTIONATE SHARE OF THE ELDERLY - AND THOSE SUFFERING THE INCREASED DEPENDENCY OF OLD AGE ITSELF-DEMONSTRATE THE WEAKNESSES OF LONG TERM CARE AS SUPPORTED BY THE FEDERAL GOVERNMENT.

FIRST, MEDICARE AND MEDICAID TEND TO BE MORE CONCERNED IN TERM OF STANDARDS AND COVERAGE WITH THE MEDICAL COMPONENT OF NURSING HOME CARE. THIS HAS BEEN TRUE FOR BOTH STATUTORY AND HISTORICAL REASONS BASED ON THEIR ORIGIN AS HEALTH INSURANCE PROGRAMS. I DO NOT THINK IT IS HELPFUL TO SEPARATE THE PHYSICAL, EMOTIONAL, SOCIAL, AND ENVIRONMENTAL COMPONENTS OF CARE, PARTICULARLY FOR THE ELDERLY. THESE ARE IMPERMANENT SEPARATIONS OF INTEREST, EMPHASIS, ORGANIZATION AND PREFERENCE; THEY REST MORE UPON TRADITION AND ARBITARY BOUNDARIES THEN THE APPLICATION OF KNOWLEDGE TO LONG TERM CARE.

SECOND THE PRESENT HEALTH FINANCING SYSTEM OFFERS MORE COMPLETE COVERAGE FOR PATIENTS INSIDE INSTITUTIONS THAN FOR THOSE WHO REMAIN OUTSIDE. SO OUR FINANCING STRUCTURE TENDS TO PUSH THE ELDERLY INTO NURSING HOMES, SOMETIMES PREMATURELY. SOCIETY PAYS A PRICE FOR THIS. INSTITUTIONAL CARE IS MORE COSTLY THEN HOME HEALTH CARE. MORE IMPORTANT, THERE IS INCREASING EVIDENCE THAT THE DISPLACEMENT, LOSS OF STATUS, AND ISOLATION CAUSED BY INSTITUTIONALIZATION MAY EXACERBATE IF NOT PRECIPITATE ACTUAL PHYSIOLOGIC DISEASE. THE TRANSFER OF A PERSON FROM HIS HOME TO AN INSTITUTION MAY MAKE HIM MORE ILL AND MORE DEPENDENT.

IF A NURSING HOME IS NOT THE MOST APPROPRIATE PLACE FOR A PERSON'S PARTICULAR NEEDS, THEN HE SHOULD NOT BE REQUIRED TO GO THERE. IF IT IS PERSONAL CARE RATHER THEN HEALTH CARE THAT IS REQUIRED, THEN THAT SHOULD BE AVAILABLE. IF IT IS APPROPRIATE HOUSING RATHER THEN INSTITUTIONAL CARE THAT IS NEEDED, THEN THE EMPHASIS SHOULD BE ON HOUSING. THE ELDERLY SHOULD HAVE MORE OPTIONS AVAILABLE.

THESE SEEM TO ME BASIC AND VALID CRITICISMS OF OUR PRESENT SYSTEM - THE SEPARATION BETWEEN MEDICAL AND PERSONAL CARE AND THE FAILURE TO PROVIDE ADEQUATE ALTERNATIVES TO INSTITUTIONAL CARE. AND IN THESE AREAS, FEDERAL PROGRAMS HAVE HAD AN UNFORTUNATE IF UNINTENDED IMPACT. THESE ISSUES CANNOT BE POSTPONED. ON DECEMBER 28, 1971, PRESIDENT NIXON SIGNED INTO LAW PUBLIC LAW 92-223, WHICH AUTHORIZES THE TRANSFER OF INTERMEDIATE CARE FACILITIES INTO THE MEDICAID PROGRAM. AN INTERMEDICATE CARE FACILITY PROVIDES HEALTH RELATED SERVICES FOR PATIENTS WHO DO NOT REQUIRE CARE IN SKILLED NURSING HOMES, BUT NEED INSTITUTIONAL CARE BEYOND

ROOM AND BOARD. AS YOU KNOW, ICF'S WERE PREVIOUSLY FINANCED BY PUBLIC ASSISTANCE PROGRAMS FOR THE AGED, THE BLIND, AND THE DISABLED, AND WERE SUBJECT ONLY TO STATE LICENSING. TRANSFER OF FINANCING TO THE MEDICAID PROGRAM MEANS NOT ONLY THAT A LARGER GROUP OF PEOPLE - INCLUDING THE "MEDICALLY NEEDY" - MAY POTENTIALLY BE ELIGIBLE FOR BENEFITS, BUT ALSO THAT THE FEDERAL GOVERNMENT IS EMPOWERED TO SET PHYSICAL AND SAFETY STANDARDS AND DEFINE THE CARE AND SERVICES THAT MUST BE PROVIDED. THE MEDICAL SERVICES ADMINISTRATION OF THE SOCIAL AND REHABILITATION SERVICES AND MY OFFICE OF NURSING HOME AFFAIRS ARE CURRENTLY EXAMINING SUCH ISSUES AS WHO SHOULD BE IN THESE FACILITIES, WHAT SERVICES MUST THEY PROVIDE, AND WHAT SHOULD BE THE LEVEL OF BENEFITS IN ATTEMPTING TO DEVELOP STANDARDS FOR INTERMEDIATE CARE FACILITIES. SO THESE FACILITIES ARE FORCING A RE-EXAMINATION OF COVERAGE ISSUES, AND THE BALANCES OF MEDICAL AND PERSONAL SERVICES WITHIN INSTITUTIONS. THE "PROBLEMS TO COME" ARE HERE ALREADY.

I WOULD LIKE TO MENTION ONE MORE PROBLEM THAT HAS DEMANDED ATTENTION, AND THAT IS THE PLANNING PROCESS ITSELF. AN IMPORTANT REASON FOR THE INSUFFICIENT AND SOMETIMES INAPPROPRIATE IMPACT OF FEDERAL PROGRAMS FOR LONG TERM CARE HAS BEEN THE LACK OF PLANNING AND COORDINATION BETWEEN FEDERAL, STATE, AND LOCAL PROGRAMS. PLANNING FOR LONG TERM CARE SHOULD MOVE FROM IDENTIFICATION OF AN ISSUE OR PROBLEM TO ITS SOLUTION, WITH IDENTIFIABLE GOALS GUIDING THE PROCESS. MOVEMENT TOWARD A GOAL SHOULD NOT BE INTERRUPTED BY CHANGES IN ADMINISTRATION. WHAT IS TRULY IMPORTANT TODAY SHOULD NOT BE CAST ASIDE TOMORROW. NEW PROGRAMS SHOULD NOT BE APPENDAGES TO SATISFY THE INTERESTS OF A FEW, NOR SHOULD THEY BE ADDED AS PACIFIERS TO THE MANY. PROGRAMS DEVELOPED THROUGH A RATIONAL PLANNING PROCESS SHOULD THEN BE ADMINISTERED THROUGH AN EFFECTIVE AND COORDINATED MECHANISMS.

THE ESTABLISHMENT OF THE OFFICE OF NURSING HOME AFFAIRS WITHIN HEW WAS A STEP TOWARD IMPROVING COORDINATION. THE EIGHTH POINT OF THE PRESIDENT'S PLAN IS A MANDATE FOR A TASK FORCE ON LONG TERM CARE. THIS TASK FORCE WILL RE-EXAMINE ISSUES AND SET NEW GOALS, DEVELOP A NATIONWIDE DATA SYSTEM NECESSARY FOR POLICY FORMULATION, AND RECOMMEND AN ORGANIZATION FOR LONG TERM CARE WITHIN HEW AND FEDERAL STATE AND LOCAL PROGRAMS WHICH CAN ACHIEVE ITS GOALS MOST EFFECTIVELY.

A NATIONAL POLICY COURSE FOR THE CHRONICALLY ILL AND FOR THE ELDERLY SHOULD BE SET. IT SHOULD BE SET BY GOVERNMENT, WITH THE FULL AND CREATIVE CONTRIBUTION OF THOSE IN OTHER AGENCIES AND ORGANIZATIONS, THOSE IN ACADEMIC TEACHING AND RESEARCH, THOSE IN VOLUNTARY AND UNSALARIED SERVICE, AND THOSE WHO RECEIVE THAT CARE.

WE CAN DO MUCH BETTER FOR OUR ELDERLY. WE MUST OF COURSE PROTECT THEM FROM INSTITUTIONAL ABUSE, RECOGNIZING THAT SOME ARE WEAK AND DEPENDENT. BUT WE CAN ALSO MAKE POSSIBLE A WIDE VARIETY OF SUPPORTING SERVICES AND LIVING ARRANGEMENTS, SO THAT THE INFIRMITIES OF ADVANCING AGE DO NOT BECOME A PRISON OF THE SPIRIT. THE ELDERLY WITH OUR HELP CAN HAVE ACCESS TO THE VARIETY AND FREEDOM WE ASK FOR OURSELVES.