96th Congress, 1st Session | COMMITTEE PRINT | CP 96-22

Summary of Senate Finance Committee Action on Health Legislation

as of June 29, 1979

Prepared by the Staff of the

COMMITTEE ON FINANCE
UNITED STATES SENATE

RUSSELL B. LONG, *Chairman*

JULY 1979

Printed for the use of the Committee on Finance

U.S. GOVERNMENT PRINTING OFFICE
47-624 WASHINGTON : 1979

S362-41

COMMITTEE ON FINANCE

RUSSELL B. LONG, Louisiana, *Chairman*

HERMAN E. TALMADGE, Georgia
ABRAHAM RIBICOFF, Connecticut
HARRY F. BYRD, Jr., Virginia
GAYLORD NELSON, Wisconsin
MIKE GRAVEL, Alaska
LLOYD BENTSEN, Texas
SPARK M. MATSUNAGA, Hawaii
DANIEL PATRICK MOYNIHAN, New York
MAX BAUCUS, Montana
DAVID L. BOREN, Oklahoma
BILL BRADLEY, New Jersey

ROBERT DOLE, Kansas
BOB PACKWOOD, Oregon
WILLIAM V. ROTH, Jr., Delaware
JOHN C. DANFORTH, Missouri
JOHN H. CHAFEE, Rhode Island
JOHN HEINZ, Pennsylvania
MALCOLM WALLOP, Wyoming
DAVID DURENBERGER, Minnesota

MICHAEL STERN, *Staff Director*
ROBERT E. LIGHTHIZER, *Chief Minority Counsel*

CONTENTS

	Page
I. Catastrophic Health Insurance	1
1. Single, fixed dollar annual deductible	1
2. "Indexing" the catastrophic deductible	1
3. Covered services	1
4. Definition of employer	1
5. Employee share of insurance premium	1
6. Coverage of dependents	1
7. Effective date of coverage and continuation of coverage	1
8. Preexisting conditions	2
9. Standards of insurers	2
10. Employer subsidy	2
11. Coordination of benefits	2
12. Failure by employer to pay premiums	2
13. Pools	3
14. Coverage in the territories	3
II. Modifications to Medicare and Medicaid	5

Provisions Relating to Hospitals

1. Criteria for determining reasonable cost of hospital services (sec. 2 of S. 505)	5
2. Payments to promote closing and conversion of underutilized facilities (sec. 3 of S. 505)	7
3. Federal participation in hospital capital expenditures (sec. 4 of S. 505)	8
4. Rate of return on net equity for for-profit hospitals (sec. 25 of S. 505)	9
5. Encouragement of philanthropic support for health care (sec. 33 of S. 505)	9
6. Flexibility in application of standards to rural hospitals (sec. 6 of S. 507)*	9
7. Certification and utilization review by podiatrists (sec. 15 of S. 507)*	10
8. Disproportionate medicare-medicaid payments for hospital care*	10
9. Prohibit medicare-medicaid payment at hospital rates for patients medically determined to need lesser levels of care	10
10. Coordinated audits under the Social Security Act (sec. 32 of S. 505/sec. 4 of S. 507)*	11
11. Hospital admissions for dental service*	11
12. Preadmission diagnostic testing*	11

Provisions Relating to Skilled Nursing Facilities, Intermediate Care Facilities, and Home Health Care

13. Hospital providers of long-term care services (sec. 13 of S. 505/sec. 2 of S. 507)*	12
14. Medicaid certification and approval of skilled nursing and intermediate care facilities (sec. 15 of S. 505)	13
15. Visits away from institutions by patients of skilled nursing or intermediate care facilities (sec. 16 of S. 505)	13
16. Study of availability and need for skilled nursing facility services under medicare and medicaid (sec. 34 of S. 505)	13

*Provisions ordered to be reported out by the Committee on June 28, 1979.

II. Modifications to Medicare and Medicaid—Continued

Provisions Relating to Skilled Nursing Facilities, Intermediate Care Facilities, and Home Health Care—Continued

	Page
17. Study of criteria employed for classifying a facility as a skilled nursing facility (sec. 37 of S. 505)	14
18. Presumed coverage provisions (sec. 17 of S. 507)*	14
19. Reimbursement rates under medicaid for skilled nursing facilities and intermediate care facilities*	14
20. Intermediate sanctions for skilled nursing and intermediate care facilities*	15
21. Home health amendments*	15
22. Repeal of 3-day hospitalization requirement and 100-visit limitation for home health services (sec. 29 of S. 505, sec. 10 of S. 507)*	16

Provisions Relating to Medical and Other Health Services

23. Incentives for physicians to accept assignments (sec. 5 of S. 505)	16
24. Use of approved relative value schedule (sec. 7 of S. 505)	17
25. Teaching physicians (sec. 8 of S. 505) *	17
26. Certain surgical procedures performed on an ambulatory basis (sec. 9 of S. 505/sec. 18 of S. 507)*	17
27. Criteria for determining reasonable charges for physicians' services (sec. 10 of S. 505)	18
28. Disclosure of aggregate payments to physicians (sec. 23 of S. 505)	18
29. Payment for certain antigens under part B of medicare (sec. 11 of S. 505/sec. 7 of S. 507)*	19
30. Payment on behalf of deceased individuals (sec. 12 of S. 505/sec. 8 of S. 507) *	19
31. Physician treatment plan for speech pathology (sec. 16 of S. 507 *	19
32. Payment for durable medical equipment (sec. 30 of S. 505)	19
33. Deductible not applicable to expenses for certain independent laboratory tests (sec. 26 of S. 505/sec. 12 of S. 507)*	20
34. Rural health clinics*	20
35. Outpatient rehabilitation clinics*	20
36. Reimbursement for outpatient hospital care	21
37. Ambulance services (sec. 20 of S. 505/sec. 3 of S. 507)*	21
38. Coverage under medicare of certain dentists' services (sec. 35 of S. 505/sec. 5 of S. 507)*	21
39. Coverage under medicare of optometrists' services with respect to aphakia (sec. 36 of S. 505/sec. 9 of S. 507)*	22
40. Chiropractic services*	22
41. Treatment for plantar warts*	23

Other Provisions

42. Confidentiality of PSRO data (sec. 28 of S. 505/sec. 19 of S. 507)*	23
43. Direct professional review toward avoiding unnecessary routine hospital admission services and excessive preoperative stays*	24
44. Procedure for determining reasonable cost and reasonable charge (sec. 19 of S. 505)	24
45. Repeal of section 1867 (sec. 18 of S. 505/sec. 11 of S. 507)*	25
46. Development of uniform claims forms for use under health care programs (sec. 31 of S. 505)	25
47. Medicare payment liability secondary where payment can also be made under accident insurance policy*	26
48. Judicial review of decisions concerning groups of providers*	26
49. Resources of medicaid applicant to include assets disposed of at substantially less than fair market value (sec. 24 of S. 505/sec. 13 of S. 507)*	26

*Provisions ordered to be reported out by the Committee on June 28, 1979.

II. Modifications to Medicare and Medicaid—Continued
Other Provisions—Continued

	Page
50. Payment for laboratory services under medicaid (sec. 27 of S. 505/sec. 20 of S. 507) *	27
51. Authority for certain States to buy-in coverage under part B of medicare for certain medicaid recipients (sec. 38 of S. 505)	28
52. Extension of period for funding of State medicaid fraud control units (sec. 14 of S. 507)*	28
53. Federal advance payments to States*	29
54. Competitive bidding and negotiated rates under medicaid*	29
55. Notification to State officials (sec. 17 of S. 505)	29
56. Waiver of human experimentation provision for medicare and medicaid (sec. 22 of S. 505)	29
57. HMO's enrolling over 50 percent medicare or medicaid recipients (sec. 39 of S. 505/sec. 21 of S. 507)*	30
58. Demonstration projects for training and employment of AFDC recipients as homemakers and home health aides (sec. 22 of S. 507)*	30
59. Grants to regional pediatric pulmonary centers (sec. 21 of S. 505)	32
III. Other Actions	33
1. Appointment of HCFA Administrator (S. 508)*	33
2. Report on home health and other in-home services (S. Res. 169)	33

*Provisions ordered to be reported out by the Committee on June 28, 1979.

I. Catastrophic Health Insurance

The committee has tentatively approved the following elements of an employer-based catastrophic health insurance program.

1. *Single, fixed dollar annual deductible.*—The program would use a single, fixed dollar amount of $3,500 per year as the catastrophic deductible threshold under any employment-based health insurance plan. This would be an absolute maximum limit on the amount of covered health expenses for which individuals or their families would be responsible, after which catastrophic benefits would be payable in full. Individuals and families could choose to pay the deductible amount from personal funds or could insure against part or all of such liability.

2. *"Indexing" the deductible.*—The catastrophic deductible would be adjusted from time to time ("indexed") to reflect increases in the prices and utilization of covered health services. The indexing of the deductible would begin only after 2 years.

3. *Covered services.*—The catastrophic health insurance program would cover, as a minimum, at least the types of services presently covered under the medicare program.

4. *Definition of employer.*—All employers with at least one full-time employee would be required to provide and contribute financially toward the cost of a catastrophic health insurance plan. Employers would include self-insured employers, nonprofit organizations and the Federal Government. Coverage of State and local government employees would be voluntary with the State and local government. Coverage of the self-employed would not be mandatory but the self-employed would be assured access to coverage from a qualified insurance pool.

5. *Employee share of insurance premium.*—Employees could be required to pay up to 25 percent of the premium costs for catastrophic health insurance protection.

6. *Coverage of dependents.*—To be qualified, a catastrophic health insurance plan would be required to provide protection for dependents as well as for workers. The definition of dependents would include dependent students, dependent children and other persons meeting the definition of dependency under the Internal Revenue Code.

7. *Effective date of coverage and continuation of coverage.*—Employees and their dependents would be covered beginning no later than the day following completion of four consecutive weeks of full-time employment. (Full-time employment would be defined as an average by the employee of 25 hours or more per week.) Coverage for workers who have been employed for at least 3 months would continue for up to 90 days following separation from regular employment, or until the separated employee obtained coverage under another approved employer plan. Workers employed for less than 3 months would be entitled to continue coverage following termination for a period of not less than 30 days.

Coverage of a previously dependent spouse or children would continue for at least 30 days following legal separation or divorce.

In all of these cases of continued coverage, the employer would continue to pay the regular group premium with the former employee, the widow/widower, or separated or divorced spouse responsible for any previously required "employee contribution". Also, in all these cases of extension of group coverage, the persons covered would have the right to convert to an individual policy at the time their group coverage expires.

8. *Preexisting conditions.*—An approved plan could not contain an exclusion or limitation of coverage for preexisting medical conditions.

9. *Standards for insurers.*—Certain standards and qualifications would be established for insurers (including self-insurers) which offer qualified employment-based catastrophic health insurance. Such standards, specified by law, would deal with the financial soundness of the insurer, the adequacy of the benefits under the qualified catastrophic health insurance plans offered by the insurer and other matters. State insurance departments would determine whether an insurer and its qualified catastrophic policy or policies meet the requirements of Federal law and the regulations of the Secretary. The Secretary would monitor the performance of the agreed upon certification process of the State departments of insurance and could, under certain circumstances and for good cause, assure compliance at his own initiative with respect to a given State. The Secretary could also under certain circumstances handle appeals by insurers dissatisfied with a State determination. The Secretary's determination of an appeal would be final.

10. *Employer subsidy.*—A tax credit would be provided to employers based on the amount of the employer's payroll costs which exceed 102 percent of what those costs would have been had he not upgraded his employees' insurance protection to comply with the requirements of the legislation. The credit would be equal to 80 percent of the excess mandated payroll costs in the first year, 70 percent in the second year, 60 percent in the third year, and 50 percent in the fourth year and thereafter. The portion of the excess mandated payroll costs paid by the employer would not be tax deductible.

11. *Coordination of benefits.*—A coordination of benefits (COB) provision is included in most private group contracts (not individual coverage) in order to prevent an insured individual from receiving more than 100 percent of covered health expenses. In the case of multiple coverages, the insurer that is determined under the COB provision to be primary pays its regular benefits. The second insurer pays the lesser of (1) its regular benefits, or (2) a reduced amount which, when added to the benefit of the primary insurer, does not exceed 100 percent of allowed covered expenses.

All group catastrophic health insurance would provide for coordination of benefits so as to avoid duplication of benefits and to allocate responsibility for payment of claims where more than one insurer is involved. This COB provision could not provide for coordination of benefits, under the employer mandated policies, with respect to individual policies individually purchased and paid for and which might or might not directly overlap benefits under the mandatory coverage.

12. *Failure by employer to pay premiums.*—There will be situations where an employer will be unable to pay, or otherwise fail to pay, the required premiums—e.g., because of bankruptcy. In these cases, the in-

surer would be required to continue coverage of the employees for 30 days (with right of conversion) following the date of "best efforts" notice to the employees collectively and individually. Subject to penalty, the employer would be required to cooperate in notifying employees of the nonpayment of premium.

13. *Pools.*—There is no requirement that any given insurer *must* provide a qualified catastrophic benefits policy at a reasonable premium to any employer group or individual requesting to be insured.

Among the reasons for which coverage might not be provided—or where provided initially not renewed—are the high-risk nature of an employer's business, or adverse claims experience of the group. An individual might be rejected because of prior claims experience or medical history. In other instances the individual applicant might not be able to afford the higher premiums charged to nongroup members or to those with problem medical histories. Further, policies sold on a nongroup or restricted group basis may contain limitations or exclusions of benefits effectively diluting protection against catastrophic illness expense.

All qualified insurers, self-insured employers and health maintenance organizations in an area would be required to participate in residual "pools" as a source of catestrophic health insurance for firms and individuals who elect that source of protection. Premiums for coverage provided through a residual pool could not exceed 150 percent of the average premiums charged small employer groups. Any adverse experience of a pool would be borne proportionately by the insurers and other parties that underwrite the pool.

14. *Coverage in the territories.*—Employer coverage would not be mandated in Puerto Rico and the territories unless the Chief Executive Officer of the jurisdiction formally notifies the Secretary of Health, Education, and Welfare of the jurisdiction's desire not to participate.

47-624-79--2

II. Modifications to Medicare and Medicaid

PROVISIONS RELATING TO HOSPITALS

1. Criteria for determining reasonable cost of hospital services.—On June 13, 1979, the committee approved section 2 of S. 505. This section would modify the method of reimbursement for hospitals under the medicare and medicaid programs. Under the new method, which would be effective with hospital reporting periods that begin after June 30, 1980, reimbursement for most of a hospital's inpatient routine costs (essentially costs other than such ancillary expenses as laboratory, X-ray, pharmacy, etc.) would be related to a target rate based on similar costs incurred by comparable hospitals.

This initial system, described more fully below, would be studied and extended on an as-ready basis. Based on recommendations of a proposed Health Facilities Costs Commission, a permanent system would be developed over time which would establish payment rates and provide incentive payments with respect to all hospital costs and to costs of other institutions and organizations which are reimbursed on a cost basis. Continuing efforts would be made by the Commission to refine and improve the system of classification and comparison so as to achieve the greatest equity possible.

The Secretary would appoint the members of the new Health Facilities Costs Commission on or before January 1, 1980. The Commission would consist of 15 persons who are expert in the health facilities reimbursement area. At least three of the members would be representatives of hospitals and at least eight would be representatives of public (Federal, State, and local) health benefits programs. (See item 8, p. 10 for provision dealing with review of payment policies for outpatient hospital services.)

The method of reimbursement established by the bill for routine hospital costs would be as follows: Comparisons among hospitals would be made by:

1. Classifying hospitals in groups by bed size, type of hospital, rural or urban location, or other criteria established by the the Secretary; and
2. Comparing the routine costs (as defined for purposes of applying the medicare routine cost limits under present law) of the hospitals in each group, except for the following routine variable costs: capital and related costs; cost of education and training programs; costs of interns, residents and nonadministrative physicians; energy costs; and malpractice insurance costs.

When classifying hospitals by type, hospitals which are primary affiliates of accredited medical schools would be a separate category, without regard to bed size.

A per diem target rate for routine operating costs would be determined for each hospital by:

1. Calculating the average per diem routine operating cost for each group of hospitals under the classification system (excluded

would be newly opened hospitals and hospitals which have significant cost differentials because they do not meet standards and conditions of participation as providers of services); and

2. Determining the per diem rate for each hospital in the group by adjusting the labor cost component of the group's average per diem routine costs for area wage differentials. In the first year of the program only, an adjustment would be allowed where the hospital can demonstrate that the wages paid to its employees are significantly higher than the wages other employees in the area are paid for reasonably comparable work (as compared to the ratio for other hospitals in the same group and their areas).

The Secretary would adjust the per diem target rates by adding an annual projected percentage increase in the cost of routine goods and services hospitals purchase, with an adjustment for actual changes at the end of a hospital's accounting year.

Hospitals whose actual routine operating costs fell below their target rate would receive one-half of the difference between their costs and their target rate, with the bonus payment limited to 5 percent of their target rate. In the first year, hospitals whose actual costs exceeded their target rate, but were no more than 115 percent of that rate, would be paid their actual costs. Those with costs above 115 percent of their target rate would have their reimbursement limited to 115 percent of the target rate.

In the second and subsequent years of the program, the hospital's maximum payment rate would be increased by the actual dollar increase in the average target rate for its group during the preceding year. In calculating the group averages, one-half of costs found excessive would be excluded from the calculation.

Adjustments to a hospital's target rate would be made for changes in the hospital's classification. Hospitals which manipulate their patient mix or patient flow, reduce services, or have a large proportion of routine nursing services provided by private-duty nurses would also be subject to an adjustment. Also, a hospital would qualify for any higher target rate that is applicable to the hospitals placed in the bed-size category which contains hospitals closest in bed size to its actual bed size.

Adjustments would be made to the target rates of hospitals which demonstrate that their costs exceed their rates because of (1) low utilization justified by unusually high standby costs necessary to meet the needs of underserved areas; (2) atypical cost patterns of newly opened hospitals; (3) services changed for such reasons as consolidation, sharing, and approved addition of services among hospitals (e.g., costs associated with low utilization of a new wing); and (4) greater intensity of patient care than other hospitals in the same category. Some hospitals have consistently shorter lengths of stay in treating patients than their group average for a reasonably similar mix of patients with comparable diagnoses. To the extent that a hospital can demonstrate that the shorter stays result from an "intensity" of service which makes it necessary for the hospital to incur additional costs, such additional costs per day, to the exent reasonable, would be recognized under the "intensity" exception provision.

Hospitals would be exempted from the proposed cost limits if: (a) the hospital is located in a State which has a generally applicable hospital reimbursement control system which applies at least to the same hospitals and kinds of costs as are subject to the new reimbursement reform system; and (b) the State demonstrates to the satisfaction of the Secretary that, using the State's system, total medicare and medicaid reimbursable costs for hospitals in the State will be no greater than if the Federal system had been applicable. A State which exceeds, in the aggregate, the costs which would otherwise have been paid under the Federal programs for any 2-year period would be covered under the Federal limits beginning with the subsequent year. The amount of the excessive payments would be recouped over subsequent periods through appropriate reduction (not in excess of 1 percent annually) in the cost limits otherwise applicable.

States which obtain a waiver would be reimbursed for the medicare program's proportionate share of the cost of operating the State reimbursement control system. The State's medicaid program would pay its proportionate share of costs, which would be matchable with Federal funds as an administrative expense.

Medicare and medicaid would also pay a proportionate share of startup costs of approved State reimbursement control systems. The Federal share of the startup costs would be the same proportion as the Federal payment for inpatient hospital costs in the State bears to the total inpatient hospital costs which are subject to the State system. For example, if the Federal Government pays, through medicare and medicaid, 40 percent of the total hospital costs in the State that are subject to the State system, it would be liable for 40 percent of the State program's startup costs.

The committee approved a modification of the provision which is designed to ease transition of the proposed reimbursement system. The amendment provides that only one-half of the incentives and penalties would be applied during the first two years.

On June 14, 1979, the committee approved an additional modification to section 2 that would permit States with demonstrated and acceptable cost containment systems to be exempted from the criteria set forth in the section in addition to those States with acceptable mandatory programs.

2. Payments to promote closing and conversion of underused facilities.—Studies have pointed to a national surplus of short-term general hospital beds ranging as high as 100,000 or roughly 10 percent of total available beds. Excess capacity contributes significantly to hospital costs since the initial construction and financing expenses have to be recovered through the hospital reimbursement structure. In addition there are the continuing expenses associated with maintenance and nonpatient services involved in keeping an empty bed ready for use.

On March 22, 1979, the committee approved section 3 of S. 505 which provides for including in hospital reasonable cost payments, reimbursement for capital and increased operating costs associated with the closing down or conversion to approved use an underutilized bed capacity or services in nonprofit short-term hospitals. In the case of for-profit short-term hospitals, reimbursement would be limited to

increased operating costs. This would include costs which might not be otherwise reimbursable because of payment "ceilings", severance pay, "mothballing" and related expenses. In addition, payments could be continued for reasonable cost capital allowances in the form of depreciation or interest which would ordinarily be applied toward payment of debt outstanding and incurred in connection with the terminated beds. In the case of complete closing down of a hospital, payments would continue toward repayment of any debt, to the extent previously recognized by the program, and actually outstanding.

The Secretary would establish a Hospital Transitional Allowance Board which would consider requests for such payments. Appropriate safeguards would be developed to forestall any abuse or speculation. Prior to January 1, 1983, not more than 50 hospitals could be paid a transitional allowance in order to permit full development of procedures and safeguards. This limited application will also provide Congress with an opportunity to assess the effectiveness and economic effect of this approach in encouraging hospitals to close or modify excess and costly capacity without suffering severe financial penalty.

A hospital could apply for conversion payments *before* the conversion or closing takes place.

3. Federal participation in hospital capital expenditures.—Under section 1122 of the 1972 amendments, the Secretary is required to seek contract agreements with the States for their review of capital expenditures in hospital and other health care facilities which exceed $100,000, change the bed capacity, or substantially change the services in the facility. HEW may deny medicare and medicaid reimbursement for depreciation or interest costs related to capital expenditures disapproved by the State.

On March 22, 1979, the committee approved section 4 of S. 505, with modifications. This section provides for changes to be made in the current law limitations on medicare and medicaid payments related to hospital capital expenditures. These changes link the procedure more closely to the Federal health planning law (Public Law 93-641) by requiring that the designated planning agency (the State health planning and development agency as designated under section 1521 of the Public Health Sevice Act) approve capital expenditures in excess of $150,000 as a condition of medicare and medicaid reimbursement for both capital and (estimated) direct operating costs associated with those expenditures. Regulations developed by the Department to implement this section should allow for speedy replacement of capital plant and equipment in certain emergency situations.

A special procedure is established for approval of proposed capital expenditures in metropolitan areas which include more than one State or jurisdiction. In such cases the designated planning agencies of all the States or jurisdictions in the area must approve the expenditure, or it would be considered disapproved for purposes of reimbursement, subject to review and reversal by the Secretary.

The bill also makes it clear that the capital expenditures limitation does not apply to simple changes of ownership of existing and operational facilities which create no new beds or services and clarifies that the provision does apply to home health agencies and facilities which are part of a health maintenance organization.

The committee directed staff to assure that appropriate provisions are made to protect facilities of health maintenance organizations against discrimination.

4. Rate of return on net equity for for-profit hospitals.—Under present law, the medicare program allows for-profit hospitals a return on equity capital invested and used in providing patient care. The amount allowable is determined by applying to the proprietary hospitals equity capital one and one-half times the rate of return earned on Social Security trust funds. This formula produced a rate of return of 12.6 percent in October, 1978. Profitmaking hospitals argue that this return compares unfavorably to that of comparable businesses.

On June 14, 1979, the committee approved section 25 of S. 505 which changes the allowed rate of return on for-profit hospitals' net equity. The new rate of return multiplier would be: 2½ times for hospitals entitled to an incentive payment under the incentive reimbursement system in section 2 of the bill; 2 times for hospitals that are reimbursed only their reasonable costs; and 1½ times for hospitals with costs in excess of their routine cost limits. The new rates of return, payable at the time of the hospital's final cost settlement would become effective at the same time as the new incentive reimbursement system—i.e., hospital accounting periods beginning on or after July 1, 1980.

5. Encouragement of philanthropic support for health care.—Under present medicare policy, in determining the reasonable costs of services furnished by a provider of health services, unrestricted grants, gifts and income from endowments are not deducted from reimbursable costs of the provider.

On June 14, 1979, the committee approved section 33 of S. 505 which provides a statutory basis for this policy.

6. Flexibility in application of standards to rural hospitals.—Under present medicare law, a hospital must satisfy certain statutory conditions of participation relating to health and safety standards, physical plant, organizational arrangements, and qualified medical, nursing, and technical staff. The Secretary is authorized to prescribe additional requirements he finds necessary in the interest of the health and safety of patients. Current law also provides authority for the Secretary to waive the statutory 24-hour registered professional nursing service requirement in the case of a rural hospital where he determines the hospital is needed to serve the individuals in the area and the hospital is making a good faith effort to comply with the 24-hour requirement but such compliance is impeded by a lack of qualified nursing personnel in the area. This waiver authority expired on December 31, 1978.

On March 22, 1979, the committee approved section 6 of S. 507 which authorizes the Secretary to apply medicare standards to rural hospitals more flexibility to take into account the availability of qualified technical personnel, the scope of services furnished, and the economic impact of structural standards which if rigidly applied would result in unreasonable financial hardship for a rural hospital; but only to the extent that such differential application of the standards does not jeopardize or adversely affect the health and safety of patients.

Under this provision, it would still be necessary for the Secretary to assure that there is compliance with appropriate quality and safety

requirements. For example, with respect to the requirements for nursing services applicable after December 31, 1978, the Secretary may provide for a temporary waiver, on a case-by-case basis, of the requirements only for such period as he determines that the facility's failure to fully comply with the requirements is attributable to a temporary shortage of qualified nursing personnel in the area, a registered nurse is present on the premises to render or supervise the nursing service during at least the regular daytime shift, and the employment of such nursing personnel as are available to the facility during such temporary period will not adversely affect the health and safety of patients. Similar tests are to be applied by the Secretary with respect to other types of technical personnel, including tests related to the scope of services furnished by the facility and the facility's good faith efforts to fully comply with personnel requirements.

7. *Certification and utilization review by podiatrists.*—Medicare covers as "physicians' services" the services performed by a podiatrist but only with respect to functions he is legally authorized to perform as such by the State in which he performs them.

As a condition of payment for hospital and other services covered under medicare, existing law requires that a physician certify as to the medical necessity for the service. Also, medicare requires that the utilization review committee of a hospital or skilled nursing facility include at least two physicians. For neither purpose does a podiatrist qualify as a "physician."

On March 22, 1979, the committee approved section 15 of S. 507 which extends medicare recognition to podiatrists as physicians for purposes of physician certification and participation in utilization review where such recognition is consistent with the policies of any health care institution that is involved. With respect to utilization review, a podiatrist acting as a physician member of a utilizatiion review committee would not take the place of an M.D. or osteopath as one of the two required physician members of the committee.

8. *Disproportionate medicare-medicaid payments for hospital care.*—Under present policy, medicare reimburses hospitals for a disproportionately large share of the costs of routine nursing care even though there is no objective, convincing evidence that this "plus factor" is warranted.

The committee agreed that medicare would no longer pay a routine nursing plus factor nor any other plus factor until such time as evidence can be produced which, in the judgment of the Comptroller General, concurred in by the Secretary of HEW, justifies a specific plus factor as warranted under given circumstances for given facilities.

9. *Prohibit medicare-medicaid payment at hospital rates for patients medically determined to need lesser levels of care.*—Professional Standards Review Organizations (PSRO's) have found thousands of medicare and medicaid patients being kept in costly acute-care hospital beds instead of being appropriately placed in nursing facilities or detoxification units.

The situation occurs most frequently in those areas where there is a surplus of hospital beds and a shortage of long-term care beds.

On June 14, 1979, the committee agreed to: (a) Authorize a $50 million program of grants and loans to facilitate conversion to long-

term care beds of surplus acute hospital beds in public and nonprofit hospitals. Priority would be given to high cost urban areas. Priority would be given to complete conversion of a hospital to long-term care as opposed to partial changeover. (b) Effective not later than April 1, 1980, medicare and medicaid payments to hospitals would be made at the average skilled nursing facility or intermediate care facility payment rate (as may be appropriate) rather than the much higher hospital rate for patients medically determined by reviewers as not in need of acute hospital care but who are in need of a program reimbursable level of long-term care. Days of care paid by medicare at the reduced rates would be counted against the patient's eligibility for skilled nursing facility benefits and the skilled nursing facility benefit coinsurance rates would also be applicable. To prevent undue hardship, the limitation would not apply during the first day, to certain terminally ill patients nor in those geographic areas where the appropriate State or local planning agencies certify that there is no general excess of hospital beds.

Where a hospital converts active acute care beds to long-term care usage under this provision, it would be permitted to reconvert those beds back to acute care usage within a period of two years without being subject to the section 1122 approval process.

10. Coordinated audits under the Social Security Act.—The duplication of identical or similar auditing procedures used for the purpose of determining reimbursement under various Federal health benefit programs is costly to both the programs and the entity (such as hospital, skilled nursing facility, or home health agency) participating in the program.

On March 22, 1979, the committee agreed to section 32 of S. 505 (also section 4 of S. 507) which requires that, if an entity provides services reimbursable on a cost-related basis under title XVIII and titles XIX or V, audits of books, accounts, and records of that entity for purposes of the State programs are to be coordinated through common audit procedures with audits performed for the purposes of reimbursement under title XVIII. Where a State declines to participate in such common audits, the Secretary is to reduce payments that would have been made to the State under titles V or XIX by the amount attributable to the duplicative State audit activity. A State participating in the common audit procedure would continue to receive Federal matching for administrative costs associated with any additional or supplemental audit data or audits that may be necessary under their medicaid and maternal and child health programs.

11. Hospital admissions for dental services.—Under present law, medicare benefits may be paid for inpatient hospital services if they are necessary to provide medical or surgical services, but dental admissions are not covered. The committee approved a provision that would provide for payment to be made under medicare for inpatient hospital services that are justified because of the seriousness of the patient's dental condition or dental procedure. Such admissions would be subject to appropriate PSRO review.

12. Preadmission diagnostic testing.—In some cases, a patient's stay in a hospital is unnecessarily protracted because it is less expensive to the medicare patient to receive diagnostic tests in the hospital than

prior to being admitted on March 22, 1979, the committee approved a provision that would eliminate the financial incentives to unnecessarily utilize hospital care in cases where needed diagnostic services are provided in the hospital's outpatient department within 7 days of the patient's admission.

PROVISIONS RELATING TO SKILLED NURSING FACILITIES, INTERMEDIATE CARE FACILITIES, AND HOME HEALTH CARE

13. Hospital providers of long-term care services.—Many rural hospitals are the only source of acute care in their communities and as such, are a necessary and vital resource to the people they serve. Although many of these hospitals have recognized that the use of their acute care beds for needed long-term-care services during periods of excess bed capacity would be desirable, current program participation requirements under medicare and medicaid have discouraged these hospitals from doing so.

Under present law, a hospital-based skilled nursing facility (SNF) can participate in medicare and medicaid only if the facility is an identifiable, separate unit within the institution.

This requirement was developed primarily to establish a separate cost center for purposes of program reimbursement. However, it has proven to be administratively burdensome and financially detrimental to many small hospitals. In addition, the identification of specific beds, staffing and other program requirements have not allowed sufficient flexibility in meeting episodic demand for acute beds—an important consideration when working with the small total bed complement characteristic of many rural hospitals.

On March 22, 1979, the committee approved section 13 of S. 505 (also section 2 of S. 507) which establishes a simplified cost reimbursement formula which would permit small rural hospitals to avoid the requirement for separate patient placement within the facility and separate cost finding.

Reimbursement for routine SNF services under medicare would be at the average rate per patient-day paid for routine services during the previous calendar year under medicaid to SNF's located in the State in which the hospital is located. Reimbursement under medicaid would be at the rate paid to SNF's and ICF's in the previous year. Reimbursement for ancillary services would be determined in the same manner as under present law.

Reimbursement under the new formula would be allowed in a hospital which (1) has less than 50 beds; (2) is located in a rural area; and (3) has been granted a certificate of need for the provision of long-term-care services. The Secretary is also authorized to apply the new formula on a demonstration basis to hospitals of up to 100 beds provided they are otherwise qualified.

Since the general staffing pattern in small rural hospitals is relatively fixed due to minimum staffing requirements, there should be opportunities for providing needed long-term-care services at very little additional cost.

The proposed new reimbursement method is optional and hospitals may continue to elect to establish distinct part SNFs as provided for under existing law. In addition, it is not the intention that this provision prohibit States from continuing to use other approved reimbursement methods under State medicaid plans.

The bill provides that within 3 years after enactment the Secretary shall report to Congress concerning whether a similar provision should be extended to other hospitals where there is a shortage of long-term-care beds, regardless of number of beds or geographic location.

14. Medicaid certification and approval of skilled nursing and intermediate care facilities.—On March 22, 1979, the committee approved section 15 of S. 505 which would establish a uniform health care facility certification process for medicare and medicaid long-term care facilities.

On June 14, 1979, the committee deleted section 15 and approved a provision which would authorize the Secretary to validate State determinations and, on that basis, make independent and binding determinations concerning the extent to which individual institutions and agencies meet the requirements for participation.

15. Visits away from institutions by patients of skilled nursing or intermediate care facilities.—Until recently, HEW policy has limited Federal payments for the cost of reserving beds in skilled nursing facilities (SNF's) and intermediate care facilities (ICF's) for medicaid patients temporarily away from the institution. The regulations permitted Federal funds to be used to reserve a bed for 15 days each time a patient was in a hospital for acute care. They also permitted Federal contributions for a total of 18 days during a 12-month period when patients were visiting their homes or other places for therapeutic reasons.

The Health Care Financing Administration has amended the regulations to remove all limitations on Federal funding of therapeutic absences. Currently, however, there are no requirements in existing law setting forth policies with respect to reserving beds in SNFs and ICFs.

On March 22, 1979, the committee approved section 16 of S. 505 which provides that visits outside of the SNF or ICF would not necessarily constitute conclusive proof that the individual is no longer in need of the services of the SNF or ICF. However, the length and frequency of visits must be considered, together with other evidence, when determining whether the individual is in need of the facility's services. The provision thus prohibits the Secretary from imposing numerical limits. Such matters would be left to professional medical judgment.

16. Study of availability and need for skilled nursing facility services under medicare and medicaid.—Under current law, skilled nursing facilities (SNF's) participating in one of the programs are not required to participate in the other. In some States, there are a larger number of Medicaid-only participating SNF's and in other States, the reverse is true. If a greater number of SNF's could be prompted to participate in both programs, a more adequate number of skilled nursing facilities would be available for medicare and medicaid beneficiaries.

On June 14, 1979, the committee approved section 31 of S. 505 which directs the Secretary of HEW to conduct a study of the availability and need for skilled nursing facility services under the medicare and medicaid programs. The study would consider the desirability of requiring facilities that wish to participate in one program to participate

BEST COPY AVAILABLE

in both. The study would also investigate possible changes in regulations and legislation which would result in encouraging a greater availability of skilled nursing services.

In developing the study, the Secretary would consult with professional organizations, health experts, private insurers, nursing home providers and consumers of skilled nursing facility services. A report on the Secretary's findings and recommendations would be due 6 months after the date of enactment.

17. Study of criteria employed for classifying a facility as a skilled nursing facility.—Under present law, a beneficiary must remain, for 60 consecutive days, out of an institution which is determined to be primarily engaged in providing skilled nursing care and related services in order to renew his medicare eligibility for additional days of hospital and skilled nursing facility benefits. The intent of these provisions was to permit beneficiaries to renew their benefit eligibility once they have ended a spell of llness (and, thus, for at least 60 days, no longer needed skilled nursing). However, beneficiaries in skilled nursing institutions who have exhausted their benefits are sometimes prevented from renewing their eligibility even though they actually receive little or no skilled care.

On March 22, 1979, the committee approved section 37 of S. 505, which directs the Secretary to review current procedures for applying the benefit-renewal criteria to make sure that they are not too restrictive. The Secretary would report his findings and conclusions to the Congress within 9 months of enactment, together with any legislative recommendations he may wish to propose.

18. Presumed coverage provisions.—The 1972 Social Security Amendments directed the Secretary to establish a minimum number of days of care in a skilled nursing facility or visits by a home health agency which would be "presumed" to be covered by type of patient diagnosis. This provision was enacted because skilled nursing facilities and home health agencies were experiencing a high rate of retroactive denials for services they provided on the assumption that such services would be covered by medicare.

A number of skilled nursing facilities and home health agencies have found the presumed coverage regulations confusing, often mistaking what are minimum days or visits covered as the maximum allowed. The regulations implementing this provision also have created complex administrative procedures. In addition, as a result of other, more effective waiver of liability provisions included in the same 1972 legislation, the presumed coverage provisions are rarely used. According to HEW statistics, claims filed by skilled nursing facilities and home health agencies under the presumed coverage provision now represent far less than one-half of one percent of all claims for payment filed by these providers.

On March 22, 1979, the committee approved section 17 of S. 507 which repeals existing medicare provisions which authorize by type of diagnosis, presumed periods of coverage for skilled nursing facility and home health services. Protection against retroactive denials would continue to be afforded by a general waiver of liability provision.

19. Reimbursement rates under medicaid for skilled nursing facilities and intermediate care facilities.—Present law requires States

participating in Medicaid to pay skilled nursing facilities (SNF's) and intermediate care facilities (ICF's) on a reasonable cost-related basis. This requirement, added by section 249 of the Social Security Amendments of 1972, gives States the option of using medicare's reasonable cost reimbursement formula for purposes of reimbursing SNF's and ICF's or developing other reasonable cost-related methods of reimbursement acceptable to the Secretary.

On June 14, 1979, the committee approved a provision to repeal section 249. States would be allowed, effective January 1, 1980, to develop their own payment systems for skilled nursing facility and intermediate care facility services. The rate system would have to assure rates that are reasonable and adequate (1) to meet the costs incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws and regulations, and (2) to assure the reasonable availability of long term care services so that eligible persons can receive such services included in the State plan at least to the extent such services are available to the general population.

Under the committee-approved provision, a State, at its option, could include as part of its rate reasonable allowances in the form of incentive payments related to efficient performance and to attract investment necessary to assure the reasonable availability of services.

20. Intermediate sanctions for skilled nursing and intermediate care facilities.—Under current law, the sanction used to enforce requirements for participation in the medicare and medicaid programs is limited to decertification of a provider or supplier of services. In some instances this sanction has proven too severe and unwieldy to apply.

On June 20, 1979, the committee approved an amendment providing the Secretary with the authority to impose intermediate sanctions, less severe than decertification, in those cases where a skilled nursing facility or intermediate care facility has been found to be out of compliance, but with the stipulation that they may only be used if the failure does not jeopardize the health and safety of the patients.

21. Home Health Amendments.—On June 20, 1979, the committee approved several provisions related to home health services under medicare and medicaid, as described below.

Plan of care.—Under current law, a plan of care must be established by a physician in order for a person to receive home health benefits under medicare and medicaid.

The committee amendment would require that in establishing the plan of care, the plan must include a plan for patient education aimed at achieving, to the extent possible, maximum independence from the need for care provided by other persons. The amendment would also allow physician assistants and nurse practitioners located in rural areas who are under the general supervision of a physician to establish a plan of care for a home health patient living in a rural area.

Cost controls and utilization.—The committee amendment would require the Secretary of HEW, within six months after enactment, to establish guidelines for determining direct and indirect incurred costs of home health providers to serve as a basis for determining the reasonable cost of home health services. The guidelines would apply to

specific line item costs of home health services. The amendment would also require the Secretary to monitor the costs and utilization of home health care services and report to the Congress with an interim report 18 months after the implementation of the legislation and a final report within 36 months.

Demonstration projects for utilization review.—Under medicare and medicaid, utilization review is required for hospitals and skilled nursing facilities but not for home health agencies. The committee amendment would require the Secretary to establish demonstration projects over a 2-year period to test methodologies for utilization review of home health services and report the finding to the Congress within 6 months after completion of the projects.

22. Repeal of 3-day hospitalization requirements and 100-visit limitation for home health services.—Under present law, a beneficiary is eligible for 100 home health visits per spell of illness under part A of medicare following an inpatient stay in a hospital of at least 3 days. Beneficiaries are also eligible for 100 home health visits per calendar year under part B of medicare whether or not they had been hospitalized previously.

On March 22, 1979, the committee agreed to section 29 of S. 505 (also section 10 of S. 507), which removes the provision in existing law that limits medicare home health benefits to 100 visits per spell of illness under part A and 100 visits per year under part B. In addition, the bill removes the requirement that a beneficiary has to be an inpatient in a hospital for at least 3 days before he can qualify for part A home health benefits.

PROVISIONS RELATING TO MEDICAL AND OTHER HEALTH SERVICES

23. Incentives for physicians to accept assignments.—Payments for physicians' services under medicare may be made directly to the beneficiary or to the physician furnishing the service depending upon whether the itemized bill method or assignment method is used when requesting payment from the carrier. An assignment is an agreement between the physician and the medicare beneficiary under which the beneficiary "assigns" to the physician his rights to benefits for covered services included in the claim. In return, the physician must agree to accept the reasonable charge determined by the carrier as his full charge for the items or services rendered. A physician may accept or refuse requests for assignments on a bill-by-bill basis.

Total assignment rates and net assignment rates (which excludes claims from hospital-based physicians and group practice prepayment plans) have been declining. The net assignment rate is presently about 50 percent.

On March 22, 1979, the committee approved the part of section 5 of S. 505 that is designed to encourage physicians to accept assignments by expediting payment of claims by physicians. Under this provision, the Secretary would establish appropriate procedures and forms whereby: (1) physicians would submit claims on one of various simplified bases, and these claims would be given priority handling by the part B carrier; and (2) physicians would obtain signed forms from their patients making assignment for all services

furnished to them and authorizing release of medical information needed to review the claim.

The committee also agreed to authorize five to ten pilot projects to experiment with ways of encouraging physicians to accept assignments for all their medicare claims.

24. Use of approved relative value schedule.—Third-party payors have often employed relative value schedules to determine payment rates for the many different services and procedures which physicians perform. These are lists of medical procedures and services which set forth comparative numerical values for each. These useful mechanisms for assessing reasonableness of physicians' fees have recently been cited by the FTC and the Department of Justice as being conducive to price fixing by the physician groups that have traditionally been responsible for their development.

On March 22, 1979, the committee approved section 7 of S. 505, which authorizes the Secretary to approve the use of terminology systems and relative value schedules by physicians in billing medicare, medicaid, and for other purposes. The purpose of this amendment is to establish a common language to describe the kinds of services that are covered under public and private health benefit plans and to provide for a more rational basis for evaluating the reasonableness of fees.

25. Teaching physicians.—Section 227 of Public Law 92–603, is intended to make it clear that, under medicare and medicaid, fees-for-service should be paid for medical care in teaching hospitals only where a bona fide private doctor-patient relationship exists. A further delay in the provision's implementation is needed to afford the Secretary of HEW additional time to consult with members of the medical education community and publish the necessary regulations.

On March 22, 1979, the committee approved section 8 of S. 505, which would extend from October 1, 1978 to October 1, 1979 the implementation date of section 227 of Public Law 92–603.

The committee also agreed to a provision which would apply to teaching hospitals which do not qualify for fee-for-service reimbursement for medical services under medicare because most or all of their nonmedicare patients generally do not pay fees for physicians' services.

Such institutions can, under present law, elect to receive 100 percent cost reimbursement for physicians' services and house-staff costs. Under the committee-approved provision, the hospital could, alternatively, elect to have medicare pay fees covering the medical services furnished by attending physician-resident-intern teams in lieu of cost reimbursement for physicians and house staffs provided the services are furnished under circumstances that assure that fees will be billed only where bona fide, private patient-physician relationships exist.

26. Certain surgical procedures performed on an ambulatory basis.—There are a number of surgical procedures which are often provided on an inpatient hospital basis even though they can often, consistent with sound medical practice, be performed at far less cost on an ambulatory basis. Medicare discourages the medically appropriate use of ambulatory surgery because the program does not recognize charges for the use of the special surgical facilities in a physician's private office or a free-standing surgical facility that is not part of a hospital.

On March 22, 1979, the committee approved section 9 of S. 505 (also section 18 of S. 507) with modifications. This section permits medicare reimbursement on the basis of an all-inclusive rate to free-standing ambulatory surgical centers and to physicians performing surgery in their offices for a listed group of surgical procedures. Such procedures include those which are often provided on an inpatient hospital baisis but can, consistent with sound medical practice, be performed on an ambulatory basis. The rate would encompass reimbursement for the facility, physician and related services, including normal pre- and post-operative visits and routine laboratory and other diagnostic tests usually associated with the procedure.

The list of procedures eligible for such reimbursement would be specified by the Secretary following consultation with the National Professional Standards Review Council and appropriate medical organizations including specialty groups. Subsequently, procedures could be added or deleted as experience dictated.

Under the bill, the physician operating in his own office who accepts an assignment would have no deductible and coinsurance applied to his ambulatory surgical all-inclusive payment. Similarly, reimbursement for the use of the facilities in an ambulatory surgical center would be exempted from the deductible and coinsurance where the center accepts assignment. In the case of an ambulatory surgical center, the overhead allowance could be paid directly to the center and the professional fee could be paid directly to the physician. The deductible and coinsurance would be waived for the physician fees for services performed in connection with listed surgical procedures in hospital outpatient departments.

27. Criteria for determining reasonable charge for physicians' services.—Statewide median charges.—On June 13, 1979, the committee approved section 10 of S. 505, which would provide for the calculation of statewide median charges (in any State with more than one locality) in addition to prevailing charges in the locality. To the extent that any prevailing charge in a locality was more than one-third higher than the statewide median charge for a given service, it would not be automatically increased each year. This provision would not reduce any prevailing charges currently in effect. However, it would operate, to the extent given charges exceed the statewide average by more than one-third, to preclude automatically increasing those charges.

Physician shortage areas.—Under existing law, Medicare allows a new doctor to establish his customary charge at not greater than the 50th percentile of prevailing charges in the locality. The committee-approved provision would permit new physicians in localities, designated by the Secretary as physcian shortage areas, to establish their customary charges at the 75th percentile of prevailing charges (rather than the 50th) as a means of encouraging doctors to move into these communities. It would also permit doctors presently practicing in shortage areas to move up to the 75th percentile on the basis of their actual feel levels.

28. Disclosure of aggregate payments to physicians.—Recent disclosures of physicians receiving large payments under medicare have served unjustifiably to embarrass physicians who serve a large number

of elderly patients. The disclosures have also been characterized by a high degree of inaccuracy which has unfairly embarrassed some physicians.

On March 22, 1979, the committee approved section 23 of S. 505, which prohibits the Secretary of HEW from routinely releasing medicare information, and provides that State agencies shall not be required to release medicaid information relating to amounts paid to physicians under their respective programs, except as otherwise specifically required by Federal law.

29. Payment for certain antigens under part B of medicare.—Current medicare law does not permit reimbursement for an antigen prepared by a physician unless he also administers it. However, it is common, especially in rural areas, for other dispensary practices to be followed—e.g., for a local doctor to refer a patient to an allergist who prepares a supply of antigens for the referring doctor's use.

On March 22, 1979, the committee approved section 11 of S. 505 (section 7 of S. 507), which amends current law to permit payment under medicare for the preparation by an allergist of a reasonable supply of antigens dispensed or administered under the supervision of a physician.

30. Payment on behalf of deceased individuals.—Under present law, medicare can only pay a claim on behalf of a deceased beneficiary where the physician accepts an assignment or where the family has actually paid the bill. Where a physician refuses an assignment, families have encountered difficulty in raising sufficient cash to pay the bill in order to be eligible for payment by medicare.

On March 22, 1979, the committee approved section 12 of S. 505 (section 8 of S. 507), which would permit payment by medicare to be made to the spouse or other legal representative of a deceased medicare beneficiary on the basis of a nonreceipted bill.

31. Physician treatment plan for speech pathology.—The Social Security Amendments of 1972 provided for coverage of speech pathology services furnished on an outpatient basis in an organized setting such as a clinic, a rehabilitation agency, or a public health agency. Prior to 1972, outpatient speech pathology services were covered only when furnished by an approved hospital, skilled nursing facility, or home health agency. Present law requires that the patient be referred to the speech pathologist by a physician and that the physician establish and periodically review a plan of treatment which specifies the amount, duration and scope of services to be furnished. However, since speech pathology involves highly specialized knowledge and training, physicians generally do not specify in detail the services needed when referring a patient for such services.

On March 22, 1979, the committee approved section 16 of S. 507 which repeals the existing medicare requirement that a physician establish a detailed plan of treatment for speech pathology services. The requirement for physician referral and periodic physician review of the plan of treatment would be retained.

32. Payment for durable medical equipment.—Under the medicare law, reimbursement for the rental or purchase of durable medical equipment is based largely on the supplier's customary charge for the

item and on the prevailing charge for the equipment in the locality. Medicare has experienced problems with this method of reimbursement because of the lack of uniformity in suppliers' billing and charging practices; differences in the level of services offered by different suppliers; the different approaches medicare carries follow in calculating allowances for medical equipment; and because equipment charges are not set in broadly competitive marketplace.

On June 14, 1979, the committee approved section 30 of S. 505 as modified to require a study of reimbursement methods for durable medical equipment intended to correct these problems.

33. Deductible not applicable to expenses for certain independent laboratory tests.—Legislation enacted in 1972 (section 279 of Public Law 92-603) was designed to avoid the unreasonably high administrative costs that independent laboratories and the medicare program incur in the billing and processing typically inexpensive diagnostic tests. That provision was intended to reduce these billing and processing costs by authorizing the Secretary of HEW to negotiate payment rates with individual laboratories which medicare would pay in full, without any need for the laboratory to bill the patient for the $60 deductible and 20 percent copayment amounts. The negotiated rates could be no higher than medicare would have paid in the absence of the new provision.

The new billing procedure was never utilized because, as a result of a drafting error, the $60 deductible was retained. Thus, since laboratories still have to bill patients for deductible amounts, and since medicare must still determine each patient's deductible status, the savings to laboratories and medicare cannot now be achieved.

On March 22, 1979, the committee approved section 26 of S. 505 (also section 12 of S. 507), which waives the $60 deductible in applying the special laboratory billing procedure, as was intended by section 279 of Public Law 92-603.

34. Rural health clinics.—Under present law, rural health clinics must ascertain whether their medicare patients have satisfied the program's $60 deductible before they can determine what part of its charges are to be paid by the patient. This requirement is complicated, and it has increased the costs of the billing and bookkeeping operations of these small facilities.

On June 20, 1979, the committee agreed to waive the applicability of the $60 deductible with respect to services provided in rural health clinics.

35. Outpatient rehabilitation clinics.—On June 20, 1979, the committee approved an amendment which would recognize comprehensive outpatient rehabilitation facilities as "providers of services" under the medicare program if they meet specific conditions of participation.

Reimbursement to such facilities would be authorized under part B of the program, based on the costs they incur in furnishing covered services, including: physicians' services, nursing care, physical therapy, occupational therapy, speech pathology, respiratory therapy, social and psychological services, prosthetic and orthotic devices, drugs and biologicals (which cannot be self-administered), supplies, appliances, equipment (including the purchase of rental equipment), and certain other items and services necessary for the rehabilitation of the patient.

The effect of the amendment would be to provide reimbursement for rehabilitation services provided in a certified outpatient rehabilitation facility on the same basis as these services are presently reimbursable if provided in a hospital.

36. Reimbursement for outpatient hospital care.—As a result of various limits placed by public agencies and others on inpatient hospital expenditures, some hospitals have sought to have the patients using their outpatient departments meet a disproportionately large share of the hospitals' total costs. In addition, reimbursement to community health centers and other freestanding clinics which are presently paid on a cost-related basis have sometimes proved to be excessive.

On June 14, 1979, the committee agreed that the Health Facilities Costs Commission (established under section 2 of S. 505) would give priority to development of appropriate limitations on hospital outpatient department and clinic costs. Further, the authority of the Department of Health, Education, and Welfare to establish such limits under present law would be reiterated.

37. Ambulance services.—Under present law, medicare will pay for ambulance services to the nearest participating institution with appropriate equipment and facilities where the use of other means of transportation is contraindicated by the individual's condition. Occasionally, the nearest hospital with appropriate facilities does not have a physician available to undertake the required specialized care. The present alternatives are to bring the physician to the patient—a possible misuse of physician time—or to transport the patient to the more distant facility at his own expense. For example, in some areas, particularly rural areas, radiation therapy for cancer is provided by radiation clinics rather than in a hospital. However, transportation by ambulance to a radiation clinic cannot qualify for medicare reimbursement.

On March 22, 1979, the committee approved section 20 of S. 505 (also section 3 of S. 507) which would provide medicare reimbursement for ambulance services to a more distant hospital where the nearest hospital lacks the necessary staff. The ambulance benefit would also cover patients who require ambulance transportation to receive radiation therapy in clinics in areas where the treatment is not available in a hospital.

In addition, on June 14, 1979, the committee agreed to clarify in the committee report language on section 20 that reimbursement for ambulance services would be allowed when "medically necessary" from a hospital to an outpatient facility for specialized diagnostic procedures if it is the nearest available facility where the procedure is available, and where the service in the facility has been approved by the State certificate-of-need agency.

38. Coverage under medicare of certain dentists' services.—Under present law, medicare covers the services of dentists when they are performed by a licensed doctor of dental surgery or dental medicine only with respect to (1) surgery related to the jaw or any structure contiguous to the jaw, or (2) the reduction of any fracture of the jaw or any facial bone. The law, therefore, excludes from coverage certain nonsurgical procedures which dentists and doctors of dental surgery are professional trained and licensed to perform even though the same services are covered when performed by a physician.

On June 20, 1979, the committee approved Section 35 of S. 505 (Section 7 of S. 507), which would extend the coverage of dental services under medicare to include any services performed by a doctor of dental medicine or of dental surgery which he is legally authorized to perform in cases where the services would be covered if performed by a physician.

39. Coverage under medicare of optometrists' services with respect to aphakia.—Current medicare law provides reimbursement for diagnosis and treatment of the diseases of the eye when such services are provided by physicians. Certain diseases of the eye result in surgical removal of the lens. The resulting condition, i.e., absence of the lens of the eye, is known as aphakia. Eyeglasses (or contact lenses) which serve as the prosthetic lens for aphakia are covered under the program. Both physicians and optometrists are reimbursed under the program for services to aphakic patients. Unlike physicians, however, the reimbursement to optometrists is limited to dispensing services, the actual fitting and provision of prosthetic lenses. Section 109 of Public Law 94-182 required HEW to conduct a study concerning the appropriateness of medicare reimbursement of services performed (but not presently reimbursed) by optometrists in providing prosthetic lenses for patients with aphakia. In a report transmitted to the Congress on January 12, 1977, HEW recommended that those covered services related to aphakia and within the scope of optometric practice be reimbursable under part B of medicare when provided by optometrists.

On March 22, 1979, the committee agreed to section 36 of S. 505 (also section 9 of S. 507), which implements the Department's recommendation.

On June 20, 1979, the committee agreed to clarify the amendment by removing the proposed coverage authorization for the "physician" services provision of the medicare law and including it instead in the part of the law that deals with "medical and other health services" (sec. 1861(s)).

40. Chiropractic services.—Under present law, medicare covers only those services of chiropractors which involve treatment of a subluxation (partial dislocation) by means of manual manipulation of the spine. The existence of a subluxation must be demonstrated by x-ray; however, the cost of the x-ray is not covered when performed by a chiropractor. The x-ray requirement was intended to control costs by excluding from coverage cases in which a subluxation was not evident on an x-ray. The General Accounting Office has indicated that the extent to which x-rays play a part in claims denial is not known. Althugh chiropractors must have x-rays available upon request, the x-ray is actually reviewed by medicare carriers in only a small number of cases. The requirement for an x-ray to demonstrate the subluxation of the spine is not necessary in every case, is possibly hazardous, and—since it is not paid for by the program—represents a significant cost to beneficiaries. Since chiropractors would not ordinarily take x-rays in every case to diagnose subluxation of the spine, it is inappropriate to require x-rays, with their accompanying radiation risks, for administrative purposes.

On March 22, 1979, the committee approved a provision to modify the requirement for chiropractic coverage so that a subluxation could

be demonstrated to exist either through x-ray or other chiropractic clinical findings. Neither the x-ray nor other clinical procedures used by the chiropractor would be covered by medicare.

41. Treatment for plantar warts.—Under present law, coverage for services related to routine foot care—which is defined as "including the cutting and removal of corns, warts, or callluses, trimming of nails, and other routine hygienic care"—is specifically excluded. Warts on the feet (often called plantar warts because they may appear on the plantar surface of the foot), are tumors caused by infectious viral agents. However, because of the routine foot care exclusion in present law, treatment for plantar warts is not a covered service, while the treatment of warts located elsewhere on the body is a covered service.

On June 20, 1979, the committee approved a provision which would eliminate the present Medicare exclusion of services related to the treatment of plantar warts.

OTHER PROVISIONS

42. Confidentiality of PSRO data.—In authorizing the professional standards review organization (PSRO) program in 1972, the Congress set forth principles, in section 1166 of the Social Security Act, that were to serve as the basis for regulations governing both the disclosure and the confidentiality of information acquired by PSRO's in the exercise of their duties.

Confidentiality is critical to the success of PSRO's because they rely on voluntary service by local physicians. Should all data acquired by PSRO's be disseminated without safeguards, recruitment of physicians to perform PSRO functions would become increasingly difficult. Moreover, the intent of peer review, as opposed to Government regulation, is to allow the profession to attempt to regulate itself with some degree of privacy and candor. In addition, subjecting PSRO's to the Freedom of Information Act (FOIA) would result in increased administrative burdens, large additional expenses for the defense of lawsuits and great uncertainty and delay in the performance of PSRO functions.

However, on April 27, 1978, the U.S. District Court for the District of Columbia held that a PSRO is an "agency" of the Federal Government for purposes of the FOIA and is thus subject to the disclosure requirements of this later legislation. This decision, which is currently being appealed, means that the data and information in control of the PSRO must be disclosed, on request, unless the particular information to be protected is specifically identified.

On March 22, 1979, the committee agreed to section 28 of S. 505 (also section 19 of S. 507) with modification, which provides for the confidentiality of PSRO information that identifies an individual patient, practitioner, provider, supplier or reviewer. As under section 1166, as presently worded, information may be disclosed to the extent necessary to carry out program purposes, to assist with the identification of fraudulent and abusive activities, and to assist in the conduct of health planning activities.

It should be noted that the Secretary of HEW in his regular review of PSRO performance can, under present law, evaluate the review

activities—including practitioner profiles of practice—and thus safeguard against any general indiscriminate or willful action or inaction by a given PSRO with respect to practitioners.

43. Direct professional review toward avoiding unnecessary routine hospital admission services and excessive preoperative stays.—Present policies direct PSRO's to review the appropriateness of hospital services received by medicare and medicaid patients. This review has been limited largely to a review of the need for the patient to be admitted to the hospital and on the appropriateness of the length of the stay. PSRO studies have amply demonstrated the extent to which unnecessary or avoidable utilization occurs with respect to certain hospital practices that have not been subject to general across-the-board review, including: diagnostic tests routinely provided on admission without a physician's order; weekend elective admissions to hospitals which are not equipped or staffed to provide needed diagnostic services on weekends; and preoperative stays for elective procedures of more than one day without justification for the additional days.

On June 14, 1979, the committee agreed to direct PSRO's to review these areas of relatively frequent overutilization to assure that payment is made under the public programs only when the routine tests and unusually long preoperative stays for elective conditions are medically appropriate.

For example, as is now the case in some PSRO's, elective admissions for surgery that involve preoperative stays of more than one day would require specific PSRO approval in order to be reimbursable. Similarly, weekend admissions for elective conditions would be reimbursable only where the PSRO finds that the hospital is equipped and staffed to provide necessary services over the weekend.

The committee noted the need for additional funds for the PSRO program to engage in these reviews and directed the Department of Health, Education, and Welfare to provide an estimate of money required.

44. Procedure for determining reasonable cost and reasonable charge.—Some hospitals and other organizations that are reimbursed by medicare and medicaid deal with contractors, employees or related organizations, consultants, or subcontractors who are paid (in whole or in part, in cash or kind) on the basis of percentage arrangements.

Such arrangements can take several forms. For example, some involve business contracts for such support services as computer and data processing, financial and management consulting, or the furnishing of equipment and supplies to providers of health services, such as hospitals. Charges for such services are subsequently incorporated into the cost base against which medicare and medicaid make their payment determinations.

The contracts for these support services specify that the remuneration to the suppliers of the services shall be based on a percentage of the gross or net billings of the health care facilities or of individual departments. Other examples involve landlords receiving a percentage of provider gross (or net) income in return for office space, equipment, shared waiting rooms, laboratory services, custodial and office help and administrative services. Such arrangements can be highly inflationary and add costs to the programs which may not reflect actual efforts expended or costs incurred.

On June 14, 1979, the committee approved Section 19 of S. 505, which provides except under certain specified circumstances, that reimbursement to contractors, employees or related organizations, consultants, or subcontractors at any tier would not be recognized where compensation or payments (in whole or part, in cash or kind) is based upon percentage arrangements.

The prohibition against percentage arrangements contained in this section of the bill would include payment of commissions and/or finders' fees and lease or rental arrangements on a percentage basis. It would also apply to management or other service contracts or provision of services by collateral suppliers such as pharmacies, laboratories, etc. The percentage prohibition would flow both ways either from the supplier or service agency back to the provider or organization, or from the original provider or organization to the supplier or service agency.

There is no intent, however, to interfere with certain types of percentage arrangements which are customarily considered normal commercial business practices such as the commission paid to a salesman. Further, the bill does not prohibit reimbursement for certain percentage arrangements such as a facility management contract where the arrangement contributes to efficient and economical operation.

On June 20, 1979, the committee agreed that, in the case of physicians, percentage arrangements would be permitted if the amount of reimbursement is based on an approved relative value schedule which takes account of physician time and effort. An additional provision agreed to would direct the Secretary of HEW to conduct a study of hospital-based physician reimbursement and report back to the Congress with recommendations within two years. The committee also agreed to seek to amend the clinical laboratories bill reported by the Committee on Labor and Human Resources with a conforming amendment.

45. Repeal of section 1867.—The original 1965 medicare legislation provided for the establishment of the Health Insurance Benefits Advisory Council (HIBAC). The current need for the Council has been called into question in view of the establishment of other advisory groups, and the Secretary's authority to establish ad hoc advisory bodies.

On March 22, 1979, the committee approved section 18 of S. 505 (also section 11 of S. 507) which terminates the Health Insurance Benefits Advisory Council.

46. Development of uniform claims forms for use under health care programs.—The medicare and medicaid programs have added to the paperwork required by physicians, hospitals, skilled nursing facilities, and other health care organizations as a result of the proliferation of forms. For several years, HEW has been working with other organizations to develop standardized claims forms that might be used by physicians and institutions in billing both medicare and medicaid. Standardized physician benefit forms now have been developed and are being used by medicare, medicaid and Blue Shield in several States. A promising uniform hospital benefit form has also been developed.

On March 22, 1979, the committee approved section 31 of S. 505, which requires HEW to adopt, to the extent feasible, standardized claims forms for medicare and medicaid within 2 years of enactment.

Such forms could vary in a given State for medicaid if the Secretary determined that, in that State, a uniformed national medicare-medicaid claims forms could not be utilized.

The bill requires the Secretary, in carrying out the requirements of this section, to consult with those charged with the administration of other Federal health care programs, with other organizations that pay for health care, and with providers of health services to facilitate and encourage maximum use by other programs of the uniform claims forms. The bill further requires the Secretary to report to the Congress within 21 months of enactment on: (1) what actions he will take pursuant to this section; (2) the degree of success in encouraging third parties generally to adopt uniform claims forms, and (3) his recommendations for legislative and other changes needed to maximize the use of such forms.

47. Medicare payment liability secondary where payment can also be made under accident insurance policy.—Under present law, medicare is ordinarily the payor of first resort except in certain cases, e.g., where the patient has no legal obligation to pay, or where workmen's compensation is responsible for payment for the patient's care.

On June 14, 1979, the committee agreed that where the medicare patient is involved in an accident and his care can be paid for under the insurance policy of the individual who was a fault, medicare would have residual and not primary liability. Under this proposal, medicare would pay for the patient's care in the usual manner and then seek to be reimbursed by the private insurance carrier after, and to the extent that, its liability has been determined. The committee also agreed to leave to the discretion of the Secretary the minimum amounts estimated as recoverable, so as to avoid the administrative cost and effort of pursuing minor recoveries.

48. Judicial review of decisions concerning groups of providers.—Under existing law, individual providers of medicare part A services may obtain Federal judicial review of adverse decisions of the Provider Reimbursement Review Board in the U.S. District Court for the district in which the provider is located, or alternatively in the U.S. District Court for the District of Columbia. Because of the language of the current statute, however, judicial review of these decisions involving groups of providers may be taken only in the U.S. District Court for the District of Columbia.

On June 20, 1979, the committee approved a provision to permit Federal judicial review of adverse decisions of the Provider Reimbursement Review Board invloving groups of providers of medicare part A services to be taken in the district where the representative appellant for the group is located (or in the District of Columbia, as provided in current law).

49. Resources of medicaid applicant to include assets disposed of at substantially less than fair market value.—Under present law, States which use the SSI criteria in determining medicaid eligibility for the aged, blind, and disabled may not impose transfer of assets restrictions on those applicants. Thus, an applicant who wants medicaid coverage can transfer assets which could be applied to the cost of medicaid-financed services and immediately become eligible for medicaid. This situation damages program credibility by allowing relatively

well-off individuals to become eligible for medicaid. It also increases program costs, especially for expenditures for institutional care. The aged, blind, and disabled account for some 64 percent of all program expenditures. They are most likely to need hospital, skilled nursing, and intermediate care facilitiy services which comprise of two-thirds of medicaid benefit costs.

Some 25 to 30 States are currently imposing restrictions on the transfer of assets on some medicaid groups but not on others. Title IV-A of the act does not prohibit such State eligibility conditions. Further, those States which choose to use the more restrictive standards for medicaid eligibility for the aged, blind, and disabled rather than the SSI criteria can impose this eligibility condition if they did so in January 1972.

The only way a State can impose restrictions on asset transfers by SSI recipients is to use the more restrictive standards of medicaid eligibility for the aged, blind, and disabled permitted under section 1902(f) of the Social Security Act. However, most States do not choose this option because they either contract with the Secretary (the Social Security Administration) under section 1634 of the Social Security Act to do medicaid eligibility determination of SSI recipients, or rely on the SSI eligibility lists transmitted from the Social Security Administration for making their own medicaid eligibility determinations.

On March 22, 1979, the committee agreed to section 24 of S. 505 (also section 13 of S. 507), which as modified authorizes States at their option to deny eligibility for medicaid in cases where an otherwise eligible aged, blind, or disabled person disposes of significant assets by giving them away or selling them for substantially less than their fair market value in order to establish medicaid eligibility. Any such transaction will be presumed to be for the purpose of establishing medicaid eligibility unless and until the individual submits adequate evidence to rebut that presumption. Where a State finds that a disposal of assets has occurred, the difference between the fair market value of the asset and the actual amount the individual received for it will continue to be considered as his asset for purposes of medicaid eligibility for a period of 12 months.

This authority would be administered by the States even though other elements of medicaid eligibility may be determined by the Social Security Administration under the agreements entered into pursuant to section 1634 of the Social Security Act.

50. Payment for laboratory services under medicaid.—The Comptroller General, in a July 1, 1978, report to the Congress, recommended that States be given greater latitude in paying for independent laboratory services under medicaid. States have been restrained in adopting cost-saving contract bidding and negotiated rates with laboratories by an interpretation of the present "freedom of choice" provision. That provision was intended to permit medicaid recipients to choose from among any qualified doctors, drugstores, etc. It was not intended to apply to the types of care or services, such as laboratory services, which the patient ordinarily does not choose.

On March 22, 1979, the committee agreed to section 27 of S. 505 (also section 20 of S. 507), which allows a State to purchase laboratory services for its medicaid population through competitive bidding

arrangements for a 3-year experimental period. Under this provision: (1) services may be purchased only from laboratories meeting appropriate health and safety standards; (2) no more than 75 percent of the charges for such services may be for services provided to medicare and medicaid patients; and (3) the laboratories must charge the medicaid program at rates that do not exceed the lowest amount charged to others for similar tests.

States have been restrained from adopting cost-saving contract bidding and negotiated rate arrangements with laboratories under their medicaid programs by an interpretation of the present "freedom of choice" provision of Federal law. That provision was intended to permit medicaid recipients to choose from among any qualified doctors, pharmacies, etc. It was not intended to apply to the types of care or services which the patient ordinarily does not choose.

Similarly, judicial interpretation of the "freedom of choice" provision has hampered cost-saving arrangements by States for the purchase under medicaid of medical devices (such as eyeglases, hearing aids and wheelchairs) even though these items often do not vary in quality from supplier to supplier. The committee approved an amendment which would permit States, at their option, to provide such services and items for medicaid purposes through competitive bidding or appropriate negotiated arrangements.

51. Authority for certain States to buy-in coverage under Part B of medicare for certain medicaid recipients.—The medicare law gave States until January 1, 1970, to request enrollment of their public assistance beneficiaries in part B of the medicare program. States that entered into these so-called "buy-in" agreements pay the part B premiums for the public assistance enrollees. The "buy-in" provision was designed to encourage the highest possible participation of the elderly in the part B program. Alaska, Louisiana, Oregon, Puerto Rico, and Wyoming did not make timely arrangements to enroll their public assistance beneficiaries in the part B program. On March 22, 1979, the committee approved section 38 to S. 505 which would give the States that wish to do so an additional period of 12 months in which they could elect to make the necessary coverage arrangements.

52. Extension of period for funding of State medicaid fraud control units.—Section 17 of P.L. 95–142 provided 90 percent Federal matching in fiscal years 1978–1980 for the costs incurred in the establishment and operation (including the training of personnel) of State fraud control units. The increased matching is subject to a quarterly limitation of the higher of $125,000 or one-quarter of 1 percent of total medicaid expenditures in such State in the previous quarter. This section is intended to encourage States to establish effective investigative units on the State level.

Some States have experienced delays in establishing State fraud control units and have therefore been unable to fully avail themselves of the increased Federal matching authorized under the law.

On March 22, 1979, the Committee approved section 14 of S. 507 which extends for two years (until October 1, 1982) the period when 90 percent Federal matching is available for the funding of State medicaid fraud control units. No State may receive such matching for longer than 3 years.

53. Federal advance payments to States.—Present Federal policies permit States to draw on Federal medicaid funds before they are actually needed to pay recipients. During the period between the time when the Federal funds are drawn by the State and the time when they are disbursed to medicaid recipients, about 12 days on the average, the funds can draw interest which accrues to the State. HEW has proposed that the gap should be eliminated in fiscal year 1980 in 10 States, producing a one-time saving of $240 million for Medicaid.

On June 14, 1979, the committee agreed to extend the new "checks paid" policy to all States before the end of fiscal year 1980. In States where a modification of State law is needed to implement this change, the effective date would be deferred until after the close of the next regular session of the State legislature.

54. Competitive bidding and negotiated rates under medicaid.—States have been restrained from adopting cost-saving contract bidding and negotiated rate arrangements with laboratories under their medicaid programs by an interpretation of the present "freedom of choice" provision of Federal law. That provision was intended to permit medicaid recipients to choose from among any qualified doctors, pharmacies, etc. It was not intended to apply to the types of care or services which the patient ordinarily does not choose.

Similarly, judicial interpretation of the "freedom of choice" provision has hampered cost-saving arrangements by States for the purchase under medicaid of medical devices (such as eyeglasses, hearing aids and wheelchairs) even though these items often do not vary in quality from supplier to supplier.

On June 14, 1979, the committee agreed to permit States, at their option, to provide such services and items for medicaid purposes through competitive bidding or appropriate negotiated arrangements.

55. Notification to State officials.—There have been instances where the Governors and chairmen of the appropriate legislative and appropriation committees in State legislature have not been informed on a timely basis of deficiencies or potential compliance issues involving Federal-State programs authorized under the Social Security Act.

On March 22, 1979, the committee approved section 17 of S. 505 which provides that if the Secretary notifies a State of any audits, quality control performance reports, deficiencies, or changes in Federal matching payments under programs authorized under the act, simultaneous notification would also be made to the Governor of the State and the respective chairmen of the legislative and appropriation committees of that State's legislature having jurisdiction over the affected program.

56. Waiver of human experimentation provision for medicare and medicaid.—Under current law, State medicaid programs may impose nominal cost-sharing requirements on medicaid eligibles. Recently, a State's cost-sharing experiment was challenged as a violation of regulations implementing the human experimentation statute. The challenge would effectively prevent any cost-sharing experiments under the medicaid program, and could seriously hinder other medicaid and medicare cost control efforts.

On March 22, 1979, the committee approved section 22 of S. 505 which waives requirements of the human experimentation statute

which may otherwise be held applicable for purposes of medicare and medicaid. For example, the bill waives such requirements with respect to experimentation involving coverage, copayment, deductibles or other limitations on payments for services.

The bill further provides that the Secretary, in reviewing any application for any experimental, pilot or demonstration project pursuant to the Social Security Act, would take into consideration the human experimentation law and regulations in making his decision on whether to approve the application.

The provision would apply only to medicare and medicaid reimbursement and administrative activities not designed to directly experiment with the actual diagnosis or treatment of patients.

57. HMO's enrolling over 50 percent medicare or medicaid recipients.—Present law prohibits a health maintenance organization (HMO) which contracts with a State to provide prepaid health services under medicaid from having more than one-half of its members covered by medicaid and medicare. HMO's are given 3 years from the date of their contract with the State medicaid program to meet this condition.

Occasionally, because of administrative delays by HEW in formally finding the HMO to be eligible, an HMO may have difficulty signing up nonmedicaid/medicare members by the end of that 3-year period, and thus be forced to reduce its coverage of medicaid beneficiaries in order to achieve the 50–50 requirements.

On March 22, 1979, the committee agreed to section 39 of S. 505 (also section 21 of S. 507), which provides that HMO's contracting with States would have up to 3 years after the date the HMO is formally found qualified by the Department of Health, Education, and Welfare to meet the 50-percent requirement.

58. Demonstration projects for training and employment of AFDC recipients as homemakers and home health aides.—It is estimated that as many as 40 percent or more of the aged and disabled persons now in high cost skilled nursing facilities and intermediate care facilities do not necessarily have to be there—and would not be there if proper alternatives supportive services were available. Most would prefer to live in familiar surroundings in which they can retain their sense of independence and dignity.

At the same time there are many persons currently on the welfare rolls who, if they received proper training, could become gainfully and usefully employed members of the health professions.

On March 22, 1979, the committee approved section 22 of S. 507, which authorizes the Secretary of HEW to enter into agreements with up to 12 States, selected at his discretion, for the purpose of conducting demonstration projects for the training and employment of AFDC recipients as homemakers or home health aides. Priority would be given to those States which have demonstrated active interest and effort in supporing the concept. Full responsibility for the program would be given to the State health services agency (which may be the State medicaid agency) designated by the Governor.

The program is completely voluntary; an AFDC recipient is under no obligation to enroll and does not risk loss of AFDC funds by refusing to participate. Persons eligible for training and employment would

be only those who were continuously on the AFDC rolls for the 90-day period preceding application. Those who enter a training program would be considered to be participating in a work incentive program authorized under part C of title IV of the Social Security Act. During the first year such individual is employed under this program, he or she shall continue to retain medicaid eligibility and any eligibility he or she had prior to entering the training program for social and supportive services provided under part A of title IV. The individual will be paid at a level comparable to the prevailing wage level in the area for similar work. Federal funding will not be available for the employment of any eligible participant under the project after such participant has been employed for a 3-year period.

A State participating in a demonstration project would be required to establish a formal training program which must be approved by the Secretary as adequate to prepare eligible participants to provide part time and intermittent homemaker services and home health aide services to individuals, primarily the aged and disabled, who would, in their absence, be reasonably anticipated to require institutional care. The State would provide for the full-time employment of those who have successfully completed the training program with one or more public agencies or by contract with nonprofit private agencies. The numbers of people in a State eligible for training and employment would be limited only by their ability to be trained and employed as well as by the number of those in need of home health and homemaker services.

Persons eligible to receive home health and homemaker services are the aged, disabled, or others, such as the retarded, who are in need of such services. They must be those for whom such services are not reasonably and actually available and who would otherwise reasonably be anticipated to receive institutional care. Participating States would be required to provide for independent professional review to assure that services are provided to individuals actually needing them. Eligibility for services would be extended to individuals whose income is less than 200 percent of the State's need standard under the AFDC program for households of the same size.

The type of services included as homemaker and home health aide services include part time or intermittent: personal care, such as bathing, grooming, and toilet care; assisting patients having limited mobility; feeding and diet assistance; home management, housekeeping and shopping; family planning services; and simple procedures for identifying potential health problems. Authorized services do not include any service performed in an institution or any services provided under circumstances where institutionalization would be substantially more efficient as a means of providing such services.

Ninety percent Federal matching would be provided for the reasonable costs (less any related fees collected) of conducting the demonstration projects. Such amounts would be paid under the State's medicaid program. Demonstration projects would be limited to a maximum of 4 years plus an additional period up to 6 months for planning and development and a similar period for final evaluation and reporting. The Secretary would be required to submit annual evaluation reports to the Congress and a final report not more than 6 months after he has received the final reports from all the participating States.

59. Grants to regional pediatric pulmonary centers.—Pediatric pulmonary centers train health care personnel in the prevention, diagnosis, and treatment of respiratory diseases and provide needed services for children and young adults suffering from such diseases

On March 22, 1979, the committee approved section 21 or S. 505 which authorizes up to $5 million annually for grants to public or nonprofit private regional pediatric pulmonary centers which are part of (or affiliated with) institutions of higher learning. This section of the bill is identical (except for effective dates) to an amendment approved by the Senate in 1972 and 1978.

III. Other Actions

1. Appointment of HCFA Administrator (S. 508).—The Health Care Financing Administration (HCFA) is the agency in the Department of Health, Education, and Welfare responsible for administration, cordination, and policymaking for the medicare and medicaid programs. It was established by the Administration in early 1977 in order to provide the means for the orderly consolidation and coordination of these two major health programs.

The Administrator of this agency should be an individual experienced and knowledgeable in health care and health care financing with full awareness of the complexity of the issues involved. This position includes responsibility for both medicare and medicaid. The Administrator of the Social and Rehabilitation Service (an office now terminated) required appointment by the President and confirmation by the Senate primarily because of his responsibility for medicaid. The comparable position of the Commissioner of Social Security requires Presidential appointment and Senate confirmation.

On March 22, 1979, the committee approved the provisions of S. 508, which would provide for the Administrator of the Health Care Financing Administration to be appointed by the President with the advice and consent of the Senate. The provision would apply to individuals appointed to the position after the date of enactment.

2. Report on home health and other in-home services (S. Res. 169).—Section 18 of Public Law 95–142 required the Secretary of HEW to submit a report to Congress analyzing, evaluating, and making recommendations on all aspects of the delivery of home health and other in-home services provided under titles XVIII, XIX, and XX of the Social Security Act. The report was also to include an evaluation of the coordination of such services under the different titles, along with recommendations for changes in regulations and legislation on the scope of services provided, eligibility requirements, standards for provider certification, utilization control and quality assurance, reimbursement methods, and the prevention of fraud and abuse. As submitted, the HEW report does not contain the required recommendations for legislative changes.

On June 27, 1979, the committee favorably reported Senate Resolution 169 (S. Rept. 96–233), (1) expressing the sense of the Senate that the HEW report on home health and other in-home services is not responsive to the requirements set forth in Public Law 95–142, and (2) returning it with the direction that it be revised.

○