

Recommendations of the Task Force on Medicaid and Related Programs*

In July 1969, the Secretary of Health, Education, and Welfare appointed a task force to look into the deficiencies of Medicaid—the Federal-State medical assistance program under title XIX of the Social Security Act—and to make recommendations for improvements in that program and related programs.

The 27-member Task Force included persons representing consumers, industry, labor, government, and the social sciences, as well as the medical profession and health institutions and services. The report of the Task Force, submitted on June 29, contains 142 recommendations for program improvements and for steps needed to prepare the Nation's health system to meet increased demands. It also outlines the complexities and dimensions of the national health insurance issue and provides objectives for assessing policy in the financing of national health care.

Twenty one of the Task Force Recommendations were included in the proposed amendments to the Social Security Act, passed by the House of Representatives in May and now before the Senate. The Department of Health, Education, and Welfare has taken administrative action on several other recommendations, and the remaining proposals are to receive further study.

The Bulletin has excerpted the Introduction and Summary of the Report below, as well as the section on extended-care benefits under Medicare.

INTRODUCTION

As the Task Force grappled with its charges, several themes emerged that merit recognition in setting the stage for recommendations. One that was expressed repeatedly during the discussions was the conviction that health must remain high on the scale of social, economic and political priorities—not only because the health of the Nation is basic to the growth and pro-

ductivity of the economy, but also because human compassion insists that essential individual health needs shall be met.

With rapidly rising costs, many misgivings were expressed about the growing tendency to become excessively preoccupied with cost at the expense of community goals. The Task Force, along with what is possibly a majority in the health professions and certainly a majority of the population, considers the recent Federal enactments as intending that access to basic medical care shall be a right or entitlement of all citizens. It is the position of the Task Force that the right or entitlement is not fulfilled when millions in the population do not know about or cannot get to the places where some care is available to deprived populations, or when the millions who do get to such places are given a kind of service that is woefully inferior by every standard known to man and doctor. Neither is the right or entitlement concept honored just because physicians and hospital administrators can say, "We never turn away a patient." However virtuous the declaration may make the doctors and hospital people feel, it does nothing to make good the right or entitlement for those who never get within sight of a doctor's office or hospital. . . .

SUMMARY

. . . The scope of the inquiry was broad; neither the purposes nor design of government programs can be comprehended adequately in today's environment without reference to the health system as a whole. The Task Force sees the current system, overall, as a vital part of the American culture and economy, involving vast investments in acute care and related biomedical research. At the same time, the Task Force sees serious flaws in the system that appear in particularly bold relief against the background of an economic and political structure able, if willing, to cope with them. In essence, significant numbers of people do not have adequate access to care and the services of many who do are so far below the mark,

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with reference to the potential productivity of the system, that the credibility and accountability of the system itself is at stake.

The report contains recommendations under these headings: Eligibility and Protection under Existing Financing Programs; Effecting Changes and Improvements in the Delivery of Health Care; Management of Health Activities; Consumer Participation; Comprehensive Health Planning; Long-term Care; and Long-term Financing Policies.

The recommendations vary widely in nature and scope. Some of them deal with the logistics of implementation. A critical few call for major changes in the orientation and strategies of the total health system without which, the Task Force is convinced, revision of title XIX and related programs would be ineffectual and unproductive. No attempt is made, in this summary, to repeat all recommendations made in the text. The major ones are cited in the context of themes derived from the debate of 1 year and set forth in the introduction to the report.

Significant Deficiencies in Access to Care

Even after 4 years' experience under Medicaid and Medicare, and with parallel opportunities for expansion in the private sector, a significant number of Americans are not adequately protected against the cost of needed health services. As a direct result, too many do not get services they need. Approximately 26 million people in the United States live below the poverty line (about \$70 a week income for a family of four) and approximately 15 million more are near poor (\$90 a week income for a family of four). Only 13 million will be covered by Medicaid in 1971. Less than 30 States, despite the availability of Federal matching money, have programs for persons who are medically needy but do not qualify for cash assistance. Two out of three children in poor or near-poor families are not included under Maternal and Child Health or Medicaid programs. Among the poor and near poor, only a little over a third below the age of 65 have private prepaid medical care or medical insurance of some sort. In total, depending on different estimates, between 30 and 45 million people under age 65 are without any health insurance to speak of.

The stated objective of Medicaid was to assure adequate health care to the Nation's poor and near poor. If this continues to be a primary goal—and the Task Force believes emphatically that it should—a considerable improvement in financing and delivery capabilities will be required. We recognize that expenditures on behalf of those now lacking purchasing power and services will add initially to the problems of inflation within the health field. But against this, a double standard for a service so deeply rooted in human compassion and so essential to a productive community cannot be tolerated. Moreover, there remains the prospect that if the new money, joined with other government and private means, is spent more wisely than in the past, inflation can be minimized. To redeem the promise of Medicaid and help give meaning to the declaration that access to medical care is a right to all within the context of current legislation:

We recommend converting Medicaid to a program with a uniform minimum level of health benefits financed 100 percent by Federal funds, with a further Federal matching with States for certain types of supplementary benefits and for individuals not covered under the minimum plan. There should be maintenance-of-effort requirements upon the States to retain at least their present expenditure levels.

First priority for protection under a basic Federal floor for Medicaid should be all persons eligible for payments under the proposed Family Assistance Plan. Additional groups should be phased in until all persons with incomes at or below the poverty line are covered.

The disabled social security beneficiaries should be included as soon as possible under title XVIII.

Legislative changes are needed to establish Federal responsibility for the cost of medical care and services for migrant workers and other eligible people who do not have established residence in any State; migrant workers should be eligible for benefits of title XIX.

Several recommendations are made to improve the operation of title XIX, e.g., use a dignified and simplified method of determining eligibility and payment; give greater protection to clients who are dissatisfied with actions or failure to act; make information about the program more widely and forcibly available; eliminate discriminatory practices by providers guaranteeing the care of persons without permanent residence in any given State.

Other recommendations are directed at the private sector to improve the coverage, scope and efficiency of benefits. For example, means are

proposed to improve the protection of employees during short periods of disability or layoff, small groups and self-employed individuals, part-time and temporarily employed persons. Strong encouragements are given to greater exploitation of the work environment for health education and prevention programs.

Improving Delivery of Health Services

In the light of rapidly rising cost and troublesome inflation in the health field, the recommended addition of new expenditures through expanded and improved financing programs, and the need for all to have more readily accessible services, it is essential to improve the delivery of health services. The Task Force has concluded that the necessary changes in a myriad of personal transactions among consumers and providers will not come about simply in response to the interaction of consumers' interest and provider self-interest. If sufficient changes in effectiveness and efficiency are to be achieved, much bolder interventions will be needed than we have seen to date. These must be in the form of public policy reinforced through more aggressive management.

It is a central conclusion of the Task Force that money is needed, but that money alone will not guarantee either capacity or effectiveness to the system. In fact, if a benevolent and affluent government were to begin to pay for all the basic health care needed by all those who can't pay for it themselves, but no other change were introduced into the existing system, the result would be a disastrous rise in the cost of services that are already scarce. There isn't enough money and there aren't enough doctors to provide the needed care just on a fee-for-service basis; thus any solution will require new options, new goals and new attitudes. Without these, the health system cannot move forward to meet its growing responsibilities; with them, the Task Force is convinced that the recommendation in this Report, most of which relate in one way or another to this basic issue, can show the way toward achieving more and better health care for all Americans.

For two decades programs financing medical care, whether public or private, have been reinforcing traditional ways of providing service.

The Task Force is convinced that it no longer makes sense to keep pouring new wine in old casks—some of which are leaking. Additional financing must be accompanied now with opportunities and encouragement to physicians, hospitals and others to provide service in ways that permit a logical response to sound economic and patient-care incentives, and to engage in a competition of organization and method.

The concept of planned intervention can be organized in three interacting and interdependent categories: more responsible purchase of services, better management of health services, and broader concept of health care. Some basic recommendations follow under each.

More Responsible Purchase of Services

The methods of purchase and conditions of participation in Medicaid and Medicare and the investment policies of all Federal financing programs, with corresponding actions in the private sector, constitute powerful instruments for achieving increased capacity and new organizational patterns in the delivery of health services.

The Federal Government should provide leadership and funds to create and support systems of health care, through a variety of auspices and approaches, that will contain the following desirable elements:

1. comprehensive services and continuity of care,
2. contractual services for definable population groups,
3. integrated fiscal and managerial responsibility, and
4. risk sharing through prepayment.

Legislation should be enacted to make sums equivalent to 5 percent of Federal Medicaid appropriations per year available for the development and improvement of health care services and resources.

These funds should be expended as "front-end" money to create new or expanded capacity for service in localities with a high proportion of low-income persons and where the need for development and/or improvement of health care resources has been determined in cooperation with State and areawide comprehensive health planning agencies.

To support the development of needed services, priority should be given to: development of organized primary health care services in neighborhoods, development of services and resources which can serve as alternatives to inpatient hospital care, e.g., home health care programs; improvements in utilization, efficiency, and/or quality of existing health services directed to producing more and better health care; social and other outreach services which are an integral aspect of appropriate

utilization of services; development of ways to link and relate new and existing health services with each other, aiming toward comprehensive health care systems in communities.

Consideration should be given to legislation which would provide a percentage of Medicare funds for similar supply-influencing efforts.

In order to encourage the use of efficient, innovative and effective delivery systems, legislation should be enacted to provide the Secretary with discretionary authority to modify the Federal share of Medicaid payments for certain services to the States by providing increased Federal funds of 5 to 10 percent above the usual matching formula, on a differential basis. The higher payments would be made to those States which successfully develop and use such services and payment methods as contract payments to prepaid group practice plans, neighborhood health centers, and other arrangements for provision of comprehensive services to a definable population, or use of new types of health manpower and paramedical manpower.

All appropriate sources of Federal funding, in particular the National Center for Health Services Research and Development and the Partnership for Health Program, should be encouraged to give high priority to development, support and demonstrations of model health-care delivery systems.

To provide facilities for these programs, the Hill-Burton program should give priority to those projects and facilities which propose to use innovative methods of delivering health care.

The provisions of title XIX that recipients will have "free choice" of vendor should be interpreted as broadly as possible in order to promote use and reimbursement, under Medicaid, of new and effective organized forms of health-care delivery. Policy implementing the statute should be developed to require the States to take positive steps to arrange for reimbursement (preferably on a contract-payment basis) of neighborhood health centers, community mental health centers, migrant health projects, children and youth projects, prepaid group practice plans, and other such forms of organized health-care delivery.

With respect to State implementation of recommendations relating to use of earmarked Medicaid funds for development of resources, model development, and others, the advice and consultation of the health-planning agencies should be sought and encouraged. Other aspects of financing including participation requirements and reimbursement policy should support planning activities.

To promote the early removal of State legal barriers, the Department of Health, Education, and Welfare should take steps to require that States permit prepaid group practices through a variety of approaches including regulations or legislation that would tie the receipt of grants that flow directly to State agencies such as Hill-Burton, 314(a) and (d), and Community Mental Health Center Construction to such a requirement; and other alternatives such as Federal charters for prepaid systems.

The Task Force strongly endorses the innovative approach of the Administration's Health Maintenance Organization proposal to provide an option for Medi-

care and Medicaid beneficiaries to elect to receive health services through a single organization that provides coordinated services financed through prepaid capitation.

The HMO proposal constitutes an important step towards possible long-range improvements in the organization and delivery of health services. Specific recommendations are made to improve and help flesh out the concept.

HEW should actively program experiments for incentive reimbursement under Medicare and Medicaid, with emphasis on experiments in payment methods for physicians as the key generators of health services.

Reimbursement to providers of service under Medicare and Medicaid should be on a prospective instead of a retrospective basis.

Fees and charges under the Medicare program also should not be recognized for benefit purposes when in excess of the 75th percentile of prevailing fees; and this limit should not be permitted to rise except in keeping with an index made up of pertinent wage and price increases.

Title XIX should be amended to permit varying benefits for different population groups, or for different areas in a State if it is not feasible or possible to apply them uniformly elsewhere; e.g., States should be able to provide dental treatment to children 5-12 years of age as a first priority.

To guard against deterioration of quality of care while pursuing efficiency, various forms of professional review will be needed. These would evaluate the delivery of health care and help determine its adequacy or appropriateness.

Utilization review, including professional review programs presently required under Medicare, Medicaid or related programs should be given thorough study to evaluate effectiveness.

A standard definition of professional review should be adopted for all medical programs, and review requirements should be made uniform for comparable services covered by all Federal programs.

A legislative amendment is needed requiring uniform provisions and unified State standard-setting, certification, and consultation functions with respect to providers of service under both Medicaid and Medicare. (To the extent possible, also consistent with desired State flexibility to exceed Federal minimum standards, State-controlled licensure of health facilities and agencies should be integrated with these related functions.) The State agency with primary responsibility for health functions in the State should be responsible for all standards functions. Incentives, guidance and as-

sistance should be provided to the States in bringing this about.

Antiquated licensure laws contribute to manpower shortages and rising costs.

HEW should undertake a major, intensive, study of State health personnel licensing laws and their influence on the utilization of manpower and make recommendations to the States for changes and revisions of licensure laws.

The Task Force supports the Administration's proposed "Health Cost Effectiveness Amendments." Particularly worthy of note are the coupling of reimbursement to areawide and institutional planning and the call for wider experimentation and demonstration among delivery systems.

Better Management of Health Services

Controls and incentives will not be realized without more forceful leadership and better organization within the health field. The total job to be done will take the concerted efforts of both the public and private sectors. Many of the key considerations devolve upon HEW. It is here that primary leadership for the health system must be established and exercised.

"Fragmentation" of health service began when the doctor could no longer get everything he needed in his saddle-bags; it has been going on ever since, an inevitable result of the increasingly specialized technology. Fragmentation of services may be unavoidable at times and, of itself, is not always bad. What is bad is that, for lack of overall leadership, we have allowed organization and management to become fragmented, along with service, to the point where patients may be handed off from one institution or service or program to another in a kind of medical bucket line, with nobody in charge determining where the line begins, which way it goes, and where it ends. The result is that cost mounts and care suffers, not just for the poor but for the whole population. To find the beginning, chart the way, and determine the end will require leadership not just of the parts but of the whole. The Task Force believes this leadership is the proper role of the Federal Government.

The Federal role in health has expanded

markedly in recent years as the result of considerable legislation. Too many new programs are not coordinated well, nor integrated sufficiently with the old. HEW must be strengthened to assume a new role conceptually and to consolidate better the responsibilities assumed to date. The Task Force sees a "governing" role concentrating on goals and objectives, establishing policy, fashioning incentives, checks and balances, firmly protecting the public interest and evaluating results—presaging, perhaps, less extensive operation of programs with greater decentralization of operating responsibility.

A restructuring of HEW should have the following features: an under secretary for health and scientific affairs; a career deputy with extensive background in health administration in a public setting; major executive agencies headed by assistant secretaries in: Scientific Affairs (NIH), Health Services Systems and Resources (HSMHA), Consumer Protection, Environmental Quality, and Management and Budget; a health systems analysis and planning staff, which would serve as the motive force for goal setting, analysis, planning and evaluation and may also serve as staff for a National Council of Health Advisors.

There is an urgent need to establish a National Council of Health Advisors responsible for assessing the Nation's health status and the status of the health system, for generating national health goals, and for outlining objectives for all Federal health programs.

The Task Force made the following recommendations:

Install, within the health component of HEW, an internal management system based on the "corporate management model" adapted to the peculiar requirements of a public administration setting.

Provide the Under Secretary (HSA) with increased flexibility in the allocation of Federal resources, especially for the purposes of encouraging new institutional arrangements and the building of health-system capacity.

The operation of health-service activities should be decentralized through contractual agreements with public and private agencies. The principal features of such agreements should be specification of desired outcomes rather than specific methods of operation, and evaluation and information systems that can assess performance in terms of output or results.

Good progress has been made recently in the revitalization, reorganization and staffing of the Medical Services Administration (the agency administering the Medicaid program at the Federal level), but substantial additional staffing and other administrative resources must be provided for this program. A redirection of effort is called

for toward: strengthening the Federal Government's leadership role; employing state-of-the-art management techniques, including the development of relevant and cost-effective management control and information systems; and development of performance standards for States related to using Medicaid's purchasing power to increase accessibility of care to the needy and improve the effectiveness of the care. A series of specific recommendations are made regarding implementation, primarily under management of Federal health activities although there are others under effecting changes and improvements in the delivery of health care.

The Task Force viewed institutional area-wide planning as a major arm of the new management. Currently, considerable confusion and overlap exists among planning efforts and agencies. Also, there are important gaps by section of the country. Results to date have been generally disappointing. The Task Force made several recommendations in this area that (1) clarify roles and functions of public and private planning agencies at the national, State and local levels; (2) call for more Federal support of State and local efforts; (3) spell out the relations among the purchaser of care, the planning agencies, the constituent health institutions and the official sanctions to be exercised by Government.

Federal support was seen to include stronger leadership, greater financial assistance (manpower and program) and more extensive technical assistance.

Broader Concept of Health

Although not concentrated in any given section, various references are made in the report to the need to promote and finance a broad range of facilities and services in order to forestall excessive preoccupation with and use of acute services. Currently, the health-care system is geared primarily to care for acute illness. This is a distortion of investment in both economic and human terms. A better balance, with heavy emphasis on primary care to prevent illness, and on rehabilitation to restore function, is needed and frequently cited. In discussing total health services and long-term care in particular, the report points up the necessity of supporting organiza-

tions that view health in the context of total life style and that can evaluate the effectiveness of various courses of action including intervention in the home and working situations. Without a refocus on prevention and a broader orientation toward health generally, neither more responsible purchase of services nor better management will give health the status it deserves in an economy of scarcity.

Consumer Participation

Not only do millions of consumers get care on a hit-or-miss basis or lack access to care except in medical crises, but virtually all consumers lack access to the decisionmaking machinery that can bring about change. Few institutions and programs include representatives of everyday users of their services on policy-making or governing boards, in spite of their nonprofit or governing boards, in spite of their nonprofit and presumably "community" character. The result is that medical care is still too often delivered at the time and place and in the way convenient to provider rather than consumer. Old patterns persist in the face of new demands—a basic cause of rising dissatisfaction with the health services.

A basic tenet of the report is that greater consumer involvement in decisionmaking is required to overcome deficiencies in the health system with reasonable dispatch and to achieve better management of resources. Without substantial consumer input, health institutions can become excessively self-serving and, in fact, tangential to even fundamental community health problems. Also, without consumer input, user identity with service can deteriorate and inappropriate use can occur. Perhaps it should be added that, as in the management of other affairs, the consumer "wants in"—a valid reason for involvement in its own right. There is no national means of providing the consumer the assistance he needs to become a positive force for improving the Nation's health-care services, nor do the means now exist for bringing the consumer and provider together to work jointly for improvements. A number of recommendations bear on the problem of decisionmaking, involvement and education for this purpose.

Any board or group set up to advise policy-making officials at any level of Government must provide for consumer representation to protect and present the interests and needs of the consumer. In addition, executive committees, subcommittees, and ad hoc committees of such boards or groups should have a significant number of consumer representatives as members.

Federal agencies involved in planning, delivering and purchasing health services must make provisions in budget for special orientation programs for new members of policy-making groups, including the consumer representatives on such groups.

State and local agencies as well as nongovernmental agencies involved in planning for, delivering, and paying for health services should be required to make provisions for orientation and training of policy-making groups, with special emphasis on consumer representatives.

Still with focus on the consumer, the Task Force underscored the desirability of instructing users of services on their rights and benefits and how to best use available services.

Programs of health education, provided they meet adequate standards set by the Federal Government, should be considered integral components of any health-care service and therefore included in the budget of such service. All agencies and institutions providing health services that receive Federal support must provide continuing programs of health education to their consumers.

State Medicaid Programs should be required to undertake educational efforts designed to: improve recipients' use of the Medicaid program; improve the health of Medicaid recipients through preventive education; improve providers' use of the program; and provide for greater participation by provider and consumer in the planning, implementation, and evaluation of the program.

THROUGHOUT ITS deliberations, the Task Force was deeply concerned about two issues that were given separate status at the end of the report, i.e., long-term care and long-term financing of health services. Each is complex and calls for extensive definition and debate. Our evaluation of title XIX and related programs has high-pointed both.

Long-Term Care

Nearly one out of three medical dollars is being spent on skilled nursing-home care, and these expenditures have been growing far beyond expectations. Major attention has been focused on the problems of medical care at one end of the

spectrum and of income maintenance at the other. Long-term care is something less than one and something more than the other. Distortions have inevitably occurred, such as caring for essential personal needs in a medical environment (which, if unchecked, could bankrupt the health system), or returning persons with medical problems stabilized to an unaltered and unsuitable social environment. There are no easy answers, but the Task Force tried at least to point the way toward modest improvements.

Importantly, the Task Force thought that although classifying patients is sound, patients should not be summarily discharged from skilled nursing homes or other health facilities if alternate facilities are not available. Keeping a patient in a health facility when his needs for support services cannot be met elsewhere does not represent misuse; it represents a default on the part of the community to match services with needs. Investments in alternative services are the only humane way to solve the problems.

In regard to Medicaid, Medicare, and public assistance programs, a number of specific recommendations are made:

Skilled nursing home regulations under title XIX should require activities programming.

Federal regulations for title XIX should require that all recipient-patients in nursing homes be visited by a public assistance agency staff member as needed, but not less often than quarterly.

The extended-care benefit should be redefined and revised to eliminate existing confusion and reduce administrative complexity.

The Department of Health, Education, and Welfare should consider:

—that the Intermediate Care Facility remain generally defined as a zone of personal and residential service between the Skilled Nursing Home and the domiciliary institution to allow flexibility to the States for further definitions.

—that the regulation on Intermediate Care Facilities be strengthened to require activity programming to provide a creative and constructive environment in these institutions.

—that in relation to the Medicare program the Intermediate Care Facility be considered a long-term care and not a medical-care institution, particularly that a stay in an Intermediate Care Facility should be considered to break a "spell of illness"; and after a stay for a sufficient period of time, the person is again eligible for hospital insurance benefits.

—that the benefits for Skilled Nursing Home and the Intermediate Care Facility Programs should be administered through a single administrative structure.

Decisionmaking on placement is a discriminating action. It is now sometimes performed by a health or welfare agency, or by the individual's physician, or several sources in concert. It requires an evaluation of the medical, nursing care and personal services needed by an individual, an appraisal of the financial resources available, a knowledge of the types and of the financial resources available, a knowledge of the types and quality of existing community services, and the ability to fashion congruence among these factors. Good information, a high degree of technical skill, and great sensitivity to individual, family and community needs are required. It is unreasonable to expect that each physician, hospital, or family faced with this decision can make an informed judgment when each must gather information through their own resources. The continual outcry about misuse of services and public money is additional incentive for an informed, community-wide process.

Long-Term Financing Policies

In evaluating title XIX, the Task Force concluded that the present financing arrangements for the existing and potentially eligible population are not adequate and that a new national policy for health-care financing is essential. Current arrangements, internally and as they relate to other financing systems, lack the structure and resources to impact sufficiently on problems of both access and productivity.

The Task Force thought that HEW should develop a policy position on this critical and comprehensive health-care issue as the basis of any legislative recommendations to be made in 1971 and as a measure against which to appraise proposals currently before the Congress, as well as those forthcoming. The issue is far too important to be debated hastily or conceived quickly in politically expedient terms.

During its tenure, the Task Force had neither the resources nor the time, in the light of its full agenda, to examine closely the full dimensions of the problem. Such an examination is needed. Major economic, fiscal and social policy implications are involved. However, the Task Force did examine current financing systems and their relationship to delivery of services, and develop observations that should be useful to those who follow. These are presented in two parts:

First, a list of central and necessary objectives against which, we believe, long-range financing proposals should be evaluated;

second, a set of specific issues and questions, by which different proposals can be compared and appraised.

In an economy of scarcity, decisions regarding even such valued considerations as good health come hard. With this in mind, the Task Force believes strongly that a sizable unmet need for health service is a disgrace and cannot be tolerated in an affluent society. We must be prepared as a Nation to spend more money so that all citizens have reasonable access to health care. This target will not be reached unless interim objectives are set, commitments are made, and the system is more aggressively managed. The report points out ways to move ahead and identifies HEW as a critical leadership force. HEW's commitment is now the key to improving health of the Nation in the decade ahead.

The following excerpt is from the section on Long-term Care under the heading "Issues and Recommendations."

EXTENDED-CARE BENEFITS IN TITLE XVIII

The purpose of the Medicare program is to remove the major financial burden of acute medical-care services from the aged population. The program has had great success in achieving this goal. However, since its inception, there has been difficulty in differentiating acute medical conditions from terminal conditions, chronic disability and related social factors which influence the institutional placement of patients. . . .

As the hospital insurance program has evolved, increased administrative emphasis has been given to assuring the appropriateness of determinations dealing with coverage of care provided to beneficiaries in extended-care facilities. Operationally it has been necessary to stress that the Medicare legislation provided extended-care benefits as an extension of the hospital benefit, on a relatively short-term basis, and not within the context of the traditional, long-term nursing-home experience. . . .

While the concept of a post-hospital benefit is valid, the medical circumstances of some hospitalized patients (who could be moved to less-intensive levels of institutional care for an

immediate period of recuperation or who may become destined to long-term care) do not lend themselves to the fine coverage distinctions required by present law. It would seem, therefore, to be more equitable, more manageable administratively, and more comprehensible to beneficiaries to define program financial responsibility by providing access to a limited number of days of covered services, rather than attempting to set tight medical criteria for admissions, based on the key element of "continuous skilled nursing care."

The extended-care benefit should be redefined and revised to eliminate existing confusion and reduce admin-

istrative complexity. This restructuring should include the following elements :

1. Eligibility for admission to an extended-care facility should be determined in the same manner as admission to a hospital, i.e., on the clearly stated determination by the physician of the need for admission.
2. The extended-care-facility benefit should not exceed a relatively short period of fixed duration to be determined by analysis of the extended-care-facility program experience and of its cost.
3. The definition of a skilled nursing home in title XIX should be incorporated by reference in the extended-care-facility definition in title XVIII, or other steps should be taken to eliminate subtle and unnecessary distinctions between the institutions eligible to furnish these two types of services.