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DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

STATEMENT

OF

M. KEITH WEIKEL, PhD

COMMISSIONER, MEDICAL SERVICES ADMINISTRATION

BEFORE THE

SUBCOMMITTEE ON LONG-TERM CARE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

AND

SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE

SELECT COMMITTEE ON AGING

HOUSE OF REPRESENTATIVES

TUESDAY, OCTOBER 28, 1975

Mr. Chairman, I am pleased to appear before these two distinguished committees to testify on HEW's proposed home health care regulations which would permit proprietary agencies to participate in the Medicaid program. I am looking forward to discussing these regulations with you and to hearing your views, for the Department is vitally interested in considering a variety of opinions before the revised final regulations are published. As you know, the proposed regulations were published for comment in the Federal Register on August 21. While the thirty day comment period was scheduled to close September 20, because of the quantity and quality of comments we were receiving, the period was extended to October 7, to give as many different individuals and organizations as possible a chance to comment. So far, we have received over 1,000 comments which we are analyzing at the present time.

In addition, have issued invitations to a wide variety of representative national and State professional and provider organizations and consumer groups to discuss first hand all of the issues and questions related to the proposed amendments to these regulations in order to achieve the most effective development of the final regulations.

I also welcome this hearing as an opportunity to discuss the proposed regulations with you and perhaps to clear up some misconceptions as to how they would work in practice.

The Medicaid program devotes over five billion dollars, or thirty-eight percent of its expenditures to the area of long-term care. Almost all of these funds are for institutional care. Over one million Medicaid recipients spent some time this year in a nursing home, mental or tuberculosis hospital as a long-term care patient.

Many studies, including the GAO report to the Congress on Home Health Care Benefits under Medicare and Medicaid, in July 1974, have pointed to the under-utilization of non-institutional services. While acknowledging that hospital and nursing home care are necessary and essential elements of a continuum of care, so too, are non-institutional services for those individuals who no longer require institutional care or, more importantly, for those who can be maintained in their own homes, thus delaying or averting the need for institutional care.

The excessive utilization of institutional care has been partly attributed as well to the fact that Medicare and Medicaid reimbursement has been more readily available for institutional services, that alternatives to institutional care did not exist in sufficient quantity or comprehensiveness, and when they did, their Federal reimbursement was restricted to skilled care over a limited period of time.

One alternative to institutionalization is a viable home care program. However, for some time it has been recognized that a clarification of existing Medicaid home health regulations was necessary if the legislative intent of home health services under Medicaid is to be achieved. Although it is a mandatory service, there are indications that many

States have not adequately implemented it as a mechanism of non-institutional care. For instance, reports from 45 States show that 7 had fewer than 100 recipients of such services during fiscal year 1974, and 3 had fewer than 10.

Before going into the details of the proposed regulatory changes, I would like to address two general but basic issues which are readily misinterpreted.

First, these regulatory changes are, in a sense, clarification and definition of the services that were mandated by Congress in the Social Security Act Amendments of 1967. The law requiring States to provide home health care under Medicaid does not limit either the source or type of home health services as in Medicare. In fact, Congress made it clear that Medicaid should direct its attention to providing reimbursement for long-term care. Because existing regulations are either not clear or were too closely patterned after Medicare conditions of participation, we must now define more clearly what services Medicaid programs can reimburse, if these services are to reach all individuals in need of home care. These proposed regulations, therefore, are considered to be necessary to fully implement the law.

A second general concern expressed is that through these regulations, the Department is usurping State's rights to establish the dimensions of their Medicaid program. The example cited is that these regulations would require States to include proprietary agencies as Medicaid providers. In fact, the States, or even the Medicaid agencies themselves, may specify

that such agencies are excluded from participation and at least one State has done so. In addition to meeting Federal criteria for reimbursement, States may also require such agencies to be licensed by the State and the licensing standards, which are entirely a State responsibility may, and have been, set at a higher level than Federal regulations. This is in keeping with the Medicaid statute - a State-administered program which leaves Medicaid participation itself up to the States, as well as many choices on extent and type of services.

It should also be noted that similar considerations have resulted in suggested legislative and regulatory changes in Medicare. The proposed regulations, published in the Federal Register on June 9, 1975, would permit non-profit and official agencies to contract to buy additional services from a proprietary agency. Comments, which generally are favorable to the proposal, are being analyzed at the present time as a Final Regulation is being prepared. In addition, a legislative change in Medicare has been recommended by the Department which would repeal the requirement that proprietary agencies be licensed by the States before they can participate. These two changes would make the Medicare home health agency requirements generally consistent with those proposed under Medicaid.

As these changes develop, both Medicare and Medicaid authorities are carefully reviewing them to assure that Federal requirements for certification and reimbursement do not work at cross purposes in the two programs and that the States and agencies avoid unnecessary duplication of effort and overlapping responsibilities.

The GAO report identified three major obstacles in Medicaid programs to full utilization and support of home health services: services covered varied from State to State; in some States, the patients' eligibility was more restrictive than the legislation intended; and the States' payment rates were not adequate. The proposed regulations particularly address the first two deterrents, and while Social and Rehabilitation Service does not have the authority to require States to adopt a certain level of payment for home health care, it has emphasized to them the importance of realistic payment rates. A recent review of Medicaid payment methods shows that nearly one-hald of the States already pay for home health services on the same basis as Medicare, i.e., at reasonable costs or charges, whichever is the lesser.

With respect to the home care services to be covered, existing Medicaid regulations have been interpreted by some States as requiring that they provide only one rather than all three mandatory components of home health care services: intermittent or part-time nursing care, services of a home health aide, or medical supplies and equipment. Because of this, States may not be providing the full extent of home health services which are available to eligible patients. Under present legislation, however, the scope and extent of home health care services is left to the States.

Another inhibiting factor affecting expansion of the Medicaid home health benefit has been the use of the presently limited Medicare definition of a home health agency. Under current Medicaid regulations, a home health

agency is defined as one which (1) is a participating Medicare provider or (2) although not a participating Medicare provider, is qualified to participate in Medicare. Medicare legislation and regulations state that a home health agency is one which provides skilled nursing services and at least one of the following services: physical, speech or occupational therapy, medical social services, or home health aide services. Agencies, such as visiting nurse associations and county public health nursing services, which do not provide a second service beyond nursing, have therefore not been able to participate. It is estimated that there are 500-700 such agencies throughout the nation, primarily in rural areas, which provide the valuable service of nursing care of the sick at home. These agencies, now unable to receive Federal reimbursement under Medicare or Medicaid, could with adequate support be built upon and encouraged toward more comprehensive services through the proposed new regulations.

The new regulations also address the limitation that has resulted because Medicaid adopted the Medicare restriction on participation of proprietary agencies, unless licensed by State law. There is no comparable restriction against proprietary agencies in present Federal regulations with respect to other Medicaid services. Thus, the proposed regulation would remove the discrimination in this field which is based on the motive for existence of a class of providers. Extension of accessibility to profit-making agencies may improve the possibility of restraining costs of home health care services, both through their

economic incentives to be efficient and through the competition engendered by the increased number of participants.

Although eleven States have licensure laws, and therefore proprietary agencies are eligible for Medicare certification once licensed in these States, only 43 such agencies are thus certified, principally in two States, each with 20 agencies, California and Louisiana.

This small number of proprietary home health agencies is at present, the extent to which participation in Medicaid can be measured. Other proprietary agencies, already providing needed services in communities to private paying patients, have been precluded from reimbursement by Medicare and Medicaid. Although precluded also from even selling their services to the non-profit or official agency, until recently many have good existing relationships with such agencies. Even large voluntary and official home health agencies readily admit they are not meeting the total needs for home care in their urban communities. One visiting Visiting Nurses Association recently reported that it estimated it was reaching between one-fourth and one-fifth of the patients discharged from the hospital needing home health care services. The same agency had no estimate of how well it was meeting the needs of those still in their own homes.

Expansion of existing home health agencies is, of course, highly desirable to meet these untouched needs. It is equally desirable to attract additional resources to the community, provided that these resources are

not overlapping, provide quality care, and work in concert with other related agencies.

This, obviously, is easier said than done, but the Department is even now considering how over-development of home health agencies can be avoided. One method being explored is the desirability of including home health agencies under "certificate of need" requirements. We understand States such as Florida already have passed certificate of need legislation to cover these activities.

In the States without licensure laws for home health agencies, an unknown number of proprietary agencies, in order to participate in Medicare, have incorporated and have been declared by the Internal Revenue Service to have a tax exempt status. These agencies are often franchises of large, nation-wide organizations and are established specifically to avoid the restriction on participation in Medicare. The agencies show no profits however. Such agencies show no profit at the end of the year, often because of their higher administrative salaries, and more spacious, luxurious quarters, and this in turn is reflected in their cost data. If the proprietary agency has not chosen this route, they then operate within the community without the quality controls of State survey, certification and monitoring of services provided.

The legislative intent of Title XVIII has resulted in the specification that patients require skilled services such as nursing, physical or speech therapy, in order to be eligible for home health coverage. Medicaid, by contrast, was never intended to be restricted to home health services for patients who only require skilled care.

The absence of a secure source of reimbursement for such patients has affected the development and expansion of agencies which could serve these kinds of personal care needs at significantly less cost than institutional care. Obviously, there is need to clarify and improve the Federal regulations governing this service.

In recognition of these several needs, a revision of the Medicaid regulation was drafted and published for the purpose of increasing the use of home care where such care is appropriate and determined by a physician to be necessary.

In summary, the proposed regulations:

(1) clarify which home health services are required and which are optional with States. The States must provide nursing services (RN or LPN as appropriate), home health aide services, and medical supplies, equipment and appliances suitable for home use. They may, at their option, provide physical, occupational, or speech therapy. Any service, whether required or optional, must first be found necessary by the patient's physician and must be included in a written plan of care developed by the physician and home health agency personnel, and reviewed by him as the patient's condition requires. This revision will assure that all States will reimburse a basic package, and at the same time encourage expansion of coverage of other optional services.

(2) clarify which recipients are eligible. Some States have limited home health care to those who need "skilled" care or those either

leaving or about to enter institutions. No such limitation appears either in statute or regulation, and it should not, since many persons need some home care to maintain or recover their health in order to avoid institutionalization. They should receive home care before they reach the crisis point of institutionalization.

The revised regulation clearly repeats the statutory requirement that all "categorically needy" persons age 21 or over must receive home health services when determined necessary by the physician (the categorically needy are generally those eligible for casy payments under SSI or AFDC). The revision also clarifies that certain groups chosen by the State to be eligible for nursing home care must also be eligible for home health services, and that the State may provide home care to all Medicaid eligibles if it wishes to do so. This clarification expands the population eligible for coverage.

(3) Expand the types of agencies which may participate under Medicaid, in addition to those certified under Medicare. Under the proposed expansion, agencies offering the single service of either nursing or home health aide services as well as proprietary agencies may be certified for Medicaid if they meet certain prescribed Federal standards. These changes are intended to make home health services more available to Medicaid recipients and thus in future years decrease need for institutional services under Medicaid. The proposed standards for such agencies parallel those for the Medicare program whereever possible.

The objection to single-service agencies is that they may provide only fragmented care for patients who need multiple services. We do not think this concern is valid, since in all cases a registered nurse must make an initial home evaluation visit and must supervise the care given by home health aides. This will provide coordination of care and guard against fragmentation of services. Allowing single-service agencies of this type to participate will overcome the current lack of care for recipients who need only home health aide services and who live in neighborhoods where multi-service agencies do not exist or are not willing to participate in Medicaid. While a multi-service requirement is ideal, there are not now enough such agencies especially in rural areas to make that realization possible.

This regulation is of particular importance to the rural areas of the U.S. In half of the counties in this country, there are presently no certified home health agencies. This regulatory change will permit a sizeable number of agencies to enter the Medicaid program and to grow as need is demonstrated. Even before Medicare was enacted, such nursing care of the sick at home programs proved to be the foundation for building up services until certification was reached. In Arkansas, Tennessee and many other States, through a combination of Federal and State monies, support was given to expand those services geographically as well as including the second service, so that by the time Medicare was enacted they were ready for certification. The work is not yet complete, and there are many communities where the principle provider of health care is the public health nurse. If this resource of existing home health agencies is to be fully utilized and expanded, adequate reimbursement

is necessary.

We realize that there is potential for abuse of the program by both proprietary and non-proprietary providers of home health care services, just as there is potential for fraud and abuse by proprietary and non-proprietary providers of all types of services. As some of you know, as Commissioner of the Medical Services Administration, I have made the fraud and abuse surveillance effort one of my highest priorities. To date, we have focused on assisting States to set into place systems for detection of fraud and abuse in three major areas: nursing homes, physician services and pharmacies. It is my intention, should the proprietary provisions remain part of the final regulations, to add home health services as a fourth major area of surveillance. In addition, our utilization review requirement will minimize potential fraud and abuse. The Medicaid statute requires each State to have a system for the review of the utilization of all services provided under the State plan. The State must develop appropriate methods and procedures to carry out the review for each type of care provided. The Utilization Review regulations which were published on November 29, 1974, require the State to provide for the on-going evaluation, at least on a sample basis, of the necessity for and the quality and timeliness of services provided. The State must also establish and implement a past payment review process which provides for the development of provider and recipient profiles and exceptions criteria. This process is designed to identify questionable patterns of care and misutilization practices of recipients, providers and institutions.

In conclusion, I would like to emphasize that the regulations we have been discussing are not final: we have received well over 1,000 comments which we are in the process of considering. I will be pleased to hear your views and discuss the issues with you.

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DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

STATEMENT

BY

STUART H. ALTMAN

DEPUTY ASSISTANT SECRETARY FOR
PLANNING AND EVALUATION/HEALTH

Before the

TASK FORCE ON HEALTH POLICY

HOUSE REPUBLICAN CONFERENCE RESEARCH COMMITTEE

U. S. HOUSE OF REPRESENTATIVES

Auditorium
Baptist Hospital
2000 Church Street
Nashville, Tennessee

October 24, 1975

MR. CHAIRMAN AND MEMBERS OF THE TASK FORCE:

I am pleased to have this opportunity to discuss with you the concerns and actions of the Department of Health, Education, and Welfare in a most important area. At a time when the President is attempting to reduce Federal outlays and to control inflation in the general economy, inflation runs rampant in the health sector. Health expenditures are increasing with few constraints, and the effects on Federal and State budgets, private insurance companies and consumers of health services have once again reached crisis proportions.

Health spending is likely to increase over 17 percent this year and could reach over $160 billion by 1977. Federal Medicare and Medicaid expenditures alone will increase from $21.7 billion in FY 1975 to over $30 billion in FY 1977, an increase of almost 40 percent in two years, due almost entirely to price and utilization increases rather than growth in the number of program beneficiaries. The Civil Service Commission has just announced that premiums under the Federal Employees Health Benefits Program will rise an average 35 percent for 1976. Premiums for private health insurance are expected to go up comparably. The effects of this premium increase on firms in the private sector are especially serious during periods of severe economic pressure. In addition it will cost the Federal government $1 billion in lost tax revenues.

To understand the political and economic environment which has fostered this situation as well as to gain some insight into the types of policies that both the Congress and the Administration can implement, it would be useful for us to discuss the basic structure of this industry, its past performance, and current Federal efforts to contain the rise of health care costs.

The Structure of the Health Industry

The health industry lacks much of the discipline of the competitive market and is in many respects geared to spending money. In part, this situation results from the following characteristics:

-- Widespread insurance coverage for hospital care has reduced the cost-consciousness of both consumers and providers and has provided incentives for patients to be treated on an inpatient as opposed to an outpatient basis.

-- The reimbursement methods employed by both public and private payors provide incentives for hospitals to continually expand and physicians to increase fees.

-- Restrictive laws and licensure practices have prevented the widespread use of new categories of manpower.

-- The physician, who is generally reimbursed on a fee-for-service basis, rather than the consumer, often makes the ultimate decision on the number and types of services provided and whether the patient will be hospitalized.

-- Consumers lack information about the quality, efficacy, price or even the nature of the product that they and/or their physician-agents are buying.

Consequently, the health industry has evolved into one in which payment is guaranteed for virtually any expenditures incurred; consumers and providers are not conscious of the real costs of the resources being consumed; and public and private third-party payors pump seemingly endless streams of money into the health system with little understanding of the effects on health status.

I would like to emphasize that while inflation has always been a problem in the health industry, it has been exacerbated by the tremendous growth of the health sector and the availability of large amounts of public and private funds. These are relatively recent phenomena due in large part to the growth of insurance coverage.

Health Cost Inflation

The enactment of Medicare and Medicaid in 1965 represents the largest single extension of insurance benefits in history. Immediately after their introduction, both per capita health expenditures and medical care prices rose rapidly. Per capita personal health expenditures which had been increasing at an annual rate of 6.4 percent between 1950-1966, jumped to an annual rate of increase of 12.1 percent between 1967-1970. While some of this increase can be attributed to increased utilization of services, over half of this increase in expenditures was due to increases in medical care prices.

From 1960-1966, the charge for a semi-private room increased at a 6 percent annual rate. With the introduction of Medicare and Medicaid, this rate jumped to 14.6 percent, over three times the rate of increase in the overall Consumer Price Index. The rate of increase in average expense per patient day, a more inclusive measure of hospital costs, also doubled. In fact, hospital and physician price increases have exceeded increases in the overall cost of living in every period except during the 1971-1974 Economic Stabilization period.

Current Efforts to Contain Health Cost Inflation

In the late 1960s and early 1970s the Congress and the Administration began to discuss modifications in the Medicare and Medicaid programs to address the problem of rising medical costs. Out of these discussions came a series of amendments to Titles XVIII and XIX of the Social Security Act which were designed to limit uncontrollable increases in Federal spending for medical care. I would like to spend a few moments discussing two of these provisions, since they represent the major component of the Federal government's ability to deal with inflation in the health industry at the present time. The provisions are (1) hospital cost limits and (2) physician fee index. While an effective utilization review program / PSRO must be a cornerstone of any cost containment program, I will not discuss this area myself, since Dr. Van Hoek is also with us today.

Hospital Cost Limits

As a partial remedy for some of the previously discussed incentives for inefficiency that are inherent in retrospective cost reimbursement, Section 223 of P.L. 92-603 gave the Secretary of Health, Education and Welfare authority to limit prospectively our reimbursement of provider costs where these are judged to be unreasonably high. Both the Congress and the Department felt that the most equitable approach was to compare the costs of providing care in similar hospitals. In particular, hospitals that provide similar types of services and experience similar expenses of doing business were to be grouped together. After extensive investigation it was found that three measures were the most appropriate for classifying hospitals into groupings of similar institutions; the bed size of the hospital, its geographic location, and State per capita income. In all, hospitals were divided into 70 groupings.

Medicare per diem payments were limited to the 90th percentile of the distribution of routine per diem costs within each group, plus 10 percent of the median cost in the group. Limits were initially set at this fairly high level so that hospitals would have time to adjust to the new provision of the Medicare law and to allow for any lack of precision in the initial classification system. We estimated that only 4.5 percent of all hospitals would exceed the limit. It is important to point out that since these limits are set prospectively, all hospitals may potentially come in under the limits. To improve the equity of the regulations, sole community providers were exempt from the limits, and exceptions were to be allowed

for the costs of atypical services or of circumstances beyond the control of the hospital.

We have now issued a new schedule of limits which is effective for cost reporting periods beginning on or after July 1, 1975. The hospital classification system has been modified slightly and reduced from 70 to 32 groupings. We have also lowered the group limits to the 80th percentile plus 10 percent of the median cost.

We project that approximately 11 to 12 percent of all hospitals potentially could be affected by these limits--hopefully, fewer if those potentially over the limit respond by reducing their costs. Although a few hospitals will have large amounts of reimbursement questioned, most will be only slightly over the limits. It should be emphasized that it is not the intention of the Department, nor do we believe of the Congress simply to limit Federal spending. It is our hope that these controls can be helpful in reintroducing some financial constraint to the almost unlimited increases in costs that we have experienced in the last decade.

Physician Fee Index.

Congress also enacted as part of P.L. 92-603 a physician fee index provision to limit increases in physician fees that could not be justified on the basis of increased practice costs or increases in productivity. Fee increases that are justified because of higher office practice costs and increases in the productivity of physicians are fully allowed and recognized.

The physician fee index is being applied to every prevailing charge in each locality. It will also be applied on a cumulative basis with FY 1973 serving as the base year, as specified by Congress. In other words, increases in prevailing charges over the 1973 base year level cannot exceed the rate justified by the economic index calculated for that period. The economic index figure for fiscal year 1976 is 17.9 percent. Thus, any individual prevailing charge that increases by more than 17.9 percent over its 1973 base level will have its rate of increase limited to 17.9 percent. Prevailing charges that have increased by less than 17.9 percent will be unaffected, and any portion of the allowable increase not used will be carried forward to future years.

Recently, the rising cost of malpractice insurance has become a major concern. As you know medical malpractice costs differ widely by both physician specialty and locality. Unfortunately, there are no reliable data on malpractice insurance costs at the local or national level. As a result, malpractice costs are only indirectly captured in the office practice expense component of the index. The Department is currently working to refine the index to account for medical malpractice costs directly and will implement such changes as soon as the appropriate data are developed.

Legislative Initiatives with Implications for the Future

While the 1972 Social Security Amendments are the basis of present cost containment efforts, two recently enacted legislative measures have the potential for longer-run relief of the problem of health cost inflation, the Health Maintenance Organization Act of 1973 and the Health

Planning and Resources Development Act of 1974. The HMO Act seeks to promote efficiency in the health services industry by encouraging the development within the private sector, of alternatives to traditional fee-for-service health care. The Health Planning Act addresses the broader issues of how our health care system is organized at the community and State level and the extent to which planning can reduce the duplication and maldistribution of our expensive health care resources.

Health Maintenance Organization Act of 1973

Public Law 93-222, the Health Maintenance Organization Act, was signed into law in December 1973. This Act (1) provides Federal grant and loan support for HMO development, and (2) requires employers offering health insurance to offer an option of a prepaid plan where such plans exist (the dual choice provision). It is the latter provision which is potentially more far-reaching.

Health Maintenance Organizations (HMO) represent a major attempt to restructure the delivery system. Unlike the traditional fragmented fee-for-service system, the HMO provides both inpatient and ambulatory care within one organizational structure. The financial interdependence between physicians and hospitals eliminates the incentive for physicians to overutilize more costly inpatient hospital services. Evidence exists that significant reductions in inpatient hospital days have been achieved as a direct result of HMO medical care management. In exchange for a single, monthly prepayment, HMO enrollees are guaranteed a comprehensive range of health care services.

There are approximately 170 HMOs serving almost 6 million persons, an enrollment increase of about 12 percent during the past year alone. The number of HMOs has increased about 30 percent within the last 3 years.

HMOs have yet to achieve maximum penetration of the health care market place. This is the result of several major obstacles:

-- The HMO Act requires that all HMOs offer a more comprehensive benefit package than is provided by traditional health care insurers;

-- Implementation of the dual choice provisions of the Act has been delayed;

-- HMOs have thus far had difficulties attracting physicians;

-- Consumers are uncertain about the advantages of HMO membership.

Nevertheless, I believe it is essential that activities such as HMOs have a chance to compete in our health care system and that we should not stifle such innovation with overly restrictive Federal or State laws.

The Health Planning and Resources Development Act of 1974

Public Law 93-641 was signed by the President on January 4, 1975. The Health Planning and Resources Development Act, as its provisions become implemented over the next several years will hopefully produce long-run relief from some of the inflationary pressures now inherent in the structure of the health industry. National guidelines for health planning are being developed to offer assistance to local communities in their attempts to better organize their health care resources. In

particular we are most concerned with assuring all Americans that they have access to primary care and that new and more economical types of health professionals are utilized where appropriate.

Among the many activities of local planning agencies is the requirement that they establish local health plans. The local planning agencies will then review proposed expenditures for new capital and services to determine if they are consistent with their plans. The results of these deliberations will be used by the State to regulate the expansion of our most expensive facilities and services under required certificate-of-need laws. The Act also provides for experiments in State level rate regulation designed to encourage reform of the reimbursement system. Currently 26 States have already enacted certificate-of-need programs and 18 States have implemented some form of health care rate regulation.

Future Directions

It has become increasingly apparent that as health expenditures continue to rise we must evaluate where the added funds come from and what they buy us. Increases in health spending are now beginning to come at the expense of other basic human and social services programs. In addition, as I pointed out earlier, over half of the increase in health spending has been going to feed inflation in medical prices, not to buy added services for society.

Previous government efforts to control health care costs have been only marginally effective and have fostered an adversary relationship between the government and health service providers. While we do not

actively seek added regulatory powers, it does not appear that a liassez-faire approach will eliminate the problems.

How, then, can the health system be improved? I believe two paths are available for reducing the future rate of increase in health care spending. We should institute more cost-sharing by patients, and we should restructure the reimbursement system to increase providers' incentives to use more efficient means to produce health services.

The Department has continuously favored cost-sharing as a means to make program beneficiaries aware of the true value of the resources they consume. We have advocated cost-sharing in our comprehensive health insurance proposal and have introduced legislation to initiate cost-sharing for Medicare inpatient services. Elimination or modifications in the provisions in the tax laws that encourage individuals to purchase first dollar insurance coverage would also be helpful.

But, increases in cost-sharing alone are not adequate. Institutional providers must also become more cost-conscious and seek to improve efficiency and productivity. We believe that a restructuring of the reimbursement system toward prospective, rather than retrospective cost, payments is the appropriate vehicle to promote efficient market behavior on the part of the health service providers. I must admit, though, that we still have many unanswered questions about how it should be structured, but we do feel that the States should play a major role. We particularly are looking to avoid the creation of any new bureaucracy to oversee the health financing system.

In conclusion let me repeat a comment I made earlier. Spending for health care has now reached such high levels that it is forcing government and private groups alike to cut back on expenditures for other important human and social needs. I am fully aware that some of the solutions proposed by the Administration to bring a degree of moderation to increases in health care spending have not met with universal acclaim. But I would urge you not to limit your deliberations to whether one or two laws or Departmental regulations are good or bad. Instead, I would hope that groups such as yours would offer alternative proposals for reaching the same goal; that is, a balanced spending pattern for all our human and social needs.

D R A F T

PATIENT ASSESSMENT : VANTAGE POINT - FEDERAL ROLE *

It is timely to place emphasis on patient assessment. This calls for demonstration and evaluation of alternative methods of caring for chronically ill and elderly persons. The efforts to develop approaches to patient assessment stem back as early as 1950 when there were directed efforts to develop a whole system of long-term care. Later in 1957 some of us were involved in the early development of the concept of progressive patient care which looked at the arrangement of resources and related these to patient needs.

Efforts have also been directed at developing uniform terminology to describe the patient needs and services to be provided. Most significant is the collaborative work of four groups:

Dr. Sidney Katz at Michigan State University

Dr. Paul Densen at Harvard University

Dr. Charles Flagle at Johns Hopkins University

Mr. Danehy, then with the Syracuse University Research Corporation, now with the Hospital Association of the State of New York.

The Introductory Report of the Long-Term Care Study was released recently and is entitled, "Long-Term Care Facility Improvement Study". Essentially, this study used, for the first time, the patient assessment form developed by the Densen group on a national basis.

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*Notes by Dr. Faye G. Abdellah from the Consumer/Provider Meeting, October 14, 1975.

We sought at that time to find out if it was possible to get the information required for assessment of long-term care patients and we found it to be available, although not always readily accessible. We made no effort to validate the reliability of the instrument since that had already been completed by the Densen group.

Significant portions of the patient assessment tool have application to other acute care settings but our focus in the survey was upon seeking to use an instrument which would truly access the patient in that setting. This was a shift from the present survey process which emphasizes the assessment of the capability of the facility to provide care rather than looking at the next step as to whether or not the services were provided, and also an evaluation of those services. The data in the long-term care study include information on health status and health services provided including such things as activities of daily living, impairments in sensory perception, patient diagnoses, dentition and patient care services including physician services, nursing, rehabilitation, pharmacy, nutrition and dietetic and social services.

From the vantage point of the Federal government, the timing to move in the direction of patient assessment away from the facility is very critical. The specific goals which we have in the Federal government are as follows:

1. We are seeking to change the whole survey/certification process to work toward recording uniform comprehensive patient assessment data and using these data as an integral part of the delivery of services. Thus, the

information would flow from the individual provider to the State to the Regional Offices and then to the Federal government. This would attempt to consolidate the survey effort using one uniform form, that is the survey agencies of JCAH, Medicare, Medicaid and PHS would use a uniform form in the survey assessment of long-term care facilities.

2. We are also seeking implementation of the use of the common dictionary approach to patient assessment described by the Densen group by the provider and the State. We feel that the use of common terminology by all groups is critical even though the form itself may vary to meet specific needs of that setting. We are also seeking to set our goals in terms of providing an optimum level of care for patients and residents rather than maximum which is an even higher level and we feel unattainable at this time. In providing the optimum level of care, it is important to make the best use of scarce manpower and resources available. One advantage of the patient assessment tool is that it can be used as a management tool by providers on a daily or monthly basis, so in essence the materials that the state surveyor would be covering would also be a part of the management tools used by the provider.

3. We are convinced that the use of the patient assessment approach is an appropriate way to go in terms of providing an optimum level of care for patients. Important in this assessment would be the evaluation of the appropriate placement of patients and residents

in the whole system of health care. Since we are seeking to find and develop a total system of health care delivery for meeting the needs of the long-term care patient, the nursing home would become only one component of that system providing an open door policy so that one might move from home to nursing home back to the community or back to the home and then to the community. This would be a much more positive approach rather than only one entry point to the nursing home where there is unliklihood of return to the home and community.

4. We are also seeking more realistic community resource allocation and task assignment within individual facilities. This can have important implications in terms of planning the staffing needs and also eventually relating the manpower needs to the cost requirement and the optimum level of care. We feel this is a much more valid approach than requiring rigid hours of care such as 2.5 hours of care proposed by some states and artificial ratios. The emphasis would be upon first identifying the needs of patients and residents, second, the manpower requirements to provide these and third, the allocation of resources and on a cost related basis in provision of these services.

5. The patient assessment approach from our vantage point provides a solid basis for policy making in relation to long-term care. Policies can be determined much more realisticly in relation to planning and evaluating programs for the chronically ill, including

the mentally retarded and the developmentally disabled and the aged. You recognize as we do the importance of basing long-term care policy upon valid and reliable data. You are also aware of the importance of this and its implications for some form of future National Health Insurance.

6. Critical to the whole effort in terms of achieving an optimum level of care for patients and residents is the education and training of health professionals at all levels and others in the long-term care setting whether in the institution, community, or the home.

Most of all from the vantage point of the Federal government we are seeking to reassess the total survey/certification process and hope to replace the present cumbersome 68 page survey form designed for acute care settings with a patient assessment approach designed specifically for a long-term care setting. We have highlighted and identified this as a high priority for this fiscal year. We feel that we must work toward having providers and States and all Regions fully implement the patient assessment approach with a form considerably modified focusing on patient evaluation or patient assessment and on the fire safety factors related to the facility. This should tighten the survey process and provide additional time for state surveyors and our regional personnel to provide the needed consultation and technical assistance to the providers.

Thus one could make better use of scarce resources and develop Federal policies that truly assess the needs of patients and residents and stress the importance of accountability from providers for the provision of essential services. The approach we propose this afternoon interlocks with PSRO, Utilization Review,, and Medical Review. Once the process is provided, this in turn will be related to outcome measures for the result of the care or services provided. Thus, we see an important linkage between the process and the outcome measures as they relate to the provision of care.

We are grateful for your participation here this afternoon. The message is clear and the timing is right for us in the Federal government working with you as Providers/Consumers and Association representatives to achieve a realistic goal of optimum care for patients and residents in long-term care facilities and settings. Thank you very much.

file - broken care WP 9/21/75

Interstate Business: Troubled Youngsters

By Seth Kantor

Kantor is a reporter in the Washington bureau of the Detroit News.

IN MAINE, an emotionally disturbed teen-aged girl, six months pregnant, is forced into a boxing ring to fight another angry teen-ager as part of her "treatment" at a child-care center.

In southwest Virginia, an unlicensed school with children from broken homes is accused of lending its teen-aged wards to a businessman for trips around the country.

In Texas, disturbed children at a dude ranch turned "treatment center" are frightened by fanatical staff members trying to persuade them the end of the world is near.

In each case, the youngsters involved are from other states, shipped off at public expense to privately operated facilities in what has become a booming new "child-care" industry.

These facilities have been springing up across small-town and rural America. Usually they have no identifying signs. Often they score poorly in fire and sanitation inspections. Some are run for profit and concentrate on amassing real estate properties. Others are designated non-profit institutions but are run haphazardly.

Among the residents of these centers are at least 15,000 children sent across state lines since 1973. The cost of their maintenance, not including transportation and medical expenses, can be conservatively put at $120 million over the two-year period. That cost is borne by the public.

These children are categorized, under a catch-all term, as "emotionally disturbed." Many are under 12; they may be compelled to remain in these often inadequate institutions until they are 18.

Some are juvenile offenders, wards of courts. Others, victims of broken homes, legally designated as abandoned or neglected, are sent away by welfare agencies serving as their guardians.

Military Dependents

IN SOME CASES, the interstate movement represents a desire by courts to banish juvenile trouble-makers into somebody else's jurisdiction hundreds of miles away. In many other cases, state and local agencies are motivated by economics pure and simple; child-care costs are higher in industrial states than in rural areas.

But 2 out of every 3 of these youngsters are supported entirely by federal funds, through the Defense Department's Civilian Health and Medical Program for the Uniformed Services (CHAMPUS). The program was designed to purchase psychiatric care for military dependents who could not get proper care at military hospitals.

The problem is that CHAMPUS was set up strictly as a financial conduit to pay the bills, with no control over who goes where or the kind of treatment received. Private psychiatrists and juvenile courts decide where to send CHAMPUS wards. They are dispatched from virtually every state and from overseas bases into more than 450 private facilities with CHAMPUS contracts.

See CHILDREN, Page C5

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DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

STATEMENT

OF

THEODORE COOPER, M.D.

ASSISTANT SECRETARY FOR HEALTH

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

BEFORE THE

SUBCOMMITTEE ON HEALTH

COMMITTEE ON WAYS AND MEANS

HOUSE OF REPRESENTATIVES

Friday, September 19, 1975

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

I am pleased to appear before you today to review with you a number of issues with respect to the Medicare program and the Department's efforts to insure quality health care through utilization review and Professional Standards Review Organization activities.

In his testimony of June 12 before this Subcommittee, former Secretary Weinberger expressed his deep concern about the adverse effects of rampant inflation in the health care industry on both the Federal Budget and Federal health program beneficiaries. As you may recall, the former Secretary specifically cited the underlying structural characteristics of the health industry and the faulty design of Medicare and Medicaid reimbursement as principal protagonists of this inflationary situation.

Unfortunately, these inflationary pressures in the the health care industry still persist. Since Secretary Weinberger's previous testimony, medical care prices have continued to rise at rates well in excess of the overall cost of living. The so-called "temporary" bulge in medical care prices following the expiration of the Economic Stabilization Program

is indeed becoming permanent. Although the ESP controls expired over 15 months ago, for the first seven months of the calendar year, the medical care component of the Consumer Price Index increased at an annualized rate of 11.9 percent vs. a 7.3 percent increase in the overall CPI.

The effects of these rising medical care prices on Federal Medicare and Medicaid outlays are becoming quite apparent. FY 76 Medicare and Medicaid outlays are expected to exceed $25 billion, an increase of almost $3 billion over FY 75 outlays. Thus, Medicare and Medicaid outlays increase by billions of dollars each year due to the chronic inflation in the health care industry

I would like to begin by identifying some of the Administration's legislative initiatives which should interest you.

Cost-Control Amendments

In order to control the projected 15 to 18 percent increase in Medicare outlays in FY 76, to promote more efficient utilization of medical services, and to protect the elderly against the catastrophic costs of illness, the Administration submitted to the Congress the Social Security Cost Control Amendments. The bill was introduced in the House by Congressman Staggers and Devine as H.R. 4820 and in the Senate by Senator Curtis as S. 1720.

The proposal included:

-- subjecting all Part A services to a 10 percent coinsurance
-- allowing the current annual $60 Part B deductible to increase automatically in proportion to future increases in cash benefits (the dynamic deductible)
-- instituting cost-sharing liability limits of $750 per spell of illness under Part A and Part B

The 10 percent cost-sharing on Part A, coupled with the limitations on Parts A and B liability, is designed to protect Medicare beneficiaries against the catastrophic costs of illness, while discouraging unnecessary hospitalization.

It would place some additional cost-sharing on beneficiaries with short stays while providing additional protection for those with long hospitalizations.

The proposal to make the Part B deductible dynamic can be viewed in a similar light. Both Social Security cash payments and the Part A (hospital services) deductible increase each year to reflect increases in the cost of living and higher hospital costs, respectively. Yet the Part B deductible remains fixed. (It was originally set at $50 in 1965 and was increased to $60 by the 1972 Social Security Amendments.) Thus, the real value of the deductible either as a deterrent to unnecessary utilization or as an initial liability for medical services consumed by Medicare beneficiaries steadily declines. The dynamic deductible proposal would more appropriately allow the deductible to reflect increases in costs of living and medical care prices.

Unfreezing the SMI Premium

As the Subcommittee is aware the provisions of Public Law 93-233, which amended Title II of the Social Security Act to advance the effective date of an automatic cost-of-living benefit increase from

January of a calendar year to June of the previous year, had the unintended effect of permanently freezing the Medicare Part B premium at the July 1974 level of $6.70 per month. Unless this problem is corrected, Federal revenues will be reduced by $297 million in FY 1977, requiring an additional general revenue contribution to the Federal Supplementary Medical Insurance Trust Fund of this amount.

Last January, the Administration submitted to the Congress draft legislation to reinstate the mechanism previously in effect to permit increases in the Part B premium. This legislation was introduced in the House as H.R. 4822 by Representatives Staggers and Devine and as S. 1722 in the Senate by Senator Curtis.

The full Ways and Means Committee has reported similar legislation as part of H.R. 5970, the "Emergency Health Insurance Extension Act of 1975." However, the House of Representatives has not taken action with respect to this bill, which was reported out by the Committee on Interstate and Foreign Commerce on May 7.

While H.R. 5970 and the Administration proposal are conceptually similar with regard to unfreezing the SMI premium, we prefer our approach because it establishes a more direct relationship between changes in social security cash benefits and increases in the Part B premium. We urge the Committee to enact the Administration proposal.

Coordination Between the Medicare and the Federal Employees Health Benefits Programs.

We hope that the Congress will give speedy consideration to legislation which would change the Social Security Act and the Civil Service laws to provide improved coordination between the Medicare and the Federal Employees Health Benefits (FEHB) program. This legislation is required in order to comply with the provisions of Section 210 of P.L. 92-603. Earlier this year, the Department and the Civil Service Commission submitted draft legislation to the Congress which would implement this change.

Unless this legislation is enacted before January 1, 1976, payment may not be made under the Medicare program for any services furnished to a Medicare beneficiary

if that service is also covered under a FEHB plan in which the beneficiary is enrolled. Even where the FEHB plan would not make full payment because deductibles and coinsurance are involved, Medicare would not be able to reimburse the individual for the amount of the deductibles and coinsurance so long as the service is covered by the FEHB plan.

We hope that Congress will act in a timely manner so that joint Medicare-FEHB beneficiaries will receive the level of coverage to which they are entitled.

Waiver of 24-Hour Nursing Requirements for Rural Hospitals

We share the Subcommittee's concerns with respect to unique problems faced by rural hospitals in attempting to comply with staffing requirements under Title XVIII.

At the present time, the Secretary of HEW can waive the 24-hour nursing service requirement for some rural hospitals if these hospitals provide the services of a registered professional nurse during at least the regular daytime shift. To be granted a waiver, a hospital: (1) must be located in a rural area; (2) must be essential to the adequate availability of hospital services; and

(3) must demonstrate good faith efforts to upgrade its nursing service so that, over time, full compliance with the nursing standard can be achieved. This waiver authority is temporary and is scheduled to expire at the end of this year.

H.R. 1792, sponsored by Representative Burleson, would extend the waiver authority for an additional five years. We believe that such a blanket extension could impede the progress that has been achieved in improving the quality of care provided to patients in rural areas. In 1971, several hundred rural hospitals were granted waivers.

Since that time the availability of registered nurses in rural areas has steadily increased and fewer than 100 waivers are now in effect. Nevertheless, we agree that those remaining hospitals which need additional time to come into full compliance with the 24-hour nursing requirement should be given the opportunity to do so.

Therefore, we are submitting for your consideration a draft bill which would provide a modified extension of the waiver authority and would promote the progress that has been achieved. Our approach would extend the waiver

for one year, to January 1977, and hospitals granted waivers would be required to provide registered nursing service for one other daily shift in addition to the day shift now required. We have attempted to balance the Department's concerns for the quality of care furnished to hospital patients with our recognition of the difficulties faced by rural hospitals.

Implementation of Regulations

On June 12 of this year, former Secretary Weinberger testified before this Subcommittee on the Department's efforts to implement specific cost control provisions of the 1972 Social Security Amendments. I would like to review the current status of the implementation of those regulations:

(a) Termination of 8-1/2 Percent Nursing Differential

On May 23, 1975, the Department published regulations in the Federal Register which terminated the 8-1/2 percent inpatient routine nursing salary cost differential.

This 8-1/2 percent routine nursing differential had originally been instituted by regulation effective with provider accounting periods beginning after June 30, 1969. The differential was based mainly on a study conducted by the American Hospital Association which indicated that elderly patients required more routine nursing services than those under age 65.

The Department had reasoned that changes in the Medicare law, changes in the way services are furnished, and changes in the way in which Medicare reimburses for routine services have occurred make the recognition of this differential for routine nursing services inappropriate. Thus, regulations were promulgated to rescind the recognition of that differential for reporting periods beginning after July 1, 1975.

The American Hospital Association, the American Protestant Hospital Association, the Catholic Hospital Association, and the Federation of American Hospitals filed suit on June 9, 1975, to enjoin HEW from enforcing these regulations. The plaintiffs contended that: (1) the regulation would conflict with statutory and regulatory provisions by causing part of the costs attributable to Medicare beneficiaries to be borne by non-Medicare patients; and (2) the previous regulation required additional studies to be undertaken prior to a revision of the differential, and no such studies were conducted.

On August 1, 1975, the U.S. District Court for the District of Columbia declared the regulation invalid. In view of this decision, which we do not intend to appeal, and which will increase Federal outlays in FY 76 by $20.0 million and $175.0 million in FY 77, the Department will shortly undertake a study having as its objective the development of evidence bearing on the issue of whether, and to what extent a nursing care differential is currently justified.

(b) Limits on Reasonable Costs of Hospital Inpatient General Routine Services.

The 1972 Amendments to the Social Security Act gave the Secretary of HEW authorization to establish prospective limits on provider costs that would be recognized as reasonable under the Medicare program. The regulations for FY 1975 were published in the Federal Register on June 6, 1974, and established 70 groups of hospitals with prospective limits set at the 90th percentile plus 10 percent of the median of routine per diem costs for each group. Providers whose costs exceeded the limits would be required to justify the payment for any excess in comparison with peer hospitals or have their Medicare and Medicaid reimbursements for routine costs reduced to the group limit.

On May 30, 1975, the fiscal year 1976 schedule of hospital cost limits was revised and published in the Federal Register, for reporting periods beginning on or after July 1, 1975. As you will recall, two changes were made: (1) the hospital classification system was modified slightly and the number

of groups was reduced from 70 to 32; and (2) the group routine cost limits were lowered from the 90th percentile plus 10 percent of the median to the 80th percentile plus 10 percent of the median.

The Association of American Medical Colleges (AAMC) filed a lawsuit for a permanent injunction against the implementation of the new hospital cost limits, on the grounds that the limits make no direct provision for the effect of patient mix and the scope of services. On July 1, 1975, the U.S. District Court for the District of Columbia decided in favor of the Government and denied the AAMC's request for an injunction. When plaintiff filed a "Motion for Reconsideration" of the court's decision, it was denied. A formal appeal has not yet been filed.

The new classification system was based on an extensive statistical analysis. We found that routine costs do not generally vary with the intensity of services required. We also learned that patient mix and service complexity were so highly correlated with bed size that their inclusion in the classification system would not affect the cost limits for most hospitals. While we believe that the favorable decision in the AAMC suit was in part due to the soundness of our classification system, improving the method of grouping hospitals remains an ongoing area of analysis within the Department.

A Complaint for Declaratory Judgment and Injunctive Relief was filed by the Peter Bent Brigham Hospital in the U.S. District Court for the District of Massachusetts on July 11, and by University Hospital on July 29 regarding implementation of the initial schedule of limits on hospital costs.

The Department is also developing a proposed schedule of limits applicable to skilled nursing facility inpatient routine service costs incurred in cost reporting periods beginning on or after January 1, 1976. These regulations will be published in the Federal Register in the near future.

(c) Economic Index Limitation on Increases in Prevailing Charges for Physicians' Services

As you know, the Department published final regulations implementing the economic index provisions, Section 224 of P.L. 92-603, on June 16, 1975. These regulations limited increases in Medicare prevailing charges to increases that could be justified on the basis of an economic index reflecting increases in office practice costs and in general earnings level. The index is applied

on a cumulative basis with FY 1973 prevailing charges as the base. The cumulative index for FY 1976 is 1.179. Thus, an increase in any FY 1976 prevailing charge greater than 17.9 percent over the FY 1973 prevailing charge for that service will be reduced to 17.9 percent, while any charge that increased by less than 17.9 percent will be allowed in full and any unused portion of the allowable increase would be carried forward for use in future years.

Our principal concern at this time is that the application of the index appears to be causing FY 1976 prevailing fees in a substantial number of cases. Prior to the application of the economic index to FY 1976 increases, we had assumed that such a rollback in prevailing fees from the FY 1975 level would occur in only a very few cases. In order to evaluate the extent of the problem, we requested that all Medicare carriers submit data on the prevailing charge screens in each reasonable charge locality for 18 commonly performed physicians' services. Reports received to date covering 153 (approximately 55 percent) of Medicare's reasonable charge localities indicate that over 15 percent

of FY 1976 prevailing charges are being decreased below FY 1975 levels as a result of the application of the economic index limitation. The outstanding reports covering the remaining reasonable charge localities are expected to be consistent with these data from the preliminary reports. The "rollback" problem is essentially due to a change, required by the law, from the method by which ceilings on prevailing charge increases were imposed in prior years and will not reoccur in future updates of prevailing charge screens.

(d) Utilization Review (UR) and Professional Standards Review Organizations (PSRO)

As you know, the American Medical Association filed suit opposing the November 29 utilization review regulations. Judge Julius Hoffman issued a preliminary injunction on May 27, 1975, which was upheld on July 22, enjoining the Department from enforcing portions of these regulations dealing with review of hospital admissions and with the structure of the review committee. The Department has now determined that changes should be made to perfect and strengthen the regulations. As stated in the Federal Register Notice of September 10, these changes are currently being developed within the Department and the proposed revision will be published in a future Notice of Proposed Rulemaking. The effective date of these provisions is postponed until after the completion of such rulemaking.

PSRO's were designed as an improved review mechanism which would replace utilization review activities as soon as feasible. Congress recognized that there would be a time lapse prior to full PSRO implementation nationwide and passed Sections 207 and 237 of the 1972 Social Security Amendments in order to strengthen utilization review nationally and eliminate duplicative review requirements imposed upon hospitals and physicians.

Local, physician-sponsored organizations are established on a voluntary basis under the PSRO program to assume responsibility for assuring the medical necessity of health care provided under the Medicare, Medicaid and Maternal and Child Health Programs.

Physician support for PSROs has grown considerably over the past year. To illustrate, although many segments of of the physician community opposed the PSRO program over a year ago, we can now report that over 86,000 physicians have joined PSROs in their local areas. Approximately one of every four physicians in the nation is a PSRO member. Of 66 conditional PSROs which complied with the statutory requirement of notification, only five had 10 percent of

the physicians in the PSRO areas question whether the PSRO was representative of the physicians in its area. In addition, we estimate that there are an additional 40 physician groups that are interested in starting PSROs in their areas. There are only four States without a planning or conditional PSRO (Texas, Louisiana, Nebraska, and Georgia).

The implementation of the PSRO program has been and will continue to be a complex undertaking. However, the most important factor to successful implementation--physician acceptance of PSRO--appears to have been met. The issues of coordinating procedures between the Medicare and Medicaid programs and the development of appropriate regulatory policies will continue to receive considerable attention and effort to assure smooth and rapid implementation.

The Department has examined many proposed bills to amend the PSRO law.

One amendment would direct the Secretary of HEW to establish or revise areas after consultation with professional organizations, such as State and County medical associations and specialty societies located in

the areas affected and provide opportunity for public hearing. We would note that professional organizations were consulted prior to designation of PSRO areas. The Notice of Proposed Rulemaking for proposed area designations allowed 45 days for public comment. The Department has now provided for modification of PSRO areas if operating experience or changing conditions indicate the need.

Another amendment would authorize the Secretary to enter into contracts with State medical societies or private, non-profit organizations designated by them to provide technical assistance in the creation and operation of PSROs. We feel that PSRO Statewide Support Centers funded by HEW do serve this objective. Several State medical societies and other groups are presently providing technical assistance to local PSROs in their respective areas.

In addition, the Department feels that we must now examine how PSROs operate in order to determine the best approach to any amendment of the statute. Until further operating experience with PSROs has been gained, we believe that the PSRO law should be implemented as enacted, although changes will undoubtedly be necessary at a later date. I would like to assure you that the Department remains firmly

committed to the continued and rapid implementation of the PSRO program as the most effective and appropriate means for assuring both the quality of care and the effective utilization of health care facilities and resources.

Hemodialysis and Kidney Transplant Provision

Representative Vanik of this Subcommittee and Chairman of the Ways and Means Oversight Subcommittee, recently held hearings on Section 299I of the Social Security Amendments of 1972, which made dialysis and transplant services available to virtually all patients suffering from end-stage renal disease. The Congress authorized the Secretary of Health, Education, and Welfare to develop mechanisms to assure that ESRD care was both of high quality and cost-effective. Concurrent with implementation of the interim program in June of 1973, the Department began to develop long-term ESRD program policies which were designed to assure that the program would: provide for the total health care needs associated with treatment of end-stage renal disease; maintain and encourage the conditions insuring the availability and reasonable access to needed resources and service; assure quality through effective review; promote effective utilization of resources through the establishment of minimum utilization rates and contain the costs of covered services.

The Department published a Notice of Proposed Rulemaking in the Federal Register on July 1, 1975, which would establish conditions of coverage that a facility would have to meet to receive Medicare reimbursement for the delivery of ESRD services. The proposed regulations require ESRD treatment facilities to join together into "networks." The network must organize itself through the establishment of a Network Coordinating Council which will serve as liaison between the Federal government and available community resources. Each network would also establish a Medical Review Board to review the appropriateness of ESRD patient care and service. The proposed regulations would also establish a medical information system and all ESRD facilities participating in the program will be required to supply data to this system.

To date, there are a number of identical bills pending before Congress to modify both the eligibility and cost-sharing provisions of the ESRD program. These provisions would:

(1) begin eligibility for dialysis patients with the month in which the patient begins training for self-dialysis in an approved program;

(2) begin eligibility for transplant patients with the month in which the patient is admitted to a hospital for transplant evaluation, provided that the transplant surgery takes place within the next two months;

(3) extend the final month of eligibility for transplant patients to the 36th month after the month of transplant;

(4) remove the cost-sharing provisions of the Medicare law, making the program responsible for 100 percent of the reasonable charge or reasonable charge for covered services or supplies, for those patients who are participating in an approved self-dialysis program or who are self-dialyzing.

(H.R. 7708 by Congressman Carter, H.R. 7618 by Congressman Quillen, and H.R. 8786 by Congressman Perkins)

The Department favors efforts to encourage the use of home dialysis and early transplantation under the renal disease program. We have consistently supported these as preferred treatment modes, from the standpoint of both therapeutic benefit and cost savings. While we do support certain portions of these bills, in general we do not think that the incentives embodied in the bills are appropriate for encouraging home dialysis.

Because transplantation should be encouraged as early as medically and technically feasible for those patients suited for this form of treatment, the Department does not oppose allowing Medicare eligibility for renal transplantation to begin within the month in which the patient is admitted to a hospital for transplant evaluation, provided that surgery takes place within the next two months. Extending full patients' benefits to 36 months following transplantation would also have long-term medical and cost-savings justification and we are not opposed to this provision.

Our most serious concern with H.R. 7708 et. al is with the provisions to remove the normal Part B cost sharing for all expenses incurred in connection with "home dialysis." When

maintenance dialysis is appropriate and/or preferred, home dialysis is clearly preferable for reasons of treatment flexibility and convenience, decreased complications, and cost savings. Home dialysis is not without serious limitations, however, and there are some considerable barriers to its greater utilization. These include: medical suitability; the patient's psychological strength and sense of motivation; imminence of transplant; family support; space and utility requirements of the physical setting; accessibility of home training programs; the financial constraint of uncovered services and supplies required for the installation and operation of a home dialysis unit, including such medical supplies incident to dialysis for which reimbursement is now denied; patient ignorance of the various treatment options; the individual physician preference, practice patterns and decisions and the limitations imposed by the available technology. Altering patient reimbursement policy will not affect many of the elements influencing the therapeutic decision, which are not subject to manipulation by financial incentives or disincentives.

The Department agrees that a more liberal reimbursement of items, services or supplies would be desirable to reduce

patient expenditures and that better coverage might serve to induce greater utilization of home dialysis. We therefore would support expanding coverage to include all supplies and equipment necessary for home dialysis, subject to the co-insurance provisions which affect all Medicare beneficiaries.

H.R. 7708 further draws the distinction between patients as participating in facility dialysis or home dialysis, while experience shows that there is a great deal of fluctuation between those foci of care. Severe administrative difficulties would be created if the Social Security Administration would be required to identify patients seeking reimbursement by treatment setting. It is estimated that a six-month lead time would be required to develop the appropriate tracking capability; considerable administrative costs would be associated with such a requirement.

In addition, the provisions of the bill applicable to "self-dialysis" facilities raise serious concern in the Department. Because there are very few facilities which permit patients to self-dialyze, this provision invites potential disruption in the delivery of dialysis services. A facility would be granted an incentive to reduce or remove the present professional staffing, call itself a self-dialysis facility, and command 100 percent of reasonable costs.

Congress has under consideration--as part of an integrated cost-sharing proposal--a bill, H.R. 4820, submitted by the Department on behalf of the Administration, which would place a cost-sharing liability limit in 1975 of $750 per spell of illness under Part A, with a similar limit on Part B expenses. Inclusion of such a maximum annual liability would provide financial protection not only to end-stage renal disease patients but to all Medicare beneficiaries who incur large medical bills. This approach to limiting financial liability, we believe, is far more equitable to all Medicare recipients.

The Department believes that the waiving of all Part B cost sharing for home dialysis is medically undesirable and would give the beneficiary population, already categorically eligible, a further categorical benefit denied to the rest of the Medicare population. Removing the cost-sharing provisions for home dialysis might set a dangerous precedent, thereby raising serious questions of equity, considering that there are patients with other diseases with equally appropriate and technically available therapeutic alternatives who are categorically excluded from receiving the same benefits.

On the basis the the above, we recommend that H.R. 7708, et. al, not be favorably considered as currently written. Amended, as we propose, the bill when enacted will result in costs of $16.0 million.

Home Health Care

The Department of Health, Education, and Welfare is making an extensive review of the broad spectrum of long-term care, with a view to developing a comprehensive approach to provision of adequate long-term care services for persons of all ages. Home health services will be an integral part of this program, and I would like to review briefly the Department's efforts to expand these services.

Under Section 222 of the Social Security Amendments (P.L. 92-603), the Department is funding research and demonstration projects using, when medically appropriate, certain day care and homemaker services as alternative options to institutionalization in hospitals and skilled nursing facilities. Through these experiments we hope to determine whether such coverage would provide quality and effectively lower long-range costs by reducing the demand for higher cost institutional care. We also hope to ascertain the costs of providing various types and groupings of alternative services and to evaluate alternative eligibility regulations.

The 1972 Amendments should also improve overall administration of home health benefits in that we are authorized

to establish in advance specific minimum numbers of home health visits, under Part A, which a patient would be presumed to require following hospitalization. On July 9, 1975, the implementing regulations were promulgated for a 30-day public comment period (later extended) and drew a large number of responses. I would like to re-emphasize that the limits set forth in these regulations are only guaranteed minimums and that other services and additional periods of coverage may be approved and reimbursed. Implementation of this authority should reduce uncertainty on the part of physicians and patients as to whether or not home health care services would be covered, thereby encouraging prompt discharge from institutional care to the home care setting.

Another significant new regulation was proposed in the June 9 Federal Register which would greatly expand the ability of home health agencies to provide a large range of services by allowing such agencies to contract with a proprietary provider of home health services.
A further change in the rules governing proprietary home health care providers has been included as part of the Administration's proposed "Social Security Amendments of 1975," transmitted to the Congress as draft legislation. Section 302 of this proposal would repeal the requirement that proprietary agencies be licensed under State law and subject them to the same licensure requirements as public

and private nonprofit agencies. In this way we hope to increase the number of participating home health agencies and make home health services more accessible.

A number of bills have been introduced in the House which would expand the scope of the Medicare home health benefit. Most, such as H.R. 4869, introduced by Representative Pike, seek to encourage the use of home health services by making these services available to patients who require less intensive treatment and by providing an expanded number of home health visits and services to beneficiaries. We share the concerns of the sponsors of this and similar legislation that the costs of hospital and other institutional services are high and could be reduced in part by the substitution of appropriate high quality home health services. We would caution, however, that such substitutions can be effective only if they are professionally controlled to prevent misutilization.

We are hopeful that the preliminary results of the experiments now underway under Section 222 will provide a basis for identifying additional, more definitive research which will provide a sound basis for any proposed changes in the present home health benefit package.

Prospective Reimbursement

The current reasonable cost system of payment for institutional services under Medicare--under which the amount of reimbursement is determined retroactively on the basis of incurred costs--has been criticized for failing to provide incentives for cost containment and therefore contributing to the recent rapid increase in hospital costs. Prospective, rather than retrospective, establishment of reimbursement levels appears to have the potential to restrain hospital costs increases. Prospective reimbursement facilitates intelligent financial planning by hospital administrators, and could have long-range, real impacts on hospital costs.

The Social Security Administration is currently engaged in a broad and comprehensive research and experimentation program designed to test several prospective reimbursement methods.

Preliminary results of our studies indicate that prospective rate setting systems developed at the State level may offer a feasible method of moving toward a full-scale prospective reimbursement system. Since we are currently dealing with a multiplicity of systems in various States and are basically

in the developmental and experimental stages of the program, we do not yet have the empirical evidence to demonstrate that any single system is superior. Rather, it seems clear that any system which might be developed for general use at this time must include a high degree of flexibility. We are intensifying our review and evaluation of various prospective rate setting provisions in two areas: (1) a general provision which would, in the short range, address the problem of excessive escalation in hospital costs which has occurred nationwide; and (2) systems which could be implemented at the State level.

Physicians' Services Reimbursement

Reimbursement under the supplementary medical insurance program (Medicare Part B) for physicians' services is based on the reasonable charges for such services. The Medicare carrier is responsible for determining the reasonable charge for a particular service by taking into consideration the physician's customary charge, the prevailing charge in the locality for similar services, and the payment made by the carrier under its own health insurance plan for comparable

services provided under comparable circumstances to the carrier's own policy holders and subscribers. Thus, in effect, Medicare payments are limited to an amount based on the lower of the physician's customary charge or a recognized prevailing charge for a given service in the area in which the physician practices. As you know, beginning in FY 1976, the prevailing charge for a particular service may increase only to the extent justified by an economic index.

A Medicare beneficiary may assign Part B benefits to the physician performing the services who, in voluntarily accepting an assignment, must agree to accept the "reasonable charge" as determined by the Medicare carrier as payment in full for his service (i.e., he must agree to accept the Medicare payment from the carrier and bill the beneficiary no more than the deductible and coinsurance amounts related to that charge). The physician's acceptance of assignment is not a one-time decision, but, rather, a decision that can be made with respect to each separate Medicare claim. Program experience indicates that in cases where the bill is particularly high or where the beneficiary's income is low, the physician generally accepts assignment. When an assignment is not accepted, the beneficiary is responsible for making up the difference between the charge recognized by the program and any higher amount the doctor charges.

The rate of physician acceptance of assignment has steadily declined from 61 percent of bills in FY 1969 and FY 1970 to slightly less than 52 percent in FY 1975.

The Department is studying alternative reimbursement methods to determine how the current system might be changed to provide greater protection to beneficiaries against excessive out-of-pocket costs and at the same time to assure fair compensation to the physician.

Coverage of Pap Tests

Several bills currently pending before this Committee, including H.R. 2764, introduced by Representative Corman, would expend Medicare coverage to include routine periodic papanicalaou tests (pap smears). In enacting the Medicare program, Congressional intent was that it be an insurance program designed to provide protection against the costs of "medically necessary" health services. These are the costs which are unpredictable and, hence, difficult to plan for. As a result, Medicare does not generally cover preventive services. However, pap smears are fully covered when they are medically necessary in the diagnosis and treatment of a medical condition.

Payment for Physicians' Services When the Beneficiary is Deceased

Representative Burke has introduced a bill, H.R. 6022, which would change the present procedures for disposing of Medicare claims for payment for physicians' services after the death of the beneficiary. Under the Social Security Act, where the physician's bill has been paid, payment is made to the person who paid the bill, or where the beneficiary paid the bill, to the representative of the estate, or to the beneficiary's survivors. Where the bill has not been paid, the Medicare payment may be made only to the physician if the physician has accepted assignment of the claim--that is, he agrees to accept the reasonable charge as the full charge for services. H.R. 6022 would require the Medicare program to pay the physician ahead of all other creditors, without an agreement to accept the reasonable charge as payment in full.

We would not favor a change in the law which would permit payments to be made directly to a beneficiary's estate on the basis of an itemized, unassigned claim where a physician's bill has not been paid.

Administrative and Judicial Review under SMI

Several bills pending before this Subcommittee would provide for administrative appeal and judicial review of Medicare supplementary medical insurance (Part B) claims in certain cases. Under present Medicare law, a beneficiary who disagrees with the determination made on his Part B claim may request a review of that claim by the carrier. If, after the review, he is still dissatisfied with the carrier's determination regarding his claim and the amount in controversy is $100 or more, he may request a fair hearing by the carrier. There is no provision in the law for an appeal beyond the decision of the carrier's hearing officer on a supplementary medical insurance claim, nor is there a statutory right to judicial review of the disallowance of a Part B claim.

Prior to the enactment of the Social Security Amendments of 1972 (P.L. 92-603), hearings were held on all Part B claims in controversy, regardless of the amount. Data show that during that time approximately 45 percent of the hearings involved an amount of less than $100 and that the cost of hearings in cases invoving claims as small as $5 and $10 usually exceeded $100. The imposition of the

$100 minimum on the amount in controversy in order to be eligible for a hearing recognized that such costly procedures were unwarranted where very small claims were at issue. We believe that current review and hearing procedures adequately protect the rights of program beneficiaries and eliminate unwarranted program costs.

Ambulance Services

From time to time proposals are introduced which would expand current coverage of ambulance services. Presently, reimbursement for these services under Medicare is limited to situations where the use of normal transportation would endanger the health of the patient and where the individual is transported to the nearest hospital with appropriate facilities or to one in the same locality. Under similar restrictions, reimbursement can be made when the patient is transported from one hospital to another, to his home, or to an extended care facility. The regulations which set forth these conditions were developed in accordance with the clear intent of the Congress. We feel that the current regulations provide an adequate level of coverage for those beneficiaries in need of ambulance services.

Medicare Reimbursement for Provider Malpractice Insurance

In general, the Medicare law requires that all payments to providers be based on the reasonable cost of services covered by the program and related to the patient care of Medicare beneficiaries. It is Congressional intent that payments to providers approximate as closely as practicable the actual cost, both direct and indirect, or services rendered to beneficiaries of the program. The rationale is that the costs of services to individuals covered by the program will not be borne by individuals not covered and the costs of services to individuals not covered will not be borne by the program. Accordingly, Medicare principles of reimbursement recognize not only direct costs in connection with the rendering of inpatient services, such as room and board, but also indirect costs, such as depreciation, interest on indebtedness, bad debts, educational costs, and medical malpractice insurance premiums.

The Department does not favor direct Federal intervention at this time with respect to current medical malpractice problems. Traditionally, the area of medical liability insurance has been the responsibility of the States. The diversity among State laws, the great variation in the scope and intensity of the problem, the responsibility

of the States for hospital and physician licensure, and the locus of authority for regulation of the insurance industry are elements which enter into belief that malpractice belongs in the realm of State responsibility.

We wish to point out that insurance companies, State legislators, hospitals and physicians are all actively involved in seeking solutions to the medical malpractice problem. A large variety of initiatives are under consideration and proposals are being developed by most of the interested groups. Our sources of information indicate that 35 States have already enacted legislation related to malpractice and various activities and studies are currently underway in all but two jurisdictions of the United States. We are currently evaluating Medicare reimbursement policies to make sure that they are not contributing to the problem. As part of our review, we are examining the issue of whether payments for self-insurance should be reimbursed currently.

CONCLUSION

Mr. Chairman, we appreciate the opportunity to present the Department's views on the topics of interest to the Subcommittee. My colleagues and I would be pleased to answer any questions you may have.

FOR RELEASE ONLY UPON DELIVERY

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

STATEMENT

OF

JOHN B. RHINELANDER

GENERAL COUNSEL

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE

HOUSE OF REPRESENTATIVES

Wednesday, September 3, 1975

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

I am pleased to be here at the request of the Subcommittee to discuss the Department's implementation of section 1903(g) of the Social Security Act, which provides for a reduction in federal Medicaid matching if certain utilization control requirements are not met by the States.

Since Dr. Weikel's previous testimony, the new Secretary of Health, Education, and Welfare has taken office and has decided to suspend imposition of the utilization control reductions of matching funds pending a review of all reductions or penalties under the Social Security Act. As you know, the Secretary is aware of the status of the imposition of the utilization control reductions and has expressed great concern that imposition of those reductions not be counter-productive to the purposes which both the Congress and the Department seek to achieve: better and more economical health care for Medicaid beneficiaries. At this time, I would like to insert into the record the Secretary's letter to the Chairman announcing this decision.

While the Secretary thus clearly recognizes that the statute requires imposition of the reductions when a satisfactory showing of an effective utilization control program is not made, he is also aware that the statute mandates no date certain when the reductions must actually be imposed. Accordingly, he has directed that an intensive study be made of the problems in this area and of possible alternatives which would better effectuate the purposes of the various reduction or penalty provisions.

With respect to the utilization control reductions, this review will focus on several areas of Secretarial concern:

1. Whether the amount of the reduction is disproportionate to the deficiency in the State's utilization control program. While the penalty is imposed only with respect to Federal financial participation claimed for long-term care, the amounts involved represent a substantial percentage of Federal financial participation in all State Medicaid expenditures.

The review will accordingly consider, among other things, the desirability of recommending a lower reduction rate, or a reduction coupled with financial incentives for those States which have an effective utilization control program (by means of a bonus or a higher Federal matching rate).

2. Whether the requirement for a mechanistic application of a formula reduction is counter-productive. The reduction provision in section 1903(g) does not distinguish between those States which are doing little or nothing to control utilization of medical services and those which are making a substantial effort but fail to attain a precise adherence level. This failure to distinguish qualitatively among the States may act as a disincentive to those States which, even with strenuous effort, cannot expect to attain required adherence levels for some period of time.

Thus, the review will consider the desirability of recommending a graduated reduction directly related to State efforts in implementing a utilization control program, or a reduction which the Secretary has the discretion to suspend when such State efforts are apparent.

3. Whether the application of the reduction might force States to reduce the amount, duration and scope of benefits provided under their Medicaid programs, thus harming the very people the statute was designed to assist. It would be a small comfort to Medicaid beneficiaries to know that a statute designed to assure they were not subject to unnecessary medical procedures had the effect of assuring they could not obtain some necessary medical care and services.

Moreover, we are aware of the adverse programmatic impact of the preliminary injunction issued in the case of American Medical Association v. Weinberger, a suit challenging the Department's utilization review regulations. (Utilization review is one of the statutory components of utilization control.) The court preliminarily enjoined portions of both the Medicare and Medicaid utilization review regulations -- but not the same portions, and 42 U.S.C. section 1396b(i)(4) requires hospitals and skilled nursing facilities participating in both Medicare and Medicaid to have the same utilization review plan for both programs (in the absence of a specific Secretarial waiver). State agencies have advised us that the effect of the

apparent conflict between the injunction and the statute is massive confusion. Hospitals are having difficulty ascertaining which specific utilization review procedures are currently required and which may not be imposed. While trial in this case is now set for September 8, the present confusion would have a serious effect on any utilization control surveys conducted in the near future.

To sum up, the Department does not question that the present statutory provision requires, back to its effective date, the imposition of the reduction for those States that do not make a satisfactory showing of control over utilization of services. However, a suspension of the imposition of the reduction in order to give Secretary Mathews an opportunity to assess the problems in this area and their possible solutions will result in no loss of the government's legal rights. The Department has an on-going relationship with all States participating in the Medicaid program. Each State requests and obtains a grant award each quarter to operate its Medicaid program. If it is ultimately decided to do so, and it must be if the statute is not changed, the reduction can be taken against any grant award at any time.

I welcome your questions.

August 27, 1975

MEMORANDUM FOR: ART QUERN

FROM: SARAH MASSENGALE

SUBJECT: HEW POLICY IN EVALUATING PATIENT CARE IN LONG TERM CARE FACILITIES

Attached is a memorandum from the Office of Dr. Abdellah, Office of Nursing Home Affairs (ONHA), about steps being taken by the Office to change HEW evaluation techniques of nursing homes and other long term care facilities. The aim is to change the focus of the evaluation process to assess care provided to patients rather than capability to provide care.

A project experiment is underway in Region 4 (Atlanta) involving 8 states, including Florida. The project, which was started in early July, is expected to continue until October. ONHA, working with state officials and nursing home providers, is striving to develop and test a patient assessment system for the government evaluators and for the providers to use as a management tool. ONHA is encouraged with the acceptance of the experiment in Region 4.

If the experiment seems to be successful, ONHA would like to use the system to evaluate patient care throughout the country. They say that this would ~~best~~ not require a change in the regulations.

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August 27, 1975

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Dr Claire Ryder
443-6584

file

THE WHITE HOUSE

WASHINGTON

August 27, 1975

MEMORANDUM FOR: ART QUERN

FROM: SARAH MASSENGALE Sarah

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Sarah
What's the value
on this experiment?

BD

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Public Health Service
Rockville, Maryland 20852

August 26, 1975

MEMORANDUM FOR: MISS SARAH MASSENGALE
STAFF ASSISTANT TO THE PRESIDENT
DOMESTIC COUNCIL

Subject: Information Regarding Steps Being Taken by the Office of Nursing Home Affairs, Public Health Service (PHS) to include Patient Assessment to Present Facility Capability for Providing Care

At this point in time Federal regulations and survey procedures for long-term care facilities are directed toward facility and structural factors with no attention to the actual care given an individual resident. It is generally acknowledged that there must be an expansion or change to incorporate a patient-oriented approach in assessment of care. The Office of Nursing Home Affairs, PHS, is providing leadership in bringing about this change.

There is a growing acceptance of the thesis that appropriate care for the person with long-term illness must be based on his physical, social and psychological needs regardless of his health status. There is also the belief that every individual who appears to require continuing care should have his needs assessed with attention to each dimension of need and have a plan of care tailored to meet the variety of his needs. These can be accomplished by the use of a system of patient assessment.

The Office of Long-Term Care Standards Enforcement, DHEW, Region IV, has taken the lead in the crucial area of patient assessment in long-term care. In May, they sponsored a three-day workshop at Daytona Beach for regional office personnel, State surveyors and providers of care within the region. The purpose of the workshop was to introduce the concept of a system of patient assessment based on the "Patient Classification for Long-Term Care." This classification was developed and tested by research investigators from Harvard, Johns Hopkins and Michigan State and is a tool for decision-making comprised of a set of descriptors and their definitions that form a uniform terminology with which to assess the status of an individual at one or more points in time.

In the light of the above the aim of the Region IV staff is two-fold: (1) to serve as a catalyst by assisting providers to establish a system of patient assessment within their facilities and (2) to develop and test a patient-oriented abstract form based on the "Patient Classification for Long-Term Care" and other management factors that can be utilized by surveyors, utilization and medical review committees, PSRO groups, and by the providers of care as a management tool. The former was given impetus by the three-day workshop and the latter is currently being developed by the Region IV staff in conjunction with industry representatives from the National Health Corporation, National Council of Health Care Services, American Health Care Association, as well as State agencies, consumers and staff of the Harvard Center for Community Health and Medical Care. The Patient Abstract is complementary to the patient assessment tool presented at the workshop. Currently the Abstract is undergoing final revisions prior to testing in a limited number of long-term care facilities.

Faye G. Abdellah

Faye G. Abdellah
Assistant Surgeon General
Director, Office of Nursing
Home Affairs

Dr. Claire Ryder 443-6584

10/24/75 patient assessment project - Region 4

working on developing tools
not yet operational

existing patient assessment tool
Bensen tool (Harvard)
for long term care
- functional - daily living
- socialization
is lengthy

Reg 4 — develop abstract
for use of abstractor
to determine if quality & type
of care is right (management
tool)
observational surveys based on examination
of patient care
need common language for all to
evaluate — Bensen provides
shorter Bensen form
industry working to develop tool:
Texas Nursing home providers
Natl Hlth Corp (chain of nursing homes) (Dr. Adams - Pres)
Amer Hlth Care Assoc (sending Bensen tool
to all homes)
Regional office

have developed abstract tool - patient assessment form

~~tested~~ applied in Sept
initially tested
will be field tested in Jan.

tells surveyer how patient is,
what's being done for him

in N.C., Tenn, Ga., Fla.
in private nursing homes by providers
Surveyors: HCFA regional + state + providers

will be presented in March to all nursing home administrators in region 4

State nursing home associations
will do print-outs & collect data
- for providers
- for state certification people

can be applied in PSRO, U.R.

Eventually HCFA will review own regs etc
to reassess

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DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

STATEMENT

OF

JOHN B. RHINELANDER

GENERAL COUNSEL

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE

HOUSE OF REPRESENTATIVES

Wednesday, July 30, 1975

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

I am the General Counsel of the Department of Health, Education, and Welfare. I am pleased to be here at the request of the Subcommittee to discuss the Department's implementation of section 1903(g) of the Social Security Act, which provides for a reduction in federal Medicaid matching if certain utilization control requirements are not met by the States.

The Office of the General Counsel in the Department of Health, Education, and Welfare is a staff office in the office of the Secretary. It is responsible for furnishing all legal services to the Secretary, the Under Secretary, and the various offices and operating components of the Department. Among the agencies within the Department for which we furnish legal assistance is the Social and Rehabilitation Service, which has been delegated authority by the Secretary to administer the Medicaid program under title XIX of the Social Security Act.

In the past several years, the litigative functions of our Office have increased tremendously. We can no longer do "business as usual" or business in the old way; we do all business under the scrutiny of the Federal courts. I am not at all reluctant to defend the Department's actions in court. However, I am very concerned that the proper foundation be laid beforehand so that all the many

years which are often required for litigation will not be for naught. We have no desire to stand in the way of the fiscal reductions required by section 1903(g); we do have a desire to have those reductions applied in a way that will withstand legal attack.

The delays that the Department has experienced in implementing section 1903(g) are indeed regrettable, but I want to emphasize that no legal rights have been lost to the Government. The provision will be applied with full force for the entire period since it became effective. The SRS survey for the last quarter of fiscal year 1974 is currently being recomputed. When that is done -- and I understand that it will be done soon -- the reductions will be made for the entire fiscal year 1974, the first year for which the reduction provision became effective. Another survey will be conducted for fiscal year 1975. SRS is examining whether future surveys can rely in part on self-surveillance by the states with appropriate sample checks by SRS.

I appreciate that many believe that we are exaggerating the litigative difficulties which section 1903(g) entails. After all, the statute states that unless a state makes a satisfactory showing, the Secretary shall withhold a percentage of federal funds. Thus, it would seem that if a state fails to make a showing that satisfies the Secretary, the burden is on the state to justify its showing in court

and until such time as it is able to do so, the Secretary may continue to withhold federal funds. While this seems to me a very reasonable reading of the statute, I can assure you that it is a most unlikely scenario. Our consistent experience with cases in which the Department is disallowing federal funds to a state is that the state suffering the disallowance immediately seeks a preliminary injunction in the district court, and that the court -- which is located in the affected state -- almost invariably enjoins the Department from disallowing the funds until the matter has been fully heard on the merits. As a practical matter, even once the Department announces that it is withholding funds pursuant to section 1903(g), it probably will not actually be able to withhold these funds until after months of protracted litigation, and only then after having persuaded the court that the state in question had indeed failed to make a satisfactory showing that it had an effective program of utilization controls. It is with this experience in mind that the concern we expressed in our memorandum of April 3 regarding the defensibility of the Department's case in court must be understood. While I can well appreciate the Subcommittee's frustration over the additional time spent for recalculation, I believe that these few months devoted to assuring that the Department has a defensible case in court, when measured against the

years which I anticipate will be spent in litigation once the Department imposes these decreases, is time well spent.

I gather that the testimony heretofore given before this Subcommittee has given rise to much confusion regarding our legal interpretation of section 1903(g). I would, therefore, like to set out our views on the proper interpretation of those aspects of the statute in which the Subcommittee has expressed interest.

1. The question has been raised whether the Department may currently impose a fiscal reduction pursuant to section 1903(g) of the Social Security Act with respect to any calendar quarter subsequent to June 30, 1973 for which a state has failed to make a showing satisfactory to the Secretary. The answer is clearly in the affirmative.

Indeed, we believe that the Department is legally obligated to take the one-third decrease provided for in section 1903(g) if a state has failed to make a showing satisfactory to the Secretary that it has in operation an effective utilization control program with respect to each calendar quarter. If the Department has yet to determine whether a state's "showing" for a particular quarter was "satisfactory," it may currently conduct sample surveys to make this determination with respect

to any quarter since the effective date of the statute (i.e., the first calendar quarter of fiscal year 1974 to the present).

2. A second question which has arisen is whether the Secretary may assume, if he finds that a state has failed to make a satisfactory showing that it has an effective program of utilization control for a particular calendar quarter, that the state did not have an effective program for prior quarters, and impose the fiscal reduction provided for in section 1903(g) for those quarters based upon this assumption. In our view, the answer is clearly no.

The "showing" which the state must make is "with respect to each calendar quarter." It is not legally permissible for the Secretary to assume that a state has failed to make a satisfactory showing for one quarter because he knows that it failed to make a satisfactory showing for the subsequent quarter. The Secretary has the statutory duty to make a determination for each quarter whether the state's showing for that quarter is satisfactory.

Nonetheless, while we do not believe that the Secretary can make the assumption that has been suggested, we note that as a practical matter such an assumption is unnecessary since the fiscal reduction provided for in section 1903(g) applies for the entire fiscal year and not

for just the quarter in which the state has failed to make a satisfactory showing. The statute states that the one-third decrease shall be made "with respect to amounts paid for any such care furnished thereafter to such individual in the same fiscal year...." This result occurs "unless the State agency...makes a showing satisfactory to the Secretary...with respect to each calendar quarter...." Thus, if in any one of the calendar quarters, the state fails to make a satisfactory showing, the full fiscal reduction applies for the entire year. Under the statute, a state which makes a satisfactory showing for three calendar quarters but fails to make a satisfactory showing for one quarter will suffer the fiscal reduction to the same degree as the state which makes no showing at all for the entire four quarters. Thus, for fiscal year 1974 the reductions based on the last fiscal quarter of 1974 will be reductions for the entire first year of the section 1903(g) process.

3. A third question in which the Subcommittee has expressed interest is whether the statute requires the Secretary to conduct validation surveys for every calendar quarter. While a survey for every quarter would certainly be consistent with the statute, I do not believe that the statute requires this. In my view, the statute can be reasonably interpreted as requiring a survey for only one quarter a year.

Clearly the statute requires each state to make a "showing" for every calendar quarter, and clearly the Secretary must make a determination for every quarter as to whether the state's showing is "satisfactory." It is not at all clear, however, that in order to make this determination, the Secretary must make a survey for every quarter.

What the statute says is that the Secretary shall conduct sample onsite surveys "as part of his validation procedures." The statute does not state that these surveys must be made for every quarter, nor does it state that they must be conducted in every case in order for the Secretary to make a finding that there has been a satisfactory showing. Rather, it says that the surveys must be "part of" the Secretary's validation procedures. The other major part of the Secretary's procedures is, it seems clear to us, review of the documentation which the state should be required to submit as its "showing." In light of the immensity of the logistical problem involved in conducting sample surveys, it seems a reasonable interpretation of the statute that the Secretary may place sole reliance on this "other part" of his validation procedures -- i.e., review of the state's "showing" -- for certain quarters, so long as he employs surveys for some quarters. This interpretation seems especially reasonable since the statute requires imposition of the reduction for the entire fiscal

year, rather than for just the quarter in which a state has failed to make a satisfactory showing. Since a Secretarial finding that a state's program is ineffective for any quarter within the fiscal year results in the imposition of the fiscal reduction for the entire year (regardless of the effectiveness of the state's program in the other quarters), it would seem reasonable that the Secretary should have to use a sample survey for only one quarter a year.

4. A fourth question is whether the Secretary may impose the reduction provided for in section 1903(g) in the absence of a validation survey. In our view the answer is yes.

The statute requires a state to make a "showing." This "showing" must be "satisfactory to the Secretary." If a state has failed to make a "showing satisfactory to the Secretary," a survey would not be required since there would be nothing to "validate." The purpose of the survey prescribed in section 1903(g)(2) is, in the words of the Senate Finance Committee, to "assure actual...compliance" with utilization control standards, not to confirm patent non-compliance.

We believe that reductions based solely on a state's failure to make a "showing satisfactory to the

Secretary" will stand up in court, even in the absence of a follow-up validation survey, provided that: (a) the Secretary clearly prescribes in advance the documentation a state must submit in order to make this "showing"; (b) the standards established by the Secretary for this purpose are reasonable and fully supported by the statute and regulations; and (c) the Department applies these standards consistently and uniformly to all states.

5. A fifth question which has arisen is whether section 1903(g) mandates a 100% adherence standard. In our view, it clearly does not.

It is, of course, true that the statute is worded very rigorously. The substantive criteria are worded in terms of "in each case" or for "each patient," thus appearing to suggest that 100% ahderence is required. However, several points should be noted. The substantive standards which are listed so rigorously are preceded by the words: "a showing satisfactory to the Secretary." The statute itself does not define what form the "showing" must take -- only what sort of evidence must be part of the "showing" -- thus leaving this to the Secretary to define. Moreover, the determination as to whether this "showing" (as defined by the Secretary) is "satisfactory" is also left to the Secretary. Thus the statute clearly grants the Secretary broad authority in establishing the standards to be applied.

The Senate Finance Report accompanying passage of section 1903(g) in no way confirms the "100% adherence" notion. Its constant reference is to an "effective program of utilization controls," not to a "perfect" program. If the Congressional intent was actually to mandate such a draconic result as "100% adherence," it is very curious that there is no suggestion of this throughout the Committee Reports.

Indeed, the Senate Report very strongly indicates that this is not the case. The Finance Committee viewed its approach for imposing the reduction as one that "would differentiate between those states which are adequately controlling utilization and those which are failing to meet this objective, and would not unfairly penalize those states which have established proper controls." S. Rep. No. 1230, 92d Cong., 2d Sess. 218 (1972). A literal reading of the statutory language would not accomplish this result. It would require the penalty to be imposed on a state with a 99.9% adherence level to the same extent as a state with a 0% adherence level. Moreover, such an approach would violate basic notions of justice and "fair play," and clearly not be in keeping with the Congressional stricture against unfair penalization.

In our view, while the statute may well authorize the Secretary to require 100% adherence, it certainly

does not mandate this level of adherence. The statute vests broad authority in the Secretary; we interpret this authority to encompass the establishing of reasonable adherence standards. It does not seem to me unreasonable that the Department would choose to adopt a relatively lenient standard during the first year of the statute's effectiveness. I would think that as the states become more accustomed to the criteria in section 1903(g), a more rigorous standard would be appropriate for future surveys.

Finally, I understand that the Subcommittee has requested our comments regarding the report of the Comptroller General. While I believe that the Comptroller was unrealistic in his view that the substantive criteria of section 1903(g) are clear, I am in complete agreement with him that application of the statute is mandatory and that fiscal reductions may be made back to the effective date of the statute. There is nothing in our memorandum of April 3 inconsistent with this view. We did not state there that the Department need not apply the statute. We said, instead, that the Department must apply the statute in a manner that will be legally defensible in court. I believed then -- and believe now -- that that was wise, sound, responsible, and unexceptionable legal advice.

Mr. Chairman, this concludes my prepared remarks. My colleagues will be happy to try to answer any questions you may have.

FOR RELEASE ONLY UPON DELIVERY

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

STATEMENT

OF

ROBERT VAN HOEK, M.D.

ACTING ADMINISTRATOR

HEALTH SERVICES ADMINISTRATION

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE

HOUSE OF REPRESENTATIVES

Friday, July 18, 1975

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

I am pleased to appear before this Subcommittee today to discuss with you the subject of unnecessary surgery and the programs we are implementing to deal with this and related problems. These programs include, specifically, the Professional Standards Review Organization (or PSRO) and the new utilization review requirements issued last November. These closely related activities represent significant efforts by the Congress and the Department of Health, Education, and Welfare to assure that the medical care delivered to beneficiaries of the Medicare, Medicaid, and Maternal and Child Health and Crippled Children's Services programs is of high quality and is provided in a manner which reflects the most appropriate and efficient utilization of our nation's health care institutions.

Unnecessary surgery and the quality of medical care have been of significant concern to the Department for several years. For example, the studies which were presented to the Subcommittee this past week, such as the Vermont study by Dr. Wennberg and the New York study by Dr. McCarthy on surgical consultations were funded by the Department. We plan to continue to support such needed investigations and

to thoroughly evaluate them so that their findings can be utilized to help prevent the provision of unnecessary care.

Most important, however, is the need to take steps to assure the quality of medical care. We believe that the PSRO program and the new utilization review requirements are mechanisms which will significantly help us achieve these goals.

It is the intent of both the PSRO program and utilization review to establish effective peer review systems in hospitals and long-term care facilities to assure that Federal and State expenditures for Medicare and Medicaid services are spent on medically necessary, high-quality medical care. While these programs have frequently been characterized as cost-containment measures, I should like to emphasize that they are primarily mechanisms to assure the appropriateness and quality of medical care. It is through quality assurance review systems that we can ultimately affect the costs of medical care. These are the systems that assess and reduce such factors as unnecessary surgery and medically unnecessary admissions. PSROs will use explicit, areawide medical care criteria in their review systems. These criteria will include, for example,

indications for surgery, and it is through the use of such written criteria that the system may affect the amount and quality of care delivered. By reducing the volume of unnecessary services, we thereby reduce the expenditures for medical care and provide higher quality care.

While both PSRO and utilization review have the same intent, and they share many common characteristics in the conduct of peer review, they differ significantly in their approach and organizational arrangements for carrying out such review. PSRO introduces new approaches to the concept of utilization review which should significantly improve the quality and effectiveness of such review for the Medicare, Medicaid, and Maternal and Child Health programs. In particular PSROs carry out review as voluntary community- or area-wide physician organizations, whereas utilization review is carried out under the auspices of an individual hospital or nursing home.

As physician organizations, PSROs are given authority by legislation to make decisions for the Medicare and Medicaid programs on issues of medical necessity and the appropriateness of care which are binding for payment purposes. Under the U.R. system such final decision-making authority is

vested with the Medicare intermediaries and Medicaid fiscal agents. Giving physicians the responsibility as well as the authority to review care in an organized fashion should significantly improve the quality of care and the efficiency with which health services are delivered.

We are all aware that the costs of the Medicare and Medicaid programs have escalated considerably over the past several years. In fiscal year 1970, the Department was spending about $10 billion for the Medicare and Medicaid programs. By fiscal year 1975, the Federal costs for these programs are estimated to run about $20 billion and are expected to continue to rise. This, of course, does not include the additional $6.0 billion which the States are spending as their share of the Medicaid program.

We are aware too of the high cost associated with surgery-related services financed through the Medicare and Medicaid programs. For calendar year 1974, we estimate that about $4.7 billion, or 38 percent of Medicare's benefit expenditures, were spent for services related to surgical cases (see attached insert). Under Medicaid, the proportion for surgical patients ranges between 30-40 percent of the total hospital payments.

We are also well aware of the variations across the country, both in length of stay and surgery rates. For example, of all Medicare discharges in a recent study, 29-31 percent had surgical services during the hospital stay. In the Northeast, a surgical procedure was recorded for 34-36 percent of the discharges; in the South, the proportion with surgery (25-27 percent) was the lowest among the regions (see attached insert).

For Medicare patients involving surgery who were discharged from short-stay hospitals in the United States during the Study period, the average length of stay was 13.6 days. Among the four Census regions marked differences were found in length of stay, ranging from 10.7 days in the West to 15.5 days in the Northeast. We know that the length of the hospital stay is closely related to the condition for which the patient is hospitalized, and when we look at the data for discharges, with and without surgery for specific diagnoses, we find similar variations across the country.

It is not possible to identify the actual dollar costs associated with the incidence of unnecessary services or extended length of stay, but one can speculate that it

may be considerable in view of the large expenditures under Medicare and Medicaid.

As I mentioned earlier, the Department has had a continuing interest in, and concern about, the incidence of unnecessary surgery, especially as it affects the cost and quality of health care programs which we administer, and we funded a number of studies on this subject. One of these HEW-funded studies was conducted by Dr. Eugene McCarthy of Cornell University. I understand that Dr. McCarthy testified yesterday regarding his findings on the effects of screening by consultants on recommended surgical procedures. He found that 24 percent of all procedures recommended were not confirmed. His findings are significant, but we need to address several questions which must be answered before the full value of the surgical screening program can be established. The primary issue is to determine how many of the patients, whose operations were not confirmed, later had an operation for the condition screened and how many required continued medical treatment. The Social Security Administration is now funding this followup study on a contract basis (see attached insert).

Another HEW-funded study of utilization patterns was conducted by Dr. John Wennberg of Harvard who also testified here earlier this week. This study revealed significant differences in rates of hospital admission and in rates of certain surgical procedures in different areas of the State of Vermont. Tonsillectomy rates varied widely from one locale to another, and did not appear to be related to the incidence of tonsillitis, but rather to physician preferences.

These are the types of utilization and quality issues that prompted the enactment of the PSRO Amendment and the strengthening of the utilization review requirements. These peer review systems are clearly one of the best vehicles for addressing the problem of unnecessary services. Experience has indicated that systematic, well defined physician review systems such as these can deal with a major segment of the dilemma.

The PSRO program was based upon the experience of a number of review organizations, most of which were formed during the late 1960's. In Utah, for example, the Utah Medical Care Foundation, a State-wide physician organization which had been conducting hospital utilization review, had reduced the average length of stay in hospitals by about one-half day. In Colorado, Oregon, and Sacramento, California, other physician organizations achieved similar results. The average length of stay was generally reduced, and the qualify of medical care was not adversely affected. Given the high cost of hospital care, a half-day savings can be very beneficial. In addition, the review systems addressed the problems of appropriateness of hospital and nursing home admissions, and also addressed such issues as the necessity of services such as elective surgery. It was organizations such as these which were prototypes for PSRO's. They were community-wide physician review organizations, which were able to improve upon the existing institutional-based utilization review activities of the Medicare and Medicaid programs.

Most of these review organizations became operational in the late 1960's, when the utilization rates and costs of the Medicare and Medicaid programs were escalating. There was also some dissatisfaction with the effectiveness of the existing institutional-based utilization review committees, as they did not seem to be having any significant success in controlling unnecessary utilization. State Medicaid programs were concerned, as was the Federal government, and we all were seeking appropriate remedies to these problems. The effectiveness of the community-wide physician organizations in improving utilization rates had become increasingly apparent, as I indicated earlier, and their experiences eventually became the basis for the PSRO legislation.

The PSROs were authorized by the Social Security Act Amendments of 1972 (P.L. 92-603). The legislation called for the establishment of a voluntary network of physician organizations, located within geographically designated PSRO areas, to review for payment purposes the medical necessity, appropriateness and quality of institutional care for Medicare, Medicaid, and Maternal and Child Health beneficiaries. The legislation authorized but did not require the review of ambulatory care by PSROs. The statute required that each PSRO have as members a substantial number of thephysicians in the PSRO area, defined as 25 percent.

The requirements for such extensive physician involvement reflect the basic premise of the PSRO program. That is to say, effective utilization review requires broad physician commitment and participation because without it effective peer review is not possible.

One of the most significant features of the PSRO statute, as I mentioned earlier, is that it transfers from the Medicare fiscal intermediaries and the State Medicaid agencies to the PSROs the authority to make final determinations of medical necessity and appropriateness for payment purposes. Under the existing system, for example,hospital utilization review committees make recommendations to fiscal agents about the medical necessity of the services rendered. The fiscal agents may overturn these recommendations and deny payment.

Under the PSRO system, the physicians in the PSRO make these decisions against explicit criteria, standards, and norms. We believe that this approach offers significant potential for more effectively controlling unnecessary services and encouraging appropriate use of hospital and nursing home facilities.

A PSRO management information system is being developed which includes three major components: the first set of informational

requirements is designed to assist PSROs to collect the data they will need to manage and assess their own performance. In addition, Federal reporting requirements specify data which PSROs must submit to the Department so that we can assess performance and compare PSRO effectiveness. We are also developing, with the National PSRO Council, an evaluation plan and we will be conducting special studies of the PSROs. Another key component of the Management Information System for PSRO is the use of the Uniform Hospital Discharge Data Set--commonly referred to as UHDDS. The Department will soon implement, through Medicare and Medicaid, the UHDDS which will require each hospital to file uniform medical care data for all Medicare and Medicaid discharges. This data set will enable PSROs to develop hospital and physician profiles and practice patterns which can be reviewed and assessed to identify problem areas requiring correction by the PSROs, the institutions, or the physicians. This uniform hospital data set represents a significant Departmental initiative to obtain a consistent set of core medical data for peer review and planning purposes.

The legislation requires that PSROs review hospital and nursing home care; develop and maintain profiles of physicians, hospitals, and patients; and most significantly, requires that area-wide norms, criteria, and standards be used in the

review of care. These norms, criteria and standards are to be developed by local physicians in the area, based upon accepted practice patterns. Physicians are encouraged to participate widely in all activities of the PSRO program, including the development of the criteria and the actual conduct of the review.

The legislation also requires that PSROs delegate review functions to a hospital if the hospital demonstrates to the PSRO that it has effective utilization review activities. Assessing hospital review programs thus becomes a major PSRO activity.

In implementing the PSRO program, we decided at an early stage that the most appropriate place to begin PSRO review activities was in the hospitals. The most significant volume of Medicare and Medicaid services are those of inpatient hospital care. We have therefore defined a PSRO hospital review system which we believe will significantly impact on improving the utilization and quality of hospital care. It includes three integrated components: concurrent review, medical care evaluation studies and profile analysis.

Concurrent review involves review of the appropriateness of all Medicare and Medicaid admissions and of the continued stay of such patients during the course of their hospitalization.

Review is conducted while the patient is in the hospital. Medical care evaluation studies are short-term retrospective studies of the medical and management practices within the institutions so that aberrant patterns can be identified and corrected. Profiles of hospitals, physicians, and patients display trends which can be analyzed by the PSRO to identify needed changes. Essentially, these profiles will allow PSROs across the country to conduct studies similar to the one Dr. Wennberg did in Vermont.

The purpose of this review system is fairly simple--physicians are to set and apply standards of care, assess performance, identify deficiencies, and arrange corrective action through existing continuing medical education programs or other means. This system should significantly contribute to effective utilization of services and improve the quality of medical care.

These same hospital review requirements, except for profile analysis, are contained in the strengthened utilization review requirements which were published as final regulations in the Federal Register on November 29, 1974. These new regulations were specifically designed to be consistent with the PSRO program in order to facilitate the transition from U.R. to PSRO, as well as to upgrade institution-based review.

Utilization review has been a condition of participation for institutions participating in the Medicare program since 1965. The Social Security Act Amendments of 1967 required States to develop processes of utilization review for covered services under their medical assistance plans.

Basically, States implemented three types of review systems differing from Medicare's hospital-based requirements. Some, such as Michigan and New York, used State employees to review exceptional claims in addition to hospital-based review. Another alternative, implemented by California, used State employees and consultants to accomplish all review activities. California also implemented a preadmission certification requirement. Others, such as Illinois, Maryland and Massachusetts, contracted with physician organizations to carry out review activities. These latter groups included several PSRO prototypes.

These types of improvements in utilization review were not uniformly applied throughout the country. In order to strengthen U.R. nationally and to eliminate duplicate review requirements imposed on hospitals and physicians prior to full PSRO implementation, the Congress passed Sections 207 and 237 of the 1972 Amendments to the Social Security Act. These were implemented by the new U.R. regulations. Prior to these Amendments, Medicare and Medicaid utilization review requirements were not uniform, and in some areas they were

duplicative, if not conflicting. These Amendments sought to unify the requirements for Medicare and Medicaid and to upgrade U.R. during the period of transition to the PSRO system of review.

Proposed U.R. regulations had been published in January 1974 and generated considerable public interest and comment. Shortly thereafter the Secretary appointed an interagency committee to coordinate the development of the final regulations, to assure that Medicare and Medicaid provisions were identical wherever possible, and to guarantee that the final regulations were complementary to and supportive of the Professional Standards Review Organization program.

These new regulations, in our view, when combined with the evolving PSRO program, form a comprehensive mechanism for assuring that reimbursement will be made only for high-quality care. This Administration is fully committed to the concept of peer review of medical care through the PSRO program as soon as possible. However, the PSRO program will not become fully operational nationwide for some time. In the interim, there remains a need for effective and efficient peer review. These new U.R. regulations build upon and are fully congruent with the concepts of the PSRO review system.

A number of sources have expressed concern with the capacity of smaller hospitals, particularly in rural areas, to comply with the utilization review requirements. PSROs will significantly help to assure effective review in rural hospials. In areas with no PSROs, we must develop specific approaches.

We plan to publish a Federal Register Notice shortly revising the U.R. regulations to permit remote facility exceptions, to be granted on a case-by-case basis, which will relax the time limitations for the performance of concurrent review.

The American Medical Association has opposed the final U.R. regulations as published on November 29, 1974 on the grounds that they interfere with patient and physician rights. Judge Julius Hoffman recently issued a preliminary injunction enjoining the Department from enforcing portions of these regulations. We have appealed this ruling in order to reaffirm the right of the Congress and the Administration to provide mechanisms for determining what care shall be reimbursed under Medicare and Medicaid. We feel that physicians and other qualified medical personnel are best able to make such determinations and that, through utilization review committees and PSROs, their professional expertise can be brought to bear on these often difficult payment decisions. We expect speedy action on our appeal and a circuit court decision should be forthcoming soon.

Mr. Chairman, I should now like to present a very brief report on the status of the PSRO program. In December 1973, the Department designated 203 PSRO areas throughout the country. Thirty-one of these areas were State-wide areas, and the remaining States included more than one PSRO area. In June 1974, we designated 14 conditional PSROs to conduct review; funded 91 organizations for planning purposes; and supported 13 State-wide support centers to provide technical assistance to the PSROs. In addition, we funded several technical resource contracts to develop the needed resources for the program. One of the most significant of these was a contract with the American Medical Association to develop model sets of criteria for adaptation and use by local PSROs. Almost all of the major national specialty societies, including the American College of Surgeons, are participating in developing these. A draft of the criteria has now been sent around the country for comment and review.

Many of the original 91 planning groups qualified to become conditional PSROs during the last several months, and of the 203 PSRO areas designated throughout the country, 121 now have PSROs in various stages of development. Physician support has grown considerably over the past year. While some segments of the physician community opposed the PSRO

program over a year ago, we can report that over 86,000 physicians have joined PSROs in their local areas. We estimate that there are about 50 additional physician groups that are interested in starting PSROs in their areas.

In order for the PSROs to assume review responsibility in a hospital, they must first work out administrative arrangements with the Medicare intermediaries and the Medicaid agencies. The PSROs are now actively engaged in this process and will soon begin review on a hospital-by-hospital basis.

There is no doubt in my mind that the implementation of the PSRO program has been and will continue to be a complex undertaking. Coordinating procedures must be carefully worked out with the Medicare and Medicaid programs, including the existing utilization review systems now in place. We have spent considerable time and effort in developing appropriate policies to guide this implementation. We are now in the process of preparing regulations on a number of subjects, including confidentiality of data, reconsiderations and appeals for patients, physicians, and hospitals, hospital review, and the coorelation of PSRO activities with the Medicare and Medicaid programs.

In addition, we have devoted considerable time to developing data and informational requirements which will help each PSRO carry out its review responsibilities and help the Department monitor and evaluate the performance of individual PSROs. To this end, the PSRO management information system described earlier is being developed.

Concluding Remarks

In conclusion, Mr. Chairman, may I repeat that we share your concerns about unnecessary surgery and about the need for effective mechanisms to avoid it. We believe that the new utilization review requirements and the PSRO program will constitute such an effective mechanism.

Our nation's health programs are in need of effective quality assurance systems and we believe that the physicians of this country will be able to meet this need through the PSRO activities in their areas, as well as through involvement in improved utilization review activities.

Mr. Chairman, this concludes my prepared remarks. My colleagues will be happy to try to answer any questions you may have.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

JUL 31 1975

Honorable Carl Albert
Speaker of the House of
Representatives
Washington, D. C. 20515

Dear Mr. Speaker:

Enclosed for the consideration of the Congress is a draft bill "To amend title XVIII of the Social Security Act to modify the requirements for coordination between the Medicare program established by that title and the Federal Employees Health Benefits program, and for other purposes."

This proposed bill is intended to complement the bill recently submitted to you by the Civil Service Commission "To amend Chapter 89 of title 5, United States Code, to provide for a new Medicare Supplement option under the Federal Employees Health Benefits Program . . . ." It contains amendments to the Social Security Act under which this new Medicare Supplement option would meet the requirement for coordination of FEHB and Medicare. The proposed legislation was recommended by the Department of Health, Education, and Welfare and the Civil Service Commission in a joint report which was submitted to the Committee on Post Office and Civil Service and the Committee on Ways and Means of the House of Representatives, and to the Committee on Post Office and Civil Service and the Committee on Finance of the Senate on February 27, 1975, pursuant to Public Law 93-480. A copy of this report, which contains a detailed explanation, justification, and cost analysis of the joint Department of Health, Education, and Welfare/Civil Service Commission proposal, is also enclosed.

The CSC-proposed legislation would limit enrollment in the Medicare Supplement option to situations where the employee, annuitant, or member of the family is enrolled in an FEHB plan and is also entitled to both hospital insurance (part A

of Medicare) and supplementary medical insurance (part B); the Department's legislation would provide individuals covered by an enrollment in an FEHB plan who are entitled to only part A special periods to enroll in part B.

A special part B enrollment period is necessary because many FEHB enrollees do not have part B insurance since many of the same health care expenses that would be covered under part B already are covered under the FEHB plans. The special enrollment period would be three months in duration--from September 1 through November 30 of the year prior to the January effective date of the Medicare-FEHB bill. The part B coverage would begin January 1 following such enrollment.

The bill also permits individuals who do not enroll in part B during the special enrollment period to enroll during the following general enrollment period (January 1 through March 31) with coverage to begin the following July. Under present law, an individual may enroll in part B only twice, and he must pay an additional ten percent premium for each full twelve months elapsing between the time he could first have enrolled in part B and actually does enroll. These provisions would not apply to a qualified individual who enrolls in the special enrollment period or the first general enrollment period following enactment of the bill.

I urge speedy consideration and enactment by the Congress of the joint Department of Health, Education, and Welfare/Civil Service Commission legislation.

The Office of Management and Budget advises that enactment of this legislation would be consistent with the Administration's objectives.

Sincerely,

/s/ Caspar W. Weinberger

Secretary

Enclosures

A B I L L

To amend title XVIII of the Social Security Act to modify the requirements for coordination between the Medicare program established by that title and the Federal Employees Health Benefits program, and for other purposes.

Be it enacted by the Senate and the House of Representatives of the United States of America in Congress assembled, That (a) section 1862(c) of the Social Security Act is repealed.

(b) Effective with respect to items and services furnished on or after February 1 of the first calendar year that begins at least 180 days after the date of enactment of this Act, section 1862 of the Social Security Act is amended by inserting after subsection (b) the following new subsection:

"(c) No payment may be made under this title with respect to any item or service furnished to or on behalf of any individual if such item or service is covered under a health benefits plan in which such individual is enrolled under chapter 89 of title 5, United States Code, unless prior to the date on which the item or service is so furnished the Federal Employees Health Benefits program under chapter 89 has been modified to provide that--

"(1) the government-wide plans described in paragraphs (1) and (2) of section 8903 of title 5, United States Code, are required, and any of the plans described in paragraphs (3) and (4) of that section are authorized, to make available, to any Federal employee or annuitant who is, or a member of whose family is, entitled to benefits under parts A and B of this title, an option which provides individuals entitled to benefits under parts A and B of this title with protection supplementing the protection under this title, which option may include a requirement that all individuals entitled to benefits under part A must enroll under part B; and

"(2) the government will make available for any employee or annuitant who elects the option described in clause (1) a contribution equal to 100 percent of the subscription charge for that option, subject to the limitation imposed by paragraph (1), subsection (b) of section 8906 (b) of title 5, United States Code."

Sec. 2. (a) Notwithstanding the provisions of section 1837 of the Social Security Act, any individual who is, during the special enrollment period as determined under subsection (c),

(1) enrolled in or eligible to enroll in a Medicare supplement option under chapter 89 of title 5, United States Code, and

(2) entitled to Hospital Insurance Benefits for the Aged and Disabled under part A of title XVIII of the Social Security Act,

may enroll in the program of Supplementary Medical Insurance Benefits for the Aged and Disabled established by part B of title XVIII of the Social Security Act during the special enrollment period or the first general enrollment period, as determined under section 1837(e) of that Act, following the special enrollment period.

(b)(1) The provisions of section 1837(b) and 1839(d) of the Social Security Act shall not apply to enrollment in the program of Supplementary Medical Insurance Benefits for the Aged and Disabled under subsection (a) of this section.

(2) Notwithstanding the provisions of section 1838 of the Social Security Act, the coverage period of an individual who enrolls in the program of Supplementary Medical Insurance Benefits for the Aged and Disabled under the provisions of this Act during the special enrollment period shall begin on the following January 1.

(c) The special enrollment period referred to in the preceding subsections of this section shall begin on September 1 of the calendar year preceding the first calendar year that begins at least 180 days after the date of enactment of this Act and shall end on the following November 30.

Joint DHEW-CSC Report

on

Improved Coordination Between Medicare and the Federal Employee Health Benefits Program

to the

Committee on Post Office and Civil Service

and the

Committee on Ways and Means

of the

House of Representatives

and to the

Committee on Post Office and Civil Service

and the

Committee on Finance

of the

Senate

Required by Public Law 93-480

To Effectuate Section 1862(c) of the Social Security Act

on January 1, 1976 Rather Than July 1, 1975

INDEX

REPORT ON PLANS FOR IMPROVED COORDINATION BETWEEN MEDICARE AND THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM (FEHB)

I. Legislative Background

Section 4 of Public Law 93-480 (approved October 26, 1974) requires that a joint DHEW-CSC report on the steps being taken to better coordinate the FEHB and Medicare programs by adjusting Federal employee health benefit plans so that they complement the protection provided under Medicare be submitted to Congress by 3/1/75, in order to retain the 1/1/76 effective date of section 1862(c) of the Social Security Act (42 U.S.C. 1395y.(c)). If the report is not submitted by 3/1/75, the effective date is moved up to July 1, 1975.

Section 1862(c) (as amended by P.L. 93-480) reads as follows:

> " (c) No payment may be made under this title with respect to any item or service furnished to or on behalf of any individual on or after January 1, 1976, if such item or service is covered under a health benefits plan in which such individual is enrolled under chapter 89 of title 5, United States Code, unless prior to the date on which such item or service is so furnished the Secretary shall have determined and certified that such plan or the Federal employees health benefits program under chapter 89 of such title 5 has been modified so as to assure that --
>
> "(1) there is available to each Federal employee or annuitant enrolled in such plan, upon becoming entitled to benefits under Part A or B, or both Parts A and B of this title, in addition to the health benefits plans available before he becomes so entitled, one or more health benefits plans which offer protection supplementing the protection he has under this title, and
>
> "(2) the Government or such plan will make available to such Federal employee or annuitant a contribution in an amount at least equal to the contribution which the Government makes toward the health insurance of any employee or annuitant enrolled for high option coverage under the Government-wide plans established under chapter 89 of such title 5, with such contribution being in the form of (A) a contribution toward the supplementary protection referred to in paragraph (1), (B) a payment to or on behalf of such employee or annuitant to offset the cost to him of his coverage under this title, or (C) a combination of such contribution and such payment."

The intent of section 1862(c) as expressed by the Committee on Ways and Means of the House and concurred with by the Committee on Finance of the Senate was: ". . . 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. . . ."1/

II. Present Method of Coordinating Medicare and FEHB Benefits

While FEHB plans and Medicare duplicate some types of covered expenses, duplicate benefits are not paid. Instead, FEHB benefits supplement those paid by Medicare. For Federal employees and annuitants who have hospital insurance (Part A) and/or supplementary medical insurance (Part B) of Medicare as well as a FEHB plan, supplementation has, since the start of the Medicare program, been achieved through an antiduplication provision in the FEHB plan, i.e., typically, the plan pays its benefits in full or in a reduced amount which, when added to the benefits paid by Medicare, reimburses up to 100 percent of allowable expenses. Thus, the FEHB benefits "wrap around" Medicare benefits.

Because, by law, Medicare pays its benefits without regard to other insurance (i.e., Medicare is primarily liable),2/ the "wrap around" supplementation operates with relative simplicity: No determination as to whether a person has Medicare is required until a claim for benefits is filed. At that time, the claimant indicates whether he has Parts A and/or B of Medicare; and if he does, supplementary benefits are paid under the FEHB plan up to 100 percent of allowable expenses.

Since FEHB plans' benefits are reduced by the amount of Medicare benefits that are also payable, there is a substantial savings to the FEHB program. For 1976, it is estimated that these savings will be about $235,000,000 or about 10.4 percent of the total FEHB premium. As time passes, the dollar amount of these savings would become larger as the number of FEHB people entitled to Medicare increases, and the cost of health care goes up.

The savings effected by a FEHB plan because of its nonduplication of Medicare benefits result in a lower standard premium for all employees and annuitants enrolled in that plan and for the Government.

III. Problems With Present Method of Coordination

While this arrangement for coordinating Medicare and FEHB benefits has the advantage of simplicity, the equity of the system has come into question.

1/ Excerpt from House Report No. 91-1096 Social Security Amendments of 1970, Report of the Committee on Ways and Means on H.R. 17550, p.25.

2/ The one exception to this rule is payment made under a workmen's compensation plan (see section 1862(b) of the SSA).

Although FEHB benefits are not paid to the extent that Medicare benefits are paid for the same services, FEHB annuitants and employees who are covered by Medicare pay the same FEHB premium as those who do not have Medicare coverage. Thus, although such employees and annuitants pay the full premium that is charged for comprehensive FEHB coverage, these employees and annuitants receive only complementary benefits.

Also, it is generally not advantageous for employees and annuitants under FEHB plans to enroll for Part B of Medicare because many of the same health care expenses that would be covered under Part B already are covered under the FEHB plans. Those persons who do not enroll do not get the benefit of the Federal general revenue contribution which is available to all persons who enroll in Part B. Effective January 1, 1976, for each Part B enrollee the Federal contribution will be at least $8.30 per month.

In recognition of these problems, a recommendation that Federal workers be covered under Medicare (with present Federal retirees being deemed insured with the cost being met by the Government, as employer) and the FEHB program provide its annuitants who are also eligible for Medicare with health insurance coverage which complements Medicare was included in the 1969 report by SSA to the House Committee on Ways and Means and Senate Committee on Finance entitled "Relating Social Security Protection to the Federal Civil Service."

IV. Problems With Implementing Section 1862(c)

Based on an analysis of the feasibility and effect of modifying the FEHB program in accordance with the specifications in section 1862(c), DHEW and CSC conclude that on balance the modification described in that section of the law would be disadvantageous not only to Federal employees and annuitants, but also to the Government. Some of the reasons for this conclusion are as follows:

A. The Civil Service Commission actuarial estimates are that if, as section 1862(c) implies, the premiums for the supplemental plans were based solely on the health experience of the aged and disabled who are entitled to Medicare, rather than on the health experience of all FEHB enrollees, a FEHB option to supplement Part B alone would offer the same benefits as now for a higher premium. An option to supplement Part A alone would offer the same benefits for about the same premium. Stated differently, an option to supplement when an individual has only Part A appears unnecessary, while an option to supplement when an individual has only Part B would disadvantage those FEHB enrollees who subscribed to it.

B. Section 1862(c) requires that the Government's full standard contribution to FEHB coverage (as calculated annually under 5 U.S.C. 8906) be applied to pay the beneficiary's premium for the supplemental FEHB option,

his Part B premiums or both, but does not provide for crediting any portion of the Government FEHB contribution toward the premium of the employee's or annuitant's spouse (or child) who may be covered under a FEHB family enrollment but not under Medicare.

C. Twelve additional options would be needed under each of the 46 plans participating in the FEHB program to supplement (a) Part A of Medicare, (b) Part B of Medicare, and (c) Parts A and B of Medicare, each for four family groupings: (1) for self only enrollees, (2) families where all family members are covered by Medicare, (3) families where only the enrollee is covered by Medicare, and (4) families where only the dependents are covered by Medicare--making over 500 additional options. Thus, the FEHB program would be greatly complicated.

V. Results if the 1862(c) Exclusion Goes Into Effect

One possible response to the difficulties of instituting the FEHB options as specified in section 1862(c) is to take no action to make complementary coverage available under the FEHB program. If this were to occur, then on January 1, 1976, Federal employees and annuitants covered by the FEHB program will be excluded from Medicare coverage which duplicates that provided by FEHB. SSA has determined, based on advice from its Office of the General Counsel, that the exclusionary language of section 1862(c) relates to coverage, not payments, and thus, would prohibit Medicare from making any payment for items and services covered under a FEHB plan in which the beneficiary is also enrolled, even though FEHB would not pay for such items and services. This occurs primarily when deductibles and coinsurance are involved.

From the standpoint of the FEHB plans, this alternative would be relatively simple to administer. A FEHB plan would pay its benefits in full (subject, of course, to any deductibles and coinsurance) without regard to whether the beneficiary is also covered by Medicare; and Medicare would not make any payment for items and services covered under the beneficiary's FEHB plan even though the employee or annuitant did not receive payment for such items or services by reason of such deductibles and coinsurance.

This result would not only frustrate the intent of the Congress in enacting section 1862(c), but it would also result in a serious disadvantage to dually entitled beneficiaries by depriving them of a substantial part of their Medicare protection. In addition, beneficiaries would have larger out-of-pocket expenses as they would have to pay FEHB deductible and coinsurance amounts. Furthermore, it would also cause serious administrative problems for the Medicare program. For example: (1) many inquiries would be received from Medicare beneficiaries injured by the denial of Medicare benefits for FEHB covered services, for which no payment or only partial payment was received under the latter program, (2) it would be necessary

for SSA to develop and apply policies for implementing the FEHB exclusion, i.e., for determining whether items and services are covered under the particular beneficiary's FEHB plan, and (3) the Medicare carriers and intermediaries would have to stay abreast of the benefits offered by 114 or more FEHB plan options in order to avoid paying for FEHB covered services.

The elimination of Medicare coverage for dually entitled individuals would result in increased premiums for all FEHB employees and annuitants, and the Government. The Government contribution to FEHB coverage for 1976 would be increased by $127,000,000 and enrollees would have to pay an additional $108,000,000. These increases would be offset to some extent by corresponding decreases in costs to the Medicare program and to beneficiaries who would cancel their Part B enrollment and thus save the Part B monthly premium.

Those options which contain the greatest proportion of enrollees who are individuals covered by Medicare would require the largest rate increases. Therefore, those individuals who are intended to be helped by section 1862(c) would be hit with the highest proportionate rate increase. In addition, persons who currently have Medicare and a low option FEHB plan, which together generally pay 100 percent of covered expenses, would need to consider changing to a high option in order to get relatively similar, although lesser, protection. (Whether or not such persons switched to a high option plan, they might also want to cancel their enrollment in Part B of Medicare, since they would generally derive very little benefit from such coverage.) This accounts for the additional cost to the Government and enrollees in the event section 1862(c) goes into effect.

VI. Joint DHEW-CSC Recommendation to Provide Supplementary FEHB Coverage

Both DHEW and the CSC believe that the modification of FEHB program in accordance with section 1862(c) would not be in the best interests of dually entitled FEHB Medicare beneficiaries, and would create expensive and unnecessary administrative problems. Therefore, the two agencies are developing a legislative proposal to amend section 1862(c) that would (1) permit the desired coordination between Medicare and the FEHB program; (2) provide supplemental FEHB coverage at no cost to employees, annuitants, and their families as long as the premiums for such coverage do not exceed the maximum dollar amount the Federal Government may contribute to the health insurance premiums for high option self and family enrollees; and (3) eliminate or minimize administrative complexity. Such an approach would best serve the interests of all parties.

Specifically, the proposal would require the following legislative changes:

A. Federal Employees Health Benefit Act

(1) Section 8903 of title 5 U.S. Code should be amended to permit any plan participating in the FEHB program, and require all Government-wide FEHB plans, to offer "Medicare Supplement" health insurance options

which would provide coverage for all employees, annuitants, and members of their families, where the employee or annuitant or a member of the family is also entitled to Parts A and B of Medicare.

(2) Section 8906 of title 5 U.S. Code should be amended to provide that for purposes of this proposal, the 75 percent limitation on the Federal Government contribution shall be removed; and further provide that the Federal Government shall pay 100 percent of the premium for the Medicare supplement plan where an employee, annuitant, and/or member of the family is enrolled in Medicare Parts A and B, subject however to the maximum dollar amount the Federal Government may contribute to the health insurance premiums for all employees and annuitants.

B. Medicare Benefits Under the Social Security Act

(1) Title XVIII of the Social Security Act should be amended to provide for employees and annuitants who are presently entitled to Part A of Medicare a special one-time enrollment period to enroll in Part B of Medicare. During this special enrollment period the two-time Part B enrollment limitation and the 10 percent premium increase required for each full 12 months elapsing between the time this individual could first have enrolled and actually does enroll shall not apply.

(2) Section 1862(c) of the Social Security Act should be amended to permit approval of the "Medicare Supplement" option for FEHB employees and annuitants by the Secretary of Health, Education, and Welfare.

C. Effective Date for Legislation Described in Both A and B

The first January that begins no less than 6 calendar months after the month of enactment.

D. Timing of Enactment

Legislation should be enacted by the Congress before July 1, 1975, in order to permit implementation of the CSC-DHEW recommended substitute provision by January 1, 1976. However, if this cannot be accomplished, it is recommended that section 1862(c) be amended to postpone its effective implementation date from January 1, 1976 until January 1, 1977.

VII. Explanation of Recommendations

A. Federal Employees Health Benefits Program

The FEHB program (chapter 83 of title 5, United States Code) would be amended to offer a new "Medicare Supplement" option, in addition to the option or options it already offers, and require the removal of the 75 percent limit on the Government's contribution to premiums for the new supplement. As long as the premium for the "Medicare Supplement" option does not exceed the dollar amount the Government contributed to high option premiums, removal of the 75 percent limit would require the Government to pay the full premium for this option, with no cost to the enrollee.

Current CSC actuarial estimates indicate that the Federal Government's standard (now 60 percent of the average high option premium of the 6 largest FEHB plans) contribution to premium would be more than sufficient

to pay the full premium of a "Medicare Supplement" option both for self-only enrollees who have Parts A and B of Medicare, and family enrollees who have Parts A and B of Medicare or whose family members have Parts A and B. However, if experience proves that the cost of this complementary coverage is greater than the amount that can be contributed by the Government, the beneficiary would pay a small amount toward the premium in future years. At least for the first year the only premium such an enrollee would have to pay for himself and/or his family would be the prevailing rate for Part B of Medicare.

This option would permit self-only and family enrollments. It would be open for enrollment only to a person who had Parts A and B of Medicare or whose spouse or child had Parts A and B. Under a family enrollment, all eligible family members, including those without Medicare, would be covered by the option.

For an individual who has Medicare, the option would supplement Parts A and B, up to 100 percent of expenses for covered services, as heretofore, i.e., the option would reimburse for all regular high option benefits of the plan which are not provided by the Medicare program. For an individual (enrollee, spouse, or child) without Medicare, the option would provide regular high option benefits of the plan.

This Supplemental Plan would be consistent with congressional intent in passing section 1862(c), and provide additional advantages to employees, annuitants, and family members because it (1) recognizes and retains FEHB's family coverage provisions, (2) results in a lower premium cost (for the first year at least, an enrollee would pay only Part B premiums), and (3) eliminates the need for each FEHB plan to develop a myriad of options.

Under this proposal, the new "Medicare Supplement" would not be available to persons enrolled in only one part--Part A or Part B--of Medicare, as is currently required by section 1862(c). (See section IV A for a discussion of the reasons for not providing such coverage.) An individual covered by Medicare under Part A or Part B only would, as at present, have available to him insurance coverage in one of the regular options of the plan subject to the plan's antiduplication provision, resulting in most cases in the person receiving 100 percent reimbursement for covered services with Medicare being the primary insurer.

The new "Medicare Supplement" option would be experience-rated separately from the other regular options in the Plan. Experience-rating the Medicare-subsidized group of enrollees separately results in redistributing $52,000,000 which would have been paid by enrollees in the new "Medicare Supplement" option in the absence of such a rating process: $39,000,000 would be paid by the Government and $13,000,000 would be paid by non-Medicare enrollees, in the form of higher insurance premiums.

B. Medicare Benefits Under the Social Security Act

(1) A special enrollment period is necessary for FEHB employees and annuitants because these individuals either did not enroll for or cancelled their Part B insurance as retaining this coverage was not advantageous when they did not have the opportunity to obtain supplemental and nonduplicative FEHB coverage.

(2) Authorizing the Secretary of HEW to approve the FEHB Medicare supplement would perpetuate congressional intent as now incorporated in section 1862(c) to assure effective coordination between the FEHB plans and Medicare.

C. Effective Date

It is clear that CSC and DHEW would need time, once enacted, to implement the proposed legislation. In recognition of this implementation time, the DHEW and CSC recommend an effective date which would be on the first January that begins no less than 6 calendar months after the month of enactment. This would allow CSC and DHEW time to notify all eligible employees and annuitants of the new supplement and to allow for an enrollment period in the FEHB "Medicare Supplement" and in Medicare Part B.

VIII. Recommendation

The Civil Service Commission and Department of Health, Education, and Welfare jointly recommend the substitute provision described in item VI of this report as being an effective way to coordinate FEHB and Medicare.

Estimated Impact of FEHB/Medicare Coordination Options

(Calendar 1976 incurred costs, $ in millions)

Federal Costs

	FEHB	Medicare net of SMI premium	Total
1. Section 1862(c) coordination	$ 49	$ 9	$ 58
2. FEHB primary to Medicare	$127	$-264	$-137
3. HEW/CSC proposal	$ 39	$ 9	$ 48

Enrollee Premiums

FEHB enrollees

	Without Medicare	With Medicare	Total	Medicare SMI Enrollees	FEHB Rebate	Total
1. Section 1862(c) coordination	$ 13	$-52	$-39	$ 7	$-10	$-42
(Percent change)	(1.6%)	(-100%)	(-4.5%)			
2. FEHB primary to Medicare	$100	$ 8	$108	$-33	--	$ 75
(Percent change)	(12.3%)	(15.4%)	(12.5%)			
3. HEW/CSC proposal	$ 13	$-52	$-39	$ 7	--	$-32
(Percent change)	(1.6%)	(-100%)	(-4.5%)			

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

SEP 29 1975

Honorable Carl Albert
Speaker of the House of
Representatives
Washington, D. C. 20515

Dear Mr. Speaker:

Enclosed for the consideration of the Congress is a draft bill "To amend title XVIII of the Social Security Act to extend and amend the authority for waiver of the requirement that hospitals provide 24-hour nursing service rendered or supervised by a registered professional nurse."

Under current law, a hospital participating in the Medicare program must provide 24-hour nursing service supervised by a registered professional nurse. However, the Secretary of Health, Education, and Welfare is authorized to waive this requirement for a rural hospital if he finds that (1) there is a shortage of hospital services in the area, (2) the failure of the hospital to qualify for participation in Medicare would seriously reduce the availability of hospital services in the area, and (3) the hospital has made a good faith effort to comply with the requirement but is unable to do so because of the lack of qualified nurses in the area. A hospital that is granted a waiver must provide nursing service rendered or supervised by a registered professional nurse during at least the regular daytime shift. This waiver authority was enacted in 1971 as a temporary provision and is scheduled to expire at the end of this year.

In 1971 several hundred small rural hospitals were granted waivers. Since that time the availability of registered nurses in rural areas has steadily increased and fewer than 100 waivers are now in effect. We believe that extension of the waiver authority in its present form is unnecessary

and would impede our efforts to improve the quality of care provided in rural hospitals. At the same time, we recognize that some of the hospitals which currently have waivers may require additional time to come into full compliance with the 24-hour nursing care requirement. The enclosed bill would therefore extend the authority to grant waivers for one year, until January 1, 1977, but require hospitals which are granted waivers for that year to provide nursing service rendered or supervised by a registered professional nurse during both the regular daytime shift and one other regular shift. If this proposal is enacted, the Department will evaluate, during 1976, the need for further extension and modification of the waiver authority.

I urge speedy consideration and enactment of this legislation by the Congress.

We are advised by the Office of Management and Budget that there is no objection to the presentation of this draft bill to the Congress from the standpoint of the Administration's program.

Sincerely,

/s/ David Mathews

Secretary

Enclosure

A B I L L

To amend title XVIII of the Social Security Act to extend and amend the authority for waiver of the requirement that hospitals provide 24-hour nursing service rendered or supervised by a registered professional nurse.

Be it enacted by the Senate and the House of Representatives of the United States of America in Congress assembled, That, effective January 1, 1976, section 1861(e)(5) of the Social Security Act is amended by--

(1) striking out "January 1, 1976" and inserting in lieu thereof "January 1, 1977", and

(2) inserting "and one other regular shift" immediately after "the regular daytime shift".

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

JUL 2 1975

Honorable Carl Albert
Speaker of the House of
Representatives
Washington, D. C. 20515

Dear Mr. Speaker:

Enclosed for the consideration of the Congress is a draft bill, "To amend the Social Security Act to improve the old-age, survivors, and disability insurance program, the supplemental security income program, and the program of health insurance for the aged and disabled."

This draft legislation contains a series of Administration proposals for improvements in various programs established by the Social Security Act.

Title I of the bill contains five amendments to the old-age, survivors, and disability insurance program.

Section 101 would improve the social security protection of agricultural employees. Under current law, coverage of agricultural employees, including many migrant workers, is subject to a restrictive coverage test which prevents many workers from getting social security credit for part or all of their farm employment. Under this test, a worker's earnings from a farm employer are generally not covered unless during the year he is paid cash wages of at least $150 by the employer or works for him on at least 20 days for cash wages determined on an hours of work or other time basis.

When this coverage test was included in the law in 1956 it took into account that many farmers at that time were unaccustomed to recordkeeping and might find it difficult to make reports for social security purposes of wages paid to relatively short-term employees. Since the 1950's, major changes have taken place in agriculture. Many farms keep the same kinds of records as nonfarm businesses do and there is no longer justification for preventing many of the workers who are employed by such farms from getting social security credit for their work.

Under the proposed legislation, social security coverage of agricultural employees of farms which have substantial expenditures for farm labor--$2,500 annually--would no longer be subject to a coverage test and thus would be determined on the same basis as coverage of employees of nonfarm businesses. While this change would cover about 90 percent of the wages paid to all farm workers, it would affect less than 20 percent of farm employers. The present coverage test would continue to be applicable to all farms which have annual expenditures of less than $2,500 for agricultural labor. The bill also contains a provision which is designed to improve the reporting for social security purposes of the wages of migrant farm workers who are furnished to farm operators by labor contractors by treating such workers as employees of the farm operators.

Section 102 of the bill would exclude from social security coverage the distributive share of income or loss from the trade or business of partnership which is received by a limited partner.

The Department has become increasingly concerned about situations in which certain business organizations solicit investments in limited partnerships as a means for an investor to become insured for social security benefits. In these situations the investor in the limited partnership performs no services for the partnership and the social security coverage which results is, in fact, based on income from an investment. This situation is of course inconsistent with the basic principle of the social security program that benefits are designed to partially replace lost earnings from work.

These advertisements and solicitations are directed mainly toward public employees whose employment is covered by public retirement systems and not by social security. Such advertising could debase the social security program in the public view and cause resentment on the part of the vast majority of workers whose employment is compulsorily covered under social security, as well as those people without work income who would like to be able to become insured under the social security program but cannot afford to invest in limited partnerships. The inquiries received by the Social Security Administration

requesting information as to the legality of gaining coverage based on earnings from limited partnerships indicate a growing public awareness of the inconsistency of covering this form of nonwork income.

Section 103 would permit States to terminate social security coverage for State or local policemen or firemen who are also covered under a staff retirement system without affecting the coverage of other public employees.

Social security coverage for employees of the States and their political subdivisions is available only through agreements between the Secretary of Health, Education, and Welfare and the individual States. Each State decides what groups of eligible employees will be covered, subject to statutory requirements which assure retirement system members a voice in any decision to cover them under social security.

Coverage was first made available to persons in positions covered under State or local retirement systems through a provision of the Social Security Amendments of 1954. The Congress, at the request of policemen and firemen groups, continued the exclusion from coverage of policemen and firemen in positions under a State or local government retirement system. Since that time, the Social Security Act has been amended to permit persons in twenty-one States, as well as Puerto Rico and interstate instrumentalities, who are in policemen's or firemen's positions under a retirement system to be brought under social security coverage on much the same basis as other retirement system members. In addition, firemen in the twenty-nine other States and the Virgin Islands who are under a retirement system may be covered under social security if special conditions set forth in the law are met.

The social security law permits termination of coverage of State and local government employees, but only on a "coverage group" basis. A "coverage group," as defined in the Social Security Act for purposes of coverage terminations, consists of all of the employees of a State or of a political subdivision of the State such as a city or a county. Thus, the coverage of policemen or firemen cannot be terminated unless the coverage

of all other employees of the State or the political subdivision is also terminated. It appears that in some instances policemen and firemen who wish to have their coverage terminated have been unable to accomplish this because other covered persons in the same political subdivision do not wish to have their coverage terminated. In other cases the coverage of the policemen or firemen has been terminated, along with the coverage of persons other than policemen and firemen, including those who did not wish to have their coverage terminated.

The bill would permit a State to terminate the social security coverage of all employees in policemen or firemen positions, or both, which are under a retirement system without disturbing the social security coverage of other employees of the same political subdivision. It also contains provisions which would permit a State which acts prior to January 1, 1977, to reinstate the social security coverage, with no break in continuity, of employees other than policemen and firemen whose coverage had been terminated by an action taken for the purpose of terminating the coverage of policemen or firemen if a majority of the employees involved desire to again come under coverage.

We believe that it is generally undesirable to remove employees from social security coverage. Termination of coverage causes workers and their families to lose social security protection already acquired, or diminishes such protection. In other cases the termination of coverage prevents people from acquiring social security protection, or improved protection. These results seem especially unfortunate in the case of persons who are unwillingly removed from coverage as the result of actions by one segment of their coverage group. The practical effect of the bill would be to prevent the loss of coverage for some State and local employees which would otherwise occur when policemen and firemen act to have their coverage terminated, and to restore coverage to State and local employees whose coverage has already been involuntarily terminated.

Section 104 would increase the rate of interest, now 6 percent, charged on late payments by the States of amounts due the Secretary under agreements providing social security coverage to State and local employees. Public Law 93-625

increased the interest rate on late payments of social security taxes to the Department of the Treasury from 6 percent to 9 percent, subject to adjustment on the basis of changes in the prime lending rate. This section would apply the same interest rate established under the provisions of Public Law 93-625 to late payments by the States under coverage agreements.

Section 105 of the bill would provide general authority for the President to enter into bilateral agreements, generally known as totalization agreements, with interested countries to provide for limited coordination between the United States social security system and the social security system of the other country. The Congress would be kept fully informed of all developments in the course of the negotiation of any agreement under this authority. In addition, all would be submitted to the Congress in accordance with the requirements of Public Law 92-403.

Totalization agreements would ameliorate both of the major problems which arise from the lack of coordination between our social security system and the social insurance systems of other countries by filling major gaps in protection of those who work under our social security system and the system of another country and by eliminating dual coverage of the same work.

An advantage of the totalization approach over other approaches, such as an exchange of credits, is that it is designed to allow each cooperating country to carry out its responsibilities virtually independently. The countries exchange information on covered earnings and earnings credits and provide other administrative assistance, but otherwise each country makes its determinations and computations independently and pays any resulting benefits directly. There is no need for an interchange of funds or balancing of accounts.

Totalization is a well-established means of providing limited coordination between the social security systems of various countries. Totalization arrangements have been established by a number of countries in Europe as well as by some other countries. The principle of totalization was endorsed by the International Labor Organization in 1935 and adopted by the European Common Market in 1957.

On April 7, 1975, the Italian Government enacted into law a U.S.-Italian totalization agreement. This agreement was negotiated under the authority of article VII of the Supplementary Agreement to the Treaty of Friendship, Commerce, and Navigation of September 26, 1951, between the two countries, and was signed on May 23, 1973. Enactment of section 105 of the bill would permit us to begin implementation of this agreement. A totalization agreement with the Federal Republic of Germany has been agreed to by technical negotiators and is being reviewed by both governments. Discussions have been initiated by several other countries which are interested in entering into totalization agreements with the United States.

Enactment of sections 101 through 104 would have a negligible effect on the cost of the social security program. Enactment of section 105 would have no cost until such time as a totalization agreement was approved and became operative. The cost to the United States social security program of a particular agreement would, of course, depend upon the number of persons having employment in each of the two countries and on the terms of the agreement.

Title II of the bill contains three amendments to the supplemental security income program established by title XVI of the Social Security Act.

Section 201 would amend the provisions of the supplemental security income program concerning the treatment of gifts and inheritances received by beneficiaries. Unearned income in excess of $240 a year received by a supplemental security income beneficiary results in a dollar for dollar reduction in benefit payments. Under current law gifts and inheritances are considered unearned income, and this has created a hardship for beneficiaries who received a gift or inheritance that cannot be readily converted into cash. Their benefits are reduced and they cannot use the gift or inheritance as an alternative source of funds to meet their living expenses. Section 201 would eliminate this hardship by permitting the Secretary to issue regulations providing that gifts and inheritances not readily converted into cash are not income. Gifts and inheritances which were not considered income would be subject to the provisions of the SSI program applicable to resources.

Section 202 would amend title XVI to eliminate the definition of the term "child" and all uses of that term. A child is defined in title XVI as an individual who is (1) under the age of eighteen or a student under the age of twenty-two, and (2) neither married nor the head of a household. Five provisions of the supplemental security income program are affected by this definition. First, subject to limitations prescribed by the Secretary, the income of an individual does not include any earned income if he is a child regularly attending school. Second, the income of an individual does not include one-third of the support payments received from an absent parent if the individual is a child. Third, the income of an individual does not include amounts received for providing foster care to a child who is not eligible for supplemental security income benefits. Fourth, the disability standard applicable to a child under the age of eighteen is somewhat different from the standard applicable to other individuals. Finally, the income and resources of an individual are deemed to include the income and resources of a parent in the same household if the individual is a child under age 21.

In the Department's view there is no reason for making the applicability of any of these five provisions turn on whether an individual who meets the applicable age requirement is neither married nor the head of a household, nor, in some cases, on whether he is a student. The bill would therefore provide for determination of the applicability of these provisions solely on the basis of age and student status.

Section 203 would authorize the Secretary to pay supplemental security income benefits for a period of up to three months pending a determination that an individual is blind if he is presumptively blind when he applies for benefits. Such authority currently exists with respect to individuals applying for benefits on the basis of disability.

Enactment of title II would have a negligible effect on the cost of the supplemental security income program.

Title III of the bill contains amendments to the Medicare program established by title XVIII of the Social Security Act.

Section 301 would amend section 226(f) of the Social Security Act, which establishes the time limitations for Medicare eligibility on the basis of chronic kidney failure. Under that subsection eligibility begins with the third month after the month in which a course of renal dialysis begins and ends with the twelfth month after the month in which dialysis is terminated or the individual has a renal transplant. The bill would add to these limitations an additional provision limiting entitlement to retroactive Medicare benefits on the basis of chronic kidney failure to the twelve-month period preceding the filing of an application for those benefits. This limitation would be consistent with the limits on retroactive entitlement applicable to other OASDI and Medicare beneficiaries and is necessary for efficient administration of the chronic renal disease program.

Section 303 would modify the State licensure requirements applicable to proprietary home health agencies participating in the Medicare program. Public home health agencies and private home health agencies which are nonprofit organizations exempt from taxation under section 501 of the Internal Revenue Code are required, as a condition of participation in the Medicare program, to be licensed under any applicable State or local licensure law or to meet the standards for such licensing. In contrast, private home health agencies which are not nonprofit organizations must be licensed under State law. Because only ten States have home health agency licensure laws, proprietary agencies in forty States are precluded from participating in the Medicare program.

Many of these proprietary agencies provide services of the highest quality and Medicare beneficiaries should have access to their services. To achieve this result, this section of the bill would repeal the requirement that proprietary agencies be licensed under State law and subject them to the same licensure requirements as public and private nonprofit agencies. The Secretary's authority to prescribe additional standards and requirements for proprietary home health agencies would not be affected.

Enactment of title III of the bill would have a negligible effect on the cost of the Medicare program.

I urge speedy consideration and enactment of these amendments by the Congress.

The Office of Management and Budget advises that enactment of this draft bill would be consistent with the Administration's objectives.

Sincerely,

/s/ Caspar W. Weinberger

Secretary

Enclosure

A B I L L

To amend the Social Security Act to improve the old-age, survivors, and disability insurance program, the supplemental security income program, and the program of health insurance for the aged and disabled.

Be it enacted by the Senate and the House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Social Security Amendments of 1975".

TITLE I--PROVISIONS RELATING TO THE OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE

IMPROVED COVERAGE OF AGRICULTURAL WORKERS

Sec. 101. (a) Section 209(h)(2) of the Social Security Act and section 3121(a)(8)(B) of the Internal Revenue Code of 1954 are each amended by striking out "Cash remuneration paid by an employer in any calendar year to an employee for agricultural labor" and inserting "Cash remuneration paid in any calendar year to an employee for agricultural labor by an employer who has total expenditures in such calendar year

for cash remuneration of employees for agricultural labor of less than $2,500," in lieu thereof.

(b)(1) Section 210(j) of the Social Security Act and section 3121(d) of the Internal Revenue Code of 1954 are each amended by striking out the period at the end thereof and inserting "; or" in lieu thereof.

(2) Section 210(j) of the Social Security Act is further amended by inserting at the end thereof the following new paragraph:

"(4) any individual who performs services for remuneration as a crew leader or who is furnished by a crew leader to perform agricultural labor, as provided in subsection (n)."

(3) Section 3121(d) of the Internal Revenue Code of 1954 is further amended by inserting at the end thereof the following new paragraph:

"(4) any individual who performs services for remuneration as a crew leader or who is furnished by a crew leader to perform agricultural labor, as provided in subsection (o)."

(c)(1) Section 210(n) of the Social Security Act is amended to read as follows:

"(n) The term 'crew leader' means an individual who furnishes individuals to perform agricultural labor for another person, other than an individual who is engaged in the business of providing farm management or farm machine services, as defined in regulations of the Secretary, and furnishes one or more individuals to perform agricultural labor as part of such business. Such individuals furnished by the crew leader to perform agricultural labor for another person shall be deemed to be employees of such other person. A crew leader shall, with respect to services performed in furnishing individuals to perform agricultural labor for another person and services performed has a member of the crew, be deemed to be an employee of such other person."

(2) Section 3121(o) of the Internal Revenue Code of 1954 is amended to read as follows:

"(o) For purposes of this chapter, the term 'crew leader' means an individual who furnishes individuals to perform agricultural labor for another person, other than an individual who is engaged in the business of providing farm management or farm machine services, as may be defined in regulations prescribed by the Secretary or his delegate, and furnishes one or more

individuals to perform agricultural labor as a part of such business. Such individuals furnished by the crew leader to perform agricultural labor for another person shall be deemed to be employees of such other person. For purposes of this chapter and chapter 2, a crew leader shall, with respect to services performed in furnishing individuals to perform agricultural labor for another person and services performed as a member of the crew, be deemed to be an employee of such other person."

(c) The amendments made by this section shall be effective with respect to wages paid after December 31, 1975.

EXCLUSION FROM COVERAGE OF CERTAIN LIMITED PARTNERSHIP INCOME

Sec. 102. (a) Section 211(a) of the Social Security Act is amended by--

(1) striking out "and" at the end of paragraph (9);

(2) striking out the period at the end of paragraph (10) and inserting in lieu thereof "; and"; and

(3) inserting after paragraph (10) the following new paragraph:

"(11) There shall be excluded the distributive share of any item of income or loss of a limited partner,

as such, other than guaranteed payments described in section 707(c) of the Internal Revenue Code of 1954 to that partner for services actually rendered to or on behalf of the partnership to the extent that those payments are established to be in the nature of remuneration for those services."

(b) Section 1402(a) of the Internal Revenue Code of 1954 is amended by--

(1) striking out "and" at the end of paragraph (10);

(2) striking out the period at the end of paragraph (11) and inserting in lieu thereof "; and" ; and

(3) inserting after paragraph (11) the following new paragraph:

"(12) There shall be excluded the distributive share of any item of income or loss of a limited partner, as such, other than guaranteed payments described in section 707(c) to that partner for services actually rendered to or on behalf of the partnership to the extent that those payments are established to be in the nature of remuneration for those services."

(c) The amendments made by this section shall apply with respect to taxable years beginning after December 31, 1975.

TERMINATION OF COVERAGE OF
POLICEMEN AND FIREMEN

Sec. 103. (a) Section 218(g)(1) of the Social Security Act is amended by striking out "either" after "Secretary", by striking out the period at the end of subparagraph (B) and inserting in lieu thereof "; or", and by inserting after subparagraph (B) the following new subparagraph:

"(C) with respect to services of--

"(i) all employees included under the agreement as a single coverage group within the meaning of subsection (d)(4) which is composed entirely of positions of policemen or firemen or both;

"(ii) all employees in positions of policemen or firemen or both which are included under the agreement as a part of a coverage group within the meaning of subsection (d)(4); or

"(iii) all employees in positions of policemen or firemen or both which were included under the agreement as a part of a coverage group as defined in subsection (b)(5) and which were covered by a retirement system after the date coverage was extended to such group,

but only if the agreement has been in effect with respect to employees in such positions for not less than five years prior to the receipt of such notice."

(b) Section 218(g)(3) of that Act is amended by adding at the end thereof the following sentence: "If any such agreement is terminated with respect to services of employees in positions of policemen or firemen as described in paragraph (1)(C), the Secretary and the State may not thereafter modify such agreement so as to again make the agreement applicable to services performed by employees in such positions."

(c) Notwithstanding any provision of section 218 of the Social Security Act, any agreement with a State under that section may, if the State so desires, be modified at any time prior to January 1, 1977, so as to again make the agreement applicable to services performed by employees, other than employees in policemen's or firemen's positions, in a coverage group with respect to which the agreement was terminated by the State prior to the enactment of this Act if the Governor of the State, or an official designated by him, certifies that the following conditions have been met:

(1) the majority of such employees have indicated a desire to have their coverage reinstated, and

(2) the termination of the agreement with respect to the coverage group was for the purpose of terminating coverage for those employees in policemen's or firemen's positions or both.

Notwithstanding the provisions of section 218(f)(1) of the Social Security Act, any such modification shall be effective as of the date coverage was previously terminated for those members of the coverage group who meet the conditions prescribed in section 218(f)(2) of that Act.

INCREASE IN INTEREST CHARGED IN CONNECTION WITH LATE PAYMENTS UNDER AGREEMENTS FOR COVERAGE OF STATE AND LOCAL EMPLOYEES

Sec. 104. Section 218(j) of the Social Security Act is amended by striking out "the rate of 6 per centum per annum" and inserting "an annual rate established under section 6621 of the Internal Revenue Code of 1954" in lieu thereof.

INTERNATIONAL AGREEMENTS WITH RESPECT TO SOCIAL SECURITY BENEFITS

Authorization for International Agreements

Sec. 105. (a) Title II of the Social Security Act is amended by adding at the end thereof the following new section:

"INTERNATIONAL AGREEMENTS

"Purpose of Agreement

"Sec. 232. (a) The President is authorized to enter into agreements establishing totalization arrangements between the social security system established by this title and the social security system of any foreign country, for the purposes of establishing entitlement to and the amount of old-age, survivors, disability, or derivative benefits based on a combination of an individual's periods of coverage under the social security system established under this title and the social security system of such foreign country.

"Definitions

"(b) For the purposes of this section--

"(1) the term 'social security system' means, with respect to a foreign country, a social insurance or pension system which is of general application in the country and under which periodic benefits, or the actuarial equivalent thereof, are paid on account of old age, death, or disability.

"(2) the term 'period of coverage' means a period of payment of contributions or a period of earnings based on wages for employment or on self-employment income, or any similar period recognized as equivalent thereto under this title or under the social security system of a country which is a party to an agreement entered into under this section.

"Crediting Periods of Coverage; Tax Exemptions; Conditions of Payment of Benefits

"(c)(1) Any agreement establishing a totalization arrangement pursuant to this section shall provide that--

"(A) in the case of an individual who has at least 6 quarters of coverage as defined in section 213 of this Act and periods of coverage under the social security system of a foreign country which is a party to such agreement, periods of coverage of such individual under such social security system of such foreign country may be combined with periods of coverage under this title and otherwise considered for the purposes of establishing entitlement to and the amount of old-age, survivors, and disability insurance benefits under this title;

"(3) employment or self-employment, or any service which is recognized as equivalent to employment or self-employment under this title and the social security system of such foreign country which is a party to such agreement, shall, on or after the effective date of such agreement, result in a period of coverage under the system established under this title or under the system established under the laws of such foreign country, but not under both, and shall set forth the methods and conditions for determining under which system such employment, self-employment, or other service shall result in a period of coverage;

"(C) where an individual's periods of coverage are combined, the benefit amount payable under this title shall be based on the proportion of such individual's periods of coverage which were completed under this title; and

"(D) an individual who is entitled to cash benefits under this title pursuant to such agreement shall, notwithstanding the provisions of section 202(t), receive such benefits while he legally resides in the foreign country which is a party to such agreement.

"(2) To the extent that any such agreement provides that any period of coverage under this title shall not be such a period of coverage because it is a period of coverage under the laws of a foreign country which is a party to such agreement, no employment or self-employment taxes shall be imposed with respect to such period of coverage under the laws of the United States.

"(3) Any such agreement may provide that the benefit paid by the United States to an individual who legally resides in the United States shall be increased to an amount which, when added to the benefit paid by such foreign country, will be equal to the benefit amount which would be payable to an entitled individual based on the first figure in (or deemed to be in) column IV of the table in section 215(a).

"(4) Section 226 shall not apply in the case of any individual to whom it would not be applicable but for this section or any agreement or regulation under this section.

"(5) Any such agreement may contain such other provisions, not inconsistent with this section, as the President deems appropriate.

"Regulations

"(d) The Secretary of Health, Education, and Welfare shall make rules and regulations and establish procedures which are reasonable and necessary to implement and administer any agreement which has been entered into in accordance with this section."

Relief from Taxes

(b)(1) Section 1401 of the Internal Revenue Code of 1954 is amended by adding at the end thereof the following new subsection:

"(c) During any period in which there is in effect an agreement entered into pursuant to section 232 of the Social Security Act with any foreign country, the self-employment income of an individual shall be exempt from the taxes imposed by this section to the extent that such self-employment income is subject under such agreement to taxes or contributions for similar purposes under the social security system of such foreign country."

(2) Sections 3101 and 3111 of that Code are each amended by adding at the end thereof the following new subsection:

"(c) During any period in which there is in effect an agreement entered into pursuant to section 232 of the Social Security Act with any foreign country, wages received by or

paid to an individual shall be exempt from the taxes imposed by this section to the extent that such wages are subject under such agreement to taxes or contributions for similar purposes under the social security system of such foreign country."

(3) Notwithstanding any other provision of law, taxes paid by any individual to any foreign country with respect to any period of employment or self-employment which is covered under the social security system of such foreign country in accordance with the terms of an agreement entered into pursuant to section 232 of the Social Security Act, shall not, under the laws of the United States, be deductible by, or creditable against the income tax of, any such individual.

TITLE II--PROVISIONS RELATING TO THE SUPPLEMENTAL SECURITY INCOME PROGRAM

EXCLUSION OF CERTAIN GIFTS AND INHERITANCES FROM INCOME

Sec. 201. Section 1612(a)(2)(E) of the Social Security Act is amended by inserting ", except that the Secretary may by regulation provide that gifts and inheritances which are not readily convertible into cash are not income" immediately after "inheritances".

ELIMINATION OF DEFINITION OF CHILD

Sec. 202. (a) Section 1614 of the Social Security Act is amended by striking out subsection (c).

(b)(1) Section 1612(b) of that Act is amended by--

(A) striking out "a child who" in clause (1), and inserting "under the age of 22 and" in lieu thereof;

(B) striking out "a child" in clause (9), and inserting "under age 21" in lieu thereof; and

(C) striking out "a child who is not an eligible individual" in clause (10), and inserting "an individual who is not an eligible individual or eligible spouse" in lieu thereof.

(2) Section 1614(a)(3)(A) of that Act is amended by striking out "a child" and inserting "an individual" in lieu thereof.

(3) Section 1614(f)(2) of that Act is amended by striking out "a child".

AUTHORIZATION OF INITIAL PAYMENTS TO PRESUMPTIVELY BLIND INDIVIDUALS

Sec. 203. Section 1631(a)(4)(B) of the Social Security Act is amended by--

(1) inserting "or blindness" immediately after "disability" each time it appears therein; and

(2) inserting "or blind" immediately after "disabled" each time that it appears therein.

EFFECTIVE DATE

Sec. 204. The amendments made by this title shall be effective July 1, 1975.

TITLE III--PROVISIONS RELATING TO MEDICARE

LIMITATION ON RETROACTIVE ENTITLEMENT TO MEDICARE BENEFITS ON THE BASIS OF CHRONIC KIDNEY FAILURE

Sec. 301. (a) Section 226(f) of the Social Security Act is amended by inserting before the period at the end thereof the following: ", but in no case shall entitlement to hospital insurance benefits under part A of title XVIII or supplementary medical insurance benefits under part B of that title begin earlier than twelve months before the month in which an application for such entitlement is filed by or on behalf of the eligible person".

(b) The amendment made by this section shall be effective with respect to items and services furnished after June 30, 1973, to individuals with respect to whom a written request for entitlement under title XVIII of the Social Security Act on the basis of chronic kidney failure has not been filed before the date of enactment of this Act.

MODIFICATION OF REQUIREMENT FOR STATE LICENSURE OF PROPRIETARY HOME HEALTH AGENCIES

Sec. 302. (a) Section 1861(o) of the Social Security Act is amended by striking out "it is licensed pursuant to State law and" in the matter after clause (6).

(b) The amendment made by this section shall be effective with respect to home health services for which payment is made under title XVIII of the Social Security Act provided after June 30, 1975.