TRENDS IN LONG-TERM CARE

HEARINGS

BEFORE THE

SUBCOMMITTEE ON LONG-TERM CARE

OF THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

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TRENDS IN LONG-TERM CARE

THURSDAY, MAY 7, 1970

U.S. SENATE,
SUBCOMMITTEE ON LONG-TERM CARE,
OF THE SPECIAL COMMITTEE ON AGING,
Washington, D.C.

The subcommittee met at 9:45 a.m., pursuant to call, in room S–407, the Capitol, Senator Frank E. Moss, presiding.

Present: Senator Moss.

Staff members present: William E. Oriol, staff director; David Affeldt, counsel; John Guy Miller, minority staff director; and Val Halamandaris, professional staff member.

OPENING STATEMENT BY SENATOR FRANK E. MOSS, CHAIRMAN

Senator Moss. The hearing will come to order.

This is an oversight hearing by the Subcommittee on Long-Term Care of the Senate Special Committee on Aging. We are here this morning to inquire into the application of the statutes having to do with long-term care, more particularly the amendments to the Social Security Act which were adopted in 1967 called the Moss amendments.

It might be said that the theme of this hearing is "law and order." We frequently hear this catch phrase in statements, often by Government officials, deploring the apparent attitudes of various groups of our citizens toward our laws and law enforcement. I use it here in questioning the apparent attitudes of Government officials toward laws enacted by this Congress. Government, too, must obey the law.

A depressing number of examples have been brought to our attention through the press, as well as for protection of patients in Government health programs.

We say to our young people that a citizen may not choose which laws he will obey and which he will not. As I review the actions and the failures to act of the Department of Health, Education, and Welfare in response to the nursing home amendments of 1967, the question is inescapable: Are Government officials asserting a right to choose which laws they will obey and which they will not? Evidences of governmental lawlessness are not lost on young people whom we admonish about law and order.

Nearly 2½ years have passed since the enactment of the Moss amendments and we still can see little practical result from our legislative efforts. Standards for skilled nursing homes were not developed by the time the amendment requiring States to use them became effective on January 1, 1969. Six months later, interim standards

were published which failed in important respects to be responsive to the law. Despite widespread adverse reaction to these interim regulations, including criticism from a special task force appointed by the Department itself, almost a year went by before improved standards were issued. After months of inaction, they were issued shortly after I announced this hearing.

Another of my amendments calls for a program of medical review of the care of each patient in skilled nursing homes for whom title XIX funds are being paid. This requirement became effective July 1, 1969. To date nothing has been issued to the States to implement this amendment. I understand that some believe that conducting a medical review program would be too burdensome upon the State agencies. I remind them that this question was considered and decided by the Congress, and that decision is now the law.

Under section 1861 of the Social Security Act the department has the authority and obligation to set standards for the safety of patients in extended care facilities. On January 9 of this year a tragic fire in an extended care facility pointed up clearly a specific hazard to life which had been omitted from the Medicare standards. The urgent need for a standard on flammable floor covering was developed in hearings before this subcommittee. Five months have passed and no standard on floor covering has emerged from the Department of Health, Education, and Welfare.

We want to know why this executive department seems to be immobilized when confronted with law designed for the welfare and protection of individual patients. We are here today to try to find out. We asked the department to send witnesses who could describe the policy development and decisionmaking processes which have taken place involving the nursing home amendments. We received no reply. We asked the department to identify the officials with major responsibility for reviewing and approving policies, regulations, and administrative actions to carry out the amendments. We did not receive the information. Finally we sent a telegram to the department requesting the attendance of those officials who my staff were able to identify as having something to do with these problems. We received no reply.

I am sure there must be someone here today to represent the department and answer our questions, but our experience in arranging this hearing did little to counteract the growing impression of the indifference of HEW to the plight of nursing home patients under our Government programs, to the concerns of this committee and to the law.

We will place in the record a statement by the chairman of the full committee, Senator Harrison A. Williams.

STATEMENT OF HON. HARRISON A. WILLIAMS, U.S. SENATOR FROM NEW JERSEY

Senator WILLIAMS. Thank you, Senator Moss, for aptly describing our mutual interest in the matters before your subcommittee today. Since you have a full witness list, I will be brief.

First, however, I must take a moment to thank you personally for the outstanding and dedicated contributions that you are making to the committee's overall work.

You are also to be commended for seeking clearcut answers this morning concerning the impact of recent regulations which may have the effect of dismantling the Medicare extended care program—a program which you have worked so hard to develop as an effective alternative to costly hospital care.

Reports to this committee from nursing home patients and staff personnel express deep concern principally over two regulatory changes. One directive prohibits reimbursement under Medicare for nursing home patients who are merely custodial. Although these individuals may need an extension of the type of care previously received during their hospital stay, payment can be made only if they have rehabilitative potential.

Another restriction petmits reimbursement under Medicare only if a patient comes within the meaning of "skilled nursing home care." Several directors at extended care facilities, inlluding one of our witnesses this morning, have criticized this limited definition as being artificial and arbitrary.

This hearing today, I believe, is particularly timely and appropriate. During the past 6 months, it is reported that more than 500 nursing homes throughout the country have refused to admit Medicare patients. Others are cutting back on the number of Medicare patients that they will admit.

At issue is the practice by certain insurance intermediaries of denying eligibility under Medicare to nursing home patients long after they have been admitted.

This situation is reaching crisis proportions for extended care facility administrators, staffs, patients, and their families.

Nursing homes are in a quandary because of inconsistent and confusing decisions by fiscal intermediaries concerning eligibility and entitlement to reimbursement for covered services. When Medicare benefits are denied retroactively, extended care facilities receive no payment for services they have already rendered in good faith, unless, of course, they can collect from the patient or his family. In order to avoid the risk of denied payment, nursing homes by the hundreds are dropping out of the Medicare program.

For most extended care facilities, it is extremely difficult to determine with any degree of certainty which patients will be covered. This is true although a competent physician certifies in writing that the patient needs extended care. Because of this problem, many doctors are reluctant to refer needy patients to nursing homes for extended care—even though such care would be of important therapeutic value and less costly than continued hospitalization.

The net effect is to increase hospital stays and to reduce days of nursing home care, although this care may cost the Government only one-third of the amount for hospitalization. Many patients believe that it is preferable to leave the patient in a hospital for convalescence rather than to submit him to such uncertainty. However, shaving one hospital day from Medicare's national average could result in a savings of $400 million.

Unfortunately, in the middle of this "no man's land" is the unsuspecting patient. At the time of admission, no patient can be absolutely certain of having his bills paid by Medicare, even though he has been certified by his physician. Moreover, this risk for payment of non-

covered services by the patient is substantial, since only about one-half of the claims for nursing home care last year were approved. This problem is particularly onerous for the poor and near-poor elderly who are especially hard hit by these unanticipated bills. In many instances, their financial resources are completely wiped out.

Because of this urgent problem, confusion and widespread public misunderstanding have developed over extended care. Most elderly patients believe Medicare will cover 100 days of posthospital care provided:

They have been in a hospital for at least 3 days in a row before admission to the extended care facility;

They are admitted within 14 days after leaving the hospital; and

Their doctor certifies that they need extended care for further treatment of a condition treated in the hospital.

However, little effort has been made to inform the public adequately about the program's limitations, such as the coverage for "skilled nursing care" but not for "custodial" care.

Consequently, families and patients become upset, especially if their doctor or the nursing home assured them of coverage. And, who can blame them for being upset. A retroactive cutoff in coverage of benefits can mean a charge of well over a thousand dollars in many instances.

Yet, a large number of attending physicians have refused to discharge patients following a denial of their claims. To do so, in their judgment, would be tantamount to malpractice. The result is a vicious circle in which no one is happy.

The patient is angry because his claim will not be reimbursed.

The attending physician is upset because his decision has been overruled by a nonprofessional, who may not fully understand the medical exigencies of the situation.

And, the extended care facility is frustrated because they have rendered services, but have not been paid.

With this in mind, I am sure, Senator Moss, that your subcommittee will seek answers to many perplexing questions:

What can be done to correct the present uncertainity for older persons in need of nursing care?

How can more effective procedures be developed to assure extended care facilities of reimbursement for services which they perform?

Should a nonprofessional have the power to overturn the medical judgment of the physician?

Senator Moss. We are going to proceed today first with a staff report since so much of this had to be extracted by the staff detailing the problems and questions and then we will hear from representatives of HEW who are present here today.

Mr. Val Halamandaris, an attorney and professional member of the Committee on Aging, will be asked first to give the staff report.

STATEMENT OF VAL HALAMANDARIS, PROFESSIONAL STAFF MEMBER, COMMITTEE ON AGING

Mr. HALAMANDARIS. Thank you, Mr. Chairman.

In your April 16 statement in the Congressional Record you asked the question: What ever happened to the Moss amendments?

As you know, it has been one of my missions to find an answer to the mystery. I am here to give you a report and to summarize the events that have taken place up to now. What follows is chronological.

In 1967 the Moss amendments were included with the social security amendments. The intent was to raise standards of care in Medicaid skilled nursing homes.

Today, some 28 months after enactment, it is time to take stock and measure our progress.

The reason for your amendments, Mr. Chairman, as I recall, was first the conclusion developed after 4 years of hearings that Medicaid moneys purportedly paying for skilled nursing home care were really going to pay for unskilled care or, worse, neglect, and secondly, an attempt was made through your amendments to provide uniformity of State standards often inadequate and subject to political pressures.

The bill that was sponsored enjoyed substantial support from the American Nursing Home Association and passed the Congress and was signed into law January 2, 1968.

Details of implementation were left to the newly formed Medical Services Administration under Commissioner Francis Land.

With Dr. Land the implementation of the Moss amendments was left to Frank Frantz, well known to this committee because his work as a member of our committee staff lead to the adoption of this amendment. As I said, the program enjoyed the substantial support of the then Secretary Wilbur Cohen, and the cast of characters would not be complete without the name Harold G. Smith, who served at the same time as a part-time member of MSA and as the consultant with the American Nursing Home Association.

There were substantial conflicts of opinion, charges that Medicaid rates were too low and that standards should not be raised until the rates were raised. There were cries of shortages of nurses, still a first draft of standards was available in December of 1968, reportedly in line with the policy requirements of the Moss amendments. There was substantial opposition at this December Atlanta meeting from the American Nursing Home Association on the specific provision of this draft with regard to ratio of personnel per patient.

On January 10, 1969, a second draft was available. I point out at this time the deadline for implementation January 1, 1969, had passed so HEW was already in default at the time they came up with the second draft. Reportedly at this time, with the new administration about to take over, Dr. Land made substantial changes in view of the persuasive arguments by State officials.

Mr. Chairman, a third draft was available by a new group. This was done on January 13 and a fourth draft on January 15. This fourth draft was presented by the committee on January 16. The committee was headed by Col. Thomas Laughlin and on the committee was Harold Smith. Those who viewed that fourth draft concluded it was a sell-out of the Moss amendments.

A fifth revision came on January 17. Here again there was substantial controversy about the function of the charge nurse on the evening shift and on the waiver provisions.

In what was at least the sixth draft, HEW on June 24, 1969, announced the so-called interim standards effective after 30 days for comment. These regulations extended liberal waiver provisions for charge nurses in skilled nursing home facilities through July 1, 1970.

What followed on July 31, Mr. Chairman, was your hearing before this committee. At that time you said: "We are left with regulations that say, in effect, that a single, untrained practical nurse on duty in a home with 200 or 300 patients or more constitutes properly supervised nursing services on the afternoon and night shifts."

Eleanor Baird representing the American Nursing Home Association endorsed the intent of the proposed standards but expressed "grave concern and strong reservations about the ability of the States to implement them—unless adequate lead time is provided."

Editorially, I suggest, Mr. Chairman, that adequate lead time has now been made available.

The National Council of Senior Citizens through Mr. William R. Hutton said, "The regulations, when compared to the Moss amendments, show that the interests of nursing home industry have been accommodated and the aged have been sold short."

Mary E. Shaughnessy, for the American Nursing Association, declared that standards should be set according to services that are to be provided, not on the basis of availablility of qualified personnel.

Rev. William Eggers of the American Association of Homes for the Aging commented that his group knew of no national shortage of qualified LPN's. "Facilities that cannot qualify as skilled nursing homes for personnel or other deficiency should be called by another name and reimbursed at a lower level until they can make the grade."

Col. Thomas Laughlin, testifying in place of Dr. Land who had resigned as MSA Director, said that he was in favor of grace periods which were necessary because HEW had never provided enough money for a training program to overcome a shortage of fully qualified LPN's.

In an unusual move, indicating conflict within the department, HEW had named a task force to review the interim regulations. The record of the Moss hearings was sent to the panel, including members from the top rungs of ANHA, AAHA, organized labor, senior citizens' councils and State medical-welfare units. The chairman was Mrs. Charline J. Birkins of the Colorado Department of Social Services.

Available August 19, her task force report was reportedly in vindication of the January 10 draft, calling for complete compliance with the Moss amendments. However, this first draft was recalled. The information we received was that, "It did not reflect the views of all the members."

In October, yet another draft was rumored ready to be issued in November. Throughout November we waited in vain for the draft to be issued.

On November 10 you will recall, Mr. Chairman, you were preparing to address the November 17 convention of the American Association of Homes for the Aging. By telegram you notified Secretary Finch accordingly and you asked him the following questions:

"No. 1. What action has been taken on the report of the Task Force on Skilled Nursing Home Care?

"No. 2. What plans have been made by the Department for implementation of regulations to comply with my amendment to title XIX concerning higher standards applicable to patients in skilled nursing homes?"

As you know, Mr. Chairman, you telephoned just before making your speech on Monday, November 17, to check with your office to find if there had been a reply to your telegram from Secretary Finch's office. In fact, no reply had been received. Further, HEW denied ever having received this telegram.

On January 9, Mr. Chairman, from your hearings in St. Petersburg, Fla., before this committee and again on January 15 in Hartford, Conn., in your opening statement you made a strong call to HEW for the implementation of your amendments.

On April 16, Mr. Chairman, your speech appeared in the Congressional Record and announced this hearing. On April 29 the standards appeared in the Congressional Record.

A few conclusions, Mr. Chairman.

That HEW has not allocated time, money, and personnel to implementing standards is a fact. To prove this fact, I have established a comparison with the implementation of the Medicare law as it related to extended care facilities. As you know, the Medicare law was passed in July 1965 and was to take effect with regard to the extended care provisions on the 1st of January 1967. HEW had 18 months to implement that law.

Procedurally the same steps, Mr. Chairman, are entered in implementation of the extended care law as there would be in implementation of the Moss amendments. These steps are:

1. Standards are put out in regulation form;
2. Arrangements must be made with State health departments for State surveys to apply these regulations;
3. Development of a procedure for certifying on the basis of these procedures;
4. Sending personnel out to the States to consult with States and to monitor their initial implementation.

The information that I have received from the Social Security Administration as to the manpower or the number of personnel that they had within that 18-month period—and I would believe that these are very conservative figures, Mr. Chairman—indicates that 122 people were involved at one time or another during this 18-month period to bring about the implementation of the extended care Medicare program and in fact 40 man-years of labor were exhausted getting the extended care program so that it would function.

The figures for personnel in man-years under the Moss amendments remain to be established. The question remains: Why the procrastination? Why has it taken 28 months to implement your amendments? Are the legislative actions of Congress but empty gestures?

It is one thing, Mr. Chairman, when individuals suffer injury in the face of inaction by the Congress, it is quite another thing when the Congress has acted and in spite of the will of Congress the injury continues.

What becomes clear is that the Congress in passing your amendments has acted to provide standards and protections for patients in nursing homes under the Medicaid program. From all appearances the attitude of those charged with implementing the will of Congress approaches indifference if not outright culpable neglect and as a result the patient continues to suffer.

In closing I would like to quote the 1955 Second Hoover Commission which picked up the celebrated decision of the *United States* v. *Lee*. In that decision the Supreme Court said:

> No man in this country is so high that he is above the law. No officer of the law may set that law at defiance with impunity. All the officers of the government, from the highest to the lowest, are creatures of the law and are bound to obey it.
>
> It is the only supreme power in our system of government, and every man who by accepting office participates in its functions is only the more strongly bound to submit to that supremacy, and to observe the limitations which it imposes upon the exercise of the authority which it gives.

Thank you, Mr. Chairman.

Senator Moss. Thank you, Mr. Halamandaris for setting forth your research and your views on the nature of the obstacles in the path of the implementation of statutes that have been enacted by the Congress.

We will not hear from Mr. John Veneman, Under Secretary of Health, Education, and Welfare; he could not be here today. I might say he is before a House committee.

I do know that Commissioner Newman of the Medical Services Administration is here; Mr. Laughlin, the Deputy Commissioner of the Medical Services Administration: and Mr. Frantz, Chief, Office of Nursing Home Programs.

Are there other representatives of HEW here? Mr. Butler, Mr. Walden or Mr. Twiname? Are any of those gentlemen here?

Mr. KIMBALL. No, Mr. Chairman.

Mr. Chairman, I am the Department's regulations officer, Arthur Kimball.

Senator Moss. Thank you, Mr. Kimball.

Well, now, I suppose that if there is room at the table you representatives of HEW could all come forward and sit at the table and we would proceed in whatever order seems logical. Mr. Kimball, Mr. Newman, Mr. Laughlin and Mr. Frantz.

Senator Moss. Commissioner Newman, you have heard my opening statement and that of Mr. Halamandaris. Do you have any statement you would like to make or explanation? We would be glad to hear that and we may want to ask you some questions. I will offer the same suggestion to the other gentlemen who are here at the table.

Mr. NEWMAN. I do have a brief statement, Mr. Chairman.

Senator Moss. Thank you. Would you proceed then.

STATEMENT OF HOWARD NEWMAN, COMMISSIONER, MEDICAL SERVICES ADMINISTRATION, ACCOMPANIED BY ARTHUR KIMBALL, REGULATIONS OFFICER; THOMAS LAUGHLIN, DEPUTY COMMISSIONER, MEDICAL SERVICES ADMINISTRATION; AND FRANK FRANTZ, CHIEF, OFFICE OF NURSING HOME PROGRAMS, MEDICAL SERVICES ADMINISTRATION

Mr. NEWMAN. Mr. Chairman and members of the subcommittee, we are pleased to be here today to give an account of our work in the field of nursing home care under the medical assistance program and to try to answer the rhetorical question posed by the chairman in announcing this hearing: "Whatever happened to the Moss amendments?" In this statement I shall describe very briefly the actions

which have been taken following the passage of the amendments of 1967 relating to nursing home care and the current status of implementation of each. I will treat these amendments in the order of their effective dates since the relative imminence of effective dates largely dictated their priorities.

Although not one of the Moss amendments, a major amendment dealing with long-term institutional care, added to the Social Security Act by the amendments of 1967, was that which authorized the intermediate care program. This amendment became effective on the date of enactment, January 2, 1968. As of that date, States were authorized to make payments under titles I, X, XIV, and XVI for care of individuals in intermediate care facilities. It was imperative, therefore, to give immediate priority to developing the framework of the Federal policy within which States wishing to adopt intermediate care could proceed.

While the Medical Services Administration had primary responsibility in the development of regulations for most of the amendments, other agencies of the Department were also involved. Regulations implementing the intermediate care facility program were developed initially through the joint efforts of the Medical Services Administration, the Assistance Payments Administration, and the Administration on Aging. The community Health Service and the Division of Mental Health Service programs of the National Institute of Mental Health were consulted. Additionally a number of conferences were held with representatives of the Bureau of Health Insurance of the Social Security Administration because of the implications involved in defining this type of institution for the spell of illness determinations under Medicare.

The interim regulations were published in the Federal Register on September 12, 1968. Following publication, comments and suggestions were received from State agencies, professional and provider groups and other interested persons. Final regulations were published in the Federal Register on June 24, 1969. We have provided for the subcommittee's convenience copies of these regulations.

Section 234(c) of Public Law 90–248 originated as one of the Moss amendments. It provides that no Federal funds may be paid to match payments made to any nursing home which does not fully meet State requirements for licensure. This provision was incorporated in regulations by amending the Federal definition of "skilled nursing home," as the term is used in title XIX, to provide that no facility failing to meet all State requirements would meet the definition. This amendment was first published in August of 1968. Final revisions of this particular set of regulations containing this amendment were published June 24, 1969. For the subcommittee's convenience, I have provided copies of this regulation with the pertinent section marked.

The major amendment on which a large proportion of our time and effort has been spent is that amendment which provides that nursing homes receiving payments under a State's title XIX plan must meet certain standards. This committee, through its hearing of July 30, 1969, is familiar with many of the issues and delays encountered in the development of regulations for the implementation of this amendment as published in the Federal Register on June 24, 1969.

Following publication of these regulations, a special task force was appointed to assist us in reviewing the many comments which were

received. The report and recommendations of that task force were reviewed by the several agencies within the Department concerned with the regulations and the decision was made to adopt virtually all of the recommended changes.

The regulations were rewritten accordingly and were approved by the Administrator of SRS on January 28, 1970. They were published in the Federal Register on April 29, 1970. I have provided to the subcommittee copies of these final regulations.*

Section 1902(a)(27) which originated as a Moss amendment also became effective January 1, 1969. This section provides that State agencies must enter into agreements with providers (including nursing homes), relating to records to be kept by the provider and to documentation of claims. Regulations implementing this subparagraph were published in the Federal Register on September 20, 1969.

Effective July 1, 1969, section 1902(a)(26) requires States to provide medical review programs. Such programs have two parts: first, medical evaluation of each patient's needs prior to admission and second, regular and periodic inspections, by independent review teams consisting of physicians and other health and social service personnel, of the care being given title XIX patients in nursing homes.

Development of our basic policy approach to the implementation of this amendment was begun in February of 1969 by a committee of professional staff in the Medical Services Administration. Staff of the Community Health Service, the Division of Mental Health Service Program, and the Bureau of Health Insurance were also involved and consulted. A completed draft was circulated for concurrences of these other agencies and for legal clearance during late July and August of 1969. The proposed regulations were then circulated to the States through the Advisory Commission on Intergovernmental Relations and were reviewed by the Task Force on Medicaid and by the Medical Assistance Advisory Council. We expect an early resolution of the several unresolved issues under discussion.

The amendment with the latest effective date is that which provides that after July 1, 1970, States must provide home health services for any categories of persons for whom nursing home services are provided. An initial draft of regulations implementing this amendment has been completed and is now under review in the Office of General Counsel.

As you know, the Department has established a Federal Assistance Streamlining Task Force (FAST) under the direction of Deputy Under Secretary Frederick V. Malek. FAST has reviewed more than 50 different grant programs to date. As a result of its work, a number of important steps have already been taken to speed up the processing and review of grant applications, to eliminate or reduce unnecessary reporting requirements, and to decentralize decisionmaking authority to the field.

I have been advised that this task force has under consideration for one of its next undertakings a review of the Department's procedure for processing regulations.

*See app. 1, p. 693.

Mr. Chairman, I should like to conclude with a statement of my own conviction that the Medical Services Administration can and will progressively solve the problems which have plagued the Medicaid program in its early years. The statements I have just made on the actions taken to implement the Moss amendments clearly indicate that we have moved more slowly and less effectively than we should. I would have liked to be able to make a better report to you today.

Although I have been Commissioner only a few months and am not familiar in detail with the period covered by my testimony, I have come to appreciate that the Medical Services Administration has come through a very difficult period. A new organization, a massive new program, shortages of staff and funds have characterized this period. I am not apologizing for these conditions, but noting them and noting that they are changing. We are now in the midst of reorganization. We are getting an infusion of new personnel giving us both added manpower and new skills. Implicit in these changes is a recognition within the Department of a different and stronger role for the Federal level of administration of the Medicaid program.

Medical Services Administration should stand for quality medical care for beneficiaries of our programs. I do, myself, and I wish to be associated with an organization which does. We should be the patients' protagonist and take his part in the processes of balancing fiscal, provider, and consumer interests. We should be able to give leadership, consultation, and backing to State administrators in carrying out an effective program and in acting within the framework of law and congressional intent. I assure you of my determination to see these things accomplished.

With your permission, Mr. Chairman, I should like to call on Mr. Arthur Kimball, HEW regulations officer, to comment briefly on the Department's clearance procedures.

Senator Moss. Mr. Kimball, we will be glad to hear from you, sir.

STATEMENT OF MR. ARTHUR KIMBALL, REGULATIONS OFFICER, MEDICAL SERVICES ADMINISTRATION, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Mr. KIMBALL. Thank you, Mr. Chairman.

Mr. Chairman, I brought with me several copies of the chapters of the Department's administration manual which deal with the processing and development of regulations. One chapter is 3–20 which is "Development and Processing of Regulations and Notices of Proposed Rulemaking," the other is chapter 19–11 concerning the consultation with heads of State and local governments in the development of regulations affecting Federal assistance programs.

If I may pass these to you.

There are three charts at the back of chapter 3–20. The first chart gives, I think, the most complete picture of the development of Federal regulations. It shows the requisite procedure for those cases needing consultation with the heads of State and local governments through the Advisory Commission on Intergovernmental Regulations and those cases which involve significant policy issues.

I would like to point out to the committee that in October 1969 these revised procedures were approved by Secretary Finch. I believe the keynote of the new procedures approved at that time has been the attempt to take action as early as possible. For example, in the case of regulations of State and local governments we are transmitting, at the earliest possible date, policy issues and even draft regulations to the Advisory Commission on Intergovernmental Regulations instead of waiting for the so-called final set of regulations. This will enable the ACIR and its constituent organizations, the National Governors' Conference, the U.S. Conference of Mayors, and the other organizations to make their recommendations known early in the formulation process.

Also, the new procedures encourage the operating agency, in this case the Medical Services Administration or the Social and Rehabilitation Service, to prepare memorandums of specifications setting forth the policy issues in regulations to be developed.

Those recommendations include alternatives the reasons for suggesting a particular alternative. These recommendations, in the form of a memorandum, are to be forwarded to me at the earliest possible date. I then send them to the officials in the Secretary's office who are particularly concerned; the General Counsel, the Assistant Secretary, Controller, the Assistant Secretary for Planning and Evaluation, if grant or fiscal matters are involved, and on occasion, the Assistant Secretary for Legislation.

We obtain their comments and recommendations simultaneously instead of one after the other. We are then able to present the memorandum of specifications to the Secretary with the comments and recommendations of appropriate key officials including the Under Secretary.

In this way, as Secretary Wilbur Cohen once put it, the Secretary would not receive the regulations on his desk frozen in concrete but there would be an opportunity for the top officials to determine the policy questions at the time the regulations were under development.

With these two steps under this new procedure taking place simultaneously, the drafting agency should then have the advantage of the policy decisions of the Secretary and his top staff as well as the recommendations of the State and local officials in the preparation of the final regulations. These steps are spelled out to give you a little idea of the timing because I know this is crucial in the questions you have raised.

We have pretty well set a pattern with the agreement of ACIR of 3 weeks for their initial review, of course, there are times when they may request additional time or we may ask that something be expedited.

We have also scheduled as normal timing under these procedures a 10-day or 2-week period for review of the memorandum of specifications. Obviously in any given case there may be problems which make such timing impossible but that is the goal and my office endeavors to follow up on any delayed responses to determine the cause.

The main thrust of our procedures is to try to identify the problems, obtain the recommendations, and get the decisions made as early as possible. We thereby hope to avoid surprises or delays when the regulations come up for final clearance and approval.

Senator Moss. Thank you, Mr. Kimball.

Do either of the other gentlemen have a statement they would like to make?

Mr. NEWMAN. No, Mr. Chairman, but I am accompanied by two highly respected members of the staff of the Medical Services Administration, Mr. Thomas Laughlin, Deputy Commissioner, and Mr. Frank Frantz who is the Chief of the Office of Nursing Home Programs, both of whom who have detailed knowledge of the specific issues of concern to this subcommittee.

Senator Moss. Well, now, I appreciate your laying out in detail and telling us what the timing would be but on the provisions for medical review, the deadline set by the law for compliance by the States was July 1, 1969; is that correct?

Mr. NEWMAN. Yes, sir.

Senator Moss. And we still don't have that regulation requirement even today.

Mr. NEWMAN. That is correct. I am hopeful, sir, that that regulation will be issued very shortly.

Senator Moss. Twenty-eight months have elapsed since the legislation was enacted. Don't you think that is an unreasonable time?

Mr. NEWMAN. As I said in my statement, sir, I think that it should have been done by now and I personally regret that this has not been the case. We expect to do all that we can to get it accomplished.

Senator Moss. I think in your testimony you said something about you were getting additional personnel now. Is it because you have not had adequate personnel, sufficient numbers to do it?

Mr. NEWMAN. The problem of indaequate staffing of the Medical Services Administration has related generally to difficulties in the management and administration of the program. I personally would not like to say that staff size has been the only impediment to the process by which the regulations have been developed. However, we have been authorized to increase the staff substantially and it is my hope that additional staff in the regions and the central office will enable us to cut down the time required.

Senator Moss. From the summary that Mr. Halamandaris made, in talking about the number of people involved in getting regulations implemented he says as follows. This is a letter from Mr. Tierney, Director, Bureau of Health Insurance:

> In summary some 30 people were employed substantially or on a part-time basis in the development of standards, policy, and regulations covering both hospitals and ECF's. Another 12 people were involved for approximately six months in the planning for the certification process of all providers. Finally, 65 people were involved in the certification of ECF's on a largely full-time basis for four months with an additional 15 used on a part-time basis within this period. Thus, while the total number of people used on this activity at one time or another numbered 122, as best we can determine the work as related to the implementation of the extended care benefit program required some 40 man-years of professional or semiprofessional staff time.

Now that sounds like an awful lot. How much time was put in on developing the standards for medical review?

Mr. NEWMAN. One relevant figure which I can offer is that there were three people in the Medical Services Administration at the time of the passage of the Moss amendments who had responsibility for this activity. I cannot estimate the number of man-years or the amount of time expended in developing the medical review policy.

I would point out, however, that the comparison between the Medicare and Medicaid programs often leads to difficulty when one attempts to compare the nature of the management to the programs. Ours requires the involvement of States in a way which I personally believe substantially complicates the management and administration of our program, and for this reason I don't think that the comparison of man-years expended is a terribly useful figure.

We are, however, in our reorganization attempting to devote a substantial amount of our new resources to this problem. Part of the reorganization has included an expansion of our Program Management Division with responsibility for the policy development activities. I personally feel fortunate that the staff of the Medical Services Administration, while it has had difficulty going through this period of time, is comprised of people of high caliber who are concerned about these issues. I want to emphasize that any delays have not been due to woeful neglect either by me or by any member of my staff. I hope that the new staffing pattern will allow us to be more responsive to your intent and I ask that we be given an opportunity to show what the new Medical Services Administration organization can produce to this end.

Senator Moss. Well, I recognize that you are rather new as Commissioner of the Medical Services Administration so some of the delay we are talking about does not come under your tenure there. I might ask Mr. Frantz who is Chief, Office of Nursing Home Programs, Medical Services Administration, about the size of staffing that has been put on the implementation of the Moss amendments.

Do you have any comments you can make on that, Mr. Frantz?

Mr. FRANTZ. Yes, Mr. Chairman. Initially, beginning in December of 1967, at which time the amendments had passed though they had not been signed, a unit was developed which had initially one person. During the course of the next 6 months it was increased to three people with responsibility for the nursing home phases of the program and was maintained at that level during most of the period under discussion. I would estimate that half to two-thirds of the time of these individuals was devoted to the development of the nursing home standards and the certification regulations. So we are talking about one and a half to two people.

Mr. HALAMANDARIS. Is that one and a half to two man-years? Is that what you are saying?

Mr. FRANTZ. Yes.

Mr. HALAMANDARIS. As compared to 40 man-years devoted to implementing the Medicare extended care nursing home program.

Mr. FRANTZ. Yes, that would be correct.

Mr. NEWMAN. I would point out we take exception to the use of that analogy.

Mr. HALAMANDARIS. Your exception is noted.

Senator Moss. We are trying to find out why we have had just interminable delay which seems to ignore the various deadline dates that we have in the statute for implementing the Moss amendments.

What did you say your plan was for publishing new regulations? What is the timing on medical review provisions?

Mr. NEWMAN. I would expect that we will have the publication of that regulation within the next 10 days.

Senator Moss. I am sure you are aware that this committee has been inquiring and trying to get some action on this for a long period of time. Do you have any explanation as to why we get no response or have not been able to get responses to telegrams and letters?

Mr. NEWMAN. No, sir, I cannot offer any comment to that.

Senator Moss. I recognize these are addressed to the Secretary which is the channel that I would use, but I would assume they have to be refined to your Divisions for your suggested reply recommendation.

Mr. Halamandaris mentioned in his summary the telegram that I sent to the Secretary on the 10th of November 1969 telling him I was addressing the American Association of Homes for the Aging and asking what action had been taken on the report of the Task Force on Skilled Nursing Home Care and what plans had been made by the Department for implementation of regulations to comply with my amendments to title XIX concerning higher standards applicable to patients in skilled nursing homes.

I say here in the telegram that I would appreciate a reply by Tuesday or Wednesday at the latest.

Now, did that ever come to your attention?

Mr. NEWMAN. Mr. Chairman, I take responsibility for everything after February 16, 1970.

Senator Moss. I see. Well, this was November 10, 1969, so that is out of your jurisdiction.

Does anybody else on the panel here know why we have not been getting a response?

Frank, do you know about this?

Mr. FRANTZ. I remember the telegram, Senator. Of course we get a flow of correspondence all the time, but I remember this particular telegram because of its content and its source. It came into my office and we did reply to it, as I recall, on the day that it came in. Of course after it leaves Medical Services Administration we have no way of knowing what happens to it.

Mr. HALAMANDARIS. This is rather curious to me. The telegram is dated November 10, and the Senator called November 17, just prior to making a speech in St. Louis, to make sure that we had not heard from Secretary Finch before giving him a thorough blast in St. Louis. Again we were informed that the telegram was never received and now you tell us you drafted a telegram. Now somewhere there is a logjam. I would like to find where that logjam is. I would like to find where our telegrams and letters are hiding out. Somebody is sitting on them down there and I would like to find out where.

Senator Moss. We have had much the same situation on letters, and I have copies of those letters, that we didn't get replies to as well.

Mr. HALAMANDARIS. Let me ask you about medical review while we are waiting. I understand you to say that you expect regulations within 10 days, Commissioner. Did you say that?

Mr. NEWMAN. Yes, sir.

Mr. HALAMANDARIS. All right. I am marking on my calendar May 17.

Mr. NEWMAN. So am I.

Mr. HALAMANDARIS. If my calculation is correct, that is 10 days from now.

All right. We are going to check you on that, I promise.

I want to know again what stage the preliminary standards are in. Where are they? Did you say?

Mr. NEWMAN. They will come before the Office of the Secretary within the next few days. They have been drafted, there has been review in the manner in which I described in my testimony, and I would expect that they will be presented and be cleared through the Office of the Secretary in very short order.

Mr. HALAMANDARIS. Let's see now. When were the standards drafted? How long ago were they drafted?

Mr. FRANTZ. The draft was completed, I believe, in July of 1969.

Mr. HALAMANDARIS. The conclusion obviously is that these regulations have been bouncing around down at HEW since July of 1969? I can appreciate the fact that you have got some new procedures that you might have to go through as Mr. Kimball has pointed out but——

Mr. NEWMAN. No, I would not point to the procedures which Mr. Kimball referred to as the reason for the delay. I think that establishing a means of accomplishing the intent of the Congress in a program which at present operates with 52 States and jurisdictions requires——

Mr. HALAMANDARIS. Now you are saying that you have a tough job. I can appreciate that. But darn it, you know, the Senator worked for the passage of the amendment in 1967, and we point out today that 28 months have gone by with no change or improvement. Twelve of those months were during the Johnson administration, the rest of the delay belongs to you and especially to Colonel Laughlin because of his continuous tenure. The delay, to my way of thinking, is inexcusable.

Now you have admitted that if you had things your way, certainly things would have been done differently. What we want to do today is pin down some specific dates, and that is why I made such a point about May 17. Right now I want to change our focus to talk about the provision in the Moss amendments requiring the States to establish Home Health Services.

Mr. NEWMAN. Yes. I just want to make one comment about the feeling you ascribe to me—that is, if I had my way things would be done differently. I certainly would like to see the time frame telescoped but I think the clearance review is necessary to get all of the interested parties to comment and to feel that they have participated in the development of a policy. Our obligation is to develop a workable program which is consistent with the intent of the Congress. As I indicated in my statement I understand the intent of the Moss amendments; I personally subscribe to them; and will do all that I can to see that they get implemented.

Senator MOSS. But doesn't the Secretary or somebody set some deadlines when these comments have to be cleared and be back in?

Mr. KIMBALL. Mr. Chairman, we have put out an instruction memorandum to each of the operating agencies of the Department asking them to furnish us a list of all regulations which are due by a definite date, such as June 30 for the period under discussion. We have asked the agencies if there is any slippage, the early development is, of course, in the agency, it reaches us at certain points as I indicated in that procedure. Henceforth, when deadline dates are set we should know that they are being met and know when they are being missed.

Senator MOSS. Now on this medical review, this was to be effective on the 1st of July 1969. What deadline date do we have on that now?

Mr. NEWMAN. I can't offer a comparable deadline date other than the statement that I made about the clearance of the regulation.

Mr. HALAMANDARIS. He said he would have preliminary regulations for us by May 17.

See, this is part of the problem. We would have liked to have had some of the other individuals further up in HEW here today so that we could get a rather firm commitment from them as to a specific time table. I got extremely aggravated yesterday on the telephone trying to get a few people to this hearing because (1) our letter of invitations of April 16 was not answered and (2) our telegram which went out about May 5 was also neglected. We had to resort to the telephone to find out indeed who was coming. Now that is bad. I just offer that to you for your judgment.

Mr. NEWMAN. I apologize on behalf of the Department.

Mr. HALAMANDARIS. Are you saying unequivocally that you cannot give us a deadline when you are going to have medical review in effect?

Mr. NEWMAN. I would hope the effective date would be the date of the regulation; however, I don't feel that I can make that commitment at this time. I will certainly do everything that I can to see that is accomplished.

Mr. HALAMANDARIS. I will accept your promise.

Senator Moss. Now the Home Health Services is to be effective June 30, 1970, I believe. Will you meet that deadline?

Mr. FRANTZ. Mr. Chairman, a draft regulation has been prepared on that. This was not done in my office and I am not able to comment on the content of it but I am aware of what happened.

The draft has been prepared and it has had internal clearances with other participating agencies. It is now under review by the Office of the General Counsel. As far as I am aware, there are no legal difficulties anticipated or any controversial issues involved. I would think that considering the stage it is in now that it would be out before the deadline date.

Mr. HALAMANDARIS. Again I don't believe that anybody is promising us a deadline when the Home Health Services would be in effect. Is that true? Do you stand on that position, Commissioner?

Mr. NEWMAN. I don't think that I can make a commitment of that kind.

Mr. HALAMANDARIS. But you are giving us your promise that you will earnestly work for implementations.

Mr. NEWMAN. Yes, sir.

Mr. HALAMANDARIS. That is something anyway.

Senator Moss. Now the new regulations of April 29 command MSA to establish the ratio of nursing personnel to patients. What is your deadline now when this ratio will be effective?

Mr. NEWMAN. There is at present no deadline that I am aware of, Senator.

Senator Moss. Again no deadline.

Let's see. By law the Secretary has responsibility to deny Federal funds if all of the requirements of the State licensure are not met. Is there a proper deadline for implementation of this requirement?

Mr. FRANTZ. Mr. Chairman, the amendment to the regulation which includes this provision in the definition of the term skilled nursing home was one of those which was published in final form on June 24 of 1969. This regulation is, therefore, in effect at this time.

Mr. HALAMANDARIS. Let me have a comment here. As the Commissioner mentioned, the way that this is being implemented is by supposedly integrating this requirement in the definition of skilled nursing home care. Ostensibly implementation of this portion of the Moss amendments is now complete. I point out there are two things wrong with this approach. No. 1, the statute specifically spells out that title XIX referring to skilled nursing homes is not the only title involved. There are other titles that are involved—I, V, XIV, and XVI. Now those are completely neglected they lose the protection of the law if you implement it this way.

The second thing that is wrong with your incorporating this requirement is that you are simply saying that unless your skilled nursing home is in compliance with all the State's regulations you don't get paid. That is the way the standard reads. There is no substantial change from the way the program has been before.

Under the command of the Moss amendments the Secretary has a definite responsibility to assess, to make sure, that before any Federal money goes out, that all nursing homes must be more than within substantial compliance, they must meet all the requirements of the State licensing board. That way you are implying that the Secretary's affirmative responsibility has been deleted. It is now only one of a series of the requirements that make up skilled nursing home care. Do you agree?

Mr. NEWMAN. No, sir.

Mr. HALAMANDARIS. It does not surprise me. In effect you have a negative regulation here, you have another nonregulation. That is the way I read it.

Okay. Let's go over our checklist. With regard to the ratios, then again you cannot promise us any deadline. Could you give us any thought as to what would be reasonable from your own personal point of view?

Mr. NEWMAN. No, I can't. From my personal point of view I can tell you that the question of quantitative standards in compliance with this aspect of the regulation is being extensively reviewed. I pointed out earlier the difficulties of attempting to attain the level of effectiveness of the program, which is the intent of the Congress, and at the same time accomplish in the management of the program a workable program for States. Implementation is more difficult than merely wanting it to happen.

Mr. HALAMANDARIS. Let me address a question to Colonel Laughlin.

Isn't it true, Colonel——

Mr. LAUGHLIN. Mister.

Mr. HALAMANDARIS. Mister. All right.

Isn't it true that there is substantial disagreement within your Department as to the implementation of this legislation? Is there not substantial resistance to establishing any ratios at all?

Mr. LAUGHLIN. I suppose just like everything else there are differences of opinion among professional people.

Mr. HALAMANDARIS. Substantial differences of opinion?

Mr. LAUGHLIN. Varying degrees.

Mr. HALAMANDARIS. You are very responsive, I am going to call on you again.

If I may gentlemen, I am going to talk about something else. The companion of the Moss amendments of 1967 was the Kennedy amendment requiring the licensing of the Nursing Home Administrator charging you with coming up with regulations for the licensing of nursing home administrators.

Now I want to clarify congressional intent. Let me direct this to Mr. Frantz because he was involved in the passage of these amendments.

Mr. Frantz, was it congressional policy in your opinion that at the time when you were instrumental in passing these amendments that the boards which license the Administrator would be made up of the majority of nursing home operators? Would you say that was the policy of Congress? Was it the policy of Congress?

Mr. FRANTZ. Well, I am always hesitant to talk about the policy of Congress. I can give you my recollections of the thinking of the staff and our understanding of the thinking of the sponsor of this amendment at the time.

Mr. HALAMANDARIS. Good.

Mr. FRANTZ. As I understand the issue you are raising here it is a question of whether the nursing home administrator should in effect license himself.

Mr. HALAMANDARIS. Exactly.

Mr. FRANTZ. Whether administrators should dominate the board.

It was our thinking that the language "representative of the professions and institutions" meant that the legislation did not call for a self-licensing mechanism.

Mr. HALMANDARIS. Did not call?

Mr. FRANTZ. That is right. The historical context is that even at that time when the bill was in its formative stage we were hearing the argument about doctors licensing themselves and pharmacists licensing themselves and so on and why not us? We did not think that this was a valid analogy. We did not think that nursing home administration was an established body of knowledge which was the exclusive province of the practitioners. Indeed, in order to establish it as a body of knowledge it needed the contribution of a large number of other representatives of the health and health service professions.

So in effect this language "representative of professionals and institutions is concerned with the care of the chronically ill" represented the sponsor's decision on that argument.

Mr. HALAMANDARIS. All right. I bring up the question because what is happening in many States is that the provision of the law as you stated it, that a majority of nursing home operators should not in effect license themselves, is being cut away. There has been one waiver granted in this case of the State of Iowa, there are presently four others pending. I believe I am correct in this.

Now if the four other challenges are granted, then in effect another waiver will be established and HEW will sit by and allow the nursing home boards in the States to be composed of a majority of nursing home operators, and in effect that is what is going to happen if the challenges are granted.

Now I have another letter here, it is to John Twiname who is the Administrator of the Social and Rehabilitation Service, and it expresses grave concern about this problem. It is from William Hutton, executive director of the National Council of Senior Citizens and it is dated April 14, and it is another letter that has not been answered.

Commissioner, I am going to give it to you and I would trust you with the courtesy of giving Mr. Hutton an answer. Essentially he wants to know why HEW is defaulting on the Kennedy amendment.

I will pass that to you at the end of the hearing.

I am sorry if I seem a bit intense but I point out I was provoked yesterday.

That is about all I have.

Senator Moss. Do you have any questions, John Guy?

Mr. MILLER. No.

Senator Moss. Mr. Oriol?

Mr. ORIOL. No.

Mr. HALAMANDARIS. Is Mr. Morris Levy in the audience?

Mr. LEVY. Yes.

Mr. HALAMANDARIS. Mr. Levy, we will hold you until the other two gentlemen are called.

Senator Moss. Well, thank you, Commissioner Newman, Mr. Kimball, Mr. Laughlin and Mr. Frantz. As I indicated, this is an oversight hearing. It is because of our feeling that we have not been getting the action that is called for in the Moss amendments and indeed in other parts of the statute, that we are failing to give the care to our elderly that the Congress has said by law they are entitled to have. We feel that there has been a breakdown and that we are not getting communication.

We think the way to indicate our feelings and our understandings is to hold this oversight hearing. Now if we continue to have this feeling and if it seems to us that we are not getting cooperation we will have a further hearing and decide then what further we need to do. Perhaps if we have further hearings we might want to have the Secretary come before us because of his responsibility for the higher policy matters.

We do thank you for coming and responding to our questions and for your indication that there is going to be an effort made to get compliance within reasonable time on the command of this statute.

Thank you.

Mr. NEWMAN. Thank you, sir.

Senator Moss. We have Dr. Michael B. Miller who is the medical director of the White Plains Center for Nursing Care, White Plains, N.Y. Dr. Miller has appeared before us previously.

We are happy indeed to see you again, sir. We are pleased to have you come.

Dr. MILLER. Thank you.

Senator Moss. Would Mr. Levy come forward also and perhaps be seated at the table. We may have questions to direct to you.

Dr. Miller, we are glad to have you with us, sir. You have been here and heard the dialog we have had up to now and we will be happy indeed to have your comments and testimony.

STATEMENT OF MICHAEL B. MILLER, M.D., MEDICAL DIRECTOR, WHITE PLAINS CENTER FOR NURSING CARE, WHITE PLAINS, N.Y.

Dr. MILLER. Good morning.

Mr. Chairman, thank you so much for inviting me to appear before this committee once again. It is a great privilege to meet personally, to be able to come to Washington and tell you about our personal clinical experiences that we are having in the New York area with the aged ill, particularly as it relates to the Medicare program.

I just cannot help but respond to what I have just heard. I am a physician, I am deeply committed to caring for the aged, but I am a citizen. Now I am not very diplomatic, I am a feeling person. I must tell you what I am feeling.

I have a great respect for this Government and the people who make it run, for its agents, but I must tell you how I feel on what I have just heard. I could not believe I had come here to hear such poor performance. This is not a personal comment to Mr. Newman who is a recently appointed Commissioner, but I believe the American people have a right to expect continuity of operation of their agencies because of the money they throw into the Government and its operations. It is not enough to hear that with a new Commissioner an agency comes to a halt.

If our performance in New York at a clinical level was at all similar to the performance I have heard here just now, there would be hell to pay. If we do have a new Commissioner this morning, in the last couple of months, I believe that the leadership of HEW had an obligation to send here their best informed people. What I heard this morning is not a reflection on the four men I have heard or seen, it is obviously a reflection of leadership. What we are struggling with at home at a clinical level must reflect what you heard here; it is not separate and apart, it is not the Government here and the people here—it is one.

I have full sympathy with what I have heard, but I didn't hear a sense of urgency. I heard mañana.

I must go home and face sick people. I must go home and face families in distress. What will I report to them on the basis of what I have heard here?

Well, I just had to respond.

Medicare at a clinical level is moribund. A year ago our patient population in our extended care facility was about 40 percent. We are operating at about 7 percent now. I would like to clarify an issue. I do not believe it is the policy of nursing homes in general to withdraw from Medicare. There may be an isolated incidence of that presentation. We do not want to retire from Medicare, we believe it is an effective medical, social, and legislative program if properly implemented.

We simply can't find the patients who will qualify for Medicare coverage on the basis of what this great agency has done to the legislation implemented or passed by Congress. I think it is imperative to keep in mind this was Congress's intent. I don't think it is difficult

to interpret its intent. I think it was Congress' intent to bring comfort, expert medical and nursing services to the aged and support to their family and on a broader basis support to the community in which they live.

HEW has the obligation to implement that, not strangle it. Now it is as I said before moribund. I would like to examine with you this morning how such strangulation has been effected. In a recent issue of Modern Nursing Home, January 1970, page 9, an article by Thomas Tierney, Director of the Bureau of Health Insurance, Social Security Administration, makes a major issue on one of the reasons that aged ill are unable to qualify for covered benefits. He states:

> The extended care patient is one who has been hospitalized for treatment of a medical condition and who now while no longer requiring the full range of hospital services still needs continuing skilled nursing services in an institutional setup which can assure the availability of such services on an around the clock basis.

This comment is an attempt to define what is known as extended care. He says:

> The test that has to be applied to the law of course is that if the service being furnished does not need to be furnished by skilled nursing personnel, then they do not constitute skilled nursing services for extended care coverage.

Now that sounds plain enough but it isn't. There is an assumption here and an assumption that is on thin ice. There is an assumption that there are accepted criteria, standard criteria by which patients are discharged from the hospitals. There are no such criteria. Patients are discharged from hospitals for a variety of reasons.

One, the patient has had enough, he wants out, he is in prison in a hospital room.

Two, the family has its own reasons.

Three, the doctor may have his own reasons.

And underneath is lurking the problem of who pays for the services.

Discharge often reflects a hospital's need for beds. This has little or nothing to do with the medical problems involved. In this helter-skelter situation it would take a brave man indeed to define with any degree of certainty the meaningless extended care facility or extended care. On that ground Mr. Tierney is on terribly weak grounds.

In order to fortify the effectiveness of this program he says:

> In the July-September 1969 quarter, 271,500 bills for patient care in the ECF were submitted for payment. Of these only 19,000, slightly over 7 percent, were denied in whole or in part on the basis that the care furnished did not constitute extended care services.

I am always grateful when I look to you for letting me come here. Such fallacy. Each person sees what they want to see. He is only reporting what he thinks substantiates his position. This is not personal, talking about SSA, talking about HEW. He is seeing just a part of the iceberg, those that he turns down. How about all those that we exclude in order to save them the embarrassment of retroactive denials, retroactive payments?

How about the misery of trying to exclude families when they are hit with problems that they were not previously educated to? Hospitals have now wised up in the past year. They, too, have a conscience to a substantial level; namely, they don't want their dischargees to be embarrassed in ECF and there is a whole process there.

Social agencies are not sending their people in any longer. The 7 percent is a meaningless number. We spend in our institution half of our admitting time on trying to determine which patients will or will not qualify under the following definitions which I will soon read to you. I would say to you that the 3 to 7 percent Mr. Tierney is talking about quintupling is nearer the facts. Some place the SSA must come into the field to learn the true facts. You cannot learn what is going on at a human social level behind a desk conceptualizing using criteria that don't hold water.

Now let me describe for you next the tool that SSA has used to define law and order, your term before. I never thought of it this way. I thought only citizens were concerned with law and order. It just escaped me the Government, too, must also yield to law and order. There is a law, Congress passed that law. It is not for SSA to determine what the law should be, it was passed. It should be implemented, not frustrated.

Let me show you how this Government agency has frustrated the law through our fiscal intermediary—no better, no worse than any body else, all baited and struggling with their difficulties, SSA also baited and struggling in their unpreparedness to handle this problem. Keep in mind the professionals in the intermediary who are not trained as were SSA not trained to cope with the critical problems of aging. They brought to the interpretation of these new regulations a wonderful intensive background in insurance medicine.

Now some of you who are involved in the field of medicine must know that patients who are able to take drugs by mouth are considered to be receiving an unskilled service. You know the fallacy of that. You know the fallacy that drugs given by any method—by vein, by injection, muscle, under the skin, by mouth, via a tube—carry the same hazards. Drugs given in any form must, if you are committed to topflight medical nursing, constitute a skilled service.

I am repeating again our testimony of Hartford but I think it is important to be heard in Washington. Keep in mind the use of a catheter for a population that averages 22 years of age. Forty-two percent of our population have a permanent catheter or are using catheters intermittently. Within 24 hours after the insertion of any catheter into the bladder the patient is confronted with infection. This is clinical fact. The SSA says the following: When you insert the catheter it is a skilled service; leave it there, it is a nonskilled service.

I would say the opposite. If you can get a nonskilled service person to put a catheter in, I would forgive him but once it is in, it becomes an instrument of either life or death, a highly skilled service.

I also rebel with another definition; namely, the SSA said if turning a patient every hour through the day 24 hours is the only significant or primary service, it is a nonskilled service. That would have to be written by a layman, it could not be written by a clinician who has to work with these patients daily. Could any of you who have worked with our kinds of patients who have brain disease, heart failure, kidney trouble, diabetes, can't see, can't hear—if this patient is so handicapped, is turning the patient the only significant treatment required?

He has got to be fed, he is going to have a catheter in him, he requires bowel management, he probably has brain disease if not cord disease. He has feelings, his family has feelings. Who would feel so self-assured that they feel they could bring all the necessary skills to this particular situation which I am now faced with calling a nonskilled service? It is a mighty strong person to wash out the realities of clinical medicine on a dollar basis.

Now there are other areas that can be dissected but one I feel particularly close to and I must bring it to your attention. The definitions of skilled care are related particularly to specific items of a skill doing something for the patient. There is complete absence of how a nurse, a physical therapist, an occupational therapist, a physician relates to a patient and yet this could be the critical item of whether that patient survives, moves, is immobilized, or dies.

Let me tell you what I mean. Given a patient with a major stroke—forget confusion, brain deficits, disorientation, incompetence, frightened, despondent, frustrated, threatened, and the patient confused whether he wants to live or die. The family meets that patient, please forgive me, frightened, despondent, guilt ridden. One affects the other. Whether that patient can be mobilized at a higher level of function will require the most skilled relationship of motivation, inspiration between nurse and patient, nurse and family, family and patient, patient and family.

Now I will just describe that for you. This is the skill, this is totally washed out. This is not a public service. Let alone what the doctor is going to do, let alone his responsibility in mobilizing, coordinating a total therapeutic program, it is all washed out.

I was going to ask them a question. Don't you feel as deeply as I do about this?

You come home with me. One.

VOICE. You come home with me.

Dr. MILLER. Let me define on a positive basis what is skilled care, not what it is not. What are the functions of a nurse, nursing diagnosis? One, she has got to be able to identify the patient she is dealing with and his changing nature. Two, the measure of drugs. Now what people do at home on their own time is one thing, what they do when I am responsible is quite another. Once a nurse with a license and once a doctor with a license touches a drug and delivers it to the patient, there is a great art and skill involved in that drug management and cannot be relegated to a patient. Drug management has been a major skill in nursing service.

Nursing rehabilitation has a technique. There are specific roles in which the nurse is involved but there are other roles which are equally important; namely, the coordination and a tying together of the nursing arts with other ancillary functions such as physical therapy, occupational therapy, speech therapy, recreational therapy, religious therapy, et cetera. Someone has got to put it together, it will not be put together spontaneously. There is a great art and skill in that area.

Now of course there are specific nursing functions. In our society I see we place little value on certain profound nursing functions, such as feeding a patient. There is an assumption that all nurses have been trained in feeding patients. That assumption is not true. Doctors

know how to feed patients and I assure you today that feeding is being done not by nurses but by LPN's and more important by nurses aides.

We know in our studies 30 to 40 percent of our patients lose significant weight because of the inexperience and the inability of a nurse to understand the feeding process, the inability of a patient to relate to a nurse and vice versa.

On bathing the patient, the patient who is disturbed, who is mentally ill, the bathing process is a frightening experience. They fight, they scream, they are threatened. It takes a great skill to learn how to do it.

The other day I got a patient who was admitted to the hospital—and I don't know why I go into the details on that. This patient with brain disease had diarrhea, nonformed stools which were assumed to be in consonance due to brain disease. There was a ball in there like a basketball and in consonance if managed properly is a remedial situation in some instances. Giving that old man who is frightened, confused, new to us, we new to him, give him an enema—please believe me, an age old process, required a phenomenal skill.

Another area in which the nurse is involved in long-term care is family counseling in a hospital where you stay 7 or 8 days. One can almost, by excuse, pass by the family but you cannot where patients are old, sick, on a long-term basis. The patient's relation to the nurse, the nurse's relation to the patient, the nurse's relation to the family can be a critical issue, a major nursing skill.

Now let's not forget in 1970, we don't know all the answers. Nursing should inspire research at the patient level, research at the training level. These are my definitions of nursing skill and they are unlike SSA. The critical issue as I see it is the following: What are our goals for these patients? I believe this must be studied clearly. If this society is committed to sustaining life of the chronic ill aged, if this society is committed to improving the quality of these aged people, nothing but the topflight service will achieve those ends.

The word "custodial" must go. On that tone I want to differentiate, if I can, the distinction between the ECF and the nursing home because Mr. Tierney—again it is not a personal vendetta, I believe he expresses society's point of view.

Mr. Tierney said:

> Perhaps I should mention one additional consideration that may well be as much a contributing factor as those I have already mentioned. I refer to the general feeling among many beneficiaries that extended care benefit is really after all just a fancy name for nursing home benefits.

Let me address myself to that. I suspect the real issue is what is a nursing home. There is an assumption that the sicker person, the more disabled the person, the less care he needs. There is a prevailing assumption that the sicker the person, the more disabled, the less expert care he needs. I address myself to the fact that this is a fallacy.

The sicker, the more disabled, the more serious—the opposite. The nursing home in my opinion is nothing more nor less, nor should be, than a chronic disease hospital. These patients are medically sick, emotionally ill, socially dislocated, and require diagnostic services, requiring everything but surgery. As long as we pursue the idea of the nursing home out of context of its position in the medical community, I believe, Senator Moss, we are going up the wrong tree.

The ECF has been designated as such only because those patients require presumably a short period of time for care, another fallacy. There is a spectrum between the hospital ECF and the nursing home, the chronic disease hospital which really cannot be separated. If one talks about continuity care, one does not change the address, one delivers the service required.

I think I have opened up enough questions or areas for discussion. I would like to make certain positive considerations. There is a thrust to keep the elderly aged out of the ECF, it is too expensive. I believe the SSA has closed the wrong door.

Let me show you what I mean. There are approximately 300,000 people over age 65 in hospitals throughout this country. At $100 a day that is $30 million a day. They stay an average of 13½ days. There are in this country at this moment about a million nursing home beds. Twenty percent of those are Medicare patients, roughly speaking. At $30 a day $6 million a day.

Is there any question where they should be if one is concerned about dollars? If it costs this country $30 million a day to keep the aged in the hospital, if you can reduce that 13½ days by 1 day, that is $30 million a day; if you can reduce it by a third, you are talking about a lot of money. I would like to describe to you how I believe it can be cut back. I don't think it can be cut back using these concocted, self-appointed, fallacious, unsupportable definitions. It cannot be done.

Let's try to define why we use a hospital in the first place for the ill aged. I am talking about those who are 75, 80, or 90. We send patients from our institution back to the hospital with three conditions for three reasons: (1) surgery; (2) as a specific diagnostic program. Keep in mind that at 80 and 90 there are really few diagnostic problems. They have had their heart attack, they have had pneumonia, they have had other diseases, they have had their stroke episodes, we are seeing the fourth and fifth. We are seeing heart failure 10 and 12 times. That is no longer a diagnostic problem, it is a management problem.

So it is a bona fide diagnostic problem to go to the hospital. If it is a surgical problem, they go to the hospital. If the patient requires intensive care in the cardiac unit, special management, they go to the hospital. We examined the age of our doctors and we found there is a fourth priority, doctor's convenience. I believe that has to be washed out.

Now let me address myself to those three criteria.

In the uncomplicated surgical experience I believe the average aged patient can be removed from the hospital on the fourth or fifth postoperative day. There is nothing the hospital can do that we cannot do if our place is run properly. I have an idea it can save a lot of money. There is no purpose in keeping the patient in the hospital for the doctor to remove his suture on the fifth or sixth day; it is $100 a day and that is a very expensive suture.

On average even a diagnostic problem can be substantially resolved in a week. I believe at that point if the doctors, the hospitals, the Government can define "Don't waste your time with skilled care," I think we are up the wrong tree. Let's discuss the utilization of

facilities, patients' needs. I believe we can cut that 13½ days by 30 percent. I would say don't open the doors of the ECF—open them, but close the others. I am saying our emphasis is in the wrong direction.

No. 2, with respect to title XVIII and title XIX, this society of ours is going through a major cultural upheaval. Families are under great attack, our social value is under great attack. In my personal opinion the most important unit of our society is the individual, the second most important unit is the family. Our American families are being dissolved. We need further dissolution like a hole in the head.

Let's hear title XVIII and title XIX is done. Title XIX says the following: If your parents are qualified for Medicaid, children are no longer responsible for their care and support, and what is more, supplementary payments are forbidden. You are aware of this. It is putting one of the last nails in the coffin of the family structure in our country. In title XVIII after 20 days in the ECF the family contributes $5.50 a day and they object to that, too. We have many patient discharges related to that $5.50 a day rather than medical discharges.

My suggestion: This society is committed to help those who need the help. I am committed to that, too—I know you are. I believe we should help families, help their parents. I do not believe we should relieve families from all relationship and that is an important matrix of our family structure.

My suggestion: Families should participate to a greater extent in the coinsurance factor in title XVIII and certainly under title XIX at some level. I may not know where that level is but bring us together, don't separate us.

One final statement. If the SSA and HEW—this is not a political statement—are under the pressure of saving dollars, I can understand it. If 100 days is too long, cut it. If 80 days is too long, cut it. If it has to be 20 days, let it be 20 days but speak the truth. Don't say 100 days and cut them out entirely with spurious definitions.

This is a good program, save it. Help it mature, make it work; don't destroy it. Help us. Help the people to whom we are committed.

Thank you for letting me come here again.

Senator Moss. Well, thank you, Dr. Miller. You not only know what you speak of because of your long service and your commitment but you say it so eloquently that it is rather thrilling to listen to you even though some of the things you have to tell us are not thrilling. There are many problems we have and you outline them extremely well for us, and it is for that reason that we have asked you back before the subcommittee. You testified in Hartford and did a great job there as you have done this morning.

These definitions, these medical regulations that you described in the early part, do you know whether medical doctors participated in writing them?

Dr. Miller. I see two things. I was up to my inquiries. We made inquiry to social security to determine the origin of those definitions. My response to you is hearsay. I was informed of the following: They have no nursing staff as such, they have no medical staff as such. It is my understanding that these definitions were put together by laymen, it has all the imprints of that.

I wrote a paper, it is going to be published in the Medical Journal on phasing out Medicare.* I have been moved by something else, Senator.

As the world shakes underneath us, as there are great personal injustices being done on a medical and social level, I hear no outcry of my medical colleagues. I hear no outcry from my nursing colleagues as their profession is being shaken at the roots because if this stays on the record this becomes the limitations of your profession. If this stays, 10 years from now you will have a terrible time removing it. Where are we when faced with this kind of circumscribed, unscientific, unsupported information? This gets me.

Mr. HALMANDARIS. Excuse me, Dr. Miller. I think what you are referring to might be BHI intermediary letter No. 173 which was, related to physical therapy and had the effect of relegating, as I believe you pointed out once before, physical therapy to the nursing staff. Is that correct?

Dr. MILLER. Mr. Halamandaris, I have here another release from Aetna on physical therapy. Let me give the gist of this.

In the new definitions and in the applications of physical therapy and ECF, certain things were redefined by our fiscal intermediary and I presume they are simply trumpeting what they heard from Baltimore. They said the following. They defined in great detail the functions of rehabilitative nursing; namely, amputation: training in use of prosthetics, encouraging the patients, et cetera, et cetera, et cetera. They expect the nurses to do the job that we have been for the last 25 years relegating to the physical therapist but there is a reality of the situation.

Certainly nurses should be trained in nursing rehabilitation. Now let's see what we want the nurse to do. She has to be a good administrator, she has got to select personnel, she has to train personnel, she has to be involved in the patient's care and now involved in nursing rehabilitation. Nursing rehab is going to be traded off to the nurse's aide who is certainly hardly more than a high school graduate. We are going to have unskilled people performing nursing rehabilitation not just in ECF, all of them.

We are going to relate through the use of modalities alone, and let me inform you in caring for those 80 and 90 years old we scarcely use the heat modality. Heat is a hazard when used with a lamp or diathermy machine, we just don't use it. In reality our physical therapists help the nurse. At times I cannot distinguish between a nursing restoration program and a PT nursing program. I consider we have achieved an effective PT program.

Senator Moss. Thank you.

I just wanted to ask you one question. What has been the effect of the directives of the intermediary valuating the salaries of the nursing home operators?

Dr. MILLER. Senator, I am pleased you are asking me that. It was my intent to come to Washington not to discuss dollars. My expertise rests in clinical medicine. However, dollars is the vehicle by which programs are run.

* See app. 2, p. 699.

I want to tell you what happened to me personally. May I give you a personal commentary period.

Our institution was audited for 1968, only 6 months ago. In other words, we don't know where we stand for a year and a half. In discussions with Aetna I informed them as a full-time physician with certain qualifications, teaching experience, medical schools, and so on, I felt that my full-time charge should be $50,000 a year. There was no other source of entrance.

The $50,000 a year is comparable with what men receive who are full-time professors at the medical school level. It was agreed that my salary would be $50,000 a year. That was about 6 or 9 months ago. Three weeks ago they have reopened the question. Three weeks ago in one letter they suggested I accept $18,000 a year. Then they suggested I take $30,000 a year, and now it is $31,500 a year with the written provision that in the event of disagreement with them there is no recourse to repeal, to take it or leave it.

Now I would like to discuss that for a moment. In terms of actual dollars there is not much involved. If we are functioning at 7 percent of our total experience, let's presume last year we had 50,000 patient days per year. Of that 7 percent would be about $3,500, is that right? Now my salary would be pro rated against that kind of money. So for me the discussion with Aetna now relates to only about $1,000 or $2,000 apart. I believe it is the principle.

Now this country in my opinion will have national medical care at all levels sooner or later. The criteria being set today have an unhappy way of remaining on the way like the Washington Monument, you cannot pick it up that easily. I think it is important to resolve these differences now.

First, to discuss a wage a year and a half after the fact, nobody in this room would work that way. I am not intended to work that way, either. If you want to agree with me on a wage, period, we will do it before the fact rather than after the fact. No. 1.

No. 2, if you are going to come up with guidelines, I want to see them and at the same time I want to have some part in forming those guidelines. If we are talking about reasonable compensation, not guidelines that are unilaterally conceived, I am put against a wall a year and a half later and asked to accept or not accept.

The third item, since it is all based upon so-called reasonable compensation, no appeal leaves me unimpressed. So we have that in the offering right now.

Senator Moss. Well, I was aware of some of those problems and I am glad to have you recite for the record what your own personal experience has been.

Well, I appreciate very much your testimony and, the way you have brought into focus some of these problems that are giving us great concern. The reason for having the oversight hearings is trying to pull together this report we want to make on the trends in long-term care and the recommendations we hope to make for remedying what we think are great deficiencies. You have been most helpful and I appreciate it very much.

Dr. MILLER. Thank you.

STATEMENT OF MORRIS LEVY, ASSISTANT DIRECTOR, BUREAU OF HEALTH INSURANCE, SOCIAL SECURITY ADMINISTRATION, ACCOMPANIED BY GERALD SHEINBACH, DEPUTY ASSISTANT BUREAU DIRECTOR

Senator Moss. Mr. Oriol, I think you had two or three questions you wanted to ask of Mr. Levy who is at the table now and represents the Social Security Administration.

Mr. ORIOL. Thank you, Mr. Chairman.

Mr. Levy. Mr. Chairman.

Senator Moss. Yes; did you want to respond?

Mr. LEVY. I very much regret that we did not know that Dr. Miller would be making this presentation as we would have had someone here in the event that the Chair wanted to raise some additional questions. So that the record would reflect this, I would like to make one or two comments.

Senator Moss. Yes; certainly you may do so.

Mr. LEVY. I will first comment on the guidelines on skilled nursing care.

The Social Security Administration, and more particularly the Bureau of Health Insurance, does have a medical staff and the medical staff did participate in the development of the guides on skilled nursing care. I might also add for the record that this material was coordinated very closely with the Public Health Service who, as you may know, provides professional advice and consultation to the Bureau of Health Insurance in the development of medical and medical-related policies, and also was shown to the American Hospital Association, the American Association of Homes for the Aged and the American Nursing Association. These associations both reviewed and approved this statement.

Thank you.

Mr. HALAMANDARIS. I have one question.

Mr. Levy, let me confirm, if I can, what Dr. Miller said a while ago and I am sure you would have knowledge of this. I am referring specifically to the new guidelines that came out earlier this year which require the intermediary to reevaluate the salaries of nursing home personnel. Am I correct in assuming, No. 1, that the guidelines have not been made public?

Mr. LEVY. Let me say in response to that, again you are somewhat out of my area and I really don't know whether these have been made public or not. We would be glad to find this out for you and submit this information.

Mr. HALAMANDARIS. I am sure they have not been made public.

The second question I have, are these new guidelines being imposed retroactively?

Mr. LEVY. Again I would have to check.

Mr. HALAMANDARIS. The answer is again yes to that.

Senator Moss. Mr. Oriol is the Staff Director and he would like to ask a question.

Mr. LEVY. Yes.

Mr. ORIOL. Mr. Levy, I ask your title.

Mr. LEVY. I am an Assistant Bureau Director of the Bureau of Health Insurance. I might also say for the benefit of the committee that I have with me Mr. Gerald Sheinbach who is a Deputy Assistant Bureau Director.

Mr. ORIOL. You report directly to Mr. Tierney?

Mr. LEVY. Yes.

Mr. ORIOL. I would like to ask, do you believe the Medicare extended care is being phased out?

Mr. LEVY. No; I don't, sir.

Mr. ORIOL. Can you tell us the number of retroactive denials made by intermediaries under Medicare within the past year?

Mr. LEVY. Let me respond this way again. We were advised that you wanted to discuss with us the fire safety provisions, and if we had known you wanted to get into this question of retroactive denials, we would have had someone here who could be more responsive. I might say the area of responsibility that both Mr. Sheinbach and I have related to the certification of providers—hospitals, extended care facilities, et cetera—under the Medicare program.

Mr. ORIOL. May we now ask for the record for the information I just requested?

Mr. LEVY. Yes.

Mr. ORIOL. May I also ask for the record copies of all memoranda or directives issued by Medicare to intermediaries relating to denial of benefits and standards that might apply?

Mr. LEVY. We would be happy to submit that, sir.

(See letter from Thomas M. Tierney, Director, Bureau of Health Insurance, pp. 656–659.)

Mr. ORIOL. Can you describe the appeal procedure which takes place when a nursing home questions retroactive denial of benefits?

Mr. LEVY. The nursing home itself actually in accordance with the statute does not have an avenue of repeal. The statute provides that the beneficiary who receives the denial of benefit has the right to appeal his case and then there is a provision, there is a certain monetary limitation——

Mr. ORIOL. Did you say the patient?

Mr. LEVY. The patient.

Mr. ORIOL. The patient is the one that has to make that?

Mr. LEVY. Yes. This is in accordance with the statute.

Mr. ORIOL. Can you give us an estimation how many have made such an appeal within the last 18 months?

Mr. LEVY. We would be happy to check that and supply it for the record if we have it.

(See letter, pp. 656–657.)

Mr. ORIOL. The next witness will inform us that in his experience there has been a marked increase in the number of retroactive denials within the past few months to roughly this: That over the prior year perhaps there were a dozen such denials. Within the last 3 months there have been 50 such denials, 18 of which took place on the same day.

We would like any information that can be provided on the increase in tempo of denials.

Mr. LEVY. Yes.

(See letter, pp. 657–658.)

Mr. ORIOL. Now perhaps you can tell me to your knowledge who in the intermediary agency makes the decision on retroactive denial benefits.

Mr. LEVY. The general pattern in the intermediaries is that they have a staff of so-called claims adjudicators, although this title can vary. The cases are reviewed by them.

Mr. ORIOL. What constitutes a review? What information do you insist that they have when they make a review?

Mr. LEVY. Well, they receive various documentation that the facility submits.

Mr. ORIOL. What is that?

Mr. LEVY. This could be a description from the attending physician and additional copies of pertinent clinical records from the facility.

Mr. ORIOL. What constitutes pertinent clinical records?

Mr. LEVY. Again these could be excerpts from the medical records which the facility wishes to use to support the claim or information supplied by the attending physician.

Mr. ORIOL. Do you insist that all such pertinent excerpts be provided?

Mr. LEVY. Again I would have to say that the area of intermediary review or bills is not my province, I am just speaking as a general observation.

Mr. ORIOL. May we have a statement on that?

Mr. LEVY. Yes, sir.

(See letter, pp. 658–659.)

Mr. ORIOL. These questions, by the way, are based on information which caused Senator Harrison Williams of this committee great concern within the past weeks.

Mr. LEVY. So I understand.

Mr. ORIOL. I believe Senator Williams has a statement to submit for the record.

Let me ask you here for your personal opinion on whether something is wrong in the situation I will now read.

This relates to a patient who was transferred to the Cranford Health and Extended Care Center, Cranford, N.J., from Elizabeth General Hospital on January 21, 1970, after a hospital stay of 20 days.

The diagnosis was diabetes mellitus with insulin shock, arteriosclerotic hypertensive heart disease with pulmonary congestion and left lower lobe pneumonia.

The patient was a poorly controlled diabetic with heart failure involving lungs and peripheral circulation to the point of ulcers on both legs. This patient had been admitted a year previously for similar very poor cardiac status. This patient was improving steadily and continuously with a program of medical and skilled nursing care. It was proposed to discharge him by the beginning of April. On March 31 the intermediary cut this patient off retroactive to March 1.

Judging by the facts presented here, do you think there is something wrong with the situation?

Mr. LEVY. I would like our medical staff to take a look at that and give you a response.

Mr. ORIOL. Let me give you another very brief one.

This patient was transferred from St. Elizabeths Hospital on January 17, 1970, after a hospital stay of 26 days.

Diagnoses was fracture of the right hip.

Elevated sed. rate; anemia; advanced ASHD: cystitis, requiring medication. Complete program of rehabilitative physiotherapy. Certified by the attending physician as definitely able to be rehabilitated if continued on skilled nursing care and physical therapy. Approved by Utilization Review Committee for stay until April. Cut off on March 11 retroactive to February 1, allowing only a 14 days' stay. No patient records were requested by the intermediary before making this decision.

Do you think that something is wrong with this situation, judging by the information given here?

Mr. SHEINBACH. May I ask a question. Did Cranford protest that denial with the intermediary?

Mr. ORIOL. I get a definite yes from Dr. Offenkrantz who is our next witness. Dr. Offenkrantz in his statement will also say that they have never once been given an appeal.

Excuse me.

Dr. OFFENKRANTZ. Once, by protesting to the Senator of the State involved.

Mr. LEVY. That is usually a very effective way of getting an appeal.

Dr. OFFENKRANTZ. The only way.

Mr. ORIOL. May I ask what training, what background Medicare insists that the staff person who works for the intermediary have before they can decide on retroactive denial of benefits?

Mr. LEVY. We have indicated to the intermediaries that these cases should be reviewed by a nurse and/or a physician.

Mr. ORIOL. You have recommended that?

Mr. LEVY. We have indicated this.

Mr. ORIOL. How has it been indicated?

Mr. LEVY. Again I would have to check with our Division of Intermediary Operations who are directly responsible.

Mr. ORIOL. We would like to have anything in writing.

Mr. LEVY. Yes.

(See letter, p. 659.)

Mr. ORIOL. Is it your opinion that it should be a person with medical training?

Mr. LEVY. I would think generally a person with some paramedical background on a case where we are as involved the type of case you were indicating.

Mr. ORIOL. Can you give us whatever information the Social Security Administration has on how many of those persons do have medical background?

Mr. LEVY. Yes, we would be happy to submit this to you, sir.

(See letter, p. 656.)

Mr. HALAMANDARIS. May I ask, Mr. Levy, that you remain at the table and when Dr. Offenkrantz is finished I would like to ask a few questions.

Mr. LEVY. Sure, I would be happy to.

Senator Moss. Thank you very much.

(Subsequent to the hearing, the following letter was received from Thomas M. Tierney, Director, Bureau of Health Insurance:)

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
SOCIAL SECURITY ADMINISTRATION,
Baltimore, Md., June 3, 1970.

DEAR MR. ORIOL: Listed below are answers to several questions you asked about intermediary procedures relating to denial of extended care facility claims because of non-covered level of care.

Regarding our review of the numerous denial cases from Cranford Health and Extended Care Center, Cranford, New Jersey, we are near completion of our report and will mail it to you sometime during the week of June 7.

The questions you asked, and our information, are as follows:

1. What proportion of the claims reviewers in the intermediaries serving the State of New Jersey and the New York City area have medical or paramedical backgrounds?

Hospital Service Plan of New Jersey:

12 lay people.
3 nurses (either practical or registered nurse).
1 M.D.

NOTE: Nurses review all extended care facility (ECF) and home health agency (HHA) bills as well as hospital bills for stays over 17 days. The lay people only review hospital bills for stays under 17 days. In any case where a potential denial appears on the short hospital stay cases, the bill must be reviewed by both a nurse and the physician.

Associated Hospital Service of New York:

14 lay people.
3 registered nurses.
2 M.D.'s.

NOTE: The R.N.'s review all HHA bills. The M.D.'s review all ECF bills plus any questionable hospital bills. The lay people review only hospital bills, but cannot deny any for medical reasons without review by one of the physicians.

Prudential:

21 lay people.
1 paramedical background.
3 registered nurses.
1 M.D.

NOTE: All potential denials (i.e., the bill processor believes the bill should be denied for medical reasons) must be reviewed by one of the nurses. Only if she agrees, can the bill be denied. The physician is available for consultation and for contacts with billing physicians.

2. How many retroactive denials (ECF claims) have there been in the last year? In the last 3 months?

Information on retroactive claim denials is not available. The most pertinent available data is reflected in the following table which refers to admissions and bill denials. The bill count is substantially higher than the number of beneficiaries admitted to ECF's because in many instances more than one bill is submitted per patient, depending on the length of stay and the particular ECF's billing cycle. During calendar year 1969, there were 517,819 ECF admissions and 1,129,401 processed bills of which 63,756 or 5.6% were denied fully or partially because of a non-covered level of care. For the quarter ending 3/31/70 there were 116,876 admissions, 236,970 bills processed, and 19,390 or 8.2% bill denials.

The number of denied bills is a combined total of bills which were denied both fully or partially because all or part of the care was determined to be not covered under the provisions of the law. There is no separate breakout of the full and partial denials.

Neither is there a count of how many denials covered a retroactive period. However, there is one category which constitutes from one fourth to almost one third of all denials which would not involve retroactive denials. These involve admission notices submitted under a special assurance of payment privilege granted to ECF's which in the opinion of the intermediary understand and conscientiously apply the level of care guidelines. When such an ECF admits a patient whose prescribed level of care is not clearly covered or noncovered, the ECF submits pertinent medical information with the admission notice to the intermediary. In these cases the intermediary makes a prompt decision on the bases of medical information submitted with the admission notice and notifies the ECF whether the case is covered. Even if the level of care were not covered, payment would be assured until the date the notice is received by the ECF. Thus

any bill submitted under this procedure for this period will not be denied retroactively to the date of admission. For 1969, these denials constituted 22.9% of the total denials, and for the first quarter of 1970, 29.7%.

In addition there are certain claims in which the ECF or utilization review committee may notify the intermediary of a change in the patient's level of care or the intermediary may approve coverage to a specified future date. Most of these cases would not involve retroactive denials. The number of such cases is unknown.

Quarter ending date	Total admissions	Admissions under assurance of payment denied	Total bills processed	Bills fully or partially denied for noncovered care	Col. 3 as percent of Col. 5	Col. 5 as percent of Col. 4
(1)	(2)	(3)	(4)	(5)	(6)	(7)
Mar. 31, 1969	133,400	1,100	298,638	10,679	10.3	3.6
June 30, 1969	135,581	3,289	312,124	16,402	20.1	5.3
Sept. 30, 1969	135,184	5,043	271,447	18,983	26.6	7.0
Dec. 31, 1969	113,654	5,146	247,192	17,692	29.1	7.2
1969 total	517,819	14,578	1,129,401	63,756	22.9	5.6
Mar. 31, 1970	116,876	5,756	236,970	19,390	29.7	8.2

3. What appeals procedure does an ECF have if it feels the intermediary is denying claims without proper physician review or feels the intermediary is not implementing SSA's requirements properly?

The Medicare law makes no provision for provider appeals to the Secretary whether arising from the application of the cost principles or the amount payable in a specific case. The intermediaries are charged by contract with the responsibilities of making coverage determinations and determining the reasonable cost reimbursement due the providers. The intermediaries are further charged by contract to:

> Establish and maintain such procedure as the *Secretary* may approve for considering and resolving any differences which may arise when payment to a provider of services on behalf of an individual for services furnished him has been denied or when the amount of such payment is in controversy;

The Blue Cross Association (serving 75 percent of participating providers), in conjunction with the subcontracting Plans, has developed a "BCA Provider Appeals Procedure" providing for a "two level" appeal. First the local Plan affords the provider a review it customarily grants in settling disputes in its own business. The provider, if dissatisfied with the outcome of the local review, may appeal to the national level, i.e., the "BCA Provider Appeals Committee," which includes provider representatives.

The other intermediaries provide some mechanism for higher level review of their intial decisions within the organization.

Quite apart from the appeals process, where the intermediary is, in fact, not administering SSA requirements properly, it becomes a question of performance or compliance with the terms of the agreement between the contractor and SSA. SSA does consider and pursue such complaints or protests.

4. How many denials have been appealed and the results? Also, has there been a recent increase in appeals (on a national basis)?

The health insurance appeals process (involving provider services) provides for a beneficiary dissatisfied with an intermediary decision on his claim to request a reconsideration of the claim within 6 months of the intial decision. The intermediary then reconsiders the case and the reconsidered decision is reviewed by SSA which then advises the beneficiary. The beneficiary is then given 6 months from the date of the notice of the reconsidered decision, if dissatisfied, to request a hearing by a hearing examiner of the Bureau of Hearings and Appeals.

In accordance with the above, we have the following data beginning with 12/69 broken down to show ECF denials and the number of reconsiderations received and processed each month. Prior to 12/69, information as to reconsiderations was not broken out by the type of provider categories involved, i.e., Hospital, ECF, or Home Health Agency.

Month	Total ECF denials	Recons. received by SSA	Col. 3 as a percent of col. 2	Recons. cleared by SSA			Partial reversal	Col. 6 as a percent of col. 5
				Total	Affirmed	Reversed		
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
December 1969	6,897	755	10.94	744	619	101	24	83.19
January 1970	7,558	836	11.06	846	733	88	25	86.64
February 1970	8,071	827	10.24	823	719	73	31	87.36
March 1970	10,118	1,104	10.91	853	741	78	34	86.86
April 1970	10,354	1,085	10.47	531	462	57	18	87.00

The following data shows the number of reconsidered cases which wese subsequently heard on appeal by a Hearings Examiner and returned to the Social Security Administration in each of the months indicated. Prior to 12/69 the information was not broken out by provider category.

Month	Completed hearings returned to SSA by BHA	Number affirmed	Col. 3 as a percent of col. 2	Number reversed	Col. 5 as a percent of col. 2
(1)	(2)	(3)	(4)	(5)	(6)
December 1969	34	22	64.7	12	35.3
January 1970	22	21	95.5	1	.5
February 1970	54	48	88.9	6	11.1
March 1970	1	1	100.0	0	0
April 1970	135	86	63.7	49	36.3

5. How does an intermediary go about processing a denial, that is, who sees the case, what documentation is needed to substantiate a denial, etc.

Intermediary ECF claims activities are directed toward assuring that, as a condition for payment, necessary skilled services have been prescribed for and provided to the patient for the same illness which required a stay of 3 or more days in a hospital. If these services appear to be appropriate to the patient's condition and require skilled nursing care, the intermediary determines, in the absence of evidence to the contrary, that the care constitutes covered care.

Since April 1967, we have issued several intermediary letters and other materials (see Appendix 3, p. 716) giving intermediaries instructions for determining the level of care furnished patients in extended care facilities. These instructions provide that the views of the attending physician and the utilization review committee be thoroughly considered before a case is denied, and emphasize the responsibility of the intermediary to inform the committee and facility of questionable cases so that the possibility of conflicts between the views of the patient's physician, the committee, and the intermediary's medical staff are minimized.

Followup on the provisions of our various instructions on level of care disclosed some significant inconsistencies among intermediaries in determining whether stays in extended care facilities are covered. In April 1969 Intermediary Letter No. 371 provided greater detail regarding factors that should be taken into account in making such determinations. Instructions in this letter serve as basic guidelines and do not remove the judgmental factor necessary to resolve questionable cases. Intermediaries were asked to supplement these instructions, where necessary, with specific claims review instructions and procedures adapted to their individual claims processing systems. Generally, the "typical" intermediary processes denials as follows:

The admission form is first reviewed by a claims examiner applying the screens contained in I.L. No. 371, together with any related guides prepared by the intermediary. Claims which do not pass this screen are usually referred to paramedical personnel (nurses trained in the evaluation of these cases) for review. The nurse may make a determination or request additional information. A denial is rarely arrived at based on the limited information provided in the usual billing process. Additional information requested by the reviewing nurse may include nursing notes, attending physician's orders, progress notes, medical information form, transfer form and/or the discharge summary from the hospital. If these sources of information are insufficient to approve the claim, additional documentation by the ECF utilization review committee or the patient's attending physician is requested.

Through these sources of information, intermediary paramedical personnel usually are able to determine whether to allow or deny. In exceptional cases, the claim may be referred to the intermediary's medical staff for consultation before final action is taken by the claims staff.

6. What professional or educational requirements are established for people who review and pass on claims, i.e., must they be nurses with nursing experience, physicians, college graduates, etc.?

SSA has not established any mandatory professional or educational requirements for carrier and intermediary personnel who review and pass on claims. Instead, we have emphasized that claims reviewers must have proper training and supervision and that each intermediary and carrier have medical personnel to give consultation and advice on questionable claims.

Generally, claims examiners are lay personnel. They usually undergo a training period before contractors allow them to process Medicare cases. Written guidelines are used by the examiners to enable them to uniformly review and pass on claims. If the claim falls outside of the guidelines, the examiners usually refer the cases to a medical technician or professional nurse for review. If, after this review the claim is to be denied, the case is usually referred to a physician or a physician advisory group to make a final determination of denial.

The surveillance of contractor performance in this area by the Social Security Administration indicates that while all contractors understand their responsibility and are taking steps to assure proper program reimbursement, their performance varies somewhat. Although we have full awareness of the difficulty involved in this aspect of carrier performance, nevertheless, we will continue to require whatever improvements are necessary in the claims process of contractors to assure quality claims review.

You also requested copies of all pertinent intermediary instructions, memorandums and rulings regarding denial of ECF claims. These materials are enclosed in the attached folder.

Please contact me or my staff if we can be of further assistance.

Sincerely yours,

THOMAS M. TIERNEY,
Director, Bureau of Health Insurance.

Senator Moss. We will ask Dr. Offenkrantz if he will come forward now.

Unfortunately I will have to leave, Doctor, before you complete your statement because the time has gone much faster than I expected and I have a commitment I must keep. Mr. Oriol and Mr. Halamandaris, the professional staff members will remain, will continue the hearing and will make the record on which the subcommittee and the full committee depend.

I apologize to you that I will have to leave before you have completed your testimony but we would like to have you come forward now.

Dr. Offenkrantz is the medical director of the Cranford Health and Extended Care Center, Cranford, N.J., and as such he has first-hand knowledge of the problems that we have been talking about here about rehabilitation and care of the elderly in the nursing homes of long-term care facilities.

Proceed, Dr. Offenkrantz.

STATEMENT OF FREDERICK OFFENKRANTZ, M.D., MEDICAL DIRECTOR, CRANFORD HEALTH AND EXTENDED CARE CENTER, CRANFORD, N.J.

Dr. OFFENKRANTZ. Thank you, Senator Moss, for the invitation to speak here.

My name is Frederick Offenkrantz. I am a physician, the medical director of the Cranford Health and Extended Care Center in Cran-

ford, N.J. This is a facility operated by the nonprofit New Jersey Rehabilitation Care Foundation as one of a number of projects designed to give the most advanced long-term care possible in areas of New Jersey, extending from Princeton to the inner-city ghetto of Newark. The foundation's basic purpose is to serve people who might not otherwise be able to afford or obtain such long-term care.

I wanted to say that Commissioner Newman made an interesting statement. He said he regarded his Bureau as the patient's protagonist. I am very happy to here this because in my dealings with subgroups of the SSA they act more like the devil's advocate in this type of thing.

As I am sure the committee knows, extended care is post acute general hospital institutional care, designed to cut down on the days required in an acute hospital. The ECF patient needs both medical and skilled nursing care beyond that of simple custodial care.

My purpose in coming here is to, on behalf of our patients protest the number and method of Medicare cutoffs at our facility through our fiscal intermediary, New Jersey Blue Cross. Within the past year there have been over 50 such cutoffs and only recently we were notified of 18 such terminations in one day. The tempo appears to be increasing, apparently by design, and I am here to protest these actions on the following bases.

With regard to Mr. Oriol's statement I would like to repeat that during the first 18 months of operation we had less than 12 retroactive cutoffs and in the period from March through today we had over 50 such cutoffs. During this time we admitted less than 200 patients which means for statistical purposes as I see it 50 out of 200.

Now I would like to protest these actions on the following bases:

1. Every cutoff was made despite referrals from general hospitals whose utilization review procedures embody referrals to ECF's. Further, in every instance a referring physician from a general hospital certified to the need for ECF care. These patients are sent to us from their hospitals in accordance with the Medicare rules.

2. Cutoffs were made with total disregard to the certification by the attending physician at the Cranford facility as to need for ECF care, plus a preadmission review by the administrator, the very capable and experienced director of nursing, and by the medical director.

3. The utilization review committee of this nonprofit community facility is comprised of, among others, a physiatrist—this is a physician trained in physical therapy—the medical director and a practitioner of many years standing in admitting patients to this facility. In each instance of retroactive cutoffs, this committee had certified to the necessity of additional ECF care, within the guidelines from the Social Security Administration as best we can interpret them, plus our mutual judgment.

4. In many cases no portion of the patient's chart, except for an initial checklist, was requested or reviewed by the individual making these cutoffs, which, of course, should be medical judgments.

By the way, on that last statement, No. 4, since we started raising heck about this—and the cutoffs have been in effect for over a month—we have had requests, and I have them here, from the intermediary asking for these charts that they had already cutoff without the benefit of the charts.

5. In every instance the cutoff was made retroactive up to as much as 7 weeks from the date of our notification, sometimes this was to the date of the patient's admission to this facility. In several instances the date of cutoff was actually after the death of the patient. Unheard of.

6. In many instances the attending physician has flatly refused to order discharge of patients following these cutoffs. Because of the severity of the patients' illnesses, these physicians felt strongly that discharge would constitute malpractice. I must call your attention to the fact that if this constitutes malpractice on the part of the attending physician, it constitutes malpractice on the part of the intermediary in so ordering, contrary to our combined medical judgment. Since many of these victims come from poor areas, many being inner-city ghetto residents from Newark and Elizabeth, N.J., they cannot afford the charges; and as a nonprofit facility, we are deeply in debt because of those denials which are made long after we, in all good faith and honesty, have rendered the service.

As Dr. Miller pointed out, we cut off most of the people applying for admission long before they ever get to us.

7. Despite repeated efforts, no appeal to reason, no appeal for review and no appeal to professional judgment or humanitarian need has been entertained by the New Jersey Blue Cross plan or the Social Security Administration.

I have to modify that. In the last couple weeks we received the one review and acceptance of further hospitalization on the part of the patient who had complained to us.

8. In no instance during my almost 2 years of tenure as the medical director has a physician from the intermediary or the SSA contacted me regarding a cut-off. This, in my opinion, constitutes a serious defect in the entire program. It permits unnamed persons to effect virtually a life and death decision on these patients whose requirement for additional care is certified to by referring physicians, treating physicians, consultants and utilization review physicians at this extended care facility.

May I beg the indulgence of this committee in reviewing my background, to explain what I think are my qualifications for appearing before you with this appeal. I am by training a pathologist, graduated from Bucknell University and the Columbia College of Physicians and Surgeons. In addition, I hold a master's degree in public health administration from Columbia University. My attention to the problems of pathology which are inherently those of diagnosis and the course of disease has given me interest in several associated activities. The one in which I appear before you is that of the admission, treatment, supervision and discharge of the geriatric patient under Medicare.

In the opinion of the Foundation leadership, which comprises trained educators and administrators in the health field, a pathologist so interested, constitutes a proper and valuable medical person to objectively evaluate the sick and afflicted geriatric patients being admitted for ECF care. It was felt that having someone trained exclusively in the evaluation of illness rather than subjectively in the treatment of patients was a step towards fully scientific, objective procedure. This was intended to assist the treating physician along

the path of every scientific requirement on behalf of the Medicare statutes. We attempted to avoid, by such guidance, the possibility of subjective overinvolvement of a treating physician with his patient.

Appearing before you as I do now, I find that my more than 20 years of relationship with scientists within and outside of government gives me an interesting basis for comparison with medical supervision for ECF's under Medicare. As I have indicated to this committee, there is a remarkable lack of scientific approach, medical control, and generally accepted medical attitude on the part of our intermediary and/or SSA, towards the admission, care and discharge of patients in ECF's. I will be pleased to discuss this to whatever extent this interests the committee. However, I can only conclude that judgments on the part of the government and its agent are being made by incompetent, unskilled, disinterested, uninformed or misguided personnel.

Further, the custom in most large organizations, either government or private, is to open avenues of appeal and discussion to those who might question, on a scientific basis, the original medical phenomena described. Such avenues appear closed in the administration of this program. If they are open, we have been unable to find them.

Mr. ORIOL. Dr. Offenkrantz, Mr. Levy told us a few minutes ago that the appeal procedure is open only to the patient.

Dr. OFFENKRANTZ. Yes.

Mr. ORIOL. But you are attempting to make an appeal because of the need which you have to find a way to express?

Dr. OFFENKRANTZ. On behalf of the patient, Mr. Oriol.

Mr. ORIOL. On behalf of the patient.

Dr. OFFENKRANTZ. Yes.

Mr. ORIOL. Are most of your patients in a position to take advantage of the appeal procedure?

Dr. OFFENKRANTZ. Very few of them are.

Mr. ORIOL. What stops them?

Dr. OFFENKRANTZ. Money.

Mr. ORIOL. Why is money needed?

Dr. OFFENKRANTZ. Well, it is my experience with the poor, Mr. Oriol, that they learn early in life that it is very difficult to fight city hall.

Mr ORIOL. Are the services of an attorney needed to make an appeal?

Dr. OFFENKRANTZ. Not actually. Some of the poor old people have families who are little versed in methods of dealing with these things, and they make appeals, but most of them do not, they just fall back into their home environments.

Mr. ORIOL. And you feel the only way for them to make an effective appeal is through you?

Dr. OFFENKRANTZ. Yes.

Mr. ORIOL. Mr. Miller.

Dr. OFFENKRANTZ. Excuse me. We have made the appeals directly, we think, to the individuals passing the judgments rather than to an administrative supervisor in the intermediary area. These appeals in all cases where they have been made, even doctor to doctor, doctor to nurse, have been turned down.

Mr. MILLER. A question with reference to this matter of appeal. The appeal is made to whom, the intermediary?

Dr. OFFENKRANTZ. Yes, Mr. Miller.

Mr. MILLER. Is there any appeal process available—and I direct this question also to Mr. Levy—beyond the intermediary?

Mr. LEVY. Yes. The way it works is that the patient has a right, first of all, to ask for a reconsideration of his case. If on reconsideration the case is still turned down or processed to his dissatisfaction, he has a right, if the amount of the bill at issue is $137 or more, to ask for a hearing and it is by a separate entity of the Social Security Administration and the Bureau of Hearings and Appeals. They have a number of hearing examiners on their staff that review these requests for hearing. If the amount at issue is $1,000 or more, the patient has a right to seek judicial redress. This, I might add, is set forth in the Medicare statute.

Dr. OFFENKRANTZ. Mr. Levy is correct.

Mr. MILLER. This appeal process is applicable to all types of appeal for all kinds of services under Medicare?

Mr. LEVY. No, I am only referring to cases under so-called part A of Medicare—patients either in a hospital or extended care facility or receiving home health services, not who are dissatisfied with their decision. It works a little differently under part B.

Mr. MILLER. How does it work differently?

Mr. LEVY. Under part B we are talking about a patient who receives primarily physician services. There the individual has a right to a hearing before the carrier, the paying agent. In other words, if he is dissatisfied with the way his bill is handled, he must seek redress from the carrier such as Prudential, whoever is handling his case.

Mr. MILLER. Of course, they are the ones who have made the initial decision.

Mr. LEVY. That is correct.

Mr. MILLER. Does he have any appeal available beyond the carrier?

Mr. LEVY. I don't believe so, under statute.

Dr. OFFENKRANTZ. Mr. Levy, not to correct you, but we have had a couple of appeals carried back to Baltimore, where the patient had appealed to the intermediary, was turned down, and then retained counsel and did carry the appeal forward.

Mr. LEVY. We of course would always be glad to look at the case involved.

Mr. MILLER. I would like to make the observation that it has come to our attention in a number of instances that there is considerable dissatisfaction with the lack of appeal beyond the carrier which makes the decision in the first place, and this prompts my question. The impression has been conveyed—that the judge is the one who is being accused of having made the error in the first place when the carrier does it.

Dr. OFFENKRANTZ. In most cases, Mr. Miller, this is what does happen. The patient or his family will not carry it beyond a simple letter or a telephone call to the intermediary.

Mr. MILLER. I might say that a very distinguished and highly competent journalist, now retired, has corresponded extensively with the Commissioner of Social Security on this problem. It is something that is, I think, of concern to many people. I am particularly concerned about part B, the lack of an appeal process beyond the carrier.

Mr. ORIOL. Dr. Offenkrantz.

Dr. OFFENKRANTZ. I will skip this next portion, if I may, of my statement which deals in an attempt to just comment as a side item, the fact that during World War II, I served as a medical officer under General MacArthur and had occasion to render a couple of unpalatable medical decisions to his Surgeon General and himself and was confronted by the general who accepted—I was then a major—my medical judgment on it. As I look back over these episodes I am rather proud of this and suggest that even General MacArthur was willing to accept the advice and counsel of the doctor on the scene at the particular time.

For General MacArthur to accept this, I am at a loss, therefore, having functioned for many years under the authoritarian arrangements of the military and the rather strongly held opinions of other agencies such as the FDA to understand the mechanics of this governmental program which appears to operate only by fiat. Nowhere in Government or public service does the question of human life and well-being become a matter of large numbers and special concern as it does with the Medicare admission to hospitals and ECF's. The citizens affected here are not young people with tremendous powers of recovery, they are geriatric patients in whom errors of judgment can very well be fatal.

Obviously, the Congress recognized this by giving the final authority for hospital and ECF stay into the hands of the medical profession, with appropriate and fully acceptable safeguards involving systems of review and certification. The question of a patient's stay in our ECF comprises the considered judgment of as many as 10 different unrealted, and often unknown to each other, physicians. How can all of this be discredited at the whim of a clerk or young nurse functioning in Baltimore or Newark for the thousands of ECF patients in New Jersey and elsewhere?

Other government agencies, up to and including the staff of Douglas MacArthur, have always seen fit to obtain the judgment of medical officers with regard to those problems in their jurisdiction and to accept the judgment if the physician, upon discussion, could sustain his beliefs. Why then do the administrators of the ECF component in Medicare with life maintenance at stake afford no such discussion to any of the physicians involved and, to my knowledge, refuse reversal upon appeal in almost every instance. Appeals of all types are handled in an unprofessional and frequently insulting manner in our area.

There is inherent in this problem, gentlemen, a further contradiction which may make this entire situation indeed the farce it is rapidly becoming. If SSA and the fiscal intermediary can successfully cut off the patients in ECF certified to by competent medical judgment, who may they not then refuse payment to the attending physicians who cared for the patient during the interval subsequently cut off? Logically, this should follow. If the patient should not have been in the ECF by the judgment of the intermediary, contrary to the opinions of the physician, does not the fee, for professional attendance upon that patient, to the doctor, become cut off also? This has not happened to my knowledge. I believe it could happen, and if it does I think there is one foul mess that will ensue thereafter.

The system of doctors in authority checking upon doctors in attendance upon patients has worked reasonably well in medical education, accredited hospitalization, all forms of medical insurance and in governmental agencies. Where does SSA and the fiscal intermediary derive the privilege of negating all of these activities over and over again? I am certain that in cases I have drawn to your attention the will of the Congress with regard to the Medicare patient receiving proper and just ECF attention is being thwarted.

Please accept this urgent plea from a physician who has come to see this program as the life-giving activity it is. I ask that this committee trust the physicians participating in this type of patient care and evaluation. They are healing the elderly, sick, and disabled, returning them to a status of selfcare so as not to be the great burden on family and community so frequently seen. They are doing this well within the 100-day limit envisioned by the Medicare Act.

I pledge to you my support in making this program work. But neither I nor the doctors can do anything when people of inadequate background are able to upset our best judgment with immunity from basic factors, such as reference to a patient's medical record, including utilization review, or an appeal by the patient's attending physician.

Thank you for the privilege of appearing.

Mr. ORIOL. Dr. Offenkrantz, do you have a few more minutes?

Dr. OFFENKRANTZ. Yes; I do. May I comment as to what other data I have here? I have letters from some of the attending physicians with regard to four or five cases that were outstandingly bad in their opinion. I have pictures of a poor lady with two fractured forearms who was cut off back to the day of admission by the intermediary.

Mr. ORIOL. On what grounds, Mr. Offenkrantz?

Dr. OFFENKRANTZ. They don't have to tell us.

Mr. ORIOL. But this does indicate that they thought that she would be able to fend for herself at home with two broken arms?

Dr. OFFENKRANTZ. No; Mr. Oriol. It comes back to the skilled nursing care. Ostensibly these cutoffs are made on the basis that the patient does not require skilled nursing care. This is the great phrase that Dr. Miller referred to before and which we are trying to live with but find it very difficult to.

I mean, how this lady with two fractured forearms can do it, I don't know.

One of the really significant items in this whole business, Mr. Levy, is the fact that a number—and I mean a number, not just one or two—a number of these patients, by the time the intermediary got around to cutting them off retroactive to a given date, had died subsequent to that date, this means that at that moment, if by some miracle we could have flashed back in time and sent these patients home as of the date suggested by the intermediary, these people would have died in their home from items connected in most instances with the affliction for which they were being hospitalized.

I have a list where on the last-minute basis our social service worker contacted families to find out what happened to the patients. We have about 30 comments. Many went back to acute hospitals as Dr. Miller suggests. Instead of $30 a day in the ECF, they go back for $100 a day into acute hospitals. Many have died. Many constitute an over-

whelming burden on their families. They have to be carried up and down steps, in and out of bed because their rehabilitation was not completed in the ECF.

I have some patient charts here. Our Director of Nursing is quite a fabulous gal. Every time the intermediary calls her she writes notes on pieces of paper, especially on the request of the intermediary, for more information on the charts.

And what happens? The dates, the hours of the calls and all. We have all these here showing the lapse of time between the patient's admission, the patient's hearing from the intermediary regarding the cutoff, the retroactivity of the cutoff and the request in every instance and asks for many of the things which Mr. Levy said they did ask for.

But they leave out a very interesting item that is not asked for in any of these, the certification and recertification of the attending physician that the patient needs ECF care. That is not asked for at all.

The comments of the lady with whom we deal down at the Blue Cross are noted here. There are notations. There are checklists which are requested and which we send in. We were told we didn't have to, but when these cutoffs came in we started sending them in. We have notations here on the checklist approved for medical care for ECF long-term care and then 2 weeks later we get statements saying it is cut off behind the date for which the checklist approved.

We got all kinds of documentation here to substantiate the things that I am complaining of.

Mr. ORIOL. Dr. Offenkrantz, you have provided the committee with I guess about 50 examples of retroactive denials.

Dr. OFFENKRANTZ. Yes, sir.

Mr. ORIOL. May I have your permission to give this to Mr. Levy so that we may have official commentary on this?

Dr. OFFENKRANTZ. Yes.

Mr. ORIOL. Could you tell us just a little bit more about the purposes of the foundation and the extended care center? You are trying to set high standards of care, as I understand it, with the heavy emphasis on rehabilitation.

Dr. OFFENKRANTZ. Yes; we are. We employ a physiatrist-physician trained in Medicare and physical therapy. There are very few of them around. We are very fortunate in having obtained the services of one.

We are faced with something that I have not even mentioned to this committee, I hope there will be another hearing on it. We are now getting retroactive denials of physical therapy. Physical therapy, people with fractured hips, people with strokes who are paralyzed, who are being rehabilitated. By rehabilitated, I mean able to go back to their home or to the home of a family member where they can be self-caring.

This is our intent at least to be able to care for themselves, where they won't have to be carried in and out of bed, up and down steps. This is cut off.

Now, we fussed with this. That is, this material is not even included in my documentation here. Dozens and dozens of these were cutoff, some back to where only a few treatments would have been allowed under the intermediary's judgment.

Our argument is that the number of patients who come to physiotherapy is not by any stretch of the imagination the total number of

patients in the facility, but people, who in the opinion of a physician, trained in this type of work will benefit from this treatment. Many of these people have been compelled to remain in the facility at their own expense, being treated by physiotherapy at their own expense.

In our facility, which is a nonprofit setup, we accept people without regard to ability to pay and without a deposit. Now, many extended care facilities are requiring some sort of deposit from their patients so that if there is a retroactive denial they will have in hand a few hundred dollars to defray the bill.

Mr. ORIOL. Mr. Levy, are nursing homes permitted to require deposits?

Mr. LEVY. No, sir.

Mr. ORIOL. Doctor, you say that——

Dr. OFFENKRANTZ. I know that this is being done.

I am sorry, Mr. Levy. I won't comment on names.

Mr. HALAMANDARIS. Dr. Offenkrantz, we covered this when Dr. Miller was on the stand. I talked about intermediary letter No. 173 with regard to physical therapy which came out in January and we knew then that when it was implemented we would begin to have retroactive denials with regard to physical therapy.

It is now May, it has been 4 months since January. So as you said, we are beginning to see retroactive denials with regard to physical therapy.

As you know, the latest intermediary letter requires the re-evaluation of the salaries of administrators and personnel so without sounding like a prophet, I can say that about 3 months from now you can begin to see retroactive denials in salaries of nursing home administrators and personnel.

Now, I doubt if there is anybody in the audience who would appreciate having his salary reevaluated on the basis of criteria announced today with unpublished guidelines applied retroactive to the last 3 years. I know I too would resent having to pay back money received from Medicare which is today deemed to have been improperly paid.

Now, Mr. Levy, I have one comment here to tell you why you are in the position you are. You are in your present predicament by default because we asked your superiors to be here today, they have responsibility over both Medicare and Medicaid. I refer to Under Secretary John Veneman, Mr. Lewis, Mr. Butler, and the others that we asked for who could not be here today. So you are here by default.

A second point. We have suffered from a communications gap, as you know. Your office was in contact with Mr. Howard Cohen's office, who effectively makes the decisions with regard to who appears at hearings. I was asked why we wanted people from the Bureau of Health Insurance.

The answer I gave to Mr. Cohen's office was (1), we are going to talk about retroactive denials and (2), I had a lot of questions with regard to the regulations which your office circulated with regard to inflammability of carpets.

Now, before you leave, I am going to ask you a couple of quick questions but I just wanted to explain why you are here and why you are putting up with this.

You are here because people higher up the ladder have dropped the ball.

Mr. LEVY. If I knew that had happened I would have implored them to come.

Mr. MILLER. Mr. Levy, do you know the reason for Mr. Veneman's inability to be present?

Mr. LEVY. No, sir.

Mr. HALAMANDARIS. Senator Moss said Mr. Veneman was appearing somewhere else.

Mr. MILLER. I heard Mr. Veneman was appearing before the House Ways and Means Committee today.

Mr. LEVY. Yes.

Mr. MILLER. I assume Mr. Butler is probably in attendance with him, also.

Mr. LEVY. I assume so.

Dr. OFFENKRATZ. I would like to make one more point with regard to this, I think it is quite essential. There are really two things that I am protesting. One, the cutoffs. It is illegal to cut things off retroactively, there must be a mechanism for cutting off at the time of admission. If they are going to deny all the doctor's statements that this patient should come in, let him cut the patient off, and this is what has been happening the last several months since this became known throughout the area in which we function. They are staying in the acute hospitals longer, there is no question about that. But if that is the way it is, OK. That should be done.

Secondly, that these judgments must be made by physicians at the other end. We know that when the intermediary says they are being made by physicians, they are not. They are being made by—Mr. Levy used the proper word, claims adjudicators.

Primarily in that case this means nurses. We have knowledge that never has a doctor on the staff of the intermediary ever refused what the nurse stated was her judgment.

I would like to point out to the committee that Congress did set the 100-day limit on an ECR stay. Somewhere along the line Congress must have received medical information to the effect that 100 days constituted a reasonable period of time for the rehabilitation of what is the greatest volume of geriatric patient necessity—the heart situations, the hip fractures and the strokes.

Now I think you will find that in and of themselves most extended care facilities, very seldom actually request 100 days on their utilization review procedures. They are just as much alert to the need of keeping costs down as anyone in SSA and they want to make this program work.

You will find that most of the utilization review procedures allow much less than 100 days in their reviews but the way it is working out as the intermediaries are handling these cutoffs, it seems to be coming down to an average of 20 days.

I attended a Regional Hospital Association meeting in the Fall for a southeastern part of the country and I got some really unheard of figures. Fractures of the hip in the State of Tennessee are averaging 15 days as of October 1969 in ECF care, and in other States similarly the days being permitted or utilized are coming closer and closer to zero. I think that is why the question was raised before.

Is the program being phased out for all practical purposes? It would almost seem that way.

Mr. ORIOL. Dr. Offenkrantz, what is the longest period of retroactive denial you have experienced?

Dr. OFFENKRANTZ. Seven weeks.

Mr. ORIOL. Seven weeks?

Dr. OFFENKRANTZ. Forty-nine days.

Mr ORIOL. Why did it take 7 weeks?

Dr. OFFENKRANTZ. Well, we had a dilly of a situation, Mr. Oriol. As I said, I share the committee's feelings with regard to Mr. Levy accepting all of these horrible facts but I am sure he will communicate them back to the proper officers.

Mr. ORIOL. Let the record show he nodded his head quite emphatically.

Dr. OFFENKRANTZ. There must be a purposefulness for it to happen this way. On one day we received 18 cutoffs. Now it is incredible to me as a physician that a batch of charts and records would have come down of which 18 on 1 day could have been properly judged incorrectly admitted to an ECF.

Mr. SHEINBACH. Mr. Offenkrantz, if I could just speculate because I don't know it may have been that these cases were being held for a physician's review. He came in, spent some time on them and got them all out the same day.

Dr. OFFENKRANTZ. No, sir. Unfortunately——

Mr. SHEINBACH. Struck out again.

Dr. OFFENKRANTZ. Unfortunately, it is not true. They are the first 18 on my list here. No patient records were requested by the intermediary before making this decision in any of the 18 cases.

Now I have here the request from the intermediary. This time a manager of Medicare service, not from the doctor or the nurse;

"Gentlemen: To enable us to review this case, will you please submit the information requested below regarding the services rendered from"—"physician's order sheet," and so forth.

They got all this. This is 4–16. This patient had been cut off retroactively on 3–11 back to February 1, and on 4–16 he sent for the records.

I mean this frankly. There are ladies present or I would tell you what I think about that.

Mr. ORIOL. Dr. Offenkrantz, we have two unscheduled witnesses. However, I just wanted to—Mr. Miller has some questions.

In terms of your definition of rehabilitation, are you running into conflict with what others might call custodial care?

Dr. OFFENKRANTZ. I imagine this can be correctly stated, Mr. Oriol, as being an area of overlapping. We try to define it exactly. Our physiatrist who works in many acute hospitals has a very sharp personal conviction with regard to custodial care.

He feels this program could fall down if too many custodial care patients were receiving ECF care, and especially physiotherapy. He cuts them off. He would like that if doctors review the charts, that this definition be a sharp one.

Now we do this administratively. I agree with Dr. Miller that——

Mr. ORIOL. Dr. Miller would like to say something.

Dr. OFFENKRANTZ. I know how he feels about it and I agree with him.

Dr. MILLER. Doctor, you agreed too soon. Dr. Offenkrantz, I know you are a pathologist and I appreciate you are now developing clinical experience in medicine, but the question just passed as a crucial issue.

What is the rehabilitation potential of the ill aged in the nursing home? Let me address myself to that, please.

Most physiatrists whom you have been referring to all along, Doctor, are hospital-trained physicians. Their functions in the hospital are essentially of short-term duration. Their blinders have been on for years.

Let me give you some facts, please. Rehab in the nursing home and the ECF is simply a different kettle of fish. Let me describe it. Given a patient with one, two, three, or four strokes with or without associated heart disease, who may be a diabetic, can't see, can't hear, has difficulty in standing, difficulty in walking, maybe in talking. Now we have received patients from rehab centers in hospitals where the doctors there have said this patient has now stabilized, there is no further prognosis for improvement.

We have taken those patients in our institution, they have continued to improve over periods of 1½ to 2 years.

We have learned the following: Rehab of the ill aged, the extended care facility for the nonenvironment. The prognosis cannot be described nor anything less than 1½ to 2 years in contrast to the man you are describing who essentially having trained in the hospital, who after 90 days or after 6 months will say this patient has stabilized out.

In our experience, this cannot be applied to those who are 80 or 90 years of age, and the most important issue. Let me address myself to a specific. What are the goals we are pursuing in ECF? Let me describe that. Eighty percent of our patients have associated brain disease. The vast majority have no homes. Those who do have homes live in homes not belonging to them. Those who do live in homes live in homes with their children, nephews or nieces, or supervised by neighbors.

Their disabilities are permanent and basically total. If one considers that the moment a man begins to forget, the moment a man begins to show confusion, the moment a man can no longer control his own funds, the moment a man runs the risk of being lost in the street, please believe me that person is totally disabled whether he can walk or not.

Now, what are our goals? Our goals are to help a man return or recapture function at a higher level than when he was admitted to our institution, recognizing that for 80 percent of our patients he will always require a supervising requirement as long as he lives. Please get that straight, No. 1.

No. 2, please understand the patients we are talking about have cronic progressive disease. Diseased in the elderly is not static, forget it.

A major issue that we have to face is not only the frustration of pursuing return of function but a major part of our effort is derived and directed at maintaining what they have got in the face of progressive disease. Please keep that in mind. Please keep in mind the patients we are talking about are essentially totally and permanently disabled using conventional criteria of functional capacity of daily living.

Dr. OFFENKRANTZ. Mr. Oriol——

Dr. MILLER. In this prospective environment, we will help them live or improve the quality of living, always supported by a complex of skills of all the professionals working therein.

It is the duration of care required by this particular patient, potential population, that has been overlooked by my colleagues who have been trained in the hospital. They must leave the hospitals; they must come out and see where the old people are being cared for.

Only under those circumstances will we develop a meaningful understanding of the rehab potential of the chronically ill aged.

Mr. MILLER. I think it is important that while strawberries are important and pineapples are important, that we not discuss strawberries and pineapples as if they were the same.

With reference to title XVIII, I think it is clearly recognized that the congressional intent of the law, and the HEW interpretation from its beginning, has been that the extended care facility is designed to provide an extension of hospital care.

Dr. OFFENKRANTZ. Right.

Mr. MILLER. While Dr. Miller's purpose is laudable and shared by all, it is not covered by the Medicare law at the present time. This relates to some of the questions that I wanted to ask you, Doctor.

Dr. OFFENKRANTZ. Mr. Miller, this is exactly what I wanted to say: I am completely in agreement with Dr. Miller. It would be wonderful if we could do all this but I would like the record to state as far as our facility, and I am sure his facility at this time, all facilities are trying to adjust to the law as it reads.

That law says that as long as a patient can be rehabilitated in that sense he is entitled to care and physiotherapy. Theoretically, when he can no longer be rehabilitated he should be sent to a custodial institution. Now, we are willing to accept that.

What Dr. Miller speaks of is wonderful and should be the ultimate arrangement but it is not now the arrangement. I would like for the record to say that we are trying to abide by these decisions. But the physiotherapy cutoffs come despite the efforts to abide by the arrangements which are promulgated in the law.

Mr. MILLER. This relates to several questions I wanted to ask you, Doctor. All 50 of these cases to which you referred are cases where the patient previously was hospitalized.

Dr. OFFENKRANTZ. Yes.

Mr. MILLER. Was there any cutoff with reference to payment to the hospital for these patients?

Dr. OFFENKRANTZ. Not to my knowledge, Mr. Miller.

Mr. MILLER. Secondly, were they being cared for in the ECF for the same conditions—recognizing that other conditions might enter in, the same conditions for which they were hospitalized originally?

Dr. OFFENKRANTZ. Basically. There might be other conditions superimposed but the original conditions were still present.

Mr. MILLER. And still required?

Dr. OFFENKRANTZ. Still required medical care.

Mr. MILLER. My next question relates to how many responsible physicians were involved in these 50 cases? Could you give us an estimate of how many different physicians?

Dr. OFFENKRANTZ. At least 20.

Mr. MILLER. In other words, what is involved here has been a challenge of the medical judgment of at least 20 physicians plus your Utilization Review Committee?

Dr. OFFENKRANTZ. You put it nicely, Mr. Miller.

Mr. MILLER. By the intermediary?

Dr. OFFENKRANTZ. Right.

Mr. MILLER. Thank you.

Mr. SHEINBACH. Mr. Miller, would you get mad if I asked you a question?

Mr. MILLER. Not at all.

Mr. SHEINBACH. We are dealing with 4,800 ECF's across the country ranging from very large and extremely well-staffed facilities like Dr. Offenkrantz' and Dr. Miller's, to 20-bed nursing homes, many of whom do not have physicians coming in on a regular basis to see their patients but which nevertheless offer physiotherapy and a wide range of services.

Now, as you might expect, these range from the very good to the not as good as everybody would like. Is it the feeling of this committee that the Medicare program should not attempt to review the level of care when it processes the bills for ECF services, that they should completely rely upon the judgment of the physician and the Utilization Review Committee?

Mr. MILLER. Since you direct the question to me, I am going to have to duck. As the minority staff director of this committee, I am certainly not in a position to respond for the committee.

I think that the point, however, involved here, is a question of where the judgment of the physician is to be challenged and where it is to be supreme, and Dr. Offenkrantz' testimony indicates that these decisions are being made without even reference to the reports by the physicians in attendance.

Mr. SHEINBACH. We are dealing with one of the most difficult aspects of program administration here. I think everybody can understand that.

Does the majority feel that we ought to operate by going completely with the physician's judgment?

Mr. ORIOL. Dr. Offenkrantz, what do you think the majority feels?

Dr. OFFENKRANTZ. I think the majority feels that where the law has been complied with in terms of review and doctors passing judgment on doctors all the way down the line, that their judgment should be accepted.

If it is not accepted, it should be refuted by a physician.

You know, as I said in my statement, I dealt with a great many things, including the FDA, and the FDA has made decisions which are unpalatable to me and other members, for example, of the drug industry.

But at no point has it ever been made that such decision be made without contact, without search for more information, without an attempt to evaluate scientifically man to man what is actually present.

This is the only program that I know of where a clerk, a nurse, interrogator, says no, and it stands despite the fact that any number of doctors have said it shoud be yes.

I mean we have to be quantitative about it.

The woman whose picture I showed with the two broken forearms was a patient of an outstanding orthopedic surgeon in New Jersey, no need to avoid mention of his name—Dr. Lepree, for those who might be from New Jersey—who said in all of his experience as an orthopedic surgeon he could never imagine an insurance carrier or anyone connected with the care of this patient refusing to pay for that type of care on any basis whatsoever. These are outstanding examples of how if you don't accept the doctor's word you end up with quite a fiasco. You end up with a patient being cut off, for example, on a date prior to her having died from a pulmonary cimbolus right in the nursing home.

As part of our record to the county medical examiner who did the autopsy, we sent him the cutoff.

Mr. LEVY. Doctor, could I ask a question here? I know you are very concerned and, of course, we are, too, about the retroactive denial. You mentioned one case, I think it was 49 days.

Dr. OFFENKRANTZ. Yes.

Mr. LEVY. Has your facility ever availed itself of the so-called assurance-of-payment provision which we have established?

Dr. OFFENKRANTZ. Yes.

Mr. LEVY. How is that working? I know it varies, works very well someplace and not in another.

Dr. OFFENKRANTZ. I have in my possession assurance of payment from the intermediary when we first opened and they came around and reviewed our arrangements and we did not have to send in a checklist. We have those letters from them. They do not want a checklist, they do not want anything except ratio of admissions.

Mr. LEVY. Have you submitted any cases under—for instance, this lady that you described, would that be an appropriate-type case to submit it under that procedure?

Dr. OFFENKRANTZ. You mean for——

Mr. LEVY. You see, what the assurance-of-payment provision provides, for the benefit of the committee is, we recognize, of course, that it is awfully difficult.

As Mr. Sheinbach says, it is a very, very complex area and it becomes very difficult to make a judgment on some of these cases.

We felt, however, that in a facility that it would be possible in a large number of cases to make a judgment definitely one way or the other that this was custodial care, this was skilled nursing care, depending upon the information received on transfer from the hospital.

We also recognized that there would be a number of cases—a smaller number, however—that would fall within the so-called gray area that you would look at.

Where you really could not make a clear-cut judgment that this is skilled care or this is custodial care. So the administration instituted what has become known as an assurance of payment provision whereby where you have one of the so-called gray area cases, the facility is able to submit the case accompanied by medical data to the intermediary.

I believe within something like 2 or 3 days, the intermediary is supposed to get back a response to the facility indicating whether in its judgment this case is covered as an extended care case or not. Of course, the administration assures payment for that interim time.

I was just wondering what your experience has been with this provision because a number of facilities have indicated this has worked out quite well and it has mitigated the problems of these so-called retroactive denials.

Dr. OFFENKRANTZ. It has. We were given assurance of payment without even a check list because of the so-called excellence of standards in our facility. Despite that, after a year and a half of operation when there were only less than a dozen cutoffs, we started getting these with the group of 18 in one day.

Now, we still have on file our letter indicating no check list needed. We have disregarded that, we have gone now to check-listing because of the huge volume of cutoffs.

What is happening is of even more importance to everyone concerned. The hospitals are not referring patients to ECF's anymore, they are keeping them longer. They are sending them home disabled. They refuse to send them. The rate of admissions has fallen off markedly. We have very few private patients. Those facilities that have a combination of many private patients and a small number of ECF patients don't care and they don't fuss. In many of them, if the ECF patients are terminated by the intermediary, they merely go over to the private side and continue making payment on their own.

But the hospitals, and the social workers in the hospitals are the ones who, unfortunately, have the burden of making these placements.

The doctor says, "Put this patient in an ECF," and certifies to the need for it, he feels that it will be taken care of. But they call, "Will you guarantee admission?"

You say, well, even on obvious things like hip fractures we cannot. We will submit a checklist on it.

When will the check list come back?

Within a week.

What happens if the answer is no, just for the week's care they will then be sent home?

No, the hospital's social service people will not accept this, many of them cannot. Many of these people cannot afford a week's cost in addition to which the trauma of being removed from a facility and then having to be sent home afterward is quite injurious.

Mr. MILLER. Am I correct in understanding what you just said, Doctor, to be to the effect that the hospitals and physicians working in the hospitals and so forth, and others involved, are keeping patients in the hospitals longer because of this situation?

Dr. OFFENKRANTZ. They are definitely keeping them longer and in some instances sending them home where they should really, for medical reasons, have ECF care.

Mr. HALAMANDARIS. Let me make the point if I can. It has been estimated that when you increase the average day in the hospital of patients under the Medicare program by one day, the cost to the Government is $400 million. We have now in the last year effectively extended the average stay in the hospital, if the statistics I have are correct, by 3½ days. So that is a sizeable increase as you can total it up for yourself.

As I go back to the original statistic, 1 day costs the Government $400 million. This compares favorably with the entire cost of the Medicare extended care program for last year which was $500 million.

Mr. SHEINBACH. Dr. Offenkrantz pointed out that in all of these cases we have a physician's certification of necessity for services and he feels that we ought to rely virtually completely upon the judgments of the physicians involved. The physicians who are keeping their patients in hospitals have also completed these certifications of necessity for hospitalization.

Now we seem to have a little inconsistency here. If physicians are keeping people unnecessarily in hospitals, then how can we accept all of their certifications for ECF care?

Dr. OFFENKRANTZ. I beg to differ with you on that. A good point. The doctor is certifying to the extended care facility as an extension of a hospital. If I were a practicing physician I would feel exactly the same way. If I cannot move my patient from the hospital to an ECF which is a hospital without an operating room or an emergency room, I am going to keep him in the acute hospital because he needs medical and skilled nursing care and his certification I think is very valid.

If he cannot get it in one place, he is going to get it in another. He is not just keeping him there as a custodial patient. I mean, this is not that type of case at all.

Mr. SHEINBACH. So he is deliberately and willfully committing the Government to $60 or $70 more per day for that patient under Medicare. Actually, Doctor, it is quite possible for the hospital to keep that patient there and stop billing Medicare for $70 or $80 or $90 a day, but they contine to bill Medicare for the full daily rate of hospitalization.

Dr. OFFENKRANTZ. I would presume they do.

Mr. SHEINBACH. Yes, sir; you bet they do.

Mr. ORIOL. Do you agree that the consideration exists? You say you bet they do. Are you aware of this occurring around the country? Is it you opinion that this is occurring around the country?

Mr. SHEINBACH. Yes, sir.

Mr. ORIOL. What are you doing about it?

Mr. SHEINBACH. We are attempting to have the hospital bills subjected to the same type of review.

Dr. OFFENKRANTZ. They are. I know from the acute hospitals that the intermediaries are coming around and they are still not facing up to the important fact; namely, that these people with their fractured hips wherein the hip has been nailed; they cannot go home after 2 weeks in an acute hospital, they must have extended facility care and they are just not going to get it.

If the intermediary comes and says, "All our statistics show is a need for 2 weeks in the acute hospital, and we won't give you ECF care after that," those patients are going to go home, they will die.

The death rate of these people is high because they are sent home from the acute hospital instead of to an ECF or sent home from the ECF because they don't have any money. Your death rate is high from the original illness.

Mr. MILLER. There is no question about the difficulties involved in administering a program such as this. And there is no question about the fact that a physician's individual judgment in an individual case should be subject to review and perhaps beyond the utilization review of the institution in which he is serving.

But you have to recognize the facts of life, and a physician's primary responsibility is going to be to his patient and not to the fiscal situation of the U.S. Treasury.

If he has not the alternative of transferring the patient to a lower cost facility, if he feels that the patient still needs institutional care, he is going to keep him in the hospital.

I question whether a physician can be challenged on moral grounds for making this choice. However, I would like to comment that when I interrogated Dr. Offenkrantz about the 50 cases, I asked specifically if these people were in the ECF because of the same condition that prompted them to be certified for hospitalization.

I think you have a real problem with physicians of a person being hospitalized for one illness and, because of other conditions developing, the physicians feel the need for institutional care and wants to certify them.

I think that some method has to be devised to get at this. But from what the doctor says, apparently these people are being rejected even though they are in the ECF for the same thing they were being paid for in the hospital, right?

Dr. OFFENKRANTZ. We accept some of the crazy rulings, Mr. Miller, that come out. I have not discussed this. A patient with a fractured hip who develops a lesion in her eye and she goes back to the referring hospital to have her eye operated on and has a 2-day stay there and then comes back to us, her benefits are terminated because having gone back to the acute hospital for a different illness terminated the benefits that might accrue from the hip fracture.

We live with this medically stupid interpretation. People subject to any kind of eye operations now are sharply limited to the kind of benefits they can receive.

Now, removal of cataracts, for example, have a total stay of 9 days, including the acute hospital and ECF facility. That is a set rule. If they came out with a rule saying that hip fractures operated on could only have 13 days and 4 hours of care, I would come before this committee and protest, but at least we could live with that.

But we don't want some clerk down there telling us that in her opinion we had a patient with a stroke who, following a cutoff, developed a blood pressure reading of 290 over 140 but was still to be cut off.

I think even you as lay people will know this is a fantastic blood pressure.

Our nursing supervisor called the young lady at the intermediary who handles these things and said, "Don't you think in view of this blood pressure, which has come on subsequently to the cutoff but before the patient could leave, that you ought to review your cutoff?"

She said she is not interested in blood pressure, she is interested in the chart.

Now, what kind of a nonsensical answer is that?

We had a patient with a cardiac state who was transferred from an acute hospital. Having been in cardiac decompensation she also developed gall bladder disease and she was operated on while still a cardiac for removal of her gall bladder. She was transferred to us for her cardiac condition and the intermediary said no, she should have been transferred because of the gall bladder operation which could have given her only post-operative care.

These are preposterous decisions but even ones we could live with. That is not a matter of judgment. We presume that this is in the law, that if such an arrangement has happened, such a sequence of events, that we must abide by certain sequences.

Mr. SHEINBACH. We get the message, Dr. Offenkrantz.

Dr. OFFENKRANTZ. I am sorry.

Mr. ORIOL. I am glad the message has been delivered, it is well worth delivering.

Before the panel leaves the table, is there any recommendation for legislative action that could be taken to deal with any of the difficulties discussed here?

Dr. OFFENKRANTZ. In my opinion, Mr. Oriol, I think that retroactive denials should be made only by a physician after consultation with the physicians involved.

Mr. ORIOL. You see no paraprofessional person who could do this?

Dr. OFFENKRANTZ. Not for retroactive denials; no. The initial screening might be done by a paraprofessional but I think some thing as significant as a retroactive cutoff should be done by the doctor of the intermediary.

Mr. HALAMANDARIS. Mr. Levy, I am sure this must be one of those nightmares that you think about every now and again.

I apologize for my part that you got sandwiched in here.

Let us talk about your own field, just briefly, if we can.

You may recall we had a hearing sometime back dealing with the Marietta, Ohio, nursing home fire which occurred on January 9, and which to date I think has taken some 31 lives.

Now, what I want you to tell me is step-by-step what has your office done about the conditions and faulty regulations that were revealed at the fire hearing.

Before that, let me say this. At our hearings on February 10, Mr. Norman Birch came up with the request to Senator Moss that we hear Mr. James Regan who was employed as the Fire Consultant for the American Nursing Home Association.

Senator Moss was glad to oblige Mr. Birch and Mr. Regan at that time and a specific question from me was asked whether the American Nursing Home Association would support Senator Moss' recommendation for the adoption of the Life Safety Code which is part of the Moss amendments of 1967, and relates to Medicaid facilities, to your specific field, Medicare.

I am aware of only one regulation which has been issued from your office and that is with specific regard to carpets and its so-called letter to the States. Now, if you will pick up my initial question, what step-by-step has SSA done about the Marietta fire?

Mr. LEVY. I would be happy to, sir.

On January 25, following the tragic fire, we had our first opportunity to review the State fire marshal's report which indicated that they ascribed the tragedy to the burning of carpeting in the facility.

At that point, we immediately got in touch with the Public Health Service who, as you know, is responsible for providing advice on patient health and safety requirements to the Social Security Administration, and we discussed with them various standards that do exist or are under development for assuring safety of carpeting.

Shortly after that, I might say in accordance with that discussion, we were advised that the Hill-Burton requirement calls for the so-called Steiner tunnel test and that carpeting that has a flame spread rating of 75 on this test is deemed to be acceptable, 75 or less.

So we issued an instruction to the State agencies early in February in which we told them to advise each participating Medicare extended care facility and each non-JCAH hospital that was participating in Medicare—I will come back to the reason for limiting this to non-JCAH hospitals in a moment—which advised them to tell each of those facilities that effective immediately any newly installed carpeting must be in compliance with the rating scale of 75 on the Steiner tunnel test.

We also asked them to check with each facility and ask each facility the following questions:

1. Do you have carpeting? If you have carpeting, does it comply, does it fall within this limitation of 75 on the tunnel test scale?

Or if it does not, let the State know so that what we would be winding up with is a response from each facility that participates indicating whether it has carpeting, if it has carpeting, whether it falls within or without the tunnel test scale.

We also indicated to the States that where the facility indicates that it has carpeting and it does not meet the tunnel test requirement or that the facility can't ascertain whether or not it meets the tunnel test requirement, to immediately institute temporary safety measures to try to mitigate any problems that might develop such as banning smoking in patients' rooms, removing any hazards, rather, anything blocking passageways and so forth.

At the same time, we had started consultations. Roughly about this time we had started consultations with the Joint Commission on Accreditation of Hospitals and the National Fire Protection Association.

At this point, I want to digress for just a moment and explain why we entered into consultation with the Joint Commission.

In the Medicare law, and the law is quite specific here, it says that for a so-called provider to participate under Medicare, it must meet certain statutory requirements and in addition, must be in at least substantial compliance with health and safety requirements issued by the Secretary.

It also says that where a hospital does participate, if it is a JCAH—let me go back one moment and say that the law with respect to the issuance of health and safety requirements by the Secretary does specifically say that these health and safety requirements as far as hospitals are concerned, cannot be any higher than those of the Joint Commission on the Accreditation of Hospitals; in other words, it establishes a ceiling above which we cannot go.

The law also says that where a hospital is JCAH accredited Medicare can certify the hospital if it in addition has an effective utilization review plan.

Now, this is why our instruction to the States limited the instruction to non-JCAH hospitals because the State agencies who are responsible for certifying facilities under Medicare by statute are unable to survey health and safety requirements in a JCAH institution other than utilization review.

Now, the Joint Commission standards issued in October 1969, and this is a recent revision of those standards and represents at least in the Joint Commission's estimation, a significant upgrading of their standards, has the following requirement with respect to interior finishing materials.

It says: "Interior finishing material—floor coverings, draperies, curtains, and so forth, should be in compliance with national fire standards."

It refers by footnote to the Fire Safety Code, 1967 edition.

Now, in meeting with the National Fire Protection Association, and discussions with the National Fire Protection Association, it was found that the National Fire Protection Association (the Life Safety Code) does not have a specific reference for carpeting to the Steiner tunnel test.

However, the NFPA people advised us that they have a revision coming up in June and the section which considers fire safety requirements in institutions was going to meet sometime, I believe, in April, to consider whether it wished to include the Steiner tunnel test in the new Life Safety Code edition.

Now, the significance of this, for the benefit of the subcommittee, is that if the NFPA incorporates the tunnel test in its requirement, then, of course, it becomes incorporated in the JCAH requirement by reference.

We found out after this section of the NFPA met, it voted against incorporating the Steiner tunnel test. However, there was a difference of opinion among the members of the section. Some members felt that the tunnel test should be included in the next edition of the Life Safety Code and they indicated they would bring this up before the full National Fire Protection Association in its meeting in Toronto next week. They are meeting to give their final blessing, as I understand it, as to what will be in the next edition of the Life Safety Code.

There is a possibility, and we understand a pretty good possibility, that the tunnel that will be incorporated. It will be brought up on a motion from the floor. But there is also a possibility, I submit, that it could be voted down.

At the same time that this has all been going on, and again, I want to come back to the significance of this, we were developing a regulation for issuance which incorporates by regulation the requirement for carpeting that we issued to the States back in February and we entered into discussions with our General Counsel on the legality of such a recommendation.

The General Counsel advised us that he had some problems with issuance of such a regulation if the Joint Commission did not adopt either by specific reference the requirement of the Steiner tunnel test or if the NFPA didn't adopt it.

Now we talked to the Joint Commission on this and in fact, we have been engaging in discussions with them on a continuous basis on this. They indicated to us that if the NFPA adopts the Life Safety Code there would be no problem, they would have it incorporated by reference in their requirements and then the Joint Commission standards would not be higher than the Medicare standards.

On the other hand, they would not give us a definititve statement as to what would happen if the Fire Protection Association does not incorporate the Life Safety Code.

They said let us wait and see what happens up in Toronto.

So, to try to bring this thing into one piece now and to bring it up to date, meanwhile, we are getting—there is one other factor I would have to throw in here.

While this was all going on, as you, I am sure, are aware, the Department of Commerce came out under the Flammable Fabrics Act and authorized the so-called pill test, although I understand the pill has a bad connotation and it is now called the tablet test.

Mr. HALAMANDARIS. The pill test is strictly a first generation test.

Mr. LEVY. That is my understanding, too.

Mr. HALAMANDARIS. Therefore it cannot be adopted as the test under the Flammable Fabrics Act.

Mr. SHEINBACH. However, they have raised questions about the tunnel test.

Mr. HALAMANDARIS. I am getting to that. The test for flammability will be either the Stiner tunnel test or the new test which the Department of Commerce has developed. Now, this will be discussed, for your information, in hearings before Senator Moss' Subcommittee on Consumer Affairs. The tentative date is May 20 and 26.

Mr. LEVY. We will have to find out about that.

Now, let us see, where was I?

At the same time that we were discussing these matters with the Joint Commission, with the National Fire Protection Association, with our own general counsel, we also had a couple meetings with the carpet industry since they, as you know, had a very strong interest in what HEW is going to do, and, of course, they made a very strong plea for acceptance of the so-called tablet test.

While these meetings were going on, while these discussions were going on, meanwhile, we were conducting the survey of where the carpeting is and whether it is carpet that meets the tunnel test or does not pass the tunnel test and asking the State agencies to make sure that if there is carpeting that does not meet the tunnel test or if the individual facility cannot get a specific response from the manufacturer—and you would appreciate this group represents a problem, too, because some of this carpet is 2, 3, 4, 5 years or more older, and it is not possible to determine style number and lot number so that the manufacturer can give them a specific response.

But we told the States that where the facility says it has carpeting that does not meet the standard or that they don't know (whether it meets the standard) to make sure that specific measures are taken to attempt in every way to assure the safety of that facility and also have the State Fire Marshal evaluate what steps the facility is taking and to send these evaluations to the State agencies as to what is being done.

Now, at the same time, too, we are exploring other possibilities of assuring safety. For example, we had one large chemical organization advise us that it is working on a spray for carpeting which would make the carpeting flameproof and that at least they believe they are fairly close to coming out with something where you could actually spray something to enable the carpet to meet the Steiner tunnel test and it would assure that the carpeting meets certain safety requirements.

So, at the same time, we are working to see what other measures could be taken in lieu of actually asking the facility to remove the carpet.

Now let me see if I have got everything.

Oh, yes. One other, I think, significant step that was taken in this chronology. Right after the tragedy we made a special study of all physical plant fire and safety hazards and deficiencies and we identified a number of facilities where we thought the deficiencies should be corrected.

We sent the notification of facilities out to the respective State agencies. In other words, each State got names of facilities with specific deficiencies identified and with specific instructions to have the facility correct those deficiencies with a time plan phase of correction.

For instance, we identified a number of wood frame constructed facilities that still were not sprinklered throughout the facility and we asked the State agencies to contact each of those facilities and request the facility to give specific evidence of intent to install automatic sprinkler systems within, I think, 45 days we allowed and then we required that the system be installed no later than October 1.

We also asked the State to work with the facilities over the hiatus period while sprinklers were being installed, to take special precaution measures.

Mr. HALAMANDARIS. Let us see if we can sum up. I asked the initial question, what about incorporating the Life Safety Code?

Mr. LEVY. Yes.

Mr. ORIOL. Am I to assume the Life Safety Code which the Joint Committee proposes, et cetera—let me finish there.

All right. Let me pick up this statement you made, Mr. Levy.

"Our General Counsel said that he had problems if the Joint Commission does not incorporate the Life Safety Code."

Mr. LEVY. Could I clarify that?

Mr. ORIOL. Yes.

Mr. LEVY. We have told all of the States, and let me make this clear, that as of January 1 of this year the Life Safety Code is applicable to all Medicare institutions without qualification. Now the thing I was referring to and the problem the General Counsel had, the Life Safety Code, the present edition still does not say anything, does not have a specific reference or requirement to the Steiner tunnel test for carpeting. So the problem we had was that if the Life Safety Code does incorporate their requirement, then it becomes incorporated by reference in the JCAH. So the only thing that has not been incorporated yet is the standard for carpeting.

Mr. HALAMANDARIS. I follow you. Now let's be very clear on this. You are saying that as of the first of this year the Life Safety Code will be a condition of participation in Medicare nursing home program.

Mr. LEVY. That is right.

Mr. HALAMANDARIS. Now are you saying this is something which has been installed by fiat, by regulation, or are you talking about section 1863? Are you talking about section 1863 which cranks in Medicaid standards and which Senator Robert Kennedy put into the law to make Medicare parallel Medicaid.

Mr. SHEINBACH. Yes, sir.

Mr. LEVY. That is right. We have advised the States that this is applicable specifically.

Mr. HALAMANDARIS. What happens when you do not have any Medicaid patients in the home?

Mr. LEVY. As we interpret the statute, the statute says, I believe, that as far as Medicaid is concerned effective January 1, 1970, the Life Safety Code is applicable and our corresponding requirement says that if a higher requirement is established under title XIX in effect it is applicable to title XVIII. So picking up on that statutory base we advised the facilities that if it is a Medicare certified facility or if it wishes to be certified under Medicare, irrespective of whether it has Medicaid patients in it or not, the Life Safety Code does apply.

Mr. HALAMANDARIS. Let the record so show.

Now talking specifically about carpets, the regulation which SSA issued was issued at about the 21st of February directly in response to our hearing. Now what I am asking is, I know the Public Health Service has supplied SSA with information for many years. When did you first become aware of the January 9 memorandum that the Public Health Service completed which in effect recommended the adoption of the Hill-Burton standard of 75?

Mr. SHEINBACH. A couple days after it went out.

Mr. HALAMANDARIS. Right.

Mr. LEVY. Sometime early in January, I believe.

Mr. HALAMANDARIS. So you had it early in January. It was issued on the 9th, let's assume you had it on the 12th or 13th and then you waited until after our 2 days of hearing and then another couple of weeks before you issued the "standard." Now is this a real standard that you have issued or is this merely—the question I am asking, is your communication preliminary or is it final; and beyond that, the second question, isn't it rather unusual if it is a final standard to say, "Well, we would like the States to react to this and then we will see whether we are going to implement it?"

Mr. LEVY. No. It does not have—to answer your question specifically, it does not have the force of regulation. We don't have a regulation out yet. It is an operating instruction to the State agencies telling them specifically that effective immediately upon receipt of this letter "any newly installed carpeting." And it said in effect, "Tell every facility in your State that if you are going to install carpeting it has to meet the tunnel test requirement."

Mr. HALAMANDARIS. But it is not a regulation?

Mr. LEVY. As yet it does not have the force of regulation.

Mr. HALAMANDARIS. It is a guideline.

Mr. LEVY. It is an operating instruction.

Mr. HALAMANDARIS. It is an operating instruction.

Mr. SHEINBACH. No; it is not a guideline, it is an operating instruction.

Mr. HALAMANDARIS. Like we find in section 405: 1134.

Mr. LEVY. No; this specifically tells them no new carpeting.

Mr. HALAMANDARIS. Why is it not a regulation?

Mr. LEVY. The reason it has not been issued in regulation as yet, as I tried to convey in developing this chronological summary, is that we were trying to determine whether the NFPA could incorporate the

Steiner tunnel test in order to make sure that we could legally issue a regulation.

Mr. HALAMANDARIS. Perhaps I am being unfair. It sounds to me like you feel the responsibility to issue standards in view of the tragic nature of the events of the Marietta fire. Query: What kind of standard are we going to issue, you ask? The situation being that you are caught in the middle—on the one hand industry on your necks and on the other hand you have myself and Senator Moss. So we put our finger to the wind and determine which way the wind blows the hardest and we determine a standard. Is that unfair?

Mr. SHEINBACH. Yes.

Mr. LEVY. I take issue to that.

Mr. SHEINBACH. I certainly would.

Mr. MILLER. Aren't we going beyond that?

Mr. LEVY. The law is very specific that we cannot have a standard which exceeds the Joint Commission requirement. Now if we issued it, our General Counsel says it would be illegal.

Mr. SHEINBACH. Aren't you also overlooking a point? A regulation issued by SSA for Medicare affecting 7,000 or 8,000 facilities ought to be seen and discussed by everybody who is affected by it.

Mr. HALAMANDARIS. Wait a minute. Where did you get 7,000 or 8,000?

Mr. SHEINBACH. Forty-eight hundred ECF and about 3,000 non-accredited hospitals.

Mr. HALAMANDARIS. All right.

Mr. SHEINBACH. Now Dr. Offenkrantz says that HEW ought to stop trying to run the Government from Washington and try to get down to the local level to find out what the people down there think and what their opinions are. Now one of the things that we asked for with this letter were the judgments and the considered opinions of the State and local fire marshals who are also quite expert in this area. We also felt that before issuing a regulation, and you don't get any gold points out of getting a regulation out in a week, that we had a responsibility to hear all sides of the story.

Now what we have decided to do immediately in view of our concern over the safety factor was to put everybody on board immediately which is what we did and continue to work with all of the people, including Public Health Service, to try to come up with the best possible regulation we could devise. Now that cannot be done in a month.

Mr. HALAMANDARIS. Again I appreciate that but things in Washington have a way of expanding—1 month becomes 2 months, 3 months becomes 5 months, 5 months becomes 28 months.

Mr. LEVY. It only seems that way when you are sitting up here, sir.

Mr. HALAMANDARIS. I am sympathetic. I am getting tired myself. We won't go on with this colloquy much longer, but from my point of view I wanted to find out what your legal limits are. If we need legislation, then we will give you legislation. I make very clear what our position is at this time.

We applaud your adoption of the Hill-Burton standard with regard to Medicare facilities at least on an interim basis because the patients are entitled, to my way of thinking, to a greater degree of protection where they are not ambulatory, where they cannot get around. They

should have some minimum of protection, and it should not be on the same basis as the general protection which is given the public under the Flammable Fabrics Act.

The standard which is established under the Flammable Fabrics Act I would think would be lower than the standard which applies to hospitals and nursing homes. Therefore, I think that it is probably a good requirement, that you have issued, and I would like to have it in regulation form so that it does not vanish overnight.

Mr. LEVY. So would we.

Mr. HALAMANDARIS. Sometimes they do vanish.

One question I have. Do ECF's at the present time have to have the Joint Commission equivalency?

Mr. LEVY. ECF's do not but we recognize it would be a real problem—a real problem if you were to demand a higher requirement in an area such as a type of carpeting you install for certain facilities and not for others. I think they ought to be treated the same and I think when we come out with a standard we ought to have the standard apply to both, otherwise you get some real incongruity where you have a distant part of the extended care facility in the hospital.

Mr. HALAMANDARIS. What results have you received back from these State and local people that Mr. Sheinbach is so interested in hearing from? What kind of responses have you been receiving?

Mr. LEVY. You mean as far as the numbers that have checked on their carpeting and so forth?

Mr. HALAMANDARIS. Yes. What kind of information have you received?

Mr. LEVY. All of the facilities have now responded. Let me give you the figures as to what it shows.

Mr. HALAMANDARIS. What I was asking, what is your preliminary reaction to the information you received? Do they applaud you for adopting this higher standard?

Mr. LEVY. Some do, surprisingly. Medicenters who happen to have carpeting that met the tunnel test, they think it is great.

Mr. HALAMANDARIS. Yes.

Mr. LEVY. Now there is a facility out in San Francisco that recently bought $55,000 worth of carpeting 2 days before the letter came out and his carpeting did not meet the tunnel test and he was very unhappy, and I got a lot of nasty letters from him.

Mr. HALAMANDARIS. Well, he can get that spray that you were talking about.

Mr. LEVY. We stood firm with him and he finally got the manufacturer to take the backing off the carpeting which then meant it would pass the tunnel test and he is installing the carpeting without backing, but he was a very unhappy man for a while. And there are a lot of others that are very unhappy.

Mr. HALAMANDARIS. I can appreciate that.

Now one last question. We have been talking about carpeting which is going to be installed prospectively after your February regulation. What about already installed carpeting? Is the only approach to this, the only alternative that you see, the spray? Are you going to require them to pull it out? Have you made up your mind on that? How is the wind blowing?

Answer any one of those questions.

Mr. LEVY. We have a real problem here. So far we have got something like close to a thousand facilities with carpeting that does not meet the tunnel test and we still have a lot of facilities that we are waiting to hear from that are waiting for the manufacturer to report. Obviously it becomes a very complex problem as to what you are going to do with this. If you demand, right now, that all this carpeting be ripped out and somebody comes along in 2 months with a spray that will take care of it, there is going to be a lot more unhappy facilities and I think you are going to hear about them and we are going to hear about it.

Mr. HALAMANDARIS. I think again I should emphasize the general applicability of the entire Life Safety Code because it seems a little bit ridiculous to look at the carpets and neglect other parts of the physical environment.

Mr. LEVY. Yes; if you have a wood frame constructed building with good carpeting.

Mr. HALAMANDARIS. You have to have an effective and reasonable standard to protect the patients.

Mr. SHEINBACH. May I make one point on that?

Mr. HALAMANDARIS. Please do.

Mr. SHEINBACH. We have been criticized——

Mr. HALAMANDARIS. Not by me, certainly.

Mr. SHEINBACH. By my good friend Mal Schecter and a few others on the basis that the regulations being couched as guidelines means that they are not enforced.

Mr. HALAMANDARIS. Wait a minute. What guidelines?

Mr. SHEINBACH. The ECF fire safety. You mentioned the fact that these were guidelines.

Mr. HALAMANDARIS. That is different from regulations and that is different from instructions.

Mr. SHEINBACH. No, sir; those are regulations.

Mr. HALAMANDARIS. Wait a minute. We have three separate categories going here. Your letter, you said in February it is an instruction; it is not a regulation.

Mr. SHEINBACH. Yes, sir.

Mr. HALAMANDARIS. Then there is a third category which is in the extended care facility which is a guideline.

Mr. SHEINBACH. No, sir; that is a regulation.

Mr. HALAMANDARIS. All right. You call those regulations.

Mr. SHEINBACH. I am not just calling them, they are published in the Federal Register as regulations.

Mr. HALAMANDARIS. I will accept that.

Mr. SHEINBACH. It is all legal, signed, sealed, and delivered.

Now we have been criticized on the basis since we used the phrase "these are guidelines" that these are not really enforced by the State health departments. Now that is not correct. I would not try to kid you and suggest that every single one of 400 separate requirements is enforced 100 percent; that is not true and everybody knows it.

But they are enforced as regulations and ECF's do not have the right to say to a State health department surveyor that he will not install sprinklers or fire doors or additional exits or what have you because the word "guidelines" appears in Medicare's regulations.

They have been installing sprinklers for 4 years, they have been installing fire doors, they have been taking all of the steps which the State health departments have insisted upon under the Medicare regulations.

We have got about 60 ECF's that have been terminated from Medicare for failure to cooperate in correcting many of these problems and we have made it stick. Now I wanted to make that point because even though the word "guidelines" is used it does not mean that the State health department is unable to achieve compliance.

Mr. HALAMANDARIS. I think the word "guideline" means that it really has no force on the Federal level. Now with the arguable exception that you oversee the State agency, it is the State agency which has all the muscle. The Federal Government has never had written into the law any muscle on the Federal level.

Mr. SHEINBACH. Mr. Halamandaris, I respect your opinion in this matter and I hope you will respect my opinion. The State agencies have been extremely responsive to the pressures of SSA on certification matters. We have told them in many cases to terminate facilities that they themselves were not able to terminate.

Mr. HALAMANDARIS. What is the figure on your ECF's again?

Mr. SHEINBACH. Almost 60.

Mr. HALAMANDARIS. Wait a minute. I am talking about total ECF's in the country.

Mr. SHEINBACH. 4,800.

Mr. HALAMANDARIS. 4,800. As of 1968, how many of those were licensed with deficiencies?

How many did not have deficiencies?

Mr. LEVY. There were about 2,400 in so-called substantial compliance.

Mr. HALAMANDARIS. How many are in full compliance?

I can tell you the answer, about 1,800.

Mr. LEVY. 1,800.

Mr. SHEINBACH. 1,800.

Mr. HALAMANDARIS. So you have one-fifth of the ECF's in full compliance.

Mr. LEVY. That means they meet every one of the 400 which is quite difficult.

Mr. HALAMANDARIS. I am just addressing myself to your point.

Mr. SHEINBACH. No, I think my point is simply that we have a long way to go but we have also come a long way. This is not because the States have done it on their own, this is because we have done it together and many times at SSA's prodding, urging, and insistence.

Mr. HALAMANDARIS. I think that is a good place to end. I appreciate the colloquy we have been engaging in this morning. I trust that the record is well served.

I think we have a couple of friends in the audience that we would like to hear from.

Mr. ORIOL. Yes, the record is always open to people who have information. We have two people in the audience and perhaps they could come up as a panal just to take a few minutes each to give us information that can be developed in a supplementary statement.

Harold Parker of the Georgia Commission on Aging and Mrs. Joyce Lowry of Wauwatosa, Wis.

Mr. Parker, part of your story has already been given in the Florida hearing. Perhaps we could ask you for a quick summary bringing us up to date on what has happened since then.

STATEMENT OF HAROLD B. PARKER, EXECUTIVE DIRECTOR, GEORGIA STATE COMMISSION ON AGING

Mr. PARKER. Thank you, Mr. Oriol.

The thing that disturbed us very greatly is the same thing that you have been discussing here this morning. There is a drying up of extended care facilities in Georgia. We felt for a long time that ECF was being underutilized and now we find that the ECF operators are just cutting down the number of beds that they are willing to devote to this area of endeavor. There is no rhyme or reason for the retroactive denials and the doctors seem to be reluctant to use the extended care facilities and the operators are looking to move into other areas of service.

We have got a very unique situation in Georgia where we have built nursing homes in the communities where people live so that the community life can be continued by the patient. The neighbors and family and old friends can be contacted, community life can be maintained, and we are real proud of this type of operation.

Last week my staff and I visited 46 nursing homes in southwest Georgia and we found that these nursing homes by and large had fully embraced the idea that old people can get well. And it is a sort of thrilling and exciting thing to say, as these two great doctors who preceded me said, that old people are worth treating and saving and that they can function and their functions need to be preserved. This is something that has not always been thus, as you know.

We want the full right to this service through the extended care philosophy that a person goes into a nursing home with the 100 days and there is a day they are going to leave, maybe it is not a hundred days. It used to be they abandoned hope. Today we have hope and we have hope in nursing homes.

It was very thrilling for me to observe the therapy in action in south Georgia last week. One nursing home has an outpatient therapy clinic for the community which was just great. I saw a physical therapist work with a newly blind lady. I saw one very impaired gentleman about 70 years old being taught to walk, and the therapist told me that it was just as much fun to teach an old man to walk as it was to teach a baby how to walk. We found much of this attitude that we do want to preserve this particular attitude that old people can get well.

Thank you.

Mr. ORIOL. Mr. Parker, I do not believe we have your correct title for the record.

Mr. PARKER. I am Harold B. Parker, executive director of the Georgia State Commission on Aging.

Mr. ORIOL. Can you tell me approximately how many nursing homes or extended care facilities in Georgia have stopped using the Medicare or stopped providing the Medicare extended care benefit?

Mr. PARKER. I am not aware of the number that have quit.

Mr. ORIOL. The percentage.

Mr. PARKER. The Wesley Homes, which is a very fine nonprofit church sponsored agency in Atlanta, had 166 beds devoted to ECF with a wonderfully fine staff all geared up for rehabilitation and all these great services that are available to the people under this approach. They put out an announcement the other day that they were no longer to be an extended care facility, that they were going into long-term care because they don't have any ECF patients.

Mr. ORIOL. I got the impression that perhaps dozens of extended care facilities in the State had dropped out of the program.

Mr. PARKER. That is my impression.

Mr. ORIOL. Do you have any reason to believe that the enforcement of the civil rights provisions of the Medicare has anything to do with that?

Mr. PARKER. No, sir; none whatsoever.

Mr. ORIOL. What is the most common reason given?

Mr. PARKER. We have a committee on health and related care. I am out of the Commission on Aging and we have had the intermediaries representatives from Social Security, the medical profession, nursing home operators, health, welfare, and the like to sit and talk about extended care, and it seems that the intermediaries did not exactly make this announcement but that they had been instructed to tighten up.

Mr. ORIOL. Where were they instructed from?

Mr. PARKER. From Social Security.

Mr. ORIOL. Have you seen anything in writing on this?

Mr. PARKER. No, and a member of the Commission called Social Security to follow up on this piece of information they had gotten from an intermediary and they denied it, said they are doing the same thing they had always done.

He said, "What happened to the patients?"

Mr. ORIOL. The intermediary was saying this?

Mr. PARKER. No; the Commission member.

Mr. ORIOL. Mr. Miller.

Mr. MILLER. No questions.

Mr. ORIOL. Mrs. Lowry, identify yourself and one of your positions or several.

STATEMENT OF JOYCE LOWRY, SPECIALIST IN REHABILITATION SERVICES AND THERAPEUTIC RECREATION

Mrs. LOWRY. I am Mrs. Joyce Lowry, specialist in rehabilitation services and therapeutic recreation.

My credentials are: I have a masters degree in rehabilitative recreation services plus specialized training in gerontology as an AOA trainee at the Institute of Gerontology, University of Michigan, Ann Arbor, Mich.

I would like to say one thing. There has been no mention of recreational services as a therapy. One of the times I was looking for a new position I went to a not-for-profit rehabilitation hospital, and although my credentials were good very little consideration was given to hiring me simply because, as the administration said, we can't find any way for payment for your type of services. In other words, their payment plans of different titles, et cetrra, did not include recreational therapy as a recognized service.

At the present time I am employed by an organization called Nursing Centers, Inc., which is a proprietary for profit organization. I would like to present excerpts from a paper that I gave last week in Milwaukee.* By the way, Wauwatosa is across the street from Milwaukee, we have the same post office.

* Retained in committee files.

This paper was presented at the Great Lakes Regional Conference of the National Recreation and Parks Association and its branch organization, the National Therapeutic Recreation Society.

We feel there must be recognition of a continuum of care and the team approach for development of a totally therapeutic setting for the care of our elderly sick, ill, and disabled. The role of the therapeutic recreator then may need greater definition to all those concerned with the care of the geriatric patient.

Of the populations served by therapeutic recreators, I would surmise that the older adult is the least understood and probably the least constructively worked with of all persons suffering from any disability.

Another reason for the older adult not receiving the kind of recreational program that has therapeutic value is fairly traditional. For a long time it has been the practice of nursing homes, long-term care facilities and rehabilitation units to use some form——

Mr. HALAMANDARIS. Excuse me.

Mr. Birch, Norman, I just want to ask the gentlemen if they have any remarks for the record. If you do, just stay another moment and we will be glad to hear you.

Mr. BIRCH. No.

Mr. HALAMANDARIS. That was Norman Birch, the executive director of the American Nursing Home Association.

I am sorry for the interruption.

Mrs. LOWRY. That is all right.

A lot of nursing homes have used some form of recreation activity for the elderly as a filler to the concepts of useful leisure. After all, what do older people in such settings have except a lot of time on their hands: leisure that is meaningless and nonrewarding to the individual.

Most chronically ill older adults are not expected to leave institutions and return to community life, and there is a reason for this. There is a lack of supportive services and community understanding as major factors that cause retention of certain persons in institutions when they should be living in the community.

For that portion of the elderly who will be returning to the community to live, the responsibility of any therapeutic recreator is the same as for any age group with emphasis on the resocialization processes. We work to keep the older person from becoming an isolate, a recluse in any community.

When working with the older adult, we work to expand group experiences and to give them opportunities for new and satisfying experiences in the institution or in the community and, primarily, to help them identify their position in life and the world and thus enable them to accept and utilize their potential for a life that does not disengage prematurely or to that extent that mental illness is imminent.

The goal is to prevent rejection from peer groups and thus prevent debilitation of social relationships which often leads to more intense disengagement processes which we know lead to definite mental illness. This, of course, is in relation to organic brain changes and organic brain damage. Since most older people have not had a lot of leisure time they do not really know what to do with it. I would like to say that there is one thing that the recreational therapist has to fight and that is that other therapies are thoroughly accepted and fairly well understood, but not recreation therapy.

The physical therapist teaches them to rewalk and reuse injured muscles or artificial limbs. The occupational therapist teaches the geriatric to dress, perform personal hygiene tasks, and to feed himself. But what for? If the geriatric as a person has no social identity, nor outlets for creative, stimulating or socially satisfying experiences and does not know how to obtain these, of what use are the physical or emotional therapies that have been used to put the person back together again? It is like putting all the pieces of a model together and forgetting the cement or glue which will enable the model to withstand stress and the destructive forces that can break it once again into unrelated parts.

I would like to say that I would applaud Dr. Miller and many of the things that he said. The hospital oriented physiatrist is not familiar with recreational therapy, he does not know how to write a prescription for recreational therapy. We are part of a continuum of care and we are an integral part and a necessary part because what you are asking is that people receive physical therapies, the emotional and mental therapies of psychiatric social workers, but the elderly have forgotten how to live as other people. If therapy is not accepted, then you are just putting together nothing.

Mr. ORIOL. Thank you, Mrs. Lowry.

As I understand it, there is no Federal program which in any way provides payment for the type of service you provide.

Mrs. LOWRY. No, sir.

Mr. ORIOL. Could you give us just a few examples of what a recreational specialist provides in an institution?

Mrs. LOWRY. Well, the recreational therapist has the job of coordinating with all the other therapies. For example, I coordinate with physical therapy in terms that they tell me which patients need more exercise. I set up a social group and in a social setting developing inner-personal relationships I can get these people to do physical movements that the therapist herself has been unable to attain, and I have had physical therapists tell me this.

I have had OTR's, occupational therapist, registered, tell me that unless we had a continuum of care that whatever the OTR does is lost. I know, for example, in Chicago in a rehabilitation hospital they have a director of therapeutic recreation. He takes amputees of all kinds—wheelchair, on crutches, and so forth, out into the community to help these people adjust to going out into public view. Now you can give a person all the psychiatric help he can use but until he is subjected to and withstands the stress of the public eye staring at him with a hook for a hand or no legs, you have not completed your job.

Does that answer your question?

Mr. ORIOL. That certainly gives insights into it.

What would you say is the rough daily charge for a service of this type?

Mrs. LOWRY. For example, there is no specific charge for recreational therapy. I happen to be doing at this moment some special work for my corporation as the rehabilitation recreation person in a transitional living arrangement. I have 143 men who come to us on referral from mental health institutions, both Veterans' Administration and the mental health institutions of the county. They come from correctional institutions, they come from social agencies. My job there is to get

these people to relate to each other. We don't have any title XIX or any other kind of payment because we are not a skilled nursing facility. We give no nursing service.

Mr. ORIOL. But you would say that quite often you cut down the period of time for which Federal funds are provided.

Mrs. LOWRY. Yes.

Mr. ORIOL. Under extended care.

Mrs. LOWRY. Yes.

Mr. ORIOL. Or even under Medicaid.

Mrs. LOWRY. Yes.

Mr. ORIOL. So you are saving the Government money.

Mrs. LOWRY. Right; not only that but helping the older adult to learn a function in the community. When he goes out, he does not deliberate. We are talking about giving people the know-how to live. What good is it if he lives in public housing and he does not participate in anything? He has no experiences, he sits there and disengages. He becomes mentally ill, he becomes disoriented. He does not eat properly because there is nobody to eat with, nobody to share it with. He does not know how to get together with somebody and he is going to land in a mental institution. He is going to, he can't stay out of one.

Mr. ORIOL. Mr. Parker, this is a similar type of experience that you witnessed, isn't it?

Mr. PARKER. Yes, this is true. We do have some recreators in Georgia in the State hospitals. There are some attempts at times of recreation programs but not this therapeutic type of program.

Mrs. LOWRY. The National Recreation Therapeutic Society is very interested in trying to develop accreditation programs for universities and colleges and establish a certification program.

I have been in contact with the Gerontology Society just yesterday and Ed Kaskowitz and I are going to develop some regional training for therapeutic recreation working with the geriatric.

Mr. ORIOL. Do you have any questions?

Mr HALAMANDARIS. Yes.

I would just like to give my greetings to Mr. Parker. I have not seen him since I was down in Atlanta and he conferred his many courtesies on my behalf, introduced me to a very charming young lady, a southern belle.

Mr. ORIOL. Do you want that in the record?

Mr. HALAMANDRIS. Yes, that is in the record.

I had hoped that we could come down to Atlanta sometime in the spring when the peach trees were in blossom Mr. Parker, but it did not work out that way, for which I extend my sincere appropriate apologies.

We did receive a letter from you not too long ago commenting on the mass transit bill, and I believe you had a request asking if it was not possible to include in the mass transit bill a provision which would provide reduced fares for seniors on mass transit.

Mr. PARKER. Yes.

Mr. HALAMANDARIS. I think this is certainly a laudable goal. With Washington, D.C., some 4 or 5 days ago instituting this program there are now 35 major cities that have adopted this program. This was reported, incidentally, in Aging magazine; I think it was the recent edition.

Senator Moss, as you know, has sponsored the program of reduced fares for senior citizens on the airlines but we have not made much headway with it. Mr. Oriol has explored the area once before but we are continuing the efforts.

As I said, I think it is a laudable goal and I commend you for the efforts that you are making in Atlanta, particularly with regard to the transportation. We have heard the problem time and time again.

I know you have got it up your way, too, Mrs. Lowry.

Mrs. LOWRY. We have been trying, we have not succeeded yet.

Mr. HALAMANDARIS. I certainly wish you success.

Mr. PARKER. A little airline, I believe it is the Executive Airline out of Atlanta, will give reduced fares to the over 65 age group.

Mr. ORIOL. Do you happen to know whether that has increased ridership?

Mr. PARKER. No, I don't.

Mr. ORIOL. Well, as we indicated before, this was an impromptu arrangement. We are certainly glad to have this for the hearing record, and I hope that you will feel free to add to that record.

You mentioned the national association before. Do you believe that they have information at this point which would be useful for the record? We would like to have that.

The subcommittee will adjourn, subject to the call of the Chair.

(Whereupon, at 1:55 p.m., the subcommittee adjourned, subject to the call of the Chair.)

APPENDIXES

Appendix 1

TITLE 45—PUBLIC WELFARE

CHAPTER II—SOCIAL AND REHABILITATION SERVICE (ASSISTANCE PROGRAMS), DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

* * * * * * * *

PART 249—SERVICES AND PAYMENT IN MEDICAL ASSISTANCE PROGRAMS

Standards for Payment for Skilled Nursing Home Care

Iterim policy which sets forth regulations to implement section 1902(a)(28) of the Social Security Act with respect to standards for payment for skilled nursing home care was published in the Federal Register of June 24, 1969 (34 F.R. 9788). After consideration of views presented by interested persons, the interim regulations are hereby adopted, subject to the following changes:

1. Section 249.33(a)(1) is amended to cross reference the definition of a skilled nursing home set forth under § 249.10(b)(4)(i) of Chapter II of Title 45 of the Code of Federal Regulations.

2. The provision concerning the Fire Safety Code of the National Fire Protection Association is amended to incorporate conditions under which the State agency may waive certain requirements (§ 249.33(a)(1)(vii)).

3. The review of personnel statements is amended to provide that such statements set forth (from payroll records) the average numbers and types of personnel during a week selected by the survey agency (§ 249.33(a)(2)(ii)(*b*)).

4. The requirement for one on-site inspection during the term of an agreement is amended to provide for more frequent inspections (§ 249.33(a)(2)(iii)).

5. The requirement prohibiting second 6-month agreements is amended to provide for two successive agreements on the basis of documented evidence that substantial effort and progress has been made in correcting prior existing deficiencies (§ 249.33(a)(2)(iv)(*a*)(*3*)).

6. The definition of organized nursing service under § 249.33(b)(1)(iii) (*a*) and (*b*) is revised under paragraph (b)(1)(ii)(*a*) of the final policy to provide that where a licensed practical nurse serving as a charge nurse is not a graduate of an approved State school of practical nursing, or its equivalent, such nurse may serve in this capacity until July 1, 1970, only if she was successfully discharging charge nurse responsibilities on July 1, 1967.

7. The requirement for a determination of equivalency by the appropriate State licensing authority is amended to provide that equivalency findings be made by the appropriate State licensing authority for nurses (§ 249.33(b)(1)(ii)(*a*)).

8. The definition of organized nursing service relative to the use of licensed practical (or vocational) nurses is amended to add (*b*) to provide for institutions for the mentally retarded which are certified as skilled nursing homes (§ 249.33(b)(1)(ii)(*b*)).

9. The requirement concerning the definition and assignment of duties under § 249.33(b)(1)(v) of the interim policy is redesignated and amended to clarify the criteria for assignment of staff (§ 249.33(b)(1)(iv)).

10. The requirement for written care policies is amended to add restorative services (§ 249.33(b)(1)(v)).

11. The definition of adequate nursing and auxiliary personnel is amended to clarify and define such personnel under separate subdivisions (§ 249.33(b)(2)(i) and (ii)).

12. The definition of adequate nursing service is amended to incorporate Social and Rehabilitation Service guidelines for adequate nursing services (§ 249.33(b)(3)(i)).

13. The requirement relative to written agreement provisions for other outpatient services is deleted and amended to provide written agreements for other medical services (§ 249.33(b)(8)(ii)).

14. The conditions under which single State agencies may waive environment and sanitation requirements is amended to provide for the conditions for waiver of the Fire Safety Code and to provide the waivers under this provision be made on the basis of documented evidence (§ 249.33(c)(2)).

§ 249.33 Standards for payment for skilled nursing home care.

(a) *State plan requirements.* A State plan for medical assistance under title XIX of the Social Security Act must:

(1) Provide that any skilled nursing home (see § 249.10(b)(4)(i) of this part) receiving payments under the plan must:

(i) Supply to the licensing agency of the State full and complete information, and promptly report any changes which would affect the current accuracy of such information, as to the identity

(*a*) Of each person having (directly or indirectly) an ownership interest of 10 percentum or more in such skilled nursing home,

(*b*) In case a skilled nursing home is organized as a corporation, of each officer and director of the corporation, and

(*c*) In case a skilled nursing home is organized as a partnership, of each partner;

(ii) Have and maintain an organized nursing service, as defined in paragraph (b) of this section, for its patients which is under the direction of a a professional registered nurse who is employed full-time by such skilled nursing home, and which is composed of sufficient nursing and auxiliary personnel to provide adequate and properly supervised nursing services for such patients during all hours of each day and all days of each week;

(iii) Make satisfactory arrangements, as defined in paragraph (b) of this section, for professional planning and supervision of menus and meal service for patients for whom special diets or dietary restrictions are medically prescribed;

(iv) Have satisfactory policies and procedures, as defined in paragraph (b) of this section;

(*a*) Relating to the maintenance of medical records on each patient of the skilled nursing home;

(*b*) Relating to dispensing and administering of drugs and biologicals;

(*c*) To assure that each patient is under the care of a physician;

(*d*) To assure that adequate provision is made for medical attention to any patient during emergencies;

(v) Have arrangements, as defined in paragraph (b) of this section, with one or more general hospitals under which such hospital or hospitals will provide needed diagnostic and other services to patients of such skilled nursing home, and under which such hospital or hospitals agree to timely acceptance, as patients thereof, of acutely ill patients of such skilled nursing home who are in need of hospital care. The single State agency, however, may waive this requirement wholly or in part with respect to any skilled nursing home which meets all other requirements and is unable to effect such an arrangement with a hospital, as provided in paragraph (c) of this section;

(vi) Meet conditions relating to environment and sanitation, as specified in paragraph (b)(9) of this section, applicable to extended care facilities under title XVIII of the Social Security Act. The single State agency, however, may waive for such periods and under such conditions as the approved plan provides any requirement imposed by paragraph (b)(9) in accordance with the regulations set forth in paragraph (c) of this section;

(vii) Meet (after December 31, 1969) such provisions of the Life Safety Code of the National Fire Protection Association (21st Edition, 1967) as are applicable to nursing homes; except that the State agency may waive in accordance with regulations set forth in paragraph (c) of this section for such periods as it deems appropriate, specific provisions of such code, which if rigidly applied, would result in unreasonable hardship upon a nursing home, but only if such agency makes a determination (and keeps a written record setting forth the basis of such determination) that such waiver will not adversely affect the health and safety of the patients of such skilled nursing home; and except that the requirements of this subdivision need not apply in any State if the Secretary finds that in such State there is in effect a fire and safety code, imposed by State law, which adequately protects patients in nursing homes.

(2) Provide and specify the methods and procedures which assure that:

(i) The single State agency will, prior to execution of an agreement with any facility for provision of skilled nursing home care and making payments under the plan.

(*a*) Obtain sufficient evidence through survey arrangements with the State licensing authority or with the agency of the State designated pursuant to section 1864 of the Social Security Act, that the facility

(*1*) Meets the requirement of subparagraph (1) of this paragraph; or

(*2*) Is a participating provider of extended care under title XVIII of the Social Security Act, and in addition meets the requirements of subdivisions (i), (v) and (vii) of such subparagraph (1); or

(b) Otherwise obtain sufficient evidence that the facility meets the requirements of such subparagraph (1); *Provided, however,* That if the single State agency elects not to use the services of the State licensing authority or the agency of the State designated pursuant to section 1864 of the Social Security Act, a written justification is submitted to the Administrator, Social and Rehabilitation Service that such election is not inconsistent with efficiency and economy of administration.

(ii) The single State agency will:

(*a*) Review information contained in reports of medical review teams on inspections made pursuant to State plan provisions under section 1902(a)(26) of the Social Security Act;

(*b*) Review statements obtained by the appropriate State agency from each skilled nursing home, on forms provided by such agency, setting forth (from payroll records) the average numbers and types of personnel (in full-time equivalents) on each shift during at least 1 week of each quarter, such week to be selected by the survey agency and to occur irregularly in each quarter of the year;

(*c*) Evaluate such statements to determine that requirements relating to personnel were or were not met during any quarter in which payment is being requested;

(iii) Beginning January 1, 1970, onsite inspection by qualified personnel will be made at least once during the term of an agreement, or more frequently if there is a question of compliance, and the single State agency will review the information thus obtained, except that this requirement may be deemed to be met for skilled nursing homes also certified to participate as extended care facilities under title XVIII of the Social Security Act;

(iv) The single State agency agreement with a facility for payments under the plan may not exceed a period of 1 year. Execution of a new agreement shall be contingent upon a determination of compliance with the provisions of subparagraph (1) of this paragraph except that:

(*a*) In the case of any skilled nursing home determined or certified to be in substantial compliance (i.e., is in compliance except for deficiencies) with the requirements of such subparagraph (1), the single State agency may enter into an agreement with such skilled nursing home for the provision of services and making of payments under the plan for a period not to exceed 6 months provided that on the basis of documented evidence derived from a survey the single State agency finds that:

(*1*) There is a reasonable prospect that the deficiencies can be corrected within 6 months and the skilled nursing home provides in writing a plan acceptable to the single State agency for so doing;

(*2*) The deficiencies noted individually or in combination, do not jeopardize the health and safety of the patients and a written justification of such a finding is maintained on file by the appropriate State agency;

And provided further, That

(*3*) No more than two successive agreements for 6 months are executed with any skilled nursing home having deficiencies, and no second agreement is executed if any of the deficiencies existing are the same as those which occasioned the prior agreement unless the single State agency finds on the basis of documented evidence derived from a survey that the facility has made substantial effort and progress in correcting such deficiencies;

(*b*) Notwithstanding the foregoing provisions, in the case of skilled nursing homes certified with deficiencies as extended care facilities under the provisions of title XVIII of the Social Security Act, the term of agreements may extend until 90 days after the next inspection scheduled, as required, for extended care facility certification.

For the purposes of this subdivision (iv), waivers granted pursuant to paragraph (a)(1) (v)–(vii) and paragraph (c) of this section are not considered deficiencies.

(v) All information and reports used in determining whether a skilled nursing home meets the requirements set forth in subparagraph (1) of this paragraph are maintained on file for a period of at least 3 years by the appropriate State agency for ready access by the Department of Health, Education, and Welfare; and

(*a*) Copies of reports of inspection made on or after January 1, 1970, are completed by the inspector(s) surveying the premises with notations indicating whether each requirement for which inspection is made, is or is not satisfied, with documentation of deficiencies;

(*b*) Copies of official notices of waiver of any requirement imposed pursuant to subparagraph (1)(vii) of this paragraph and regulations pertaining thereto are on file;

(vi) Facilities which do not qualify under this section are not recognized as skilled nursing homes for purposes of payment under title XIX of the Act.

(b) *Definition of terms.* For purposes of paragraph (a)(1) of this section the following definitions apply:

(1) *Organized nursing service.* The term "organized nursing service" means that:

(i) Nursing services are under the direction of a director of nursing service who is a professional registered nurse and who:

(*a*) Is employed full-time in the facility, devotes her full-time to supervising the nursing service, and is on duty during the day shift;

(*b*) Is qualified by education, training or experience for supervisory duties;

(*c*) Is responsible to the administrator for the selection, assignment, and direction of the activities of nursing service personnel;

(*d*) Is responsible to the administrator for development of standards, policies, and procedures governing skilled nursing care and for assuring that such standards, policies and procedures are observed;

(ii) There is on duty at all times and in charge of nursing activities at least one professional registered nurse or licensed practical (or vocational) nurse who is a graduate of a State-approved school of practical nursing, or who is found by the appropriate State licensing authority for nurses on the basis of the individual's education and formal training to have background considered to be equivalent to graduation from a State's approved school of practical nursing except that:

(*a*) In those instances in which a licensed practical nurse serving as charge nurse is not a graduate of an approved school and does not possess background determined to be equivalent but was successfully discharging the responsibilities of a charge nurse on July 1, 1967, such nurse may continue to be employed in this capacity until July 1, 1970, but after that date only if she has been found by the appropriate State licensing authority to have completed training equivalent to graduation from a State-approved school of practical nursing; and

(*b*) In the case of institutions for the mentally retarded or distinct parts of such institutions which are certified as skilled nursing homes, other categories of licensed personnel with special training in the care of such patients may serve as charge nurse: *Provided,* That such person is licensed by the State in such category following completion of a course of training which includes at least the number of classroom and practice hours in all of the nursing subjects included in the program of a State approved school of practical (or vocational) nursing as evidenced by a report to the single State agency by the agency or agencies of the State responsible for the licensure of such personnel comparing the courses in the respective curricula.

(iii) Lines of administrative and supervisory responsibility are clearly established in writing, and are known to all members of the nursing staff and to appropriate personnel in other units of the facility;

(iv) Duties are clearly defined and assigned to staff members consistent with the level of education, preparation, experience, and licensing of each.

(v) There are written patient-care policies and procedures governing skilled and related services, including restorative services, and staff members are familiar with them.

(2) *Nursing and auxiliary personnel.* (i) Nursing personnel means professional registered nurses and licensed practical (or vocational) nurses holding valid and current licenses as required by State law and performing duties directly related to providing nursing services to patients.

(ii) Auxiliary personnel includes nurses aides, orderlies, attendants, and ward clerks performing duties not constituting the practice of nursing as defined under State law.

(3) *Adequate * * * nursing services.* The phrase "adequate nursing services" means that:

(i) Numbers end categories of personnel are determined by the number of patients and their particular needs in accordance with accepted policies of effective nursing care and guidelines issued by the Social and Rehabilitation Service;

(ii) Nursing and auxiliary personnel are employed and assigned on the basis of their experience or qualifications to perform designated duties;

(iii) The amount of nursing time is sufficient to assure that each patient:

(*a*) Receives treatments, medications, and diet as prescribed;

(*b*) Receives proper care to prevent decubiti and is kept comfortable, clean, and well-groomed;

(*c*) Is protected from accident and injury by the adoption of appropriate safety measures;

(*d*) Is encouraged to perform out-of-bed activities as permitted;

(*e*) Receives assistant to maintain optimal physical and mental function.

(4) *Professional planning and supervision of menus and meal service.* The phrase "professional planning and supervision," when used in relation to menus and meal service for patients for whom special diets or dietary restrictions are medically prescribed means that:

(i) Menus are planned and supervised by professional personnel meeting the following qualifications:

(*a*) A dietitian who meets the American Dietetic Association's standards for qualification as a dietitian; or

(*b*) A graduate holding at least a bachelor's degree from a university program with major study in food and nutrition; or

(*c*) A trained food service supervisor, an associate degree dietary technician, or a professional registered nurse, with frequent and regularly scheduled consultation from a dietitian or nutritionist meeting the qualifications stated in subdivisions (*a*) and (*b*) of this subparagrapu (4)(i);

(ii) Special and restricted diet menus are kept on file for at least 30 days, notations are made of any substitutions or variations in the meal actually served, and the patients to whom the diets were actually served are identified in the dietary records;

(iii) Procedures are established and regularly followed which assure that the serving of meals to patients for whom special or restricted diets have been medically prescribed is supervised and their acceptance by the patient is observed and recorded in the patient's medical record.

(5) *Satisfactory policies and procedures relating to maintenance of medical records.* Satisfactory policies and procedures relating to the maintenance of medical records means the standards set forth in 20 CFR 405.1132 pertaiping to extended care facilities under title XVIII.

(6) *Satisfactory policies and procedures relating to dispensing and administering of drugs and biologicals.* Satisfactory policies and procedures relating to dispensing and administering of drugs and biologicals means the standards set forth in 20 CFR 405.1127 pertaining to extended care facilities under title XVIII.

(7) *Satisfactory policies and procedures relating to physician coverage.* Satisfactory policies and procedures relating to physician coverage and emergency medical attention means the standards set forth in 20 CFR 405.1123 pertaining to extended care facilities under title XVIII.

(8) *Arrangements with one or more general hospitals.* Arrangements with one or more general hospitals means:

(i) Written agreements providing a basis for effective working arrangements under which inpatient hospital care is available promptly to the skilled nursing home's patients when needed, which include as a minimum:

(*a*) Procedures for transfer of acutely ill patients to the hospital ensuring timely admission,

(*b*) Provisions for continuity in the care of the patient and for the transfer of pertinent medical and other information between the skilled nursing home and the hospital.

(ii) Written agreements containing provisions for the prompt availability of diagnostic and other medical services.

(9) *Conditions relating to environment and sanitation.* Conditions relating to environment and sanitation applicable to extended care facilities under title XVIII means standards set forth in 20 CFR 405.1125(i), and 405.1134, 405.1135, and 405.1136.

(c) *Conditions under which the single State agencies may waive certain requirements.* (1) The requirements for arrangements with one or more general hospitals may be waived wholly or in part if by reason of remote location or other good and

sufficient reason a skilled nursing home is unable to effect such an arrangement with a hospital. However, this requirement may not be waived in whole if it can be satisfied in part. A finding of remote location or other good and sufficient reason may be made when the single State agency finds that:

(i) There is no general hospital serving the area in which the skilled nursing home is located; or

(ii) There are one or more general hospitals serving the area and the skilled nursing home has attempted in good faith and has exhausted all reasonable possibilities to enter into an agreement with such hospital or hospitals, and

(*a*) The nursing home has provided copies of letters, records of conferences, or other evidence to support its claim that it has attempted in good faith to enter into an agreement, and

(*b*) Hospitals in the area have, in fact, refused to enter into an agreement with the skilled nursing home in question.

(*b*) Hospitals in the area have, in fact, refused to enter into an agreement with the skilled nursing home in question.

(2) The single State agency may waive the application to a skilled nursing home of one or more specific provisions of 20 CFR 405.1125(i), 405.1134, 405.1135, or 405.1136 or one or more specific provisions of the fire and safety code applied pursuant to paragraph (a)(1)(vii) of this section if it finds on the basis of documented evidence derived from a survey that:

(i) Such provisions(s), if rigidly applied, would result in unreasonable hardshi p upon the skilled nursing home;

(ii) The waiver of the specific provision(s) does not adversely affect the health and safety of the patients in the facility and a written justification of such determination is maintained on file;

(iii) Where structural changes in the facility are necessary to meet a provision; the change is of such magnitude as to be infeasible, or economically impracticable delay in making such changes would not adversely affect the health and safety of patients; and an explanation of this finding is maintained on file;

and upon assurance that:

(iv) The conditions of waiver in subdivisions (i), (ii), and (iii) of this subparagraph are redetermined at the time of each survey and written evidence of such redetermination is maintained on file;

(v) The waiver of requirements is rescinded at any time any of the conditions of subdivisions (i), (ii), and (ii) of this subparagraph are found no longer to apply.

(d) *Federal financial participation.* (1) Federal financial participation is available at 75 per centum in expenditures of the single State agency for compensation (or training) of its skilled professional medical personnel and staff directly supporting such personnel, with are necessary to carry out these regulations.

(2) Federal financial participation at applicable rates also is available for the single State agency to enter into a written contract (under the supervision of the Medical Assistance Unit) with the State licensing authority, the agency of the State designated pursuant to section 1864 of the Social Security Act or other appropriate State agencies providing for at least:

(i) On-site surveys and resurveys of skilled nursing homes applying to participate or participating as providers of service under the medical assistance plan to be performed at appropriate intervals by properly qualified personnel,

(ii) Timely furnishing to the single State agency of all information and records herein required, and

(iii) Methods and procedures acceptable to the Secretary for determining an agency's expenditures in which Federal financial participation is available.

Such Federal financial participation is available only for those expenditures of the State licensing authority or other appropriate State agencies which are not attributable to the overall cost of meeting responsibilities under State law and regulations for establishing and maintaining standards but which are necessary and proper for carrying out these regulations.

(Secs. 1102 and 1902(a)(28), 49 Stat. 647 and 81 Stat. 906; 42 U.S.C. 1302 and 1396a(a)(28))

Effective date. The regulations in this section shall be effective on the date of their publication in the FEDERAL REGISTER.

Dated: January 28, 1970.

MARY E. SWITZER,
Administrator, Social and Rehabilitation Service.

Approved: April 22, 1970.

ROBERT H. FINCH,
Secretary.

[F.R. Doc. 70–5147; Filed, Apr. 28, 1970; 8:45 a.m.]

APPENDIX 2

PHASING OUT MEDICARE: CHANGING DEFINITIONS OF SKILLED NURSING CARE AND CUSTODIAL CARE*

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ABSTRACT: **Increasingly restrictive definitions of skilled nursing care versus custodial (or non-covered) care by the Social Security Administration with respect to the Medicare program are now being implemented by fiscal intermediaries. If continued, the constructive intentions of Congress in behalf of the ill aged will be effectively frustrated and, in the name of economy, the national health care program for the aged will soon disappear.**

The new synthetic definitions require evaluation and reappraisal in clinical terms if the welfare of the ill aged is to be served.

Section 1861 of the Social Security Act (1) intended to provide to in-patients of extended care facilities:

"A. Skilled nursing care and related services for patients who require medical and nursing care, or

B. Rehabilitation services for rehabilitation of injured, disabled or sick persons."

All those interested in the health needs of the chronically ill aged recognize these goals as substantial and constructive. Two years after the implementation of the Medicare Law, and faced with the unanticipated, sharply rising costs of health care services in the United States in general plus the high cost of Medicare in particular, the Social Security Administration of the Department of Health, Education, and Welfare reacted sharply to curtail costs and, in effect, limited the distribution of services to those entitled to receive covered care.

In attempts to conserve dollars rather than enhance the quality of care received by Medicare recipients, the Social Security Administration initiated in January 1968 and continued to introduce thereafter, a series of

* Presented at a conference on "Comprehensive Management of Long Term Illness," Glen Park Auxiliary Hospital, Calgary, Alberta, Canada. The conference was co-sponsored by Bethany Auxiliary Hospital and Nursing Home District No. 7, and the University of Calgary. Division of Continuing Medical Education. Program approved for 14 hours of category-1 credit, by the College of Family Physicians of Canada.

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increasingly more stringent definitions of skilled nursing care which, although conserving Federal funds, virtually emasculated the program.

If the more recent definitions of skilled care (2, 3) and custodial care promulgated by the Social Security Administration and implemented by fiscal intermediaries (Aetna Life and Casualty, Travelers Insurance, and others) continue to be applied in their present restrictive forms, the Social Security Administration will have effectively distorted, and perhaps foreclosed, the intentions of Congress and the Medicare Law.

EXPERIENCE AT WHITE PLAINS CENTER

In 1968 the Medicare-patient occupancy at the White Plains Center for Nursing Care—an approved extended care facility—was 46 per cent of the total occupancy, whereas in August and September of 1969, Medicare occupancy was approximately 10–12 per cent.[1] This sharp reduction in Medicare experience occurred even as the total occupancy rate continued in excess of 93 per cent of capacity. The need of the ill aged for skilled services obviously continues.

This paper describes the injudicious use of synthetic definitions of "continuous skilled nursing care" and "custodial care," as promulgated by the government agencies for health care.

"Extended care" has been defined thus: "Extended care is the level of care provided in those cases in which the patient's condition upon his discharge from the hospital requires him to be in an institution for the primary purpose of receiving continuous skilled services"(4).

In a 20-month study (5) conducted at the 88-bed White Plains Center for Nursing Care (1967–1968), new Medicare admissions averaged 20–25 patients per month. With the implementation of the new stringent definitions of continuous skilled nursing care promulgated by the Social Security Administration and applicable to that period, during June 1969 the number of new admissions to the same institution averaged only 1–2 patients per month.

Approximately 36 per cent of all patients admitted were capable of substantial self-care but, because of physical and emotional disabilities, still required skilled nursing care for full attainment of the activities of daily living, as certified by the attending physician. Of all those admitted, 64 per cent had major physical or psychiatric disabilities, or a combination of both, requiring major continuous skilled nursing care for effective medical, psychiatric and social management (5).

In a previous study, criteria for determining the degree of disability in relation to physical and psychiatric causes were described.

The Medicare population of patients was typical of the population of chronically ill aged whose average age was 80 in the pre-Medicare period.

[1] In August 1970 it was 5.6 per cent.

Such patients usually have a multiplicity of somatic disabilities, and the majority (60–70 per cent) exhibit behavioral abnormalities due to cerebral arteriosclerosis with or without pre-existing psychopathology.

During the 20-month study period (5) the average length of stay was 51 days. Of this group, 34.4 per cent improved in some aspect of daily living; 41 per cent remained the same; 5.5 per cent lost function; and 18.9 per cent died in the nursing home. Of the total admitted, 349 were discharged to their own homes, to hospitals, to other nursing homes, or to other living arrangements. It is clear that when 75 per cent of these chronically ill aged either improved or remained the same despite chronic progressive disease, Medicare benefits provided them with a substantial service. Many patients were discharged with significant residual disabilities, physical and psychiatric. They were obviously in need of further care but were without any organized means of obtaining it under prevailing conditions.

In effect, there is a substantial reservoir of chronically ill aged in the community who require first-rate medical and nursing care on a continuous basis but, because of lack of funds, are not receiving it.

THE NEW DEFINITIONS

The application of the new definitions to be described can only aggravate an existing deficit in health care coverage for this disadvantaged population of patients. The law as initially written related to "skilled nursing care and related services," but unfortunately did not define "skilled nursing care."

Underlying the current conflict on definitions of skilled nursing care is the fact that neither the medical nor the nursing profession has established a generally accepted definition on a clinical basis. It is hardly to be expected that an administrative government group—either Social Security or other government agency—can successfully describe or define skilled nursing care when their prime motivation is exclusion of certain of the ill aged, with the essential thesis being conservation of dollars.

In a fine monograph (7), a warm generous physician of thirty years past, wrote: "Some of the younger members of the profession, although having enormously greater knowledge of the science of medicine, have less acquaintance than many of their elders with the art of medical practice . . ." "Primarily it depends upon devotion to the patient rather than to his disease."

Perhaps the dilemma of defining skilled and non-skilled care is due to the relegation of the patient's treatment in modern times to the nursing profession. In my experience, the scientific physician participates little in treatment. The nursing profession has been attempting to fill the gap, but the results are far from satisfactory for themselves, the patients, and the medical profession.

We shall attempt here to demonstrate that the definition of skilled nursing care and the planning of a total treatment program for the chronically ill aged must include the combined creative efforts of the physician and the nurse, on clinical grounds rather than purely on the basis of economics.

The Social Security Administration, in its endeavor to delineate covered care, has stated what skilled care is *not* rather than what it *is*. It also believes that what is not skilled care is necessarily "custodial care." Custodial care is described (8) as care designed essentially to "assist an individual to meet his activities of daily living, i.e., services which constitute personal care such as help in walking and getting in and out of bed, assistance in bathing, dressing, feeding and using the toilet, preparation of special diets and supervision of medication which can usually be self-administered and which does not entail or require the continuous attention of trained medical or paramedical personnel." Another statement (8) by the Social Security Administration in referring to non-covered care infers a level less intensive than extended care. However, it provides no clarity; rather it further befogs the issues by statements related to dollar expenditures instead of scientifically developed criteria.

Students of rehabilitation medicine will recognize the foregoing goals as the main thrust of an effective rehabilitation medical program, thus constituting a skilled service rather than non-skilled service.

It was further stated: "The controlling factor in determining whether a person is receiving custodial care is the level of care and medical supervision the patient requires rather than considerations such as diagnosis, type of condition or degree of functional limitation." Is it not axiomatic that the greater the functional disabilities of the patient the greater the need for skilled nursing and other related professional services, to meet the needs of daily living?

Several attempts at defining skilled nursing care and custodial care led the Social Security Administration into the following morass: "If the *primary purpose* of the total care provided an individual is to *assist* him in meeting the activities of daily living, the custodial care exclusion applies and no payment can be made under the program for any of the care furnished him. However, if the *skilled services* furnished the patient are the primary purpose of the total care provided, the custodial care exclusion does not apply and payment may be made for services rendered under the program."

If one can fathom the distinction as stated, the next question is: Who is to determine whether the primary purpose of total care is to assist the patient in the activities of daily living, or whether skilled services are the primary purpose for the total care provided?

Responsibility for determining need

The Social Security Administration describes the duties of the attending physician (9) and, in Section 405.1137 (Utilization Review), clearly puts the sharing of responsibility for determining the need for "skilled care" in the hands of the local attending physician and the local Utilization Review Committee.

Because of an *unanticipated* spiraling of health care costs related to the Medicare program, and because of presumably and allegedly dishonest practices by various medical and paramedical professions, review teams of the fiscal intermediary (an insurance company) or the Social Security Administration itself have in effect superseded the local medical advice and counsel. Currently these teams are making decisions regarding covered versus uncovered care, skilled or custodial, from an impersonal review of medical and nursing notes on the patients' charts. The charts all too often poorly document the total disability and total care needs of the patient. Thus, the eligible patient is at a serious disadvantage. Even as attempts are currently being made to improve the quality of medical and nursing notes, many patients suffer because of the generally poor quality of the notes available, in addition to errors resulting from the unpreparedness of the medical and nursing personnel of the fiscal intermediaries.

It is also stated (2): "Neither periodic visits by a physician nor the medical necessity for such ancillary services changes the non-covered character of the care when the primary purpose of the total care furnished the patient by the hospital or extended care facility is to assist him to meet his activities of daily living."

Approval of an extended care facility as a Medicare provider of services requires a multidisciplinary rehabilitation team, including physicians, nurses, physical therapist, occupational therapist, speech therapist, recreation therapist, and social workers. Yet, within the definitions of the Social Security Administration, the needs for medical services, "certain ancillary services," physical therapy, occupational therapy, recreational therapy, and social work services are relegated to a secondary level in determining the covered or non-covered character of the care rendered to a patient.

Thus, it would be wise for medical practitioners to understand that, with respect to the question of skilled services as the primary determinant governing covered care versus non-covered care: the disease entity under consideration is not a factor; disability in the medical situation is similarly regarded; and the coordinated multidisciplinary approach of rehabilitation medicine also is understated.

Examples of non-covered care or custodial care

For non-covered care or custodial care, examples offered by the Social Security Administration (10) are:

"1. The ambulatory stroke patient who has no bladder or bowel involvement, no serious associated or secondary illnesses, and does not require medical or paramedical care, but requires only the assistance of an aide for feeding, dressing and bathing."

Comment: If this patient requires aid in feeding, dressing and bathing, the patient is obviously seriously handicapped and undoubtedly is emotionally disturbed with his altered body image and may be suffering with anger, depression, frustration and a wish for death. He thus requires all the subtleties of the art of supportive psychotherapy by skilled nurses, including the nursing skills described previously, and certainly the skilled leadership of a physician. It should be recognized that the spasticity of hemiplegia due to cerebrovascular accidents is a chronic progressive disorder and results in muscle and tendon shortening, contractures and loss of function. Moreover, the family of such a patient will be distressed about his physical, emotional and social deterioration and will also require skilled counsel and support.

It is clear that a multidisciplinary therapeutic program is indicated to prevent further disability in cases of spasticity and perhaps strive for an increased rehabilitation potential via a coordinated program of recreational therapy and pastoral counseling. The utilization of all the fine skills inherent in milieu therapy should not become a lost art. Are these modalities the tools of the unskilled?

"2. The cardiac patient who is stable and compensated with reasonable cardiac reserve and no associated illnesses, but who because of advanced age has difficulty in managing alone in his home and requires assistance in meeting the activities of daily living."

Comment: No patient is disabled because of advanced age; he is disabled because of his past medical experiences and present disease with associated loss of function. The patient described is probably depressed and, if living in an unstable social situation, requires the psychotherapeutic skills of a gifted physician, nurse and ancillary professional personnel for effective management, including drug therapy and the opportunity to achieve his full potential in the activities of daily living in all respects.

"3. The senile patient who has diabetes which remains stabilized as long as someone sees to it that he takes his oral medication and sticks to a prescribed diet."

Comment: A diabetic patient with organic brain disease is a severely handicapped person. Because of the presence of organic brain disease and its related bizarre symptomatology, this patient requires every skill of a trained nurse, physician and other ancillary professionals in providing a meaningful environment for continued living. Relegating this patient's management to an untrained aide and entrusting untrained, unskilled personnel with supervision of the diabetes and with providing a meaningful milieu, is nothing less than a travesty.

Examples of covered care or skilled nursing care

The Social Security Administration and the fiscal intermediary (2) have taken us further into the woods of confusion and chaos regarding medical and nursing management of the chronically ill aged, in a further attempt to define covered care in the extended care facility:

"The overall goal of extended care is to provide an alternative to hospital care for patients who still require general medical management and skilled nursing care on a continuing basis, but do not require the constant availability of physician services ordinarily found in a hospital setting."

Certain clinical realities may be illuminating: Among the first 512 patients admitted to the White Plains Center for Nursing Care after the implementation of the Medicare Law (1967–1968), there were 77 deaths; 70 per cent of them occurred within the first sixty days after admission, and 38 per cent occurred within the first twenty days. These patients were clearly in an unstable medical state, and in former years probably would have been cases of hospital or home deaths. The instability of their medical state, with a majority of the deaths occurring within ten to sixty days of admission, certainly suggests the need for the constant availability of physician services.

Patients were admitted to this extended care facility from local or other hospitals, in coma, diabetic acidosis, acute and chronic congestive heart failure, and with unstable cardiac arrhythmias, active pneumonitis, active genitourinary-tract infections and frequently unstable psychiatric conditions.

Although the extended care facility has clearly functioned as an extension of the hospital, the need for continuing medical services and skilled nursing care is ever-present. Too often, medical leadership is found wanting.

The more recent attempts at definition of skilled nursing care by the Social Security Administration, as interpreted by the fiscal intermediary (2), describes the service as consisting of three components, distinguished from custodial care:

"a. Professional observation and assessment of the total needs of the patient.

b. The act of planning, organization and management of a treatment plan involving multiple services where specialized health care knowledge must be applied.

c. The rendering of direct services to a patient where the ability to provide the services requires specialized training."

Although these components of skilled nursing care are generally acceptable, they require a mature degree of judgment in identification and application.

The Social Security Administration thereupon proceeded virtually to destroy a constructive attempt to identify "skilled nursing care."

Medication and other therapy

With respect to "a. Administration of Medication," the Social Security Administration (2) states: "Oral medications which require immediate change in dosages because of certain undesired side effects or reactions should be administered to the patient and observed by licensed nurses; this is a skilled service."

Notwithstanding the validity of this statement, its impact was virtually eliminated with the following policy (2): "Where a prolonged regimen of oral drug therapy is instituted the need for the continued presence of skilled nursing personnel can be presumed only during the period in which the routine is being established and changes in dosages cannot be anticipated or accomplished by unskilled personnel."

In our experience, the fiscal intermediary has been interpreting the ruling mechanistically and literally. Thus patients receiving oral drug therapy have been disqualified from covered care and relegated to "custodial" care, regardless of the type of drug and the condition of the patient.

It is generally accepted that whenever possible the modern physician substitutes effective oral medication for parenteral medication. If an attending physician finds oral medication effective he is unwittingly exposing his patient to the risk of losing the benefits of Medicare coverage.

The Social Security Administration specifically states that since extended care represents skilled nursing care on a "continuous basis," the need for intramuscular injections twice a week (as in diuretic treatment for chronic congestive heart failure or water-retaining states) "will rarely justify the findings that the care constitutes extended care services." The inequity of this ruling is obvious. It is agreed even by the Social Security Administration that intravenous injections or routine intramuscular injections on a regular basis do require skilled service. However, when using the criteria as presented: a patient with well-regulated diabetes who receives a daily injection of insulin, but who also has chronic congestive heart failure, residual disability due to spastic hemiplegia following a major stroke, and definite evidence of organic brain disease, would be classified for non-covered custodial care! The great art and the great skill of nursing psychotherapy, as well as of medical management of this patient and dealing with his family, would arbitrarily be declared an unskilled service and the patient ineligible for covered benefits.

The passage of a Levin tube and gastrostomy feedings are correctly considered skilled services. It is astonishing that colostomy or ileostomy care is declared a skilled service only during the immediate postoperative period. "Maintenance of this condition can usually be performed by the patient himself or by a person without professional training and would not usually require skilled service," according to the Social Security Administration (2).

Apparently the professional counsel of the Social Security Administration has had little experience in managing colostomy patients who also have varying degrees of organic brain disease; the brain disease clearly constitutes a physical management problem and certainly a psychiatric and social problem. It continuously tests every skill of our nurses specially trained in geriatric care, and yet these patients are denied the benefits of Medicare coverage!

With respect to urethral catheters: Students of long-term care recognize the indwelling catheter as both a life-saving and a life-threatening device. The incidence of genitourinary-tract infection is practically 100 per cent within two or three days after insertion. Yet the Social Security Administration has interpreted the management of an indwelling urethral catheter over a prolonged period as a non-skilled, or non-covered service.

In a recent case a physician required irrigation of the catheter with Suby solution every three hours. This patient was denied Medicare benefits by the fiscal intermediary since their interpretation of the procedure recommended by the attending physician was "A routine service which does not constitute skilled care." Is this the type of nursing service one would rationally place in the hands of unskilled agents?

In addition, patients requiring this care almost always have concomitant conditions which require skilled observation, e.g., strictures, stones, tumors, recurrent infections and other organic disorders such as heart disease or brain disease.

The following patient was also denied Medicare benefits: This 81-year-old woman had chronic alcoholism, organic brain disease, severe malnutrition, peripheral neuropathy, bilateral foot drop with tight Achilles tendons, and contractures of both ankles. A Charcot-type knee arthropathy was probably due to long-term peripheral neuropathy. She had multiple, severe decubitus ulcers. A Foley catheter was part of the treatment. This patient required major skilled nursing care for management of the bedsores, and major nursing services for feeding, Foley-catheter care, bowel management, and a rehabilitation and physical therapy regimen, even when the prognosis for self-care was relatively zero. Yet this patient under the present rules as interpreted by the fiscal intermediary, was considered to be under "custodial" care rather than under continuous skilled nursing care. In the name of humanity this patient receives all the skilled services our trained staff can deliver, yet we are distressed by the fact that she needs greater skills in medical and nursing management than even we can deliver.

The use of protective restraints is not deemed a skilled service. It is completely overlooked by the non-clinicians of the Social Security Administration and the fiscal intermediaries that patients requiring restraints are so disabled, agitated and unsafe that their physical and psychiatric illnesses require the most skilled continuous nursing and medical services available.

They can scarcely receive quality medical and nursing care under non-skilled auspices.

The initial phase of a regimen of medical gas-oxygen or inhalation therapy, is classified as skilled. When the administration becomes a part of the regular routine—e.g., long-term oxygen therapy in congestive heart failure or chronic respiratory disease, or the use of intermittent positive-pressure breathing apparatus—it is considered unskilled. It is overlooked that these patients have either congestive heart failure or unstable pulmonary insufficiency. Indeed, they may have difficulty in bathing, dressing and ambulation. They have organic brain syndrome and thus requiring continuous skilled services, at least on a clinical level. Yet, according to definition of the Social Security Administration, these patients are deprived of covered care.

Particularly confusing is the directive (2) that concerns the non-ambulatory patient whose primary need is frequent changing of body position in order to avoid development of decubitus ulcers—"If changing the position of the patient is the only regular and frequent service provided it would not be a skilled service."

It would indeed be difficult for the practicing clinician to find a patient 80 or more years of age for whom changing the body position was the only regular and frequent service provided. In patients who are so disabled and ill that they require hourly changes of body position for the prevention of bedsores, pain perception is altered because of pathological lesions in either the brain or spinal cord. Moreover, because of malnutrition and disappearance of the fat pads, they represent major feeding problems. Almost always, associated disorders of the genitourinary tract and bowel require use of a Foley catheter or the administration of enemas. In view of the total physical and psychiatric needs of this patient, and the need for satisfactory management of the family when they are threatened with the stress of a severely disabled parent—how, on a realistic clinical level, could anyone declare this situation as manageable with non-continuous, non-skilled care?

Since restorative nursing care, including the skill of effective body positioning, has been declared a skilled service by the Social Security Administration (2), the ruling with respect to the management of decubitus lesions is almost catastrophic in its implications. The arts and skills of clinical medicine and clinical nursing are repeatedly put in the shadow of the mechanistic approach adopted by our government agencies, apparently motivated by the dollar sign. This approach seems almost cruel in its intentions.

In a release by an additional fiscal intermediary (10) relating to types of physical therapy based upon the objective of treatment, three objectives of physical therapy were noted:

"1. Restorative treatment, which is conceded as warranting skilled care.

2. Minimal restorative treatment wherein a patient has minimal recovery from physical disability. Skilled services are also granted.

3. Maintenance care wherein a program of physical activity, formal or non-formal, can safely be provided by unskilled personnel to maintain function and prevent deterioration."

It is interesting that both fiscal intermediaries, in interpreting Social Security Administration rulings, either overlook or deny that geriatric pathology is often progressive, except when related to non-pathological fractures of bones. Maintenance care to prevent further deterioration of function and deformity is an approved and highly desirable objective of treatment. The realization of such an objective requires the most skilled coordination of the multidisciplinary rehabilitation team of professional services. Can non-skilled personnel be entrusted with the responsibility of caring for the patient when faced with chronic progressive disease and disability?

Certain situations appear to be anathema to the Social Security Administration and the fiscal intermediaries. These situations by themselves will almost certainly disqualify the patient for receiving skilled nursing services unless there is an associated recent fracture requiring physical therapy, or an obvious unstable medical situation such as acute pulmonary edema, or the necessity for nasogastric tube feeding.

"A. If the patient's treatment program is met by oral medication alone, all other professional skills he is receiving to the contrary, such as psychotherapy or milieu therapy, the patient will be disqualified.

B. If the patient is receiving major nursing maintenance care to prevent decubitae, unless combined with a mechanistic approach to nursing care as described above (daily injections, tube feedings, etc.) the patient will not qualify for Medicare benefits.

C. If the patient is being treated with restraints and oral medications alone, the patient will not receive benefits.

D. If the patient is capable of independent ambulation, dressing, feeding and hygiene, even if the patient presents with congestive heart failure, terminal cancer or a marked behaviorial problem this patient will not be granted covered care and will be judged "custodial."

E. If the patient has outside privileges, no matter the degree of disability or pathology, it is unlikely that he will be considered as receiving continuous skilled nursing services, notwithstanding that week-end institutional passes for home visits is one of the more sophisticated modalities of rehabilitation treatment in our modern time.

F. Patients who present with post-cataract surgery convalescence almost assuredly will be disqualified from receiving skilled nursing service.

G. Patients suffering with chronic brain syndrome, senility, arteriosclerosis, old cerebral vascular accident, etc. no matter the degree of disability, will not be considered as receiving continuous skilled nursing

service unless a mechanistic approach can be demonstrated, namely tube feedings, frequent injections, etc."

It would seem that governmental agencies, with a scythe-like approach, have eliminated important aspects of the great nursing and medical skills required to manage the patient with behavioral disorders, even when associated with other somatic disease.

If patients have been in an extended care facility or a hospital for sixty to ninety days prior to a qualifying hospital stay for admission to an extended care facility, or if the patient had been confined to a hospital for sixty days or longer before being admitted to an extended care facility, or if the patient was admitted to the extended care facility after only three to five days' confinement in a hospital—all these situations, even though accepted by the original Medicare Law, will immediately excite the suspicion of the Social Security Administration and the fiscal intermediaries concerning the bona fide need for continuous skilled nursing services. Such patients, on suspicion alone, may be denied covered benefits despite the clinical facts. The Social Security Administration and the fiscal intermediaries appear to be operating with a distortion of the intent of the Federal Insurance Program for the Aged, i.e., they have overlooked the fact that the enrolled chronically ill aged have a right, not a privilege, to use or avail themselves of Medicare benefits.

Revisions—Interpretations by fiscal intermediaries

The difficulties of implementing the Medicare Law propounded by Congress have been exacerbated by revisions of definitions of skilled nursing care by the Social Security Administration, including further attempts at elucidation by the fiscal intermediaries (11). In general, Travelers Insurance Company continues the mechanistic description of skilled nursing care which relates to special procedures rather than to the great art of nursing. However, in some instances it differs from Aetna Life and Casualty (2): "The frequent need for continuous or long-term inhalation therapy usually substantiates an unstable medical condition which requires skilled care." It then proceeds to weaken this position by stating: "A physician's order for oxygen is only suggestive of a skilled service; further, many respiratory cripples can administer inhalation therapy to themselves as needed." Literal interpretation of these diverse statements by the Medical Department of the fiscal intermediaries can virtually eliminate from covered care all patients receiving inhalation therapy, regardless of their clinical status.

Travelers Insurance Company also insists that the weekly changing of a catheter by a skilled medical person does not constitute a continuous skilled service. They do admit that an indwelling catheter, provided it is an adjunct to active treatment of disease of the urinary tract or bladder, may require continuous skilled supervision. However, the use of the Foley

catheter for neurogenic bladder dysfunction is considered a non-skilled service; infection in the bladder apparently is a matter of little concern.

In an attempt to distinguish between the functions of rehabilitation and restorative nursing care versus custodial non-covered care, Travelers Insurance Company tries to differentiate between training and assisting, as applied to the activities of daily living. Assisting is not considered a skilled service. Although use of the terms "training" and "assisting" appears to differentiate the two nursing services on a clinical level, how does one really distinguish between them as skilled services? Is not assisting on a repeated basis actually training, and is not training actually assisting?

With respect to the brain-damaged aged, an opening in the clouds is noted (2): "Occasionally violent or manic senile beneficiaries may require complex and hazardous restraints which require skilled supervision." Although there is no specific recommendation or provision regarding skilled services for the aged with organic brain disease, this comment suggests there is a place for such services. However, the issue is far from qualified.

Contradictory statements such as "assistance in ambulation can be safely provided by unskilled personnel and is not a skilled service," whereas "gait training is a recognized physical medicine procedure and represents a skilled service when provided or supervised by skilled personnel," are not at all illuminating.

The discouraging attitude towards oral medication continues. "Very few medications require prolonged continuous skilled supervision; maintenance care with most hazardous medications can usually be safely administered by unskilled personnel, supplemented by periodic evaluation of the attending physician."

The great professional skills required in the nursing and medical management of oral drug therapy in patients with organic brain disease are negated. Travelers Insurance (9) seems to insist upon a guarantee of a successful rehabilitation potential in order to qualify physical therapy under "covered care." This is not consistent with a Social Security Administration ruling (11): "A decision that an individual lacks rehabilitation potential would not necessarily mean that the care furnished him is custodial care. Many patients who have no potential for rehabilitation require a level of care which is covered under the program."

New York State (12) describes the nursing home patient as:

"1. A person diagnosed by a physician as having one or more clinically determined illnesses or conditions that cause the patient to be so incapacitated, sick, invalid, infirm, disabled or convalescent as to require at least medical and nursing care, and

"2. Who do not require care as to the treatment of the patient in a general or special hospital in or near his community or home substitute through providing such home health services including medical and other health and health-related services as are available in or near his community.

"3. Cannot be met satisfactorily in the physician's office, hospital, clinic, other ambulatory care setting, because of the unavailability of medical and other health related services for the person in such setting in or near his community."

In a further attempt to define a level of care such as "skilled nursing care," the New York State Medical Assistance Program, stewarded by the New York State Department of Social Services (13), listed the following nursing practices:

"A. No regular or specific needs
B. Bed positioning
C. Bladder and bowel training
D. Catheter care
E. Drugs, injectable
F. Drugs, oral
G. General nursing care
H. Irrigations
I. Dressing changes
J. Ostomy care
K. Transfer activities, supervision
L. Skin care."

The continuing trend to define skilled nursing care and levels of care by using mechanical procedures as criteria, is apparent. If the thrust of government agencies and fiscal intermediaries, in an attempt to control the budget, is to deprive the chronically ill aged of medical and nursing services rather than to provide them, then all the tools necessary for such deprivation are present.

The following case illustrates the disintegration of the purposes of Medicare:

The patient was an 86-year-old Negro male for whom inquiry to our extended care facility was made while the patient was in the local hospital. The information was transmitted to the medical department of the fiscal intermediary for opinion as to his qualification for "covered benefits" in the extended care facility. The attending physician documented (as noted below) the diagnosis, treatment plan and clinical course in the hospital and requested continuation of a rehabilitation program with restorative nursing services and physical therapy. In addition, the referring physician claimed a positive rehabilitation potential for the patient.

"Diagnoses: Cerebral Arteriosclerotic Vascular Disease. Syncope as cause for difficulty on admission. Pneumonia now cleared. Iron deficiency anemia: disuse weakness of legs with inability to walk securely—poor equilibrium. Urinary incontinence—Foley catheter in bladder. Gouty arthritis of feet with pain on standing. Patient cooperating in rehabilitation efforts very well. He is eager to regain ambulation. With treatment of gouty arthritis I am reasonably confident

patient will be able to stand and regain ability to ambulate with aid, and perhaps alone.

Medication: 1. Lanoxin 0.125 mg. daily, p.o.
2. Feosol Spansules b.i.d.
3. Allopurinol 100 mgs. b.i.d. or t.i.d.
4. Irrigate Foley catheter with Suby solution daily, q12h.

Therapeutic Goals: Regain aided and perhaps independent ambulation and return home."

Covered care on this case was denied by the fiscal intermediary: "Even though it is quite obvious that this patient needs rehabilitation care it may not be covered under the Medicare program" (14).

This situation clearly is an injustice to the insured aged patient and represents a denial of a reasonable clinical rehabilitation trial. Was this the purpose of the Medicare Law?

CONCLUSIONS

Although there may be significant deficiencies in the application of Medicare benefits at a local level by physicians and nurses, including the administration of extended care facilities, and although administrators and owners of extended care facilities are being scapegoated and often held financially responsible for professional decisions beyond their understanding and control, the substitution of bureaucratic and other proprietary controls (fiscal intermediaries) has caused great human suffering, legal and economic injustices, and serious inhibition of the scope and practices of the medical and nursing professions. Current application of the restrictive Social Security Administration rulings with respect to definitions of covered and non-covered care, with the literal interpretations by fiscal intermediaries, has made obsolete the decisions of local attending physicians and local Utilization Review Committees as to the need and definition of skilled nursing care. Such a shift in the venue of control has not made for clearer recognition of skilled services, nor has its application effectuated the laws of Congress. Money may be saved by the device of phasing out a desirable public health program.

Several astonishing results of these developments are noteworthy:

1. The muffling of the local physicians by these new rules has occasioned no protest by the medical profession. Such indifference will exact its own price.

2. The art and true skills of nursing care (parenteral injections and the passing of tubes are not so considered here), the nurse-patient-family interrelationships, the spirit of the Nightingale and Oslerian practices (wherein the worth of the patient rather than mechanical nursing practice is revered), and family counseling are nowhere recognized in the new rules as a skilled service. Is it necessary to be reminded that the patient does not have to be insane to require skilled nursing psychotherapeutic

support? The nursing profession is permitting itself to be constricted, to the public disadvantage, and yet no outcry. A high price for such unconcern about human feelings will be paid.

3. The lack of public protest regarding the denouement of the Medicare program reflects the persistent rejection of the aged and disturbances of family interrelationships, the indifference to the obvious modern dissolution of the family structure, and the denial of the dying and dead. Perhaps, after all, a "society gets what it deserves."

Effective clinical implementation of Public Law 89-97 will require:

1. A reconfirmation of the values of the ill individual as a person with somatic, psychosomatic, organic, psychiatric and psychosocial disabilities, and the encouragement of the arts and skills of medical-nursing care supported by humane understanding, compassion and a desire to improve the life of the chronically ill aged in addition to the application of technological skills.

2. A reaffirmation that fragmentation and definition of health care facilities according to levels of care only reinforce a concept that several levels of care are acceptable—as if a compromise could be made with anything but the best and most skilled services for all those who need help. Can the idea of an "intermediate care facility providing minimum but continuous care for those not in need of continuous medical and nursing services" (15) really be defended on the basis of clinical realities? In the pursuit of economies we have created a chaotic system of health care which defies continuity of care for the chronically ill.

3. A realization that the general hospital and its professional staff must once again become the hub of all community health care activities. Medical schools and their faculties must reorient their curricula towards meaningful comprehensive care of the acutely and chronically disabled so that the physician can regain his lost position of leadership of the multidisciplinary team in its clinical rehabilitation efforts.

4. Cessation by the hospital of arbitrary and unrealistic definitions of acute and chronic illness and acceptance of the fact that since the majority of hospital in-patients are chronically ill, short-term and long-term management programs must be planned appropriately. The responsibility for care of the patient does not cease for the hospital at the time of discharge. If comprehensive care is to result in other than "lip-service," a meaningful cross-fertilization of administrative responsibilities and policies must be available at all levels of health care facilities, with the hospital providing leadership and inspiration.

5. Elimination of the distinction between proprietary and non-proprietary sponsorship. All these facilities are legal entities and can serve the public either well or ill. Serving the public need is the issue, and not status of sponsorship. Let the hospital help create the umbrella of health care services for the community. The responsibility for deciding whether care

is to be covered or non-covered can be determined on the hospital premises, thus eliminating the potential of self-serving interests in subsequent care of the patient.

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Appendix 3

INTERMEDIARY LETTERS, BUREAU OF HEALTH INSURANCE, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
SOCIAL SECURITY ADMINISTRATION,
Baltimore, Md., April 13, 1967.

BUREAU OF HEALTH INSURANCE INTERMEDIARY LETTER NO. 211

Subject: Background statement on definition of custodial care.

The Social Security Act prohibits payment to be made under the health insurance for the aged program for any expenses incurred for items of services where such expenses are for custodial care. We are enclosing for your information a background statement on the definition of custodial care as it relates to general hospitals and extended care facilities. (Since the application of the custodial care exclusion will present special problems in psychiatric and tuberculosis hospitals, a separate statement on the application of the exclusion in these hospitals is being prepared.) The Hospital and Extended Care Facility Manuals will be revised in the near future to incorporate the material contained in this paper. In the meantime intermediaries will want to get in touch with the administrator of each hospital and extended care facility and discuss the definition with him and stress the importance of having it called to the attention of the institution's utilization review committee and physicians making the necessary certifications and recertifications. In the near future, we will, after appropriate prior consultation, develop and issue to intermediaries procedural guidelines to be used in identifying custodial cases during the claims review process and instructions explaining how such cases are to be handled.

ARTHUR E. HESS,
Director, Bureau of Health Insurance.

Enclosure.

DEFINITION OF CUSTODIAL CARE

The widespread and often loose use of the terms "custodial care" and "supportive services" makes it difficult to define them with any real degree of precision. Moreover, as has been frequently pointed out, all of the shorthand terms, such as "custodial care" or "supportive services," are not really descriptive terms, have a variety of meanings and lend themselves readily to different interpretations in particular cases. For this reason no attempt has been made to develop an abstract definition of "custodial care." Rather, attention has been focused on the effort to identify more specifically the type of particular services which, where they represent the primary focus or underlying purpose of the services, constitute care not intended to be covered.

There can be no doubt that Congress in enacting Public Law 89–97 intended to provide beneficiaries with protection against the medical costs arising from an illness or injury which requires the type of care that necessitates the continuing attention of trained medical and paramedical personnel. This intent is reflected in the law in the conditions of participation for hospitals and extended care facilities which place a great deal of emphasis on the availability within the institution of a wide range of specialized medical services and the employment by the facility in adequate numbers of a variety of medical and paramedical personnel, the requirements relating to physician certification of the medical necessity for the skilled services furnished by a hospital or extended care facility, and the utilization review committee's periodic evaluation of the patient's continuing need for such services.

Accordingly, the kind of care which Congress did not intend to cover and which would, therefore, be classified as custodial care, is that type of care, wherever furnished, which is designed essentially to assist the inndividual in meeting his activities of daily living—i.e., services which constitute personal care such as help in walking and getting in or out of bed, assistance in bathing, dressing, feeding, and using the toilet, preparation of special diets, and supervision over medication which can usually be self-administered—and which does not entail or require the continuing attention of trained medical or other paramedical personnel.

APPLICATION OF THE DEFINITION

Although the custodial care exclusion applies to all hospitals and extended care facilities, it is not anticipated that the exclusion will be a major problem in the short-term hospitals. The reason for this, of course, is that the short-term hospital is geared to the patient with an acute illness who generally requires a relatively brief convalescence with early return to his normal way of life. The most significant problems in applying the definition of custodial care will arise in long-term hospitals and extended care facilities. As is recognized, a large number of the patients in these institutions are chronically ill. This is not to say, of course, that the patient with a chronic or long-term illness may not require continuing medical supervision and guidance over a prolonged period of time. However, the needs of the chronically ill vary from patient to patient and for any one patient may change from time to time.

Many individuals with a long-term illness or disability reach a relatively stable plateau during which their needs may be only the type of personal care services described above and which could be provided by a nonmedical person in the individual's home if he had a home to go to and someone willing to undertake these responsibilities. These types of patients would, for medicare purposes, be considered as receiving custodial care.

Other chronically ill patients, on the other hand, whose conditions are stabilized may need medical services to maintain the achieved stability that can be provided safely only by or under the direct supervision of physicians, nurses, or other paramedical personnel. These needs may include irrigations, catheterizations, application of dressings or bandages, administration of medications and other prescribed treatments requiring skill in administration. This group of patients would not be considered as receiving custodial care only.

Thus, the essential characteristic that is to be used for determining whether a person is receiving custodial care is the level of care and medical supervision that the patient requires, rather than such factors as the diagnosis, the type of condition, or the degree of functional limitation.

EXAMPLES OF THE APPLICATION OF THE DEFINITION

Examples of the type of patient care which would be considered as custodial care would be the care given a "stroke" patient who is ambulatory, has no bladder or bowel involvement, has no serious associated or secondary illnesses and does not require skilled medical or paramedical care but rather requires only the assistance of an aide in feeding, dressing, and bathing; the cardiac patient who is stable and compensated and has a reasonable cardiac reserve and no associated illnesses, but who, because of advanced age, would have difficulty in managing alone in his home, and requires assistance in meeting the activities of daily living; or the senile patient who has diabetes which remains stabilized as long as someone sees to it that he takes his oral medication and sticks to a prescribed diet.

Examples of the type of patient care which would not be considered as custodial care would be the care given a patient with severe arteriosclerotic heart disease who requires the skill and experience of trained medical personnel in adjusting digitalis dosage and in maintaining proper fluid balance and must be constantly watched for signs of decompensation; the diabetic amputee whose wound is healed and who needs diabetic regulation, fitting of a prosthesis and learning how to walk with it, as well as how to care for his remaining foot; or the patient with terminal cancer whose life expectancy is not more than a few months, who requires palliative treatment, periodic "tapping" to relieve fluid accumulation, and careful skin care and hygiene to minimize discomfort.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
SOCIAL SECURITY ADMINISTRATION,
Baltimore, Md., June 1968.

BUREAU OF HEALTH INSURANCE INTERMEDIARY LETTER NO. 328

Subject: Determining level of care being furnished patient in extended care facility.

I. INTRODUCTION

One of the most difficult administrative jobs of the fiscal intermediary has been to determine whether the care provided a patient by an extended care facility is the kind covered by the law. This intermediary letter is intended to reduce some of the difficulty.

In the past we have identified all noncovered care in an extended care facility as "custodial care" (which by law is specifically excluded). The 1967 amendments to the Social Security Act provide for reimbursement under the welfare provisions of that act for levels of care previously not recognized in the law. From now on we will use the term "noncovered care" to refer to any level of care which is less intensive than extended care. "Extended care," which is covered, is the level of care provided in those cases in which the patient's condition upon his discharge from a hospital requires him to be in an institution for the primary purpose of receiving continuous skilled services. ("Primary purpose" and "skilled services" are explained in greater detail in Part A Intermediary Manual Section 3159.1B).

Intermediary claims activities should be directed toward assuring that, as a condition for payment, necessary skilled services have been prescribed for and provided to the patient. If these services appear to be appropriate to the patient's condition and sufficient to constitute extended care, the intermediary should determine, in the absence of evidence to the contrary, that the care constitutes covered care.

II. SUMMARY OF MAIN POINTS

The objectives of this letter can be summarized in five main points:

A. It confirms that intermediaries are responsible for carrying out a program of claims administration which limits reimbursement to covered care and denies payments when the level of care is lower than extended care.

B. It provides a procedure for prompt decisions on coverage independent of the billing process to reduce the problem of retroactive denials.

C. It provides assurance of payment to extended care facilities where the facility and the patient's physician properly carry out their parts of the administrative process.

D. It provides that the views of the attending physician and the utilization review committee be thoroughly considered before a case is denied, and emphasizes the responsibility of the intermediary to inform the committee and facility of questionable cases so that the possibility of conflicts between the views of the patient's physician, the committee, and the intermediary's medical staff are minimized.

E. It encourages the fullest use of the educational process in fostering a clear understanding of noncovered care and of the necessity of the full cooperation of all parties.

III. PHYSICIAN AND HOSPITAL RESPONSIBILITIES

In order for an extended care facility to provide the care a patient needs, it must know promptly at admission what the condition of the patient is and what treatment it is expected to provide. At the same time, the patient and the facility need to know whether Medicare will pay for the services. In doubtful cases there is a need for prompt decisions on coverage. Otherwise, denial of a claim may mean a patient owes a large sum that is likely to cause a serious problem to him and the facility. This possibility exists when the level of care is not clearly covered and the facility furnishes the intermediary with only the information required by the regular billing procedures. Thus, in doubtful cases, the procedure outlined in Section V should be employed.

The attending physician customarily plans in advance for the needs of his patient, including, where appropriate, transfer from a hospital into an extended care facility. The hospital can and should aid in this planning process. In the case of such a transfer, the preferred approach to the provision of patient care information is as follows:

A. While the patient is in the hospital, a medical information summary may be prepared which would include physician's orders for the patient's care in the facility, a profile of the patient's condition, and the services expected to be needed.

B. This summary should be submitted by the hospital to the facility prior to the time of the transfer of the patient.

C. If the summary is to be incorporated into a form, it may be incorporated into a standard form agreed to by the intermediary and the providers of service. (A copy of a form used by the Associated Hospital Service of New York is enclosed as an example of one format in use.)

When this information has not been submitted in advance as indicated above, alternate approaches should be used to supply the needed information. In every instance, good patient care requires the extended care facility to have available by the time of admission, in writing, the required patient care information. The written data may in some instances be preceded by telephone orders which would make possible advance preparation for care.

The State agency, the intermediary, and the extended care facility should do all they can to encourage hospitals to transfer this medical information to the facility by the time of admission.

IV. MEDICAL INFORMATION FORM

Intermediaries may reproduce the enclosed model medical information form and distribute it, or they may prepare their own formats. When the forms are first sent out to facilities, a letter should explain the form, its use, and the advantages of using the procedures outlined in this intermediary letter to minimize retroactive denials.

V. PROCEDURES FOR EXTENDED CARE FACILITIES

In cases where the extended care facility has received a medical information summary, or other adequate information, which requires it to furnish "skilled services" which are obviously covered care, no special action need be taken by the facility apart from its usual billing procedures.

However, where (A) the facility has reason to doubt upon admission whether the care is covered, or (B) at any time there is a significant change in the level of care which may result in noncovered care, the steps described below should be followed to avoid retroactive denials.

(NOTE: Facilities may avoid retroactive denials only when they have effective utilization review and when the facilities and admitting physicians demonstrate their understanding of what constitutes covered care by limiting claims for payment to those in which skilled services are required.)

A. The medical information form or equivalent should be completed by the facility's director of nursing services, the charge nurse, or a physician from the attending physician's orders and from medical information from the transfer hospital. When information submitted to the extended care facility by the attending physician or hospital is adequate, copies of such information will be acceptable to the intermediary in making coverage determinations in doubtful cases instead of requiring additional forms. Medicare admission forms contain the patient's authorization for release of such information to the intermediary.

B. The medical information described in (A) should be forwarded to the intermediary within 48 hours of admission or whenever the treatment provided becomes less intensive to the point of raising a doubt as to coverage.

C. The utilization review committee should review promptly each admission where there is a question of whether the required level of care is covered to help screen out claims for care which are obviously noncovered.

D. To minimize the need for recontact by the intermediary, the utilization review committee should record the skilled services it considers to justify extended care on a medical information or other form, and the information should be included with any submission of utilization review committee findings by the extended care facility to the intermediary.

VI. DETERMINATIONS BY THE INTERMEDIARY

In making its determinations, an intermediary will take actions as follows:

A. Medical information forms will be processed promptly and the extended care facility in formed of the results.

B. Where the evidence presented demonstrates that covered care is being furnished, the facility will be reimbursed for the care provided as long as the patient continues to require that level of care.

C. (1) Where the intermediary finds that the facility is conscientiously applying the definitions of covered and noncovered care and carrying out the steps in section V, but in a particular case the evidence is unclear on whether the level of care provided is covered, the intermediary may presume that the care is covered up to the date when the facility is advised that additional supporting evidence is required and the evaluation of the facility's utilization review committee is requested by the intermediary. The evidence requested on the level of care may be restricted to the period after the coverage issue arises.

(2) If the facility has not been found to be complying with the recommended procedure, the presumption that prior care was covered may not be applied. Evidence on level of care should be obtained beginning with admission, and denial of coverage may be retroactive to the date of admission or any appropriate subsequent date.

VII. EFFECTIVE DATE

The instructions in this letter are to be implemented immediately. It is not necessary to locate or reopen claims previously decided.

VIII. INFORMATIONAL ACTIVITIES

While a continuing educational program will be necessary for some time, because of the importance of these guidelines we recommend that intermediaries take aggressive action to disseminate this information through meetings, workshops, or visits to insure complete understanding on the part of extended care facility owners, administrators, their staffs, and the utilization review committees.

THOMAS M. TIERNEY,
Director, Bureau of Health Insurance.

Enclosures.

Information for Use in Determining Level of Care
Required by Patient in Extended Care Facility
(Confidential--For Use of Intermediary's Medical Staff)

Patient's Name_____

Patient's Age_____

HI Claim Number_____

1. Prior Hospitalization

   Inclusive dates: From_____ To_____

2. Patient Characteristics

   a. Diagnosis upon admission to extended care facility:_____

   _____

   b. Hospital discharge diagnosis (if different from admission diagnosis to extended care facility):_____

   _____

   c. Overall status of patient's medical condition:

   ☐ unstabilized ☐ stabilized

   d. Anticipated length of stay for extended care:_____ days

3. Physician's Patient Care Plan

   a. Brief summary of general treatment plan and objectives

   _____

   _____

   _____

   _____

b. Tabular summary of skilled nursing care services specified by physician

Skilled nursing services provided by or under supervision of RN or LPN:	Daily	Weekly	Several Times Weekly	Biweekly
☐ medications and injections (show type and method of administration)				
_____				
_____				
_____				
_____				
☐ intravenous fluids				
☐ soaks or special dressings				
☐ special skin care, e.g., lesions, ulcers, fistulas, decubiti				
☐ oxygen (show type of administration)				
_____				
☐ servicing of indwelling catheters (show reason for use)				
_____				
☐ Rehabilitation nursing				

c. Other rehabilitative and restorative services specified by physician (include type, frequency, and by whom rendered).

_____

_____

_____
Signature

MEDICARE

ASSOCIATED HOSPITAL SERVICE OF NEW YORK
80 Lexington Avenue • New York, N.Y. 10016

SEE REVERSE SIDE OF PART 3 FOR INSTRUCTIONS
COMPLETE ALL PARTS
SEND PARTS 1 and 2 TO ECF
RETAIN PART 3

HOSPITAL TO EXTENDED CARE FACILITY (ECF) - REQUEST FOR TRANSFER INFORMATION

PATIENT NAME AND ADDRESS | HEALTH INSURANCE CLAIM NO.

HOSPITAL NAME AND ADDRESS | HOSPITAL MEDICAL RECORD NUMBER

EXTENDED CARE FACILITY NAME AND ADDRESS | MEDICAID ELIGIBLE ☐YES ☐NO | AGE | SEX

ATTENDING PHYSICIAN INFORMATION

1. NAME AND ADDRESS OF ECF PHYSICIAN

2. FINAL DIAGNOSIS(ES), OR PHOTOCOPY ATTACHED ☐
PRIMARY:

ALL OTHER CONDITIONS:

3. SURGICAL PROCEDURE(S) AND DATE(S) OR, CHECK NONE ☐

4. PHYSICIAN ORDERS ON TRANSFER:

5. ESTIMATED MEDICALLY NECESSARY ECF STAY:
_____WEEKS OR_____MONTHS

6. DRUG SENSITIVITIES OR, CHECK NONE ☐

7. DIETARY REGIMEN:

8. PHYSICIAN'S SIGNATURE DATE

NURSING EVALUATION

9. SPEECH	NORMAL ☐	IMPAIRED ☐	UNABLE TO SPEAK ☐				
10. HEARING	NORMAL ☐	IMPAIRED ☐	DEAF ☐				
11. SIGHT	NORMAL ☐	IMPAIRED ☐	BLIND ☐				
12. MENTAL STATUS	ALWAYS ALERT ☐	OCCASIONALLY CONFUSED ☐	ALWAYS CONFUSED ☐				
13. FEEDING	INDEPENDENT ☐	HELP WITH FEEDING ☐	CANNOT FEED SELF ☐				
14. DRESSING	INDEPENDENT ☐	HELP WITH DRESSING ☐	CANNOT DRESS SELF ☐				
15. ELIMINATION	INDEPENDENT ☐	HELP TO BATHROOM ☐	BEDPAN/ URINAL REQUIRED ☐	INCONTINENT ☐			
16. BATHING	INDEPENDENT ☐	BATHING WITH HELP ☐	BED BATH WITH HELP ☐	BED BATH ☐			
17. AMBULATORY STATUS	INDEPENDENT ☐	WALKS WITH ASSISTANCE ☐	HELP FROM BED TO CHAIR ☐	BED BOUND ☐			

18. DRESSINGS AND BANDAGES: OR, CHECK NONE ☐

19. APPLIANCES OR SUPPORTS: OR, CHECK NONE ☐

20. NURSING ASSESSMENT AND RECOMMENDATIONS:

SUMMARY ATTACHED ☐YES ☐NO

21. SIGNATURE TITLE DATE

SOCIAL EVALUATION

22. NAME AND ADDRESS OF PERSON TO CONTACT: | RELATIONSHIP TO PATIENT | TELEPHONE NUMBER

23. PATIENT LIVES:
ALONE ☐ WITH FAMILY ☐ WITH SPOUSE ☐ OTHER ☐ EXPLAIN:

24. PATIENT ATTITUDE:

25. SUMMARY ATTACHED SOCIAL/EMOTIONAL FACTORS ☐YES ☐NO

26. POST ECF PLANS:

27. SIGNATURE DATE TITLE

MC 568

ECF COPY

INSTRUCTIONS FOR COMPLETION

1. Name and address of physician responsible for continuing management of ECF care.

2. List all final diagnosis[es] for hospital stay or attach photocopy of completed face sheet of hospital chart. Include all conditions which relate to this patient's need for hospital and ECF care. **EXTENDED CARE FACILITY SERVICES ARE AVAILABLE TO MEDICARE BENEFICIARIES ONLY FOR CONDITIONS FOR WHICH THE PATIENT WAS RECEIVING INPATIENT HOSPITAL SERVICES.**

3. List all surgical procedures with dates performed during hospital stay.

4. Physician orders necessary to continuity of patient care upon transfer to extended care facility and pending first visit [within 24 hours] by physician responsible for ECF care. This must include all medications [dosage and frequency], specific instructions for special treatments, and allowable degree of ambulation and other activity.

5. Estimate of length of medically necessary Extended Care Facility stay, not to include any possible custodial care. **BENEFITS ARE EXCLUDED FOR CUSTODIAL CARE EITHER IN HOSPITAL OR EXTENDED CARE FACILITIES UNDER THE MEDICARE PROGRAM.**

6. List any drugs for which there had been evidence of sensitivity in the past.

7. Give detailed dietary instructions, including any special needs related to desirable fluid intake requirements.

8. Signature of private attending or other physician responsible for care during hospital stay.

9-17. **BY CHECKING ONLY ONE BOX IN EACH CATEGORY,** describe patient abilities in activities of daily living.

18. List all necessary special dressings and bandages and indicate frequency of changes.

19. Include ambulatory aids, prostheses, respiratory aids, special shoes, special eye glasses, problems with dentures, etc.

20. Include the degree of nursing intervention necessary for the following:
    a] observation of symptoms and reactions,
    b] supervision and/or teaching of special treatments, [e.g.: tracheostomy care, colostomy care, use of oxygen, etc.]
    c] attainment of nursing objectives.
    ATTACH ADDITIONAL PAGES AS NECESSARY.

21. Signature of unit nurse supervisor.

22. Identify person to be advised of patient's status, as necessary.

23. Whenever "other" is checked give name or describe type of institution or other facility involved.

24. Indicate patient reaction to:
    a] Diagnosis
    b] Hospital Stay
    c] Transfer to ECF

    ATTACH ADDITIONAL PAGES AS NECESSARY.

26. Indicate whether patient will be discharged to family, self, another unit of same institution, another institution, or will need Home Health Agency Care.

27. Signature of unit Social Service Supervisor, or person and title assessing social factors.

WHEN CARE FURNISHED TO ECF PATIENTS CAN BE COVERED BY MEDICARE

To assure prompt and equitable determinations as to whether care furnished to patients in extended care facilities is covered and can be paid for under Medicare, the understanding and cooperation of physicians, hospitals, ECFs, utilization review committees, intermediaries, and carriers are vital. We hope this message will help to achieve these objectives.

A. **WHAT IS "EXTENDED CARE"?** The covered level of care provided when the patient's condition upon his discharge from a hospital requires him to be in an institution for the *primary* purpose of receiving continuous skilled nursing services and other professional services.

B. **WHAT ARE "SKILLED SERVICES"?** A skilled service is one which *must* be furnished by or under the supervision of trained medical or paramedical personnel. A service is not skilled merely because it is performed by a trained medical or paramedical person. A service which can be safely and adequately self-administered or performed by the average, non-medical person, without the direct supervision of trained medical or paramedical personnel, is a non-skilled service without regard to who actually provides the service.

C. **WHAT IS "NONCOVERED CARE"?** *Any* level of care less intensive than extended care. Formerly, all noncovered care was referred to as "custodial care."

D. **WHAT ARE THE RESPONSIBILITIES OF THE ATTENDING PHYSICIAN AND HOSPITAL?** The attending physician customarily plans in advance for the needs of his patient including, where appropriate, transfer from a hospital into an extended care facility. The hospital can and should aid in this planning process. Following is the preferred approach:

1. While the patient is in the hospital, a medical information summary should be prepared including the physician's orders for the patient's care in the facility, a profile of the patient's condition, and the services expected to be needed.
2. This summary should be submitted by the hospital to the facility prior to the time of the transfer of the patient.
3. If the summary is to be incorporated into a form, it may be incorporated into a standard form agreed to by the intermediary and the providers of service.

When this information has not been submitted in advance as indicated above, alternate approaches should be used to supply the needed information. We have been advised by the medical profession that good patient care requires the extended care facility to have available by the time of admission, in writing, the required patient care information. The written data may in some instances be preceded by telephone orders which would make possible advance preparations for care.

E. **WHAT PROCEDURES SHOULD EXTENDED CARE FACILITIES FOLLOW?** If adequate information is received, requiring it to furnish skilled services which are obviously covered care, no special action need be taken by the ECF. However, if the ECF thinks there could be reasonable doubt upon admission that the care is covered (or if, during the ECF stay, there is a significant change in the level of care), it should take these steps:

1. Complete a "medical information form" or equivalent (by the ECF's director of nursing services, the charge nurse, or a physician) based on the attending physician's orders and the transfer hospital's medical information. A copy of the hospital's medical information summary or the attending physician's orders would generally be an acceptable substitute.
2. Forward this medical information to the intermediary within 48 hours of admission or when a change in the level of care raises doubts as to coverage.
3. The utilization review committee should review promptly each admission where there is a question of whether the required level of care is covered to help screen out claims for care which are obviously noncovered.
4. To minimize the need for recontact by the intermediary, the utilization review committee should record the skilled services it considers to justify extended care on a medical information or other form, and the information should be included with any submission of utilization review committee findings by the extended care facility to the intermediary.

F. **WHAT ACTIONS WILL THE INTERMEDIARY TAKE IN ITS DETERMINATIONS?**

1. Process medical information forms promptly and inform the ECF of the results.
2. Where the care is deemed covered, reimburse the ECF as long as the patient requires that level of care, up to the maximum benefits.
3. Where the ECF is conscientiously carrying out the procedures listed above in each questionable case, the intermediary will presume that a case with unclear evidence is covered up to the time when the ECF is advised that additional evidence and evaluation by the utilization review committee is required. However, if the ECF has not been following the recommended procedure for questionable cases described above in (E), retroactive denial may be made back to the date of admission or any subsequent date established by the evidence.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
SOCIAL SECURITY ADMINISTRATION,
Baltimore, Md., April 1969.

BUREAU OF HEALTH INSURANCE INTERMEDIARY LETTER NO. 371

Subject: Determining coverage of care in an extended care facility.

Intermediary Letter No. 328 established a procedure for marketing prompt coverage determinations on extended care facilities admissions involving types of care that are neither clearly covered nor excluded. Implementation of this procedure has pointed up significant inconsistencies among intermediaries in determining whether stays in extended care facilities are covered. It is the purpose of these guidelines to provide greater detail regarding the factors that should be taken into account in making these determinations.

It should be clearly understood that the examples that appear in these instructions are intended to serve as basic guidelines and do not remove the judgmental factor necessary to resolve questionable cases. Intermediaries may need to supplement these guidelines with specific claims review instructions and procedures adapted to their individual claims processing systems.

COVERAGE OF POST-HOSPITAL EXTENDED CARE SERVICES

The Medicare statute imposes the following requirements for coverage of inpatient services received by a beneficiary inpatient of an extended care facility:

1. The beneficiary must have been an inpatient of a hospital for at least 3 consecutive calendar days; and
2. The beneficiary must have been transferred to the extended care facility within 14 days after discharge from the hospital; and
3. The services must be required for treatment of a condition or conditions with respect to which the beneficiary was receiving inpatient hospital services prior to transfer to the facility or for a condition which arose while receiving extended care for treatment of a condition or conditions for which he was receiving inpatient hospital services; and
4. The condition or conditions must require skilled nursing care on a continuing basis; and
5. A physician must certify (and recertify where the services are provided over a period of time) that requirements 3 and 4 are met.

Compliance with all of the above requirements except no. 4 can generally be determined directly from the specific information provided on the admission notice and billing. (In some cases, it may be necessary to compare ECF admission notice with discharge diagnosis from previous hospital bill.)

The fourth requirement, however, involves individualized judgment and evaluation which require intermediary personnel to be able to differentiate between skilled and unskilled services.

CONCEPT OF EXTENDED CARE

The term "extended" refers not to provision of care over an extended period, but to provision of active treatment as an *extension* of inpatient hospital care. The overall goal is to provide an alternative to hospital care for patients who still require general medical management and skilled nursing care on a continuing basis, but who do not require the constant availability of physician services ordinarily found only in the hospital setting.

All extended care facilities participating in the program are considered capable of rendering the skilled care which constitutes extended care. However, the Medicare law identifies a specific type of inpatient nursing care which will be reimbursable under the program. For this reason, personnel who review claims from ECF's should be particularly familiar with those characteristics which distinguish "extended care" from other types of inpatient nursing care.

LEVEL OF CARE DETERMINATIONS—GENERAL

There are three basic considerations in every level of care determination:

1. The individual patient's medical needs;
2. The specific services required to fill these needs; and
3. The health personnel required to adequately provide these services.

Determining a patient's medical condition and the appropriate services for that condition is primarily a physician's function. Physicians should refer a hospitalized

patient to an extended care facility as soon as his condition has improved or stabilized sufficiently that it requires continuous skilled services but does not require the constant availability of medical services as provided in a hospital. If questions arise regarding the propriety of some or all of the services ordered by the attending physician because the services ordered appear unusual for the type of patient involved, the case should be referred to the intermediary's medical staff or consultant.

SKILLED CARE

Skilled nursing care includes components which distinguish it from supportive care which does not require professional health training. One component is the observation and assessment of the total needs of the patient. Another component is the planning, organization and management of a treatment plan involving multiple services where specialized health care knowledge must be applied in order to attain the desired result. An additional component is the rendering of direct services to a patient where the ability to provide the services requires specialized training.

In evaluating whether the services required by the patient are the continuous skilled services which constitute "extended care," several basic principles must be kept in mind:

1. Since extended care represents skilled nursing care on a continuous basis, the need for a single skilled service—for example, intramuscular injections twice a week—would rarely justify a finding that the care constitutes extended care services.

2. The classification of a particular service as skilled is based on the technical or professional health training required to effectively perform or supervise the service. For example, a patient, following instructions, can normally take oral medication. Consequently, the act of giving an oral medication to a patient who is too senile to take it himself would not be a skilled service, even when a licensed nurse gives the medication (although the observation and evaluation that may be required of the nursing personnel might be skilled).

3. The importance of a particular service to an individual patient does not necessarily make it a skilled service. For example, a primary need of a nonambulatory patient may be frequent changes of position in order to avoid development of decubiti. If changing the patient's position is the only regular and frequent service provided, it would not be a skilled service.

4. The possibility of adverse effects from improper performance of an otherwise unskilled service—for example, improper transfer of patients from bed to wheelchair—does not change it to a skilled service.

The following sections list those services commonly furnished by nursing personnel in ECF's and their usual skill classification. Any generally nonskilled service could, because of special medical complications in an individual case, require skilled performance, supervision or observation. However, the complications and special services involved should be documented by nursing notes and/or physician orders. Recording may include the observations made of physical findings, new developments in the course of the disease, the carrying out of details of treatment prescribed, and the results of the treatment.

Administration of medication.—Medications given by intravenous or intramuscular injections usually require skilled services. The frequency of injections would be particularly significant in determining whether the patient needs continuous skilled nursing care. Injections which can usually be self-administered—for example, the well-regulated diabetic who receives a daily insulin injection—do not require skilled services. Oral medications which require immediate changes in dosages because of sudden undesirable side effects or reactions should be administered to the patient and observed by licensed nurses. This is a skilled service. Where a prolonged regimen of oral drug therapy is instituted, the need for continued presence of skilled nursing personnel can be presumed only during the period in which the routine is being established and changes in dosage cannot be anticipated or accomplished by unskilled personnel.

Administration of eye drops and topical ointments (including those required following cataract surgery) is not a skilled service. In some states, institutional patients must receive all medications from licensed nurses; this fact, however, would not make the administration of oral medication a skilled service where the same type of medications are frequently prescribed for home use without skilled personnel being present.

Intravenous feeding.—See section on medications.

Levine tube and gastrostomy feedings.—These feedings must be properly prepared and administered. Supervision and observation by licensed nurses are required, thus making this procedure a skilled service.

Naso-pharyngeal aspiration.—The services and observation required for such care constitute skilled nursing care.

Colostomy or ileostomy.—Skilled service might be required during the immediate post-operative period following a newly created or revised opening. The need for such care should be documented by physician and nursing notes. General maintenance care of this condition can usually be performed by the patient himself or by a person without professional training and would not usually require skilled services.

Catheters.—Insertion or replacement of urethral catheters constitutes skilled services. Repeated catheterizations during the immediate postoperative period following abdominal surgery could, with a few other skilled services, constitute *continuous* skilled nursing care. Routine services in connection with indwelling bladder catheters do not consitute skilled care. Catheters used in other parts of the body, such as bile ducts, chest cavity, etc., require skilled care.

Incontinence.—General methods of treating incontinence, such as use of diapers and rubber sheets, are not skilled services. Secondary skin problems resulting from incontinence may require special treatment. Physician's orders should indicate the treatment required and should be noted in the patient's record.

Skin care.—Existence of extensive decubiti or other widespread skin disorder may necessitate skilled care. Physician's orders for treating the skin (rather than diagnosis) would be the principal indication of whether skilled care is required.

Routine prophylactic and palliative skin care, such as bathing, application of creams, etc., does not constitute skilled services. Presence of a small decubitus ulcer, rash or other relatively minor skin irritation does not generally indicate a need for skilled care.

Dressings.—Special services in connection with application of dressings involving prescription medications and aseptic technique constitute skilled services. Routine changes of dressings, particularly in noninfected post-operative or chronic conditions, generally do not require skilled services or supervision.

Plaster casts.—Special care for patients who have casts over any part of the body should be reflected in the physician's orders. Ordinarily however, the presence of a cast does not necessarily establish a need for skilled services.

Braces and similar devices.—Routine care in connection with such appliances does not constitute skilled services. Care involving training in proper use of a particular appliance should be evaluated in relation to the need for physical therapy. (See section on physical therapy.)

Heat treatments.—The therapeutic use of sun lamps, infrared lamps, diathermy and similar equipment constitutes skilled care when:

1. The service is specifically ordered by a physician as part of an active treatment regimen; and
2. Observation by skilled personnel is required in order to adequately evaluate the results of the treatment and inform the physician of the patient's progress.

Routine use of such equipment for palliative and comfort purposes is not a skilled service.

Restraints.—The use of protective restraints generally does not require services of skilled personnel. This includes such devices as bed rails, soft binders and wheelchair patient supports.

Administration of medical gas.—Any regimen involving regular administration of medical gases would be instituted only upon specific physician order. The initial phases of instituting such a regimen would be skilled care. However, when such administration becomes a part of regular routine, it would not generally be considered a skilled service since patients can usually be taught to operate their own inhalation equipment.

Restorative nursing.—Restorative nursing procedures constitute skilled services when they are prescribed by a physician, are designed to restore functions which have been lost or reduced by illness or injury, and are a type whose performance requires the presence of licensed nurses. In many cases, these procedures would be an adjunct to an intensive program of physical therapy.

When a patient has attained his restoration potential, the services required to maintain him at this level generally would not constitute skilled nursing care. General supervision of exercises which have been taught to the patient would not be considered skilled services.

PHYSICAL THERAPY

Physical therapy, one aspect of restorative care, consists of the application of a complex and sophisticated group of physical modalities and therapeutic services. Physical therapy, therefore, is a skilled service. However, since the statute defines extended care as skilled *nursing* care on a continuing basis, provision of physical therapy only would not justify a finding that the patient requires extended care. In some situations, however, a patient whose primary need is for physical therapy will also require sufficient skilled nursing to meet the definition of extended care. The need for such supportive skilled nursing on a continuing basis may be presumed when:

1. The therapy is directed by the physican who determines the need for therapy, the capacity and tolerance of the patient, and the treatment objective; and
2. The physician, in consultation with the therapist, prescribes the specific modalities to be used and frequency of therapy services; and
3. The therapy is rendered by or under the supervision of a physical therapist who meets the qualifications established by regulations; when the qualified therapist is the supervisor, he is available and on the premises of the facility while the therapy is being given, he makes regular and frequent evaluations of the patient, records findings on the patient's chart, and communicates with the physician as indicated; and
4. The therapy is actively concerned with restoration of a lost or impaired function. For example, frequent physical therapy treatments in connection with a fractured back or hip or a CVA can be presumed to be directed toward restoration of lost or impaired function during the early phase—when physical therapy can be presumed to be effective. However, when the condition has stabilized, the *presumption* that continuing supportive skilled nursing services are required is no longer valid. Such cases must be evaluated in relation to the specific amount of skilled nursing attention required in the individual case as evidenced by physician orders and nursing notes.

IDENTIFYING PROBLEM CASES

There are some situations in which a patient's condition requires the institutional services provided by an extended care facility but does not require the type of care which is defined as extended care. Such situations often arise where a patient needs extensive personal services due to permanent handicap or general debility and alternative living arrangements are impractical.

Cases where the primary diagnosis or the primary needs of the patient are psychiatric rather than medical represent an important segment of problem cases. The Medicare statute prohibits an institution which is primarily engaged in treating psychiatric disorders from participating as an ECF since only active psychiatric treatment is intended to be covered by Medicare in institutions. This type of active psychiatric treatment requires considerably more sophisticated nursing techniques and physician attention than are available in any but very unusual ECF's. Therefore, the type of mental condition which could be adequately handled in the usual ECF would be one which requires only a supportive environment that does not involve continuous skilled services. (Where the patient who is suffering from mental illness needs the types of services which constitute "extended care," the need would normally occur because the mental condition was secondary to another more acute medical disorder.) Where a patient is transferred to an ECF from a psychiatric hospital, the normal presumption would be that the primary need was for noncovered care unless evidence revealed the presence of an acute medical condition requiring continuous skilled nursing services as described in these guidelines or the provision of a high degree of psychiatric nursing services which require specialized training beyond the usual professional nursing curriculum.

When any of the following circumstances exist there must be evidence that continuous skilled nursing service is also concurrently required and received:

1. The primary service is one or more of the following:
   a. Oral medication.
   b. Skin care to prevent decubiti.
   c. Restraints.
   d. Frequent laboratory tests.
2. The patient is capable of independent ambulation, dressing, feeding and hygiene;

3. The patient has outside privileges;
4. The stay is for uncomplicated post-cataract surgery convalescence;
5. The diagnosis shown is not of a type which is sufficiently specific to indicate skilled treatment regimen, i.e., the diagnosis is chronic brain syndrome, senility, arteriosclerosis, "old" CVA, etc.
6. Return to a hospital preceding the ECF stay occurred shortly after the expiration of 60 days from the last discharge from hospital or extended care facility;
7. Long-term hospitalization (60 days or longer) occurred prior to extended care facility admission;
8. Discharge from extended care facility occurred after exactly 100 days of care (or many discharges from the institution occur after nearly 100 days);
9. Transfer occurred from an institution to a hospital for 3, 4, or 5 days followed by an immediate admission to an extended care facility.

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