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REPORT
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AMENDING TITLE XVIII OF THE SOCIAL SECURITY ACT

DECEMBER 12, 1975.—Ordered to be printed

Mr. LONG, from the Committee on Finance, submitted the following

REPORT

[To accompany H.R. 10284]

The Committee on Finance, to which was referred the bill (H.R. 10284) to amend title XVIII of the Social Security Act to assure that the prevailing fees recognized by medicare for fiscal year 1976 are not less than those for fiscal year 1975, to extend for 3 years the existing authority of the Secretary of Health, Education, and Welfare to grant temporary waivers of nursing staff requirements for small hospitals in rural areas, to maintain the present system of coordination of the medicare and Federal employees' health benefit programs, and to correct a technical error in the law that prevents increases in the medicare part B premiums, having considered the same, report favorably thereon with amendments and recommend that the bill as amended do pass.

I. SUMMARY OF THE BILL

H.R. 10284 as passed by the House contained provisions relating to prevailing charges, nursing requirements in rural hospitals, the relationship between medicare and the Federal employee health program, and the medicare part B premium. The committee amendment incorporates these provisions, with some modifications, and adds a number of new provisions.

PREVAILING CHARGE DETERMINATIONS UNDER MEDICARE

Due to the late issuance of regulations implementing the provision in law intended to limit increases in physicians' prevailing fees from year-to-year, some physicians' fees have unintentionally been rolled back to a point below their previous level. The first provision of the House bill would assure that no prevailing charge in fiscal year 1976 is less than it was in fiscal year 1975. The committee amendment modi-

fies the House provision to indicate that, in calculating the index by which physicians' prevailing fees can increase, the Department should include, to the extent feasible, factors related to any increases in costs of malpractice insurance and that index calculations should be prepared on a regional rather than a national basis.

WAIVER OF 24-HOUR NURSING REQUIREMENTS FOR CERTAIN RURAL HOSPITALS

The second provision of the House bill extends for 3 years (until December 31, 1978) the Secretary's authority to grant temporary waivers of nursing staff requirements in hospitals located in areas where nurses are in short supply and other hospitals are not readily accessible. The committee amendment provides instead for a 1-year extension of the waiver authority.

RELATIONSHIP BETWEEN MEDICARE AND FEDERAL EMPLOYEES HEALTH BENEFIT PROGRAM

The House bill would repeal a provision of Public Law 92-603 which provides that, unless the Federal employees' health program were rewritten to provide supplementary benefits to those older or retired Federal employees who also have medicare eligibility, the medicare program would no longer serve as the primary payer of benefits. The committee amendment incorporates this change, so that the medicare program would continue as the primary payer of benefits without requiring any change in the Federal employees' program.

MEDICARE PART B PREMIUM

The fourth provision of the House bill, included in the committee amendment, would correct a drafting error in Public Law 93-233 which, in modifying the social security cash benefit provision, had unintentionally failed to make corresponding changes allowing for annual changes in the part B medicare premium. The provision would correct this drafting error and permit adjustments in part B premiums on July 1, 1976 and in future years at rates no greater than the percentage rate of increase in cash social security benefits.

In addition, the committee amendment includes the new provisions described below.

PROFESSIONAL STANDING REVIEW ORGANIZATIONS (PSRO) AREA DESIGNATIONS

The committee amendment provides that in those States (1) which have been divided into more than one PSRO area, and (2) in which no conditional PSRO's have been designated, the Secretary would poll the physicians in each designated area as to their preference for a local or statewide PSRO. If a majority of physicians in each currently designated PSRO area in that State approved a statewide PSRO, the Secretary would redesignate that State as a single area.

PSRO DIRECT UTILIZATION REVIEW ACTIVITIES

The committee amendment also contains a provision aimed at equalizing the reimbursement for utilization review activities where they

are carried out by a hospital under delegation from a PSRO or by the PSRO itself. Under current law, utilization review expenditures are reimbursable by medicare for delegated review. Under this provision, utilization review expenses of the PSRO in carrying out nondelegated review would also be reimbursable through medicare benefit payments.

MEDICARE PAYMENTS TO VETERANS' ADMINISTRATION HOSPITALS IN CASE OF "GOOD FAITH" ERROR

Under this committee provision, the medicare program would be authorized to pay for care rendered to a medicare-eligible patient in a Veterans' Administration hospital if the patient had entered the hospital and the hospital had accepted the patient under the belief that he was eligible for veterans' benefits, and it was later determined that he was not eligible.

UPDATING OF THE LIFE SAFETY CODE REQUIREMENTS APPLICABLE TO SKILLED NURSING FACILITIES

The next committee provision would update the current requirements for skilled nursing facilities under the medicare and medicaid programs by replacing the current requirement that such facilities meet the provisions of the 1967 Life Safety Code with a requirement that they meet the conditions of the 1973 edition of the code. The provision would also assure that facilities currently qualified under the 1967 code, or State codes which are approved by the Secretary, would not lose their eligibility for participation in the programs.

GRANTS TO DEMONSTRATE APPROPRIATE MECHANISMS FOR CAPITATION PAYMENTS

Another committee provision would remove a technical barrier to the Secretary's approval of a grant to the Sacramento Medical Care Foundation which is aimed at obtaining data to assist the Department in developing appropriate reimbursement mechanisms for health maintenance organizations.

OCCUPATIONAL THERAPY UNDER MEDICARE

The committee amendment includes a provision to expand coverage of occupational therapy services under the medicare program to cover such services when they are provided through clinics, rehabilitation agencies and other organized settings. The provision also allows patients to qualify for home health services on the basis of a need for occupational therapy services alone.

FOOD STAMP PURCHASES BY WELFARE RECIPIENTS

Another provision of the committee amendment to H.R. 10284 relates to food stamps. Agriculture Department regulations scheduled to go into effect in January 1976 will require welfare agencies in all States to allow recipients of Aid to Families with Dependent Children (AFDC) to purchase food stamps through a withholding procedure. The price of the stamps would be deducted from the AFDC check and the stamps themselves would be mailed with the check. Current law requires the Department to impose this procedure on the States on a mandatory basis even though a significant number of States

believe that the adoption of this procedure will create severe problems of administration. The committee amendment will allow each State to decide whether or not to use this method of distributing food stamps to welfare recipients.

II. General Explanation of the Bill

Prevailing charge determinations under medicare

(Section 1 of the Bill)

The committee concurs in the House provision to avoid any rollback in allowable medicare fees which have occurred in fiscal year 1976. In addition, the committee is concerned that the administrative policies that HEW has adopted to carry out the economic index provisions do not conform to the legislative intent and result in reasonable charge ceilings which may unfairly benefit individuals in some areas while disadvantaging others. The legislative history of the 1972 amendments clearly intended that indexes be calculated separately for "areas of a size and nature permitting proper calculation and determination of the types required to adjust prevailing change levels." The objective of requiring at least regional indices was to assure that changes in office practice costs (including malpractice premiums) and general earnings levels that take place in varying areas, be reflected in the ceilings placed by the index or increases in physicians' allowable fees.

Nevertheless, HEW regulations provide for the establishment of a single, national index applicable to all physicians. Therefore, the committee has included in the bill a provision requiring the Secretary of HEW to submit a report to the Finance Committee and to the House Committee on Ways and Means explaining why it has not complied with the legislative intent by establishing separate indices on other than a national basis (certainly in at least 10 regions) and the steps that the Department is presently taking to conform to the legislative intent. If necessary, the committee would expect the Department to include in its report any recommendations as to remedial legislation which might be necessary to further implement congressional intent with respect to this provision. The report would be due 90 days after the date of enactment.

The committee has also noted that HEW has based the earnings component of the index on changes in the earnings of production and nonsupervisory workers. The committee expects that social security data be used to measure changes in general earnings levels because social security covers substantially all wage earners and self-employed people. The choice of the more limited data by HEW makes the index nonrepresentative of the earnings level of the general population. The report from the Secretary of HEW will also explain its choice of data on earnings and the steps it is taking to make the data base more representative.

Extension of authority to waive 24-hour nursing service requirements for certain rural hospitals

(Section 2 of the Bill)

In order to participate in the medicare program, providers and suppliers of health services must comply with specific requirements

set forth in the statute and with other conditions pertaining to the health and safety of medicare beneficiaries which the Secretary of Health, Education, and Welfare is authorized, by statute, to prescribe.

According to policy established by the Social Security Administration, a hospital is certified for participation in medicare if it meets all of the statutory requirements and is in "substantial" compliance with all regulatory requirements. Thus, while an institution may be deficient with respect to one or more regulatory requirements, it still may be found to be in substantial compliance, if the deficiencies do not represent a hazard to patient health and safety, and efforts are being made to correct the deficiencies.

In recognition of the fact that there is a need to assure continuing availability of medicare-covered institutional care in rural areas (many of which have only one hospital) without jeopardizing the health and safety of patients, the Social Security Administration follows the approach of certifying "access" hospitals which, to the extent they are capable have succeeded in overcoming deficiencies. Access hospitals are those located in isolated areas or in areas with insufficient facilities, the failure of which to approve for medicare reimbursement would seriously limit the access of beneficiaries to needed inpatient care.

However, during the 91st Congress, it became apparent that several hundred rural hospitals, despite proper efforts were unable to secure required nursing personnel and were thus unable to meet the statutory requirement for 24-hour registered nurse coverage.

To deal with the dilemma created by the need to assure the availability of hospital services of adequate quality in rural areas and the fact that existing shortages of qualified nursing personnel were making it difficult for several hundred rural hospitals to meet the nursing staff requirements and come into compliance with the law, legislation (H.R. 19470, Public Law 91–690) was enacted to authorize the Secretary of HEW, under certain conditions, to waive the requirement that an access hospital have registered professional nurses on duty around the clock.

Under this amendment, the Secretary is given the authority, until December 31, 1975, to waive the nursing requirement if he finds that:

(*a*) the hospital is located in a rural area and the supply of hospital services in the area is not sufficient to meet the needs of medicare beneficiaries residing therein;

(*b*) the failure of the institution to qualify as a hospital would seriously reduce the availability of services to beneficiaries; and

(*c*) the hospital has made and continues to make a good faith effort to comply with the nurse staffing requirement, but compliance is impeded by the lack of qualified nursing personnel in the area.

While the House report notes that there has been considerable progress in reducing the number of "waivered" hospitals (presently 90), there are approximately 40 additional rural hospitals, while able to meet the statutory nurse staffing requirement, have major regulatory deficiencies. Such hospitals are also certified as "access" hospitals.

Based upon a 1974 study funded by the Department of Health, Education, and Welfare, besides those formally identified access hospitals, there are approximately another 400 rural hospitals with essentially

the same attributes, which have managed to meet certification requirements either through extraordinary efforts by the hospital or through lenient application of standards by the medicare surveyors.

Further, with respect to the specific problem of nurse staffing, there are indications in some States of licensure requirements which may tend to restrict the flow of nurses into shortage areas. For example, in one State, where approximately 50 percent of the "waivered" hospitals are located, the requirements for nurse licensure include, among other things, graduation from an accredited program in professional nursing of at least 2 *calendar* years in length. It is important to note that, of the 574 accredited associate degree programs in the United States, 486 are programs of 2 *academic* years. Accordingly, the State is able to draw from less than 20 percent of the schools which offer associate degrees in nursing. It appears inconsistent to the committee for a State with an identified nurse shortage to have, at the same time, what may be questionable licensure barriers against increasing the supply of nurses.

In the opinion of the committee, the inability to attract qualified nursing personnel is only one of several problems facing rural hospitals in providing health care services. Accordingly, the committee feels that there should be a review of all the conditions of participation imposed upon rural hospitals, as well as barriers to the flow of nurses into shortage areas.

Inasmuch as the Department of HEW completed an in-depth study of access hospitals in June, 1974, the committee feels that a further study as requested in the House report is unnecessary at this time, and that a 3-year extension of the waiver authority as provided for in the bill would serve to delay a more permanent solution to the access hospital problem. The committee has therefore approved a 1-year extension of the waiver authority and has asked committee staff to work with other committees and appropriate health organizations toward developing recommendations for legislative changes designed to establish specific rural hospital certification requirements commensurate with staff and facilities in rural areas.

RELATIONSHIP BETWEEN MEDICARE AND FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

(Section 3 of the Bill)

The statute (section 1862(c) of the Social Security Act) calls for medicare to stop making payment, as of January 1, 1976, for services furnished to a beneficiary for which he also has coverage under the Federal Employees' Health Benefits (FEHB) program. The January 1, 1976, deadline is the result of a provision, originated by the Committee on Ways and Means, that was included in the 1972 Social Security Amendments (Public Law 92-603.). It was designed to focus attention on the need to consider improved coordination of medicare and the FEHB program.

Many Federal employees and retirees over 65 have worked long enough in employment covered by social security to become insured for benefits under part A of medicare. (Part B is available to everyone over age 65 except recent immigrants.) The Civil Service Commission estimates that by June 1976 about 258,000 FEHB enrollees, or 50

percent of the enrollees age 65 and over, and 150,000 dependents will be covered by medicare part A.

At present, when a person who has such dual entitlement receives health care, medicare acts as the primary insurer and makes payment first for the covered services; thereafter, the FEHB plan in which the person is enrolled makes payment, but only to the extent that medicare has not already paid for the services covered by the FEHB plan. Although medicare thus bears a major share of the dually entitled person's health care costs, the person pays the same FEHB premium as people not entitled under medicare.

Because of overlapping benefits, many Federal employees and retirees age 65 and over have not found it advantageous to enroll in medicare part B. As a result, they do not benefit from the general revenue contribution (equalling more than half of the program's cost) which is available to all who enroll in part B.

Section 210 of Public Law 92–603 (October 30, 1972) amended title XVIII of the Social Security Act by adding a new subsection 1862(c) prohibiting payment by medicare, on or after January 1, 1975, for any item or service covered by an FEHB plan in which the medicare beneficiary was enrolled, unless prior to that date the Secretary of HEW was able to certify that the individual FEHB plan in question or the entire FEHB program had been modified in specified ways. The intent of this provision was described in the report of the Committee on Ways and Means as "to assure a better coordinated relationship between the FEHB program and medicare and to assure that Federal employees and retirees age 65 and over will eventually have the full value of the protection offered under medicare and FEHB."

To comply with this provision, the modifications in FEHB would have had to assure the following:

1. That one or more FEHB plans supplementing medicare protection are available to each Federal employee or retiree who is entitled to medicare parts A or B, or both A and B, and

2. That the Government or the FEHB plan will make available to each such individual a contribution at least equal to the contribution the Government makes toward the high-option coverage of any enrollee in the Government-wide FEHB plans. This contribution could be in the form of (a) a contribution toward the individual's FEHB protection supplementing medicare, or (b) a payment to offset the premium cost of part B of medicare, or (c) a combination of the two.

In the fall of 1974, when it became apparent that not enough progress toward coordination had been made to permit the requirements of subsection 1862(c) to be complied with by January 1, 1975, the effective date was extended for 1 year, to January 1, 1976, by Public Law 93–480 (October 26, 1974). The extension was conditional upon submission, no later than March 1, 1975, by the Department of HEW and the Civil Service Commission of a progress report (in the absence of which the effective date would have been July 1, 1975).

The report jointly submitted by the DHEW and the CSC pursuant to Public Law 93–480 pointed out a number of problems that it said would result from efforts to comply with all the requirements of section 1862(c), and proposed instead an alternative plan for coordination of the medicare and FEHB programs that would require amendment of both the medicare law and the FEHB Act.

Under the proposal, an FEHB medicare supplement option would be made available where the FEHB enrollee or a member of his family is covered by both parts A and B of medicare. The Government would pay 100 percent of the premium for this medicare supplement so long as this did not exceed the maximum dollar amount the Government pays with respect to other FEHB enrollees. For at least the first year, the enrollee would not have to pay any premium. The supplement, together with medicare, would cover up to 100 percent of expenses for a medicare beneficiary; for other family members, the regular high-option benefits of the FEHB plan would be provided.

The increased cost of this proposal to the Government is estimated for calendar year 1976 as $48 million ($39 million in increased FEHB contributions, and $9 million in increased general revenue contributions for medicare part B which would result from increased enrollment in part B by FEHB enrollees). Also, an additional $13 million in increased premiums would be paid by nonmedicare FEHB enrollees (their premiums would no longer reflect the reduction in FEHB program costs that results because medicare makes payment first for FEHB enrollees who have medicare coverage).

The committee has carefully considered this proposal by the administration as well as an alternative suggested in a report by the Comptroller General on the coordination issue—that the Government simply pay medicare part B premiums for all eligible FEHB enrollees. (The Comptroller General's report also suggested consideration of continuing without change the existing system for coordinating the benefits of the two programs.) The substantial costs of these proposals need to be weighed against the increased benefit protection or improved equity they would provide for people covered under both FEHB and medicare.

In general, the medicare supplements provided under FEHB today are richer than those offered to medicare beneficiaries under group health insurance plans in private industry. The coordination methods used by the various FEHB plans differ, but in general, after medicare makes payment, the FEHB plan pays for the services it covers in an amount that ordinarily will result in full coverage of most of the charges. Usually, enrollment in the low option of an FEHB plan (rather than the more costly high option) will achieve this result. The CSC has been advising medicare beneficiaries, during FEHB open enrollment periods, that low-option plans will in most cases adequately supplement both parts of medicare at lower cost than the high option.

Since section 1862(c) was enacted, the standard Government contribution toward FEHB premiums has increased from 40 to 60 percent of the total premium, and proposals have been made to increase the Government contribution again in future years. Medicare beneficiaries, as well as other FEHB enrollees, have benefited from this increased contribution.

Although it can be argued that more generous provisions than now exist for coordination of FEHB and medicare are merited, the committee is not convinced that equity requires the Government to substantially increase its expenditures under the two programs in an effort to accomplish this. It should be noted that Federal employees who have acquired medicare insured status have generally done so by

splitting their careers between Federal and private employment or by moonlighting, rather than through a lifetime of work covered under social security. Some offsetting of the benefits of one program against the other, such as now exists, seems justified in view of the major contributions the Government makes toward the financing of both programs.

The committee has therefore concluded that the existing relationship between the medicare and FEHB programs should be maintained. Accordingly, the bill would repeal section 1862(c) of the Social Security Act.

MEDICARE PART B PREMIUM

(Section 4 of the Bill)

The current monthly premium charged for part B of medicare is permanently frozen at $6.70 (the same amount as for last year) because of a technical error in the law that prevents the premium from being increased even though the Congress clearly intended to permit increases on July 1 of each year. The intention was to permit premium increases corresponding with increases in program costs, but limited to a maximum percentage increase no greater than the percentage by which monthly social security benefits have increased during the year.

Part B of medicare—the voluntary medical insurance part of the medicare program covering physicians' and certain other health services—has since its inception been financed through a combination of monthly premiums paid by beneficiaries who choose to enroll and matching payments from Federal general revenues. For the great majority of beneficiaries, the medicare premium is deducted each month from the social security benefit check.

The amount of the premium is determined through a calculation that begins with the cost of providing part B protection to beneficiaries age 65 and over. The premium was originally designed to equal one-half of this cost, but subsequent legislation enacted in 1972 limited the maximum premium increase each year to the percentage by which monthly social security benefits increased. (Beneficiaries under age 65 who are covered by part B by virtue of their status as social security disability beneficiaries or as end-stage renal disease patients pay the same premium as the aged, even though the cost of providing benefits to them is far greater.)

The technical error, freezing the premium, occurred when Public Law 93–233, enacted December 31, 1973, modified the schedule for automatic increases in social security cash benefits, but unintentionally failed to make corresponding changes in the provisions that relate percentage increases in the medicare part B premium to increases in cash benefits. Federal general revenues are used to finance whatever part of the cost of part B is not met through premiums paid by beneficiaries. So long as the premium amount remains frozen, the proportion of part B costs financed by general revenues will continue to rise.

The committee recognizes that many people would prefer not to allow the part B premium to increase at a time when the elderly, as well as others, are feeling the effects of inflation in health care costs. Failure to increase the premium, however, results in millions of dollars

of increased general revenue expenditures in future years. If such amounts were to be expended, the money might better be used to provide some improvement in benefit protection.

The committee's bill would correct the technical error in the law by changing from June 1 to May 1 the date used in determining the percentage increase from one year to the next in social security benefit levels, to arrive at the maximum percentage by which the medicare premium may be increased. The premium increase would be determined and promulgated in December of each year as under present law and the increased premium would be deducted from the same benefit check that reflects a cash benefit increase under the provisions for automatic increases in social security benefits. Thus, as intended by the Congress in enacting Public Law 93–233, premium increases would not result in reducing the amount of the monthly checks received by beneficiaries (because both a benefit increase and a very much smaller premium increase would be reflected in the same check).

Because of the technical error, the monthly premium has remained at $6.70 for the 12-month period beginning July 1, 1975, instead of increasing. The committee bill would not attempt to "catch up" by permitting 2 years' worth of benefit increases to be reflected in the single increase for the year beginning July 1, 1976. Instead, that premium increase would reflect only 1 year's increase in social security cash benefits.

Thus, the present $6.70 premium would go up only 50 cents on July 1, 1976, the same date that the social security benefit checks will be increased by reason of the automatic cost-of-living provisions in title II of the Social Security Act. Current estimates are that cash social security benefits will be increased by about 7 percent for the checks that are mailed early in July. The minimum dollar increase would be several times the 50-cent increase in the premium which is deducted from the same check in which the general benefit increase appears.

PROFESSIONAL STANDARDS REVIEW ORGANIZATION AREA DESIGNATIONS

(Section 5 of the Bill)

Under present law, the Secretary of Health, Education, and Welfare is required to and has, in fact, designated geographic areas in the several States as "Professional Standards Review Areas." There are 203 such areas in the country. In more than one-half of these areas, physician-sponsored organizations have formally contracted with the Secretary as either designated PSRO's with operating responsibility (64 organizations as of this date) or planning PSRO's (56 as of this date).

There are, however, a number of States in each of which multiple PSRO areas have been designated, and in which no formal PSRO relationships have been established. It is the committee's understanding that the development of PSRO's in those States has, in large part, been inhibited by widespread physician concern over their inability to establish a single statewide PSRO rather than the presently required multiple PSRO's.

The committee amendment would, under certain circumstances, eliminate the barrier to designating a single statewide PSRO area in a

number of States where multiple areas now obtain. The amendment requires the Secretary to conduct, as soon as possible, separate polls in each of the presently designated areas of a State with multiple areas if in no area of that State, as of the effective date of this act, has the Secretary designated and entered into an agreement with an organization as the Professional Standards Review Organization. As has been noted, the Secretary has so designated and entered into such agreements with more than 60 organizations thus far.

The physicians in each presently designated local area meeting the conditions described would be polled, on a confidential basis, as to whether they were willing to forego the local designation in favor of a statewide area. If in each presently designated local area a majority of the physicians responding opt for the statewide designation, then the Secretary would be required to redesignate and consolidate the multiple areas into a statewide area. Thus, if a majority of the physicians elect a change in every presently designated local area in a State, the Secretary would follow up with statewide designation. If, however, a majority of physicians in an area elect to retain the local designation then the present multiple area designations in that State would continue.

PSRO DIRECT UTILIZATION REVIEW ACTIVITIES

(Section 6 of the Bill)

Public Law 92–603 established Professional Standards Review Organizations (PSRO's) throughout the country. These organizations, consisting of practicing physicians in an area, are charged with reviewing the quality and necessity of health services provided under the medicare and medicaid programs.

The PSRO's may discharge their review responsibilities with respect to hospitals in two ways: first, they can delegate their review responsibilities to hospital review committees where the PSRO is satisfied as to the capacity of the hospital to conduct proper review (in which case the PSRO is charged with the responsibility to continuously monitor the effectiveness of the hospital review committee); alternatively, the PSRO's can carry out the review activities on their own in those cases and, to the extent that a hospital either cannot conduct satisfactory review or chooses that the PSRO perform the review for it.

Under present law, where the PSRO delegates review responsibility to a hospital committee, the costs of that review are reimbursed through Medicare and Medicaid benefit payments to the hospital since these costs are considered a part of the hospital benefit cost. However, where the PSRO does not delegate review to a hospital, the PSRO must bear the cost of the review out of its own administrative budget.

Since PSRO administrative budgets are often quite limited, the PSRO's in effect have an incentive to delegate review so that they will not have to bear the cost—conversely, they have a disincentive to perform review directly. The result of this may be inappropriate or premature delegations of review authority to hospitals which are not really competent or willing to carry out the review.

The committee amendment would allow the medicare benefit trust fund to pay not only for delegated review to the hospitals, but to also pay the PSRO through the hospital for nondelegated hospital review.

This would equalize reimbursement treatment of review activities. The payment in the case of nondelegated review would flow from the hospital to the PSRO following billing by the PSRO on a prospective or retroactive basis with the hospital then fully reimbursed for the total amount of the charge (without any requirement of allocation) by the intermediary for such payments under guidelines established by the Bureaus of Health Insurance and Quality Assurance defining the amount and circumstances of such charges. The Federal agencies, and not the hospitals or intermediaries, would be responsible for assuring the appropriateness and reasonableness of PSRO charges for direct utilization review.

Further the committee anticipates that in order to completely eliminate any financial incentive either for or against the delegation of review responsibility and authority by a PSRO to a hospital, existing medicare policies of the Bureau of Health Insurance will be modified to provide that a separate cost center be established by a hospital to clearly identify the reasonable costs of required review activities. It is expected that for medicare and medicaid reimbursement purposes (whether such review be conducted under a delegation by a PSRO to a hospital review committee, or directly by the PSRO), 100 percent of the reasonable costs incurred in the reasonable review of medicare, medicaid, and material and child health patients admitted to the hospitals concerned shall be recognized as a direct cost of such programs without requirement of any apportionment of the review costs among patients of the institution for whom such costs had not been incurred.

Of course, in the case of the costs of any review and related activities which have customarily been undertaken as a routine aspect of medical staff privileges in a hospital any costs for such work (such as that of hospital tissue and formulary committees, etc.) are not intended to be compensated on other than an apportionment basis.

This amendment also provides for the transfer of funds for medicaid appropriations to the medicare trust fund to reimburse the trust fund for funds expended for PSRO nondelegated review of medicaid patients.

MEDICARE PAYMENTS TO VETERANS' ADMINISTRATION HOSPITALS IN CASE OF "GOOD FAITH" ERROR

(Section 7 of the Bill)

Under present law, payments may not be made under part A of medicare to any Federal provider of services, such as a Veterans' Administration hospital, where such institution is otherwise obligated by law to render care at public expense.

The committee has had its attention called to circumstances in which an individual, entitled to part A benefits, was admitted to a veterans' hospital with both the hospital and the beneficiary believing the patient was eligible for such care and was subsequently found to be ineligible for care as a veteran. Following such a determination, the Veterans' Administration is required, by law, to recover the costs of such care from the patient (or his estate, if the patient is deceased).

The committee amendment would permit payment by the medicare program to VA hospitals for care rendered to a part A beneficiary in certain circumstances. Payment may be made only when (1) the beneficiary is admitted to the VA facility in the reasonable belief that he

is entitled to have service furnished to him by the VA free of charge; (2) the authorities of such hospital and the beneficiary acted in good faith in making such admission; (3) that the beneficiary is, in fact, not entitled to care in the facility free of charge; and (4) the care was provided while those operating the facility remained unaware of the fact that the individual was not eligible for VA benefit or before it was medically feasible to arrange a transfer or discharge.

Payment for services would be in an amount equal to the charge imposed by the Veterans' Administration for such services, or (if less) reasonable costs for such services (as estimated by the Secretary following consultation with the Chief Medical Director of the Veterans' Administration).

UPDATING OF THE LIFE SAFETY CODE REQUIREMENTS APPLICABLE TO SKILLED NURSING FACILITIES

(Section 8 of the Bill)

Under present law, skilled nursing facilities participating in the medicaid and medicare programs must meet such provisions of the Life Safety Code of the National Fire Protection Association (21st edition, 1967) as are applicable to nursing homes. The committee amendment would update medicare and medicaid requirements by deleting the reference to the 1967 edition of the Code and adding the 1973 edition. The amendment would also assure that facilities currently qualified under the 1967 Code or State codes which are approved by the Secretary, would not lose their certification status due to any changes in requirements imposed by the 1973 edition of the Code.

GRANTS TO DEMONSTRATE APPROPRIATE MECHANISMS FOR CAPITATION PAYMENTS

(Section 9 of the Bill)

Under present law the various State medicaid programs can make capitation payments to Health Maintenance Organizations (HMO's) which contract in advance to provide services to enrolled medicaid recipients. The use of this type of arrangement has occurred most prevalently in the State of California.

Over recent years, audits by the General Accounting Office and extensive investigative activities by the Senate's Government Operations Committee have shown that the basis on which payments have been made to these organizations is not necessarily reasonable. Officials of the State of California have agreed with this judgment and have applied to the Department of Health, Education, and Welfare for a grant in order to support a program to develop appropriate mechanisms to measure the true cost of providing health care services through HMO's and to measure the quality of services so provided. The results of this HEW-grant-supported project would be used to structure a reasonable payment mechanism for HMO's in California and other States.

One key aspect of the project for which HEW grant support has been sought would include measuring the costs of providing care in an individual practice association—a type of HMO which, while receiving prepaid capitation payment from the State, would continue to pay its member physicians on a fee-for-service basis.

State officials maintain that cost data from this type of HMO is essential to any valid study.

There is one large-scale operating independent practice association in the State, the Sacramento Foundation for Medical Care. This foundation involves over 800 physicians and 20 hospitals and is providing prepaid health services to more than 36,000 medicaid enrollees. Because of an unalterable fixed payment rate set by State law, the State has been unable to pay the foundation an amount fully equal to the costs of providing care for the medicaid enrollees. However, State officials want to pay the foundation a rate sufficient to cover its costs so that it can continue to operate and so that its unique costs data can be used as a part of the overall study.

A problem has arisen in that the General Counsel of HEW has ruled that the section of the social security law which authorizes cost and quality evaluation studies does not allow for any funding of costs already incurred for providing patient care.

This provision would clarify existing law and congressional intent so as to specifically allow in this case for the payment of such retroactive costs where these payments are necessary to assure that the individual practice association can continue in a study, carried out by a State agency aimed at developing a rate setting methodology for HMO's.

The total grant from HEW to the State of California would call for payments of approximately $5.2 million. Of this amount, approximately $1.6 million will be used for conducting the rate setting experiment with the foundation and approximately $700,000 of this $1.6 million will be used to reimburse the foundation for health services provided from July 1 to December 31, 1975.

OCCUPATIONAL THERAPY UNDER MEDICARE

(Section 10 of the Bill)

Under present law, occupational therapy services are covered under part A when provided to medicare beneficiaries who are inpatients in medicare-approved hospitals or skilled nursing facilities. Patients receiving home health services under part A or part B are entitled to occupational therapy services only if they are receiving either intermittent skilled nursing care or physical or speech therapy. In addition to coverage as part of home health services, occupational therapy services are covered under part B only when provided to outpatients in medicare-approved hospitals. Occupational therapy services provided to outpatients in a clinic, rehabilitation agency or other organized setting are not now covered.

The committee is concerned that present law treats occupational therapy differently from physical or speech therapy on two grounds. First, occupational therapy services are not covered when outpatient services are provided through clinics and organized health settings, although physical and speech therapy services are covered in such settings. Second, patients cannot receive occupational therapy through a home health agency unless they also require skilled nursing services, physical therapy or speech therapy.

The committee bill, therefore, eliminates these distinctions between occupational therapy and the other therapy groups. It expands the

outpatient physical therapy and speech pathology benefit as provided through clinics, rehabilitation agencies, and other organized settings to include occupational therapy. Additionally, it amends the requirements for patients to qualify for home health services to provide that a need for occupational therapy alone can qualify the homebound patient for this benefit. However, the need for occupational therapy alone would not qualify a person for the service of a home health aide.

In administering the occupational therapy benefit, the committee intent is to have the Department of HEW apply the definition, guidelines, and criteria as to covered and noncovered occupational therapy services included in the "Skilled Nursing Facility Manual" Revision No. 109, issued by the Social Security Administration in November, 1975.

FOOD STAMP PURCHASES BY WELFARE RECIPIENTS

(Section 201 of Title II of the Bill)

Under a provision of Public Law 93–86, State agencies were mandated to withhold, at the option of the recipient, the amount of the AFDC grant needed to purchase the recipient's food stamp allotment and to distribute the food stamp coupon allotment along with the reduced cash grant (usually by mail).

Although many States do use Public Assistance Withholding (PAW) issuance successfully, some States have found the mandatory provisions in present law extremely difficult to implement. There is a serious problem in the mail issuance of food stamp coupons in urban areas where the probability of mail loss is high. Major design problems are met in attempting to coordinate State-run AFDC systems with locally run or contracted-out food stamp issuance systems. Many States even though they utilize computers encounter the costly problem of computer incompatibility between the AFDC and food stamp systems. The heavy additional cost of establishing computer capability to implement withholding or computer compatibility is a financial burden with which a number of States cannot cope. There is, in addition, strong opposition in some States to requiring that the public assistance withholding (PAW) issuance program operate in all areas of the State.

The committee believes the problems posed by State agencies are valid. To date, only 21 States and one jurisdiction have fully implemented PAW and mail issuance program of food stamp coupons. Eight other States have implemented the program in some of the counties in the State. However, 21 States and 3 jurisdictions have not implemented the PAW and mail issuance program. The following shows the breakdown by State.

States with full implementation

Alaska, Arizona, Arkansas, Delaware, Guam, Hawaii, Idaho, Iowa, Kansas, Kentucky, Mississippi, New Mexico, North Carolina, Ohio, Oklahoma, Oregon, South Carolina, Utah, Vermont, Virginia, Washington, and West Virginia.

States with partial implementation

California, Colorado, Indiana, Maryland, Minnesota, New York, Texas, and Wisconsin.

States without implementation

Alabama, Connecticut, District of Columbia, Florida, Georgia, Illinois, Louisiana, Maine, Massachusetts, Michigan, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, North Dakota, Pennsylvania, Puerto Rico, Rhode Island, South Dakota, Tennessee, Virgin Islands, and Wyoming.

Under current law, Agriculture Department regulations mandate that all States offer, statewide, PAW food stamp issuance procedures to AFDC recipients beginning January 1, 1976.

In response to the problems encountered by some States, title II of the committee bill will give States the option of offering PAW issuance procedures. States could choose not to offer PAW procedures, offer them statewide, or offer them only in selected areas of the State. For those States choosing to offer PAW issuance procedures to AFDC recipients, the administrative cost of the procedures would continue to be governed by the Federal-State cost-sharing provisions of the Food Stamp Act.

III. Costs of Carrying Out the Bill

In compliance with section 252(a) of the Legislative Reorganization Act of 1970, the following statement is made relative to the costs to be incurred in carrying out this bill.

The provision allowing the Part B premium to increase would result in reduced general revenue outlays of $184 million in fiscal 1977, with increased reduction each year to a reduction of $725 million in fiscal 1981.

The provision preventing rollbacks in physicians' fees would cost $37 million in fiscal 1976.

The provision broadening coverage of occupational therapy services would have a cost of $1 million in fiscal year 1976 and $2 million per year thereafter.

The provision relating to food stamps will save an estimated $3 million in Federal funds in fiscal year 1976.

The committee believes that the other provisions have either no cost or have only a nominal cost.

IV. Vote of Committee in Reporting the Bill

In compliance with section 133 of the Legislative Reorganization Act, as amended, the following statement is made relative to the vote of the committee on reporting the bill. This bill was ordered favorably reported by the committee without a rollcall vote and without objection.

V. Changes in Existing Law

In the opinion of the committee, it is necessary in order to expedite the business of the Senate, to dispense with the requirements of subsection 4 of rule XXIX of the Standing Rules of the Senate (relating to the showing of changes in existing law made by the bill, as reported).

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