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9

MEDICARE-MEDICAID

MEDICARE-MEDICAID AMENDMENTS

1. MISCELLANEOUS AMENDMENTS

2. PRINTED AMENDMENTS

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

MARCH 17, 1972

Prepared by the staff and printed for the use of the Committee on Finance

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MEDICARE-MEDICAID AMENDMENTS

1. Miscellaneous Amendments
2. Printed Amendments

MISCELLANEOUS AMENDMENTS

Hospital Insurance for the Uninsured

(SECTION 202)

Problem

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

House Bill

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

Change from 1970 Senate Provision

Provision included in both the House and Senate passed versions of H.R. 17550. Senate version also required enrollment in Part B as condition of "buying" into Part A.

Incentives for States To Undertake Required Institutional Care Review Activities and To Emphasize Compresensive Health Care Under Medicaid

(SECTION 207)

Problem

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

House Bill

1. Unless a State can make a showing satisfactory to the Secretary that the State has an effective program of control over the utilization or nursing home and hospital care, to discourage overutilization of institutional care, effective June 30, 1971, the House bill provides for a one-third reduction in the Federal Medicaid matching share for stays in a fiscal year which exceed: (a) 60 days in a general or TB hospital; (b) 60 days in a skilled nursing home.

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

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

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

Change from 1970 Senate Provision

1. A somewhat similar provision was included in the House version of H.R. 17550. The major Senate modification to that provision, suspension of the reduction in nursing home matching if adequate utilization controls exist in a State, has been incorporated into H.R. 1 except that the State must now make an affirmative showing of proper control rather than the Secretary making a negative finding of noncompliance.

2. The 25 percent increase in Federal matching percentages for amounts paid to HMO's is a new feature of the provision. It replaces last year's 25 percent increase in Federal matching for all outpatient clinic and home health services. The 25 percent "bonus" was deleted from the House bill by the Finance Committee last year.

Proposal

1. It is suggested that, in addition to the utilization review requirement, it be made clear that States must also be conducting the independent professional audits of patients as required by present law which are intended to assure that the patient is getting the right care in the right place.

2. The staff suggests making inapplicable the 90-day or 120-day annual limitation and the 365-day lifetime limitation on care in mental hospitals, but only in a State which makes a satisfactory showing to the Secretary that it has an effective program of control over the utilization of mental hospital care. If proper procedures assure that the mentally ill patient needs the care and is benefiting from it, it would seem inappropriate to cut off Federal matching utilizing arbitrary limitations on the number of days of covered care in a year and lifetime.

3. The staff suggests deleting the House provision which calls for a 25% increase in matching for amounts paid to HMO's, since if HMO's deliver services more efficiently, and economically, it would be in the States interest to deal with HMO's without an increase in matching. There is also the policy issue as to the advisability of subsidizing States to encourage one form of medical organization and practice over others.

4. The staff suggests that intermediate care services also be subject to a reduction in Federal matching after 60 days, unless the State provides satisfactory assurance that required review is being undertaken. This appears appropriate in view of the shift of intermediate care to Medicaid in legislation enacted subsequent to House consideration of H.R. 1. At present, the House bill does not subject ICF's to the requirement of proper review.

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

Determination of Reasonable Hospital Costs Under Medicaid

(SECTION 232)

Problem

Many States maintain that use of the Medicare formula for Medicaid reimbursement can result in their paying more than the actual costs of providing inpatient care to Medicaid recipients and hampers their efforts at controlling the costs of hospital care.

House Bill

Allows States to develop their own methods of hospital reimbursement rather than requiring States to reimburse hospitals under Medicaid on the basis of the Medicare reasonable cost formula. The method developed must cover actual reasonable costs but may not exceed the reasonable cost determined under Medicare.

Change from Senate Provision

Similar to both the House and Senate passed versions of H.R. 17550, except that the House has transferred from amendment language to report language the condition stating that hospitals or private patients should not subsidize the costs of inpatient care for title 19 recipients nor should payment for such recipients subsidize the costs of caring for other patients.

Suggestion

Hospitals argue that under the House provision States will reimburse them for less than the cost of Medicaid services and urge that the House provision be deleted. The staff feels the provision should be retained in the bill but it recommends that the 1970 language be reinstated in the bill to assure hospitals that States are expected to pay the full reasonable costs for medically-necessary hospital care they provide and may not limit reimbursement to less than reasonable costs.

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

(SECTION 235)

Problem

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

House Bill

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

Change from 1970 Senate Provision

Similar to both the House and Senate-passed versions of H.R. 17550, except that the House has added a provision to provide 90% matching for 2 years (up to a total of $150,000 annually) for the development of cost determination systems for State-owned general hospitals.

Proposal

The staff agrees with the thrust of the House bill that States should be permitted to develop suitable data processing capacity of their own. However, we believe the situation in many States may be such that they would be unlikely to have the volume of work needed to operate a computer system efficiently and economically. We believe it is not necessary at the present time to provide for computer systems in each of the 50 States as the House bill contemplates.

Accordingly, the staff suggests modification of the House provision so as to:

(1) Authorize regional or multi-State data processing systems rather than State-by-State systems, unless the Secretary finds that a system for a single State would be more feasible, economical, and efficient than a regional system.

(2) Require that the design of any such new systems, to the extent feasible, be compatible with Medicare data processing requirements so as to permit expansion of the system, if necessary, where suitable carrier or intermediary performance is not available.

The intent of this staff suggestion is not to create excess capacity (as the House bill seems to encourage), but to encourage a system capable of national expansion to assist in Medicare administration, if that became necessary.

Provider Reimbursement Review Board

(SECTION 243)

Problem

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

House Bill

Establishes a Provider Reimbursement Review Board to consider disputes between a provider and intermediary where the amount at issue is $10,000 or more and where the provider has filed a timely cost report. Decisions of the Review Board would be final unless the Secretary reversed the Board's decision within 60 days. If such a reversal occurs the provider would have the right to obtain judicial review.

Change from 1970 Senate Provision

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

Proposal

1. Staff suggests approval of prior Senate language modified so as to authorize a joint appeal where the aggregate amount is $50,000 instead of $10,000. This would avoid a possible "jam-up" of the Review Board with a multiplicity of appeals.

2. The staff also suggests that the Report include a request to the Secretary that he report to the legislative committees at the end of the first year of operation of the provision concerning its capacity to function effectively and equitably as well as any suggestions he might have for improvement of the process.

3. Additionally, subsection (d) of the section, could be modified so as to authorize the Board to make rules and establish procedures in accordance with regulations of the Secretary rather than in unilateral fashion. Because this Board is partially composed of provider representatives, it is difficult to expect it to work with the same impartiality and objectivity as would ordinary independent hearing examiners.

Mandatory Medicaid Deductible for Families with Earnings

(SECTION 209)

Problem

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

House Bill

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

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

Proposal

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

1. The staff suggests that in order to avoid establishing a substantial work disincentive the Committee amend Section 209 and deal with the "Medicaid Notch" by allowing AFDC families currently eligible for cash assistance and Medicaid, who would ordinarily lose eligibility as a result of earnings from employment, to remain eligible for Medicaid for one year (or longer if desired by a State). States could at their option, charge a family premiums reasonably related to the family's earned income above the highest cash assistance level not to exceed 10 percent of such income. This would likely aid the States by saving cash assistance payments which should more than offset any additional Medicaid costs.

2. Alternatively, if the Committee believes that the premium is excessive, it might want to consider 100 percent Federal financing of the Medicaid cost, if the family has been on the cash assistance rolls for at least 3 out of the 6 months preceding ineligibility for Medicaid because of earnings.

PRINTED AMENDMENTS

Summary of Printed Medicare-Medicaid Amendments to H.R. 1

AMENDMENT NO. 396 (METCALF)

Chiropractic Under Medicare.—Provides for the coverage of the services of chiropractors under medicare, but only with respect to those services which the chiropractor is legally authorized to perform.

Cost.—$100 million in 1973, requiring a 21-cent increase in the Supplementary Medical Insurance premium.

AMENDMENTS NO. 428 AND 439 (PACKWOOD)

Cytotechnologists Under Medicare.—Includes cytotechnologists among the health personnel who may demonstrate their professional competence for purposes of the Medicare program through the successful completion of a proficiency examination.

Cost.—Negligible

AMENDMENT NO. 464 (MONTOYA)

Drugs Under Medicare.—Provides for the coverage of outpatient prescription drugs, with a co-payment of $1 (subject to revision by the Secretary to reflect changes in the per capita costs of prescription drugs.

Cost.—0.57 percent of taxable payroll; $2.4 billion in 1973.

AMENDMENT NO. 823 (BENNETT)

Peer Review of Services Under Medicare.—Establishes a system of Professional Standard Review Organizations formed by practicing physicians which would assume the responsibility for reviewing the care and services provided under Medicare and Medicaid to assure that the services are medically necessary and meet proper quality standards.

AMENDMENT NO. 824 (RIBICOFF)

Drugs Under Medicare.—Provides for the coverage of outpatient prescription drugs, with a co-payment of $1, (subject to revision by the Secretary to reflect changes in the per capita costs of prescription drugs).

Cost.—0.57 percent of taxable payroll; $2.4 billion in 1973.

AMENDMENT NO. 825 (RIBICOFF)

Disclosure of Information.—Modifies Sec. 1106 of the Social Security Act by specifically limiting the Secretary's authority to withhold disclosure of Social Security records to taxpayer-beneficiary-patient records. All other information, including information related to the performance of medicare providers, would be available to the public.

AMENDMENT NO. 826 (RIBICOFF)

Inspector General for Medicare-Medicaid.—Establishes an Office of Inspector General for Health Administration in the Department of Health, Education, and Welfare. The Inspector General would undertake audits and reviews of the Medicare and Medicaid programs and any other health care programs established under the Social Security Act to determine efficiency and economy of operation consonant with provisions of the law and attainment of objectives and purposes for which the law was enacted.

(Amendment contains a number of provisions affecting the Social Security cash benefit programs; in addition):

AMENDMENT NO. 831 (HARTKE)

(a) Combines supplementary medical insurance and hospital insurance programs under Medicare; eliminates premium contribution under supplementary medical insurance: provides for general revenue contribution to new combined program equal to 20 percent of total program expenditures in fiscal 1973, rising to 33 percent beginning fiscal year 1976;

(b) Extends Medicare coverage to include expenses incurred for routine eye care, eye glasses, dentures, and hearing aids; and

(c) Extends Medicare coverage to include maintenance drugs, with a copayment of $2 per new prescription and $1 per refill prescription.

Cost.—For (b) above, $3.7 billion in 1973; for (c) above, $1 billion in 1973.

AMENDMENT NO. 870 (NELSON)

Physician Assistants under Medicare.—Provides for the coverage under the supplementary insurance program of the services of physicians' assistants if (a) the assistant is legally authorized to perform the service; (b) the physician assumes full responsibility for the services; and (c) the physician bills for the services.

AMENDMENT NO. 893 (HARTKE)

(Amendment contains a number of provisions affecting the social security cost benefit programs; in addition):

(a) Combines supplementary medical insurance and hospital insurance programs under Medicare; eliminates premium contribution under supplementary medical insurance; provides for general revenue contribution to new combined program equal to 20 percent of total program expenditures in fiscal 1973, rising to 33 percent beginning fiscal year 1976.

(b) Extends Medicare coverage to include expenses incurred for routine eye care, eye glasses, dentures, and hearing aids; and

(c) Extends Medicare coverage to include maintenance drugs, with a copayment of $2 per new prescription and $1 per refill prescription.

Cost.—For (b) above, $3.7 billion in 1973; for (c) above, $1 billion in 1973.

AMENDMENT NO. 906 (HATFIELD)

(Amendment affecting the social security cost benefit programs; in addition):

(a) Repeals social security taxes for hospital insurance program (Part A of Medicare) and instead provides for general revenue financing of the program; and

(b) Automatically enrolls in the supplementary medical insurance program (Part B of Medicare) any individual covered under the hospital insurance program.

AMENDMENT NO. 944 (HATFIELD)

Drugs Under Medicare.—Provides for the coverage of outpatient prescription drugs under the Hospital Insurance Program, with a copayment of $2.

Cost.—$2.1 billion in 1973.

AMENDMENT NO. 955 (STEVENSON)

Post Hospital Outpatient Rehabilitation Services.—Provides for the coverage under Medicare of up to one hundred visits to an authorized post hospital rehabilitation facility. Covered services would include: (a) physical and occupational therapy; (b) speech pathology and aduiology; (c) medical social services; and (d) services related to the use of prosthetic and orthotic devices.

Cost.—$50 million in 1973.

AMENDMENT NO. 958 (RIBICOFF)

Uniform Health, Safety, Environmental and Staffing Standards for Extended Care Facilities and Skilled Nursing Homes.—Conforms Titles 18 and 19 standards for skilled nursing homes and authorizes demonstration projects to develop alternative methods of providing long-term nursing care.

AMENDMENT NO. 963 (HUMPHREY)

Automatic Coverage (Without Premium Payment) Under Part B.—Provides for the financing of the supplementary medical insurance program under general revenues and eliminates the payment of Part B premiums by the beneficiary required by present law.

AMENDMENT NO. 964 (HUMPHREY)

Medicare: Modification of the Hospital Insurance Deductible.—Eliminates the provision in H.R. 1 which would provide for a copayment of one-eighth of the inpatient hospital deductible beginning with the 31st through the 60th day. (The provision in H.R. 1 calling for an increase in the lifetime reserve days from 60 to 120 would be retained.)

Cost.—$70 million in 1973.

AMENDMENT NO. 965 (HUMPHREY)

Medicare: Modification on the Hospital Insurance Deductible.—Amends H.R. 1 to limit the hospital coinsurance amount payable from the 61st through the 90th day of hospitalization to $15.00.

AMENDMENT NO. 966 (HUMPHREY)

Reduction and Eventual Elimination of the Part B Deductible.—Provides for the gradual elimination, by January 1, 1975 of the supplementary medical insurance deductible.

Cost.—$0.9 billion when deductible is eliminated.

AMENDMENT NO. 969 (HUMPHREY)

Medicare: Reduction and Eventual Elimination of the Part B Deductible.—Provides for the gradual elimination, by January 1, 1975, of the supplementary medical insurance deductible.

Cost.—$0.9 billion when the deductible is eliminated.

AMENDMENT NO. 970 (HUMPHREY)

Coverage of the Disabled Under Medicare.—Eliminates the requirement presently in H.R. 1 that in order to qualify for Medicare coverage disabled persons must have been entitled to disability benefits for at least 24 months.

Cost.—$0.7 billion in 1973; $2.2 billion in 1974.

AMENDMENT NO. 973 (RIBICOFF)

Medicare: Limitation on the Effect of Hospital Accreditation by the JCAH.—Authorizes the Secretary of HEW to review of process by which the Joint Commission on Accreditation of Hospitals accredits hospitals for participation in the Medicare program; and requires the Secretary to develop new accreditation guidelines where the present ones are inadequate or non-existent.

Cost.—Negligible.

AMENDMENT NO. 989 (GURNEY)

Medicare: Coverage for Spouses Under Age 65.—Provides Medicare coverage for voluntary enrollment in the hospital and medical insurance program for a beneficiary's spouse who is at least sixty years old but under 65 years old. The amount of the premium for coverage under the hospital insurance program would be $31 a month (subject to future modifications to reflect the changes in the cost of hospital care); the Part B premium would be an amount equal to 200 percent of the premium paid by individuals who have reached age 65 at the time of enrollment.

Cost.—No cost to Government.

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