96th Congress, 2d Session } COMMITTEE PRINT { CP 96-36

SPENDING REDUCTIONS:

Recommendations of the

COMMITTEE ON FINANCE

Required by the Reconciliation Process
in Section 3(a)(15) of H. Con. Res. 307, the

FIRST BUDGET RESOLUTION FOR FISCAL YEAR 1981

COMMITTEE ON FINANCE
UNITED STATES SENATE

JUNE 25, 1980

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FOREWORD

The Congressional Budget Act provides for the adoption by May 15 of each year of a First Concurrent Budget Resolution setting an overall budgetary framework within which the Congress will operate as it considers revenue and spending legislation for the upcoming fiscal year. The revenue and spending totals in the First Budget Resolution are not binding under the usual rules of the Budget Act. In the Fall of each year a binding Second Concurrent Budget Resolution is adopted to reaffirm or revise the budgetary totals which were incorporated in the First Budget Resolution. The Congressional Budget Act provides for a "reconciliation" procedure under which the Second Budget Resolution may include instructions directing specified House and Senate committees promptly to report out legislation raising revenues or reducing spending in programs within their jurisdiction by specific amounts. The Congressional Budget Act does not provide for a reconciliation procedure under the First Budget Resolution. However, the act does permit the inclusion in that Resolution of any "procedure which is considered appropriate to carry out the purposes of this Act."

The First Concurrent Budget Resolution for fiscal year 1981 (H. Con. Res. 307) does include reconciliation instructions to the Committee on Finance and several other committees of the Senate and House. In the case of the Finance Committee, the resolution includes both revenue and spending instructions. The committee is directed by the resolution to recommend reductions in outlays for spending programs under its jurisdiction totaling $2.2 billion for fiscal year 1981, decreases in budget authority totaling $0.9 billion, and increases in revenues for that year totaling $4.2 billion.

The revenue changes will be incorporated in a separate document. This committee print incorporates committee report language and bill language relating to the outlay and budget authority reduction provisions required of the Finance Committee, assuming that these provisions will appear as title VI of the overall reconciliation bill in the Senate.

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SPENDING REDUCTIONS: RECOMMENDATIONS OF THE COMMITTEE ON FINANCE REQUIRED BY THE RECONCILIATION PROCESS IN SECTION 3(a)(15) OF HOUSE CONCURRENT RESOLUTION 307, THE FIRST BUDGET RESOLUTION FOR FISCAL YEAR 1981

I. Summary of Finance Committee Recommendations

The recommendations of the Committee on Finance for amendments to reduce spending in programs under its jurisdiction for fiscal year 1981 pursuant to the reconciliation instructions of House Concurrent Resolution 307 have been drafted as a separate title VI. References in this summary and in the following general discussion of title VI to "the committee" should be considered as references to the Committee on Finance.

LEGISLATION ALREADY ENACTED INTO LAW

At the time the Budget Resolution was under consideration in the Senate, two Finance Committee bills were awaiting final action—H.R. 3236, the Social Security Disability Amendments of 1980, and H.R. 3434, the Adoption Assistance and Child Welfare Act of 1980. Both of these measures have now been enacted into law. The $225 million of savings in these two new laws is creditable towards the $2.2 billion required under the reconciliation instructions.

UNEMPLOYMENT COMPENSATION PROVISIONS

Elimination of national trigger.—Under present law States generally pay unemployment benefits for a maximum of 26 weeks. In times of high unemployment, however, the Federal-State extended unemployment compensation program becomes effective. Under the extended benefits program an additional 13 weeks of benefits are payable. Half the cost of these extended benefits is borne by the Federal unemployment tax and half is borne by State unemployment taxes. The extended benefits program goes into effect on a State-by-State basis if the State insured unemployment rate reaches a level of 4 percent and is also 20 percent higher than the rate during the comparable period of the 2 previous years. At State option, the program can also become effective whenever the State insured unemployment rate is 5 percent or higher regardless of how it compares with the rate in the 2 prior years. In addition to these "State triggers," the program becomes effective in all States whenever the national insured unemployment rate reaches a level of 4.5 percent. (For both State and national triggers, the rate is measured over a moving period of 13 consecutive weeks.) The committee provision would eliminate the national trigger so that the program would go into effect only in those States where one of the State triggers applies. No savings are

now estimated for this item for fiscal year 1981 because the national trigger would not have been reached this year under the CBO assumptions which were used to develop the budget resolution. In fact, however, it now seems likely that CBO reestimates later this year will indicate that the national trigger level will be reached. At that time, the provision will represent a savings of several hundred million dollars for fiscal year 1981. This provision was previously approved by the committee and passed by the Senate as an amendment to H.R. 4612.

Waiting period for benefits.—Under present law, some States pay unemployment benefits starting with the first week of unemployment while other States provide that benefits will become available only after the unemployed individual has served a "waiting week." (In some cases, States which have a waiting-week provision pay benefits retroactively for the waiting week after the individual has experienced a specified duration of unemployment.) The committee amendment would eliminate the Federal 50 percent matching share for the first week of extended unemployment compensation in any State which does not have a waiting week for regular benefits. (The elimination of Federal matching for the first week of extended benefits would also apply to States which have a waiting week which is subject to retroactive payment when the worker completes a certain duration of unemployment.) This provision is also included in H.R. 4612, as previously approved by the committee and the Senate. The provision is estimated to save $25 million in fiscal year 1981.

Optional State trigger.—Under present law, States must implement the extended benefit program when the State insured unemployment rate is both 4 percent or higher and 20 percent above the level prevailing in the State in the 2 prior years. When the "20 percent higher" factor is not met, States may at their option provide for the program to become effective when the State insured unemployment rate is at least 5 percent. If States choose this option, the trigger point for the program must be set at 5 percent. In other words, States may not provide that the program will become effective only if the rate is at least 5½ percent or 6 percent. The committee amendment would modify the optional State trigger provision so that States could specify any rate of insured unemployment which is 5 percent or higher as the optional trigger point (that is, the point at which the extended benefit program would become effective in the absence of the "20 percent higher" factor). This provision is also included in H.R. 4612. It would reduce program costs in fiscal 1981 by $30 million.

Unemployment benefits for ex-servicemen.—Under present law federally funded unemployment benefits are provided to former servicemen upon their separation from military service. To qualify, an individual is required to have served on active duty for a period of at least 90 days and to be separated under other than dishonorable or bad-conduct circumstances. The 90-day requirement does not apply where separation results from a service-incurred injury or disability. The committee amendment would require that, except in cases of service-incurred disability or injury, individuals must have served a minimum of 1 year before unemployment benefits would be payable. This provision is also in H.R. 4612. It would save $43 million in fiscal 1981.

Unemployment benefits for Federal employees.—Under present law, a Federal employee who suffers unemployment may qualify for unemployment compensation under the same rules as apply to employees of private businesses in the State in which he was last employed. The costs of benefit payments to former Federal employees are reimbursed to the State paying benefits by the Federal Government. At present, all such costs are funded through a single appropriation account within the budget of the Department of Labor rather than being charged to the appropriations of the employing agencies. The committee amendment would establish a special account within the Unemployment Trust Fund from which States would be reimbursed for the costs of unemployment benefits based on Federal employment. Each agency would be required to reimburse that account from its appropriations for the costs attributable to its employees. This provision was also included in H.R. 4612. It is estimated to reduce Federal expenditures in fiscal year 1981 by $11 million.

Limitation on extended benefits for nonresidents.—Under present law, States are required to pay unemployment benefits to individuals who meet the State qualifying requirements even if they are or become residents of another State. If an individual works and qualifies for benefits in a State in which the extended unemployment program is in effect, that State will be required to pay him such benefits (so long as he meets the requirements for them) even if he has changed his residence to a State in which the extended program is not in operation (because the new State of residence has a lower rate of insured unemployment). The committee amendment would limit benefits in the case of persons who change their State of residence. If an individual changes his State of residence after the beginning of a period of unemployment during which he would otherwise qualify for extended benefits, no extended benefits will be payable if the new State of residence is one in which the extended benefit program is not triggered on. This limitation would not apply to the first 2 weeks after the individual takes up residence in the new State. This same provision was included in H.R. 4612. It is estimated to reduce expenditures in fiscal 1981 by $46 million.

Extended benefits not payable on the basis of less than 20 weeks of employment.—Under existing law, most States pay regular unemployment benefits for a maximum of 26 weeks. In times of high unemployment, benefits are payable for an additional period of up to 13 weeks under the extended benefits program. The committee amendment would require that benefits not be paid under the extended benefit program to any individual who has less than 20 weeks of qualifying employment in the base period. It is estimated that this provision will reduce benefit costs by $120 million in fiscal 1981.

Extended benefits not payable to persons who leave jobs voluntarily or for misconduct.—When an unemployed worker has voluntarily left his job without good cause, has been discharged for misconduct, or has refused what the State agency considers a suitable job offer for him, he becomes ineligible for benefits. However, in many States the disqualification is lifted after a period of time. Other States continue the disqualification for the duration of unemployment. The committee has included a provision under which an individual who had been dis-

qualified for one of these reasons could not be paid extended benefits (even though he may have been reinstated to regular State benefit status because his State provides for only a limited period of disqualification). This provision will result in benefit savings of $32 million in fiscal year 1981.

Extended benefits not payable to persons refusing any reasonable job offer.—Generally, a worker qualifies for up to 26 weeks of benefits if he was laid off from work for reasons other than his own misconduct or his own voluntary decision to quit and if he remains ready, willing, and able to accept new employment. Newly unemployed workers are not required to take any available job but are permitted to seek a job which matches their previous experience, training, and earnings level. After seeking such work unsuccessfully for a reasonable period of time, however, individuals may be required to seek jobs not meeting their full qualifications as a condition of continued benefit eligibility. The committee amendment would establish a requirement that, as a condition of eligibility for extended unemployment benefits, the unemployed individual must be willing at that point to accept any job which meets minimum standards of acceptability (such as basic health and safety standards, compliance with the Federal minimum wage, and other existing Federal standards). This provision will reduce program costs by $94 million in fiscal year 1981.

SUPPLEMENTAL SECURITY INCOME (SSI) PROVISION

Limit SSI eligibility for individuals who dispose of resources.—Under current law, the disposal or transfer of a resource prior to the filing of an SSI application does not preclude eligibility, even though the individual would be ineligible if he retained the resource. This is true with respect to cash and real or personal property although the resource may have been sold for less than its market value. The committee provision would delay SSI eligibility in the case of applicants who dispose of resources for less than current market value if retaining such resources would make them ineligible for benefits. The provision would make an individual ineligible to the extent that within the two years prior to application he disposed of assets for substantially less than their fair market value. This amendment would result in estimated savings of $15 million in fiscal year 1981.

SOCIAL SERVICES PROVISION

Federal day care regulations.—When the Social Security Act was amended in 1974 to establish a new title XX social services program, a provision was included requiring that day care services provided under State social services plans must meet the 1968 Federal Interagency Day Care Requirements, with some modifications. However, because of the controversial nature of those requirements, the Congress also included a provision requiring the Secretary of Health and Human Services to make a study of the appropriateness of the standards imposed by the legislation, and to submit a report of his findings together with recommendations to the Congress prior to July 1, 1977.

In response to the concern expressed by a number of States that they could not meet certain staffing requirements, which were to become

effective October 1, 1975, the Congress enacted temporary legislation delaying their implementation and providing, instead, that day care provided with Federal funds must meet the staffing standards of the State. This temporary legislation was extended several times.

On March 19, 1980, the Department of Health and Human Services issued final rules for day care, to become effective September 19, 1980. These regulations are to apply to services funded under title XX and title IV (WIN and child welfare services). A number of States have expressed concern about the cost and effect of implementing the new standards. In view of this concern, the committee has included a provision to defer implementation of the new regulations for purposes of Social Security Act programs until October 1, 1981, providing instead that child care provided prior to that date would be subject to State standards. Savings are estimated at $20 million in fiscal year 1981.

TERRITORIAL PROVISION

Public assistance payments to territorial jurisdictions.—Under the Social Security Act there is a dollar ceiling on Federal matching for costs of cash assistance, administration and social services provided under the programs of aid to families with dependent children and aid to the aged, blind and disabled in the jurisdictions of Puerto Rico, Guam and the Virgin Islands. The permanent ceiling under prior law was $24 million for Puerto Rico, $1.1 million for Guam, and $0.8 million for the Virgin Islands. The jurisdictions were limited to 50 percent Federal matching. For fiscal year 1979, under temporary legislation enacted in November 1978, the ceiling on Federal funds for the jurisdictions was tripled, from $26 million to $78 million, and the Federal matching percentage was raised from 50 percent to 75 percent.

H.R. 3434, as recently enacted, includes a provision which would make permanent, beginning with 1980, the increases provided for the jurisdictions in the earlier temporary legislation, that is, a tripling of dollar ceiling amounts. The committee amendment would defer the implementation of the full amount of these increases. Under the amendment, the amount of the increase would be limited to one-fourth of the total for fiscal year 1980 ($13 million rather than $52 million, to allow some increase in the last quarter of 1980) and to one-half the total for fiscal year 1981 ($26 million rather than $52 million). The full amount of the increased funding would thus become effective beginning with October 1, 1981. Estimated savings would be $39 million in 1980 and $26 million in 1981.

SOCIAL SECURITY PROVISIONS

Three-month limit on retroactive benefits.—Individuals who apply for benefits under the social security program are now allowed to backdate their applications by as much as 1 year to claim benefits for months prior to the actual date of application. The committee amendment would limit retroactivity of applications to a period of 3 months. The 3-month period (as is the case with the present 12-month period) would run from the date the application is filed and not from the date on which a decision is made on the claim. It is estimated to reduce fiscal year 1981 Federal expenditures by $150 million.

Social security benefits for prisoners.—Under present law individuals who are inmates of penal institutions or other incarcerated persons, such as the criminally insane who are confined to mental institutions, may become entitled to social security benefits if they can meet the several conditions required for benefits. The committee amendment would restrict the payment of benefits to persons convicted of crimes. Under the provision, benefits would not be payable to convicted felons except as specifically provided for by a court of law during their participation in an approved program of rehabilitation which is expected to result in their return to productive employment. The amendment would also provide that a person may not be considered a full-time student for purposes of student benefits while he is incarcerated. Moreover, any disabling condition arising in the commission of a crime would not be considered in determining whether an individual was under a disability for benefit purposes. A disabling condition which arises while an individual is imprisoned could not qualify him for disability benefits for so long as he remains in prison. This proposal is estimated to reduce benefit costs by $16 million in fiscal year 1981.

Reallocation of OASDI taxes between OASI and DI trust funds.—The optimum level of reserve in the social security trust funds has generally been considered to be an amount equal to approximately 1-year's benefit payments. Because of high inflation and other factors, the funds in recent years have fallen far below these optimum levels. The old-age and survivors insurance fund in particular has fallen to a level at which possible cash-flow problems could occur sometime in 1981. However, under current estimates, sufficient funds can be made available to assure continuing cash flow capability for the cash benefit trust funds through the end of 1981 and into 1982 from the existing cash benefit tax rate. To accomplish this, however, it is necessary to reallocate the distribution of that tax rate for 1980 and 1981 between the two cash benefit trust funds. While a reallocation of the social security cash benefit tax rate does not have any direct budgetary impact, the absence of such action would necessitate some other means of providing adequate financing to maintain cash flow in the OASI trust fund. Regardless of what funding source was used, any such alternative method of meeting the cash flow requirements (e.g. a general fund appropriation or an additional social security tax) would result in an increase in budget authority at a time when the committee is under reconciliation instructions to reduce budget authority. On this basis, the committee has included an amendment to reallocate the OASDI tax.

PROVISIONS RELATING TO MEDICARE AND MEDICAID

Hospital routine cost limits.—The bill would establish a new method of reimbursement for routine operating costs for hospitals under the medicare and medicaid programs. The new mechanism, to be effective July 1, 1980, would provide for incentive reimbursement rewarding hospitals whose routine operating costs are below average, and penalizing hospitals whose routine operating costs are substantially above average. The bill requires the Secretary to appoint a Health Facilities Costs Commission to recommend refinements in medicare and medicaid hospitals reimbursement.

Closure and conversion of underutilized facilities.—The bill would provide for including in short-term hospitals, reimbursement payments for increased operating costs and, in the case of nonprofit institutions, for increased capital costs, associated with the closing down or conversion to approved use of underutilized bed capacity or services.

Coordinated audits.—The bill would provide for medicare, medicaid, and the maternal and child health programs to share findings from a single audit where these programs reimburse the same entity on the basis of its reasonable costs.

Apportionment of provider costs.—The bill provides that medicare would not reimburse any institution for a disproportionately high share of costs until evidence is produced which justifies a specific adjustment under given circumstances for given facilities. The effect of this amendment would be to make such modifications, effective April 1, 1980, in the 8½ percent routine nursing cost differential that medicare now pays to hospitals the modification will be determined on the bases of a study to be carried out by GAO and will represent a more equitable method of reimbursing for routine nursing costs.

Inappropriate hospital services.—The bill would provide that in certain cases medicare and medicaid payments to hospitals be made at the average skilled nursing facility, intermediate care facility or detoxification facility payment rate (as appropriate), rather than the higher hospital rate, for patients medically determined by PSRO reviewers to need the lower level of care rather than acute hospital care. The bill would also authorize that benefits be provided and payment be made under medicare to qualified nonhospital inpatient detoxification facilities.

PSRO review of hospital admissions routine tests and preoperative stays.—The bill would direct PSRO's to review areas of frequent overutilization (such as diagnostic tests routinely provided on admission without a physician's order and weekend elective admissions and preoperative stays for elective procedures in excess of 1 day) to assure that payment is made under medicare and medicaid only where such services are medically appropriate.

Ambulatory surgery.—The bill would permit medicare reimbursement to be made to free-standing ambulatory surgical centers and physicians performing surgery in their offices for the use of surgical facilities needed to perform a listed group of surgical procedures. Such procedures include those which are often provided on an inpatient basis but can, consistent with sound medical practice, be performed on an ambulatory basis. Financial incentives to provide and use this type of services are included.

Criteria for determining reasonable charge for physician services.—The bill would modify existing medicare criteria for determining reasonable charges for physician services. It would require calculation of statewide median charges (in any State with more than one locality) in addition to the local prevailing charges. 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.

Procedures for determining reasonable cost and charge (hospital-based physician services and business services).—The bill would provide, except under certain specified circumstances, that compensation

paid to contractors, employees or related organizations, consultants, or subcontractors at any tier would not be recognized for medicare-medicaid reimbursement purposes where the payments (in whole or part, in cash or kind) are based upon percentage arrangements. Percentage arrangements involving payment to hospital based physicians would nevertheless be recognized if the amount of reimbursement does not exceed an amount that would reasonably have been paid under an approved relative value schedule which takes into consideration the physician's time and effort.

Outpatient services charge limit.—The bill would require the newly established Health Facilities Cost Commission to give priority to the development of limitations on reimbursement for hospital outpatient service costs. Further, the Secretary would be required to issue regulations providing for the establishment of such limitations.

Medicare liability in accident cases.—The bill would provide that medicare not be the payor of first resort in cases where the patient was involved in an accident and his care could be paid for under liability coverage of the individual who was at fault or under no fault insurance.

Access to and purchase of medicaid services.—The bill gives the States greater discretion in arranging for care and services for medicaid recipients through cost-effective arrangements. Provision would be made to assure that beneficiaries have reasonable access to services (including emergency and elective services) that fully meet program standards of quality. In addition, provision would be made to avoid having an adverse effect on appropriate and necessary use of hospitals with graduate medical education programs.

Medicare hospital reimbursement: periodic interim payments (PIP).—The bill amends the medicare periodic interim payment (PIP) procedure for hospitals so that payment would be withheld during September 1981, in order to increase the lag between rendition of a service and payment for it to about six weeks, the delay experienced by hospitals that use the standard billing method. The deferred payments would be paid to the hospitals in October 1981.

Disallowance of State claims for Federal medicaid funds.—At present, when a State's claim for medicaid matching funds is disallowed by the Federal Government, the State may appeal the decision and retain the funds that are in dispute until a final determination is made. The bill authorizes the Secretary of HHS to offset amounts in dispute from other medicaid funds due the State until the appeals process has been exhausted. If the final decision is in the State's favor, the Federal Government would repay the money to the State with interest.

Reimbursement under medicaid for skilled nursing facilities and intermediate care facilities.—The bill amends section 249 of the Social Security Amendments of 1972, which requires States to pay skilled nursing facilities (SNF's) and intermediate care facilities (ICF's) on a reasonable cost-related basis. This provision would be amended to permit States, effective October 1, 1980, to develop their own payment systems for skilled nursing facility and intermediate care facility services. The State would have to assure the Secretary of HHS

that its rates are reasonable and adequate to meet the costs incurred by efficiently and economically operated facilities in providing care and services in conformity with applicable State and Federal laws and regulations. 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 investments necessary to assure the reasonable availability of services.

Home health agency reimbursement limits.—The bill limits allowable costs for home health agency services under medicare to amounts not in excess of the 75th percentile of weighted average audited costs. These limits would be applied separately to each type of visit, rather than on an aggregate basis, when revisions in the existing cost reporting procedures make this possible. The allowable cost of skilled nursing visits and home health aide visits may not exceed medicaid skilled nursing facility per diem rates, hospital-based facility rates in the case of hospital-based home health agencies and other skilled nursing facility rates in the case of nonhospital-related agencies.

Calculating medicare reasonable charges.—Medicare reasonable charges are updated in July of each year to keep pace with economic changes. All bills that the medicare carrier receives after the charges are updated are, [therefore] paid at the higher. In effect, the amount of the medicare payment often depends on how long the claimant delays billing rather than on the charge levels in effect when the medical service was provided. To eliminate this inequity, the bill contains a provision under which the medicare reasonable charges that are payable would depend on the date the medical service was rendered rather than the date the medicare claim was processed.

FUND TRANSFER PROVISION

Transfer from general funds to trust funds.—The social security and medicare programs are funded through earmarked payroll taxes paid into the Treasury. Amounts exactly equal to the tax collections are appropriated out of the General Treasury and into the social security and medicare trust funds under a permanent standing appropriation in the Social Security Act. Under the accounting system used for purposes of the Budget Act, budget authority for trust fund programs is considered to arise at the moment when the tax receipts are appropriated into the trust funds. As a result, the various savings provisions approved by the committee in trust fund programs will not result in a reduction in the 1981 budget authority for those programs although they do result in 1981 outlay reductions and do reduce the amount of budget authority that will ultimately be needed to operate the programs. In order to meet the reconciliation requirements for fiscal 1981 budget authority reductions, the committee agreed to a provision under which $0.6 billion in social security and medicare tax receipts which would otherwise be transferred to the trust funds at the end of September 1981 will instead be transferred to the trust funds after the end of that month. This will reduce budget authority for fiscal 1981 by that same amount.

SPENDING REDUCTIONS UNDER FINANCE COMMITTEE PROPOSALS FOR RECONCILIATION PROCESS FOR FISCAL YEAR 1981 BUDGET RESOLUTION

[In millions]

	Budget authority	Outlays
Social security disability amendments (H.R. 3236)	−$12	−$133
Social services amendments (H.R. 3434)	−92	−92
A. Unemployment Compensation Provisions:		
Sec. 601 Elimination of national trigger		([1])
Sec. 602 Waiting period for benefits		−25
Sec. 603 Optional State trigger		−30
Sec. 604 Unemployment benefits for ex-servicemen	−43	−43
Sec. 605 Unemployment benefits for Federal employees	−11	−11
Sec. 606 Limit on extended benefits for nonresidents		−46
Sec. 607 Extended benefits:		
Not payable on the basis of less than 20 weeks of employment		−120
Not payable to persons who leave jobs voluntarily or for misconduct		−32
Not payable to persons refusing any reasonable job		−94
B. Sec. 611 Limit SSI eligibility for individuals who dispose of resources	−15	−15
C. Sec. 621 Temporary suspension of Federal day care regulations	−20	−20
D. Sec. 631 Public assistance payments to territorial jurisdictions	−26	−26
E. Social Security Provisions:		
Sec. 641 Reallocation of OASDI taxes between OASI and DI	([2])	
Sec. 642 3-month limit on retroactive benefits	+5	−150
Sec. 643 Social security benefits for prisoners	+1	−16
F. Health provisions:		
Sec. 651 Hospital routine cost limits	−10	−70
Sec. 652 Closure/conversion of underutilized facilities		−2
Sec. 653 Coordinated audits	−4	−4

SPENDING REDUCTIONS UNDER FINANCE COMMITTEE PROPOSALS FOR RECONCILIATION PROCESS FOR FISCAL YEAR 1981 BUDGET RESOLUTION—Continued

[In millions]

	Budget authority	Outlays
F. Health provisions—Continued		
Sec. 654 Apportionment of provider costs	−3	−70
Sec. 655 Inappropriate hospital services	−33	−151
Sec. 656 PSRO review of hospital admissions routine tests and preoperative stays	−1	−25
Sec. 657 Ambulatory surgery		−5
Sec. 658 Criteria for determining reasonable charge for physician services		−25
Sec. 659 Procedures for determining reasonable cost/charge (hospital-based physician and business services)	+1	−15
Sec. 660 Outpatient services charge limit	−2	−23
Sec. 661 Medicare liability in accident cases	+1	−14
Sec. 662 Access to and purchase of medicaid services	−91	−91
Sec. 663 Medicare hospital reimbursement: periodic interim payments (PIP)	+2	−675
Sec. 664 Disallowance of certain State medicaid claims		−147
Sec. 665 Reimbursement under medicaid for skilled nursing and intermediate care facilities	−2	−2
Sec. 666 Home health agency reimbursement limits	+3	−73
Sec. 667 Calculating medicare reasonable charges	+6	−147
G. Sec. 671 Transfer of funds to trust funds	−600	....
Total	−943	−2,397

[1] Based on economic assumptions used in First Budget Resolution; anticipated reestimates will result in savings.
[2] Without reallocation, increase in budget authority would be required.

Source: Congressional Budget Office.

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II. General Discussion of Finance Committee Amendments

A. Provisions Related to Unemployment Compensation (Part A of Title VI)

ELIMINATION OF NATIONAL TRIGGER UNDER THE EXTENDED BENEFITS PROGRAM

(Section 601 of the Bill)

Present law.—In most States, unemployment benefits are payable under the regular State program of unemployment compensation for a maximum of 26 weeks. The costs of these regular benefits are financed entirely from State unemployment taxes. In times of high unemployment, however, the Federal-State Extended Unemployment Compensation program becomes operative. This program provides for an additional benefit duration for workers who have exhausted their entitlement to regular State benefits. Benefits are payable under the extended program for half as many weeks as benefits were payable under the regular program. In other words, when the extended program is in effect, unemployed persons can receive up to 13 additional weeks of benefits for an overall maximum of 39 weeks. Half of the cost of extended benefits is paid for from State unemployment taxes and half of the cost is borne by the Federal Unemployment Tax.

Present law provides for the extended benefit program to be operative in any State when the insured unemployment rate (the number of persons receiving unemployment benefits as a percentage of persons working in jobs covered by the program) is sufficiently high under any one of three tests or "triggers." Under the basic State trigger, the program is in operation when the insured unemployment rate for the State is at least 4 percent and that State's insured unemployment rate is at least 20 percent higher than the average insured unemployment rate in that State during the comparable period in the two prior years. If the State insured unemployment rate is not at least 20 percent above the rate for the 2 prior years, a State may nevertheless elect to have the extended benefit program become effective whenever the State insured unemployment rate reaches a trigger level of 5 percent. In addition to the basic and optional State trigger provisions, present law also includes a national trigger. When the national insured unemployment rate is at a level of 4.5 percent or higher, the extended benefits program must be operated by all States.

Committee amendment.—The committee amendment would eliminate the national trigger for paying extended unemployment benefits. Unemployment benefits are provided in order to protect workers against the involuntary loss of income that occurs when they lose their jobs and for the period thereafter while they are trying to obtain new employment. In times of high unemployment, the availability of jobs is curtailed and the competition for them is increased. At such times, it is likely that an unemployed worker will need more time to find a new job. This relationship between the overall level of unemployment and the amount of time it takes to find a new job is the basic justifica-

tion for a program of extended benefit duration. The committee believes, however, that that relationship is more properly reflected in the State triggers than in the national trigger. When a worker becomes unemployed, the question of how long he will have to search for new employment is dependent upon the availability of, and competition for, jobs in the area where he resides, not upon the national average unemployment situation.

When the extended unemployment compensation program was originally enacted in 1970, extended benefits could be triggered on for an individual State only if the State insured unemployment rate was both 4 percent and was at least 20 percent higher than in the 2 preceding years. In the case of a prolonged national recession, States would be unable to meet the "20 percent higher" requirement even though they might be experiencing a very high level of insured unemployment. For this reason, the national trigger did serve as an important safeguard under that original legislation. In the 1976 amendments, however, the law was changed to provide for an optional alternative State trigger based on an absolute State insured unemployment rate of 5 percent. The committee believes that that change in the law eliminated the need for a national trigger.

The elimination of the national trigger for extended benefits is effective as of October 1, 1980. No savings are now estimated for this item for fiscal year 1981 because the national trigger would not have been reached this year under the CBO assumptions which were used to develop the budget resolution. In fact, however, it now seems likely that CBO reestimates later this year will indicate that the national trigger level will be reached. At that time, the provision will represent a savings of several hundred million dollars for fiscal year 1981. This provision was previously approved by the committee and passed by the Senate as an amendment to H.R. 4612.

WAITING PERIOD FOR BENEFITS

(Section 602 of the Bill)

Present law.—Although there are certain Federal requirements which State unemployment compensation programs must meet, States have broad discretion to determine qualifying requirements, benefit amounts, and duration of regular benefits. Most State unemployment compensation laws provide that no benefits will be payable for the first week in which the worker is unemployed and otherwise eligible. Twelve States, however, do not now provide for such a "waiting week." These are: Alabama, Connecticut, Delaware, Iowa, Kentucky, Maine, Maryland, Michigan, Nevada, New Hampshire, Pennsylvania, and Wisconsin. Three other States (New York, Rhode Island, and Georgia) have a waiting week but will pay benefits for that waiting week in some circumstances, and nine States (Hawaii, Illinois, Louisiana, Minnesota, Missouri, New Jersey, Ohio, Texas, and Virginia) pay compensation for the waiting week retroactively after the worker has experienced a specified duration of compensable unemployment.

Committee amendment.—The committee recognizes that eligibility and benefit provisions of the unemployment compensation program

have, with relatively few exceptions, been left to State discretion, and the committee does not wish to depart from that general practice by requiring that all States establish a waiting week for benefits. At the same time, the committee notes that a large majority of States do have a waiting week and most States do not make exceptions or pay retroactively for the waiting week. The existence of a waiting week does not impose an undue hardship since most workers will have some resources to fall back on for the very early stages of their unemployment. It does, however, have a very important positive effect in that it gives the unemployed worker a stronger financial incentive to seek reemployment immediately. The committee feels that most States have properly concluded that the system should convey the message that the priority is: 1) look for a new job and 2) apply for unemployment benefits, rather than the reverse.

Under present law, the Federal statute actually tends to reward States which have elected not to have a waiting period. In such States, 50 percent Federal funding for extended unemployment benefits begins with the 27th week of a worker's unemployment, while in States with a waiting period such funding begins with the 28th week of a worker's unemployment. The committee believes that this fiscal incentive should be modified so as to favor States which do utilize the waiting week rather than States which do not. The committee amendment provides that there will be no Federal matching of extended unemployment compensation for the first week in which such compensation is payable unless the State law provides for a waiting week (and does not make payment for the waiting week on a retroactive basis). (The same rule would apply to the first week of sharable regular compensation in States which provide more than 26 weeks of regular benefits.) In other words, if a State pays benefits for the first week of unemployment (on either a current or retroactive basis), the first week of extended benefits after the worker exhausts his regular benefit eligibility would be funded entirely from State funds and Federal matching would apply to the second through the thirteenth week of extended benefit eligibility.

This provision is also included in H.R. 4612, as previously approved by the committee and the Senate. The provision, which is effective October 1, 1980, is estimated to save $25 million in fiscal year 1981.

STATE OPTION AS TO CRITERIA FOR STATE "ON" AND "OFF" INDICATORS

(Section 603 of the Bill)

Present law.—As explained in the description of section 601 above, one of the three "trigger" situations in which extended benefits may be payable is the optional State insured unemployment rate of 5 percent. Prior to the 94th Congress, permanent law provided for extended benefits to be payable on a State-by-State basis only under the mandatory trigger of a State insured unemployment rate of 4 percent or more which was also at least 20 percent above the rate which the State had experienced during a comparable period in the 2 prior years. Because that requirement prevents benefits from being payable in States with high but persistent levels of unemployment, temporary legislation had been enacted on several occasions to waive

the "20 percent higher" requirement. To meet this problem on a permanent basis, the law was amended to give each State the option of triggering into the program at a 5 percent insured unemployment rate without regard to how that level of unemployment compared with prior years.

Committee amendment.—Inasmuch as the 5 percent State trigger is optional with the States, the committee sees no reason why States should not be given the additional flexibility to set the trigger level at whatever level of insured unemployment which the State may find appropriate so long as it is at least 5 percent. At the time the optional 5 percent State trigger was under consideration by the Congress, there was disagreement as to the most appropriate level and the Senate version of that legislation provided for a trigger level of 6 percent. Since the question of whether to pay benefits at all under this trigger has been left to the States, it seems reasonable to give the States this additional flexibility to set the trigger at 5, 5½, 6 or whatever percent they find most appropriate.

This provision is also included in H.R. 4612. It would reduce program costs in fiscal 1981 by $30 million. It would be effective with respect to weeks of unemployment beginning after October 1, 1980.

FEDERAL SERVICE OF EX-SERVICEMEN

(Section 604 of the Bill)

Present law.—Under a special provision of Federal law, States pay unemployment benefits to recently discharged servicemen. These benefits are fully reimbursed to the States out of Federal general revenues. Benefits are payable provided that the discharge was not dishonorable or for bad conduct and provided that the individual completed at least 90 days of active service (unless discharged earlier because of a service-incurred injury or disability).

Committee amendment.—The committee understands that benefits are being paid under this provision in a very substantial number of instances in which individuals are leaving military service after quite short periods of service—well below the ordinary term of an enlistment. While there are a variety of reasons why enlistments are terminated early, the committee believes that compensation for ex-servicemen is primarily intended to be available to those who have completed more substantial periods of service. The committee amendment would modify existing law to extend from 90 days to one year the minimum length of service generally required to qualify for federally funded compensation payments. It would be effective October 1, 1980.

This provision is also in H.R. 4612. It would save $43 million in fiscal 1981.

BENEFITS ON ACCOUNT OF FEDERAL SERVICE TO BE PAID BY EMPLOYING FEDERAL AGENCY

(Section 605 of the Bill)

Present law.—Under present law, individuals who are terminated from Federal employment (or partially terminated) may apply for

benefits with the State agency of the State in which their Federal employment was located. Unemployment benefits are payable to such individuals under the same rules and procedures as apply to individuals in that State who lose jobs in private employment. To the extent that benefits are based on Federal employment, the State is reimbursed by the Federal Government (out of appropriated funds) for the benefit costs. The Federal costs of benefits for former employees are appropriated into a single account as a part of the annual Labor-HHS Appropriations Act.

Committee amendment.—An important element in the unemployment compensation program in the States is the experience-rating system which provides a strong incentive for employers to avoid unnecessary employee turnover and to monitor claims for unemployment to assure that awards are not being made by the State agency to persons not entitled to benefits. Under existing law this same type of incentive does not exist for Federal agencies since they have no fiscal stake in the question of whether or how much unemployment compensation is paid to their employees. The costs of such compensation is borne by a government-wide account which is not reflected in individual agency budgets and therefore not subject to any effective review by the appropriations subcommittees responsible for monitoring these budgets.

The committee amendment would modify this arrangement by providing that the budget account from which States are reimbursed would receive its funding not from a single direct appropriation but rather from payments made by each agency out of that agency's appropriation. This should make each agency more aware of the need to monitor, and in appropriate cases contest, benefit claims of former employees in order to avoid excessive costs which would have to be absorbed from other parts of the agency's budget.

Under the committee amendment, a separate account for Federal employee benefits would be established. This account would be placed within the Unemployment Trust Fund but would be funded entirely from general revenues. It would operate on a revolving fund basis starting with a transfer to the account on September 30, 1980, of the amounts that have already been appropriated to pay for Federal employee unemployment benefits. Starting on that same date, States would be reimbursed out of this account for their benefit payments to Federal employees. The employing agencies would, in turn, be required to reimburse the account out of their individual appropriations. Additional appropriations could be made to the account to assure an adequate working balance and any excess amounts in the account would be transferred back to the general fund of the Treasury.

Although the change becomes effective as of October 1, 1980, the committee recognizes that it will take some time and effort for the Labor Department to begin making determinations as to the amounts owed the account by each agency and for the readjustment of budgets to accommodate this change. For this reason, the amendment is intentionally drawn in a manner which does not mandate a particular time limit within which determinations and reimbursements must be made. The amendment provides that agencies will make transfers to the account on a quarterly basis reflecting what they owe the account

on the basis of Labor Department determinations which have been completed as of the start of that quarter. While this does provide great leeway to the Department in implementing this provision, the committee intends that the Department should move as quickly as feasible to begin implementation and should assure that agencies are promptly made aware of the fact and purpose of this change in the law.

This provision was included in H.R. 4612. It would result in estimated savings of $11 million in fiscal year 1981.

LIMITATION ON EXTENDED BENEFITS FOR NONRESIDENTS

(Section 606 of the bill)

Present law.—Under present law, States are required to pay unemployment benefits to individuals who meet the State qualifying requirements even if they are or become residents of another State. If an individual works and qualifies for benefits in a State in which the extended unemployment program is in effect, that State will be required to pay him such benefits (so long as he meets the requirements for them) even if he has changed his residence to a State in which the extended program is not in operation (because the new State of residence has a lower rate of insured unemployment).

Committee amendment.—The committee amendment would limit benefits in the case of persons who change their State of residence. If an individual changes his State of residence after the beginning of a period of unemployment during which he would otherwise qualify for extended benefits, no extended benefits will be payable if the new State of residence is one in which the extended benefit program is not triggered on.

Extended benefits are intended to allow individuals additional time to find new employment inasmuch as employment opportunities are more difficult to find in States where there is a high level of unemployment. When an individual moves from such a State into a State with a relatively lower level of unemployment, the justification for continued payment of extended benefits would seem to be eliminated. In many cases, such a move would be premised precisely on the availability of employment in the new State. To allow some period of transitional readjustment, however, the committee provision would not apply to the first two weeks after the individual takes up residence in the new State. This same provision was included in H.R. 4612. It would be effective October 1, 1980, and is estimated to save $46 million in fiscal year 1981.

LIMITATION ON PAYMENT OF EXTENDED UNEMPLOYMENT BENEFITS

(Section 607 of the bill)

Present law.—Under existing law, regular State unemployment benefits are payable out of State unemployment payroll taxes to workers who are involuntarily unemployed and who are willing and available to accept employment which is consistent with their abilities and prior work experience. Generally, States pay benefits for a maximum

of 26 weeks. In times of high unemployment, an extended benefits program becomes effective. Under this program up to 13 additional weeks of benefits are payable. The benefits are funded half from State payroll taxes and half from the Federal unemployment tax. Under present law, each State establishes the qualifying requirements for regular benefits and individuals who meet those requirements are automatically eligible for Federal-State extended benefits if the extended benefits program is in effect.

All States establish certain prior employment requirements to establish eligibility for benefits. While some States have established rules that allow benefits only for persons with a substantial earnings history, other States require much less previous work. This can result in extended benefits being paid to an individual who has qualified on the basis of a minimal period of employment.

When an unemployed worker has voluntarily left his job without good cause, has been discharged for misconduct, or has refused what the State agency considers a suitable job offer for him, he becomes ineligible for benefits. However, in many States the disqualification is lifted after a period of time. Other States continue the disqualification for the duration of unemployment. A recent research study by SRI International concluded that the average length of unemployment tends to be lower in States which impose disqualification for the duration of unemployment.

Generally, a worker qualifies for benefits if he was laid off from work for reasons other than his own misconduct or his own voluntary decision to quit and if he remains ready, willing, and able to accept new employment. For the benefit of both the worker and the labor market, newly unemployed workers are not required to take any available job but are permitted to seek a job which matches their previous experience, training, and earnings level. After seeking such work unsuccessfully for a reasonable period of time, however, individuals may be required to seek jobs not meeting their full qualifications as a condition of continued benefit eligibility.

Committee amendment.—The amendment proposed by the Committee on Finance would establish certain limitations on the payment of Federal-State extended benefits to unemployed workers. For the most part, Federal law has left to the States the discretion of establishing benefit qualification rules since regular unemployment benefits are entirely financed from taxes imposed by State legislatures. However, in recent years, very substantial costs have been incurred to pay extended benefits. Half the cost of these benefits is borne from the Federal unemployment tax which is paid by all employers including those in States where the extended benefits program is not in operation. A very significant part of the cost of the extended benefits program has also been paid from interest-free loans from the Federal Treasury to a number of States that have not fully funded the heavy benefit costs of recent years. For these reasons and because benefits payable for a period in excess of six months have a somewhat different character from benefits payable during the first few weeks after unemployment occurs, the committee recommends an amendment designed to better target these long-term benefits to individuals who become unemployed after substantial attachment to the work force and who are clearly making all reasonable efforts to return to work.

The first part of the committee provision would require that benefits not be paid under the extended benefit program to any individual who has less than 20 weeks of qualifying employment in the base period. It is estimated that this provision will reduce benefit cost by $120 million in fiscal 1981.

Under another part of this provision, extended benefits would not be payable to an individual who had been disqualified for refusing employment or because he quit voluntarily or lost his job by reason of his own misconduct (even though he may have been reinstated to regular State benefit status because his State provides for only a limited period of disqualification). This change will result in benefit savings of $32 million in fiscal year 1981.

The committee amendment would also establish a requirement that, as a condition of eligibility for extended unemployment benefits, the unemployed individual must be willing at that point to accept any job which meets minimum standards of acceptability.

For the purposes of the extended benefits program, any work would be considered suitable if it:

was within the capabilities of the claimant;

met the conditions of present Federal law;

met the conditions of State law and practices pertaining to suitable or disqualifying work that are not inconsistent with the provisions of this section, such as not requiring an individual to take a job that involves traveling an unreasonable distance to work or poses an unreasonable threat to the individual's morals, health or safety;

paid wages at least equal to the Federal or, if higher, any applicable State or local minimum wage;

paid gross average weekly remuneration equal to the individual's weekly unemployment compensation benefit. plus any "Supplemental Unemployment Benefits" (SUB) to which the individual might be entitled because of agreements with previous employers; and

was listed with the State employment service or offered in writing. (A written job offer would involve a written statement as to the availability of the job and the hours and wages it involved. It would not have to include other details such as a description of fringe benefits.)

State agencies would be required to refer claimants of emergency benefits to any job that would be considered suitable for the individual under the provisions of this section.

If, however. an individual furnishes satisfactory evidence to the State agency that his or her prospects for obtaining work within a reasonably short period in his customary occupation are good, the determination of whether any work is suitable for the individual would be made in accordance with State law and practices pertaining to suitable or disqualifying work rather than the provisions of this section pertaining to suitable work. An example of the type of evidence required would be a recall notice from a former employer.

A similar requirement was previously enacted in the legislation extending the now-expired Emergency Unemployment Compensation Act of 1974. This provision will reduce program costs by $94 million in fiscal year 1981.

B. Supplemental Security Income Provisions

(Part B of Title VI)

LIMIT ON DISPOSAL OF ASSETS FOR PURPOSES OF SSI ELIGIBILITY

(Section 611 of the bill)

Present law.—Under current law, the disposal or transfer of a resource prior to the filing of an application for benefits under the supplemental security income program does not preclude eligibility, even though the individual would be ineligible if he retained the resource. This is true with respect to cash and real or personal property although the resource may have been sold for less than its market value or even given away.

The committee has been told that transfers of this type frequently occur, particularly in cases where an aged individual may face substantial medical expenses. For example, in connection with protracted nursing home care, by transferring assets to a relative, the individual qualifies not only for SSI but also for medicaid. Moreover, under certain court decisions, the absence of an SSI provision in this area has been found to lead to similar problems in connection with the medically needy segment of the medicaid program. (The committee does not intend that its recognition of the existence of these court decisions should be construed as agreement that they are correct.)

Committee amendment.—The committee believes that it is inappropriate for the public assistance programs to be burdened with the assumption of the support and medical care of individuals who have ample personal resources. For this reason, the committee amendment would require that any resources which an individual has given away or sold for less than fair market value would still be considered as available for his support, during the 2 years following the transfer of the asset. The amount considered to be available for support would be the value of the transferred asset less any compensation received for it. The committee recognizes that there may be cases in which such a transaction takes place in good faith and unforeseen circumstances subsequently require an individual to apply for assistance. The committee believes that such a situation would be quite rare; however, the provision would allow the rebuttal of the presumption that a transfer of assets was made in order to qualify for benefits or assistance. The burden of proof in such cases would be on the individual and would require a clear showing that at the time the transfer took place there could not have been reasonable expectation that SSI or medicaid benefits would be needed.

The committee is aware, as indicated above, that certain courts have held that the absence of a provision of this type in the SSI statute precludes States from applying such a rule in "medically needy" cases. The adoption of this provision will remedy the problems this has created for the States. However, the committee does not intend that its adoption of this rule for SSI recipients should require States to apply exactly the same provisions in "medically needy" cases. States that determine medicaid eligibility on the basis of January 1972 plans could also apply this limitation.

C. Social Services Provision (Part C of Title VI)

FEDERAL DAY CARE REGULATIONS

(Section 621 of the bill)

Present law.—A provision was included in the original title XX legislation to require that day care services provided under State social services plans must meet the 1968 Federal Interagency Day Care Requirements, with some modifications. However, because of the controversial nature of those requirements, the Congress also included a provision requiring the Secretary of Health and Human Services to make a study of the appropriateness of the standards imposed by the legislation, and to submit a report of his findings together with recommendations to the Congress prior to July 1, 1977.

In response to the concern expressed by a number of States that they could not meet certain staffing requirements, which were to become effective October 1, 1975, the Congress enacted temporary legislation delaying their implementation and providing, instead, that day care provided with Federal funds must meet the staffing standards of the State. This temporary legislation was extended several times.

On March 19, 1980, the Department of Health and Human Services issued final rules for day care, to become effective September 19, 1980. These regulations are to apply to services funded under title XX and title IV (WIN and child welfare services). The regulations contain requirements which cover the following areas: program of activities, health and safety, physical environment, staff training, group composition (including staffing requirements), parent involvement, social services, nutrition, and the role of State agency administration. According to the Department, the estimated average cost of care provided in a child care center under the new regulations is $3,500 per child year. This includes direct costs of providing care as well as administrative, training, medical, and other costs related to the provision of care.

Committee amendment.—A number of States have expressed concern about the cost of implementing the new standards, indicating that they believe that their enforcement will result in reducing the available supply of care, particularly for low income families, who are the primary recipients of Health and Human Services funded care. It has also been observed that some States are already experiencing difficulties in finding day care centers to serve children, and that without money to pay for stricter requirements, the difficulties of finding care will be increased. The result could be to force AFDC mothers to forego employment, and increase the likelihood that they will remain on welfare. In addition, some States are apparently giving consideration to eliminating the use of Federal funds for day care services in order not to be required to meet the new standards.

In view of these concerns, the committee agreed to defer implementation of the new regulations for purposes of Social Security Act programs until October 1, 1981. The committee amendment provides instead that child care provided prior to that date would be subject to State standards. This would allow time for further consideration of legislation to modify the proposed standards or to provide additional resources to enable States to meet those standards. Savings are estimated at $20 million in 1981.

D. Provision Relating to Funding of Territorial Programs (Part D of Title VI)

PUBLIC ASSISTANCE PAYMENTS TO THE TERRITORIES

(Section 631 of the Bill)

Present law.—Under existing law there is a dollar ceiling on Federal matching for costs of cash assistance, administration and social services provided under the programs of aid to families with dependent children and aid to the aged, blind and disabled in the jurisdictions of Puerto Rico, Guam and the Virgin Islands. The annual permanent ceiling is $24 million for Puerto Rico, $1.1 million for Guam, and $0.8 million for the Virgin Islands. The jurisdictions are limited to 50 percent Federal matching.

For fiscal year 1979, under temporary legislation enacted in November 1978, the ceiling on Federal funds for the jurisdictions was tripled, from $26 million to $78 million, and the Federal matching percentage was raised from 50 percent to 75 percent. As can be seen from the table, these increases did not result in a general increase in welfare payment standards. Instead, statistics show that special payments were made to individuals who were already receiving welfare. Puerto Rico, for example, amended its State plan to provide a special allowance for furniture, household replacement, and personal items, including clothing, not in the basic allowance. This resulted in a 652 percent increase over the prior month in the AFDC average payment per family in June 1979, and an increase of 1,548 percent in the month of September for persons who were already on the AFDC rolls. Puerto Rico's average payment per family for September was $756.79, compared with a national average per family of $277.48. The average payment amount declined to former levels beginning with the first month in fiscal year 1980.

AFDC PAYMENTS IN PUERTO RICO, GUAM, AND THE VIRGIN ISLANDS, APRIL-NOVEMBER 1979

A. Puerto Rico

Month	Number of families	Amount of assistance: Average payment per family	Amount of assistance: Percent increase over prior month
April	41,597	$46.71	....
May	41,247	46.21	(1)
June	40,572	347.62	+652
July	40,281	47.98	(1)
August	40,201	45.93	(1)
September	40,530	756.79	+1,548
October	40,978	55.85	(1)
November	43,834	47.23	(1)

B. Virgin Islands

Month	Number of families	Average payment per family	Percent increase over prior month
April	964	$158.69	....
May	964	325.29	+105
June	968	152.97	(1)
July	964	150.77	(1)
August	966	195.87	+30
September	951	194.36	(1)
October	954	147.24	(1)
November	959	146.38	(1)

C. Guam

Month	Number of families	Average payment per family	Percent increase over prior month
April	1,244	$204.03	....
May	1,268	203.17	(1)
June	1,295	203.35	(2)
July	1,286	203.58	(2)
August	1,260	204.49	(2)
September	1,258	206.46	+1
October	1,295	207.30	(2)
November	1,292	206.96	(1)

[1] Decrease.
[2] Less than one-half percent increase.

ASSISTANCE PAYMENTS TO THE AGED, BLIND, AND DISABLED IN PUERTO RICO, GUAM, AND THE VIRGIN ISLANDS, APRIL–NOVEMBER 1979

A. Puerto Rico

Month	Number of recipients	Amount of assistance: Average payment per recipient	Amount of assistance: Percent increase over prior month
April	37,684	$17.59	...
May	37,793	17.62	([1])
June	38,091	82.86	+370
July	37,815	17.75	([1])
August	37,655	17.32	([1])
September	37,495	201.91	+1,066
October	37,704	17.93	([1])
November	38,802	17.52	([1])

B. Virgin Islands

Month	Number of recipients	Average payment per recipient	Percent increase over prior month
April	415	$76.75	...
May	412	176.00	+129
June	419	75.27	([1])
July	413	74.94	([1])
August	416	95.99	+28
September	406	94.97	([1])
October	405	72.47	([1])
November	403	72.15	([1])

C. Guam

Month	Number of recipients	Average payment per recipient	Percent increase over prior month
April	870	$76.70	...
May	882	76.94	([2])
June	886	77.36	([2])
July	897	77.49	([2])
August	895	77.69	([2])
September	889	77.89	([2])
October	884	77.86	([1])
November	898	77.66	([1])

[1] Decrease.
[2] Increase less than one percent.

Committee amendment.—H.R. 3434, as recently enacted, included a provision to make permanent, beginning with 1980, the increases provided for the jurisdictions in the earlier temporary legislation, that is, a tripling of dollar ceiling amounts. The committee amendment would defer the implementation of the full amount of the increases. Under the committee agreement, the increase would be one-fourth of the total for fiscal year 1980 ($13 million rather than $52 million, to allow some increase in the last quarter of 1980), and one-half the total for fiscal year 1981 ($26 million rather than $52 million). The full amount of the increased funding would thus become effective beginning with October 1, 1981. This would give these jurisdictions time to develop a plan to provide for an equitable distribution of their increased funds. Estimated savings would be $39 million in 1980 and $26 million in 1981.

E. Provisions Relating to Old-Age, Survivors, and Disability Insurance Programs (Part E of Title VI)

REALLOCATION OF OASDI TAXES BETWEEN OASI AND DI TRUST FUNDS

(Section 641 of the Bill)

Present law.—The optimum level of reserve in the social security trust funds has generally been considered to be an amount equal to approximately 1 year's benefit payments. Because of high inflation and other factors, the funds in recent years have fallen far below these optimum levels. Although the 1977 amendments sought to restore somewhat the financial condition of the funds, adverse economic conditions have caused the reserve levels to continue to decline. The old-age and survivors insurance fund in particular has fallen to a level at which possible cash-flow problems could occur sometime in 1981.

Committee amendment.—The financing of the social security program will require detailed review next year. Under current estimates, sufficient funds will be available to assure continuing cash flow capability for the cash benefit trust funds through the end of 1981 and into 1982 from the existing cash benefit tax rate. However, it will be necessary to reallocate the distribution of that tax rate for 1980 and 1981 between the two cash benefit trust funds. (This reallocation would have no impact on the medicare trust funds.) While a reallocation of the social security cash benefit tax rate does not have any direct budgetary impact, the absence of such action would necessitate some other means of providing adequate financing to maintain cash flow in the OASI trust fund. Regardless of what funding source was used, any such alternative method of meeting the cash flow requirements (e.g. a general fund appropriation or an additional social security tax) would result in an increase in budget authority at a time when the committee is under reconciliation instructions to reduce budget authority. The committee therefore has included a reallocation of the OASDI tax as shown below.

CASH BENEFITS SOCIAL SECURITY TAX RATES—EMPLOYER AND EMPLOYEE, EACH

[In percent]

Year	Present law			Committee amendment		
	OASI	DI	Total tax	OASI	DI	Total tax
1980........	4.33	0.75	5.08	4.52	0.56	5.08
1981........	4.525	.825	5.35	4.70	.65	5.35

CASH BENEFITS SOCIAL SECURITY TAX RATES—SELF-EMPLOYED PERSONS

[In percent]

Year	Present law			Committee amendment		
	OASI	DI	Total tax	OASI	DI	Total tax
1980........	6.01	1.04	7.05	6.2725	0.7775	7.05
1981........	6.7625	1.2375	8.00	7.025	.975	8.00

END-OF-YEAR CASH BENEFIT FUND BALANCES

[As a percent of following year outgo]

Year	Present Law			Committee amendment		
	OASI	DI	Combined funds	OASI	DI	Combined funds
1980........	15	44	18	18	20	18
1981........	6	61	12	12	13	12

Note: Estimated by Social Security Administration actuaries.

LIMIT RETROACTIVE BENEFITS TO 3 MONTHS

(Section 642 of the Bill)

Present law.—Individuals who apply for benefits under the social security program are now allowed to effectively backdate their applications by as much as 1 year to claim benefits for months prior to the actual date of application.

Committee amendment.—In the last Congress, the administration submitted a recommendation with its fiscal 1979 budget to change this provision so as to limit retroactivity of applications to a period of 3 months. The old-age, survivors, and disability insurance program is intended to provide a source of monthly income for persons whose support in the form of wages of an insured worker is reduced because of that worker's death, disability, or retirement. Ordinarily, individuals who may be eligible for benefits apply for benefits promptly upon becoming eligible or even some months in advance of eligibility. In some instances, however, an individual may not file an application until after eligibility has already existed for some time. A period of retroactivity prior to the month of application is provided to protect against loss of benefits based on delayed filing which may have resulted from circumstances beyond the individual's control. The committee believes that a retroactivity period of 3 months prior to the month of application should provide ample opportunity for individuals to meet the program's filing requirements. The 3-month period would run from the date the application is filed and not from the date on which a decision is made on the claim. The committee amendment includes this provision. It is estimated to reduce fiscal year 1981 Federal expenditures by $150 million.

SOCIAL SECURITY BENEFITS FOR PRISONERS

(Section 643 of the Bill)

Present law.—Individuals who are inmates of penal institutions or other incarcerated persons, such as the criminally insane who are confined to mental institutions, may become entitled to social security benefits if they can meet the several conditions required for benefits. The fact that they have been convicted of crimes and are incarcerated or are otherwise institutionalized does not interfere with their rights to benefits. This is in contrast to the old public assistance programs of the act (titles I, X, XIV) and the new supplemental security income program (title XVI), all of which explicitly deny payments to an inmate of a "public institution." (That exclusion applies to prison inmates and also to other individuals who are residing voluntarily or involuntarily in institutions maintained by public funds.)

Two related social security provisions of current law and regulation, however, do authorize the withholding of benefits to persons convicted of certain crimes. One originated as an amendment to the Social Security Act in 1956, which allows a judge, as part of a sentence, to deny payment of social security benefits of any type to an individual convicted of subversive crimes against the U.S. Government (espionage, sabotage, treason, sedition, etc.).

The second provision, provided for by regulation, precludes paying benefits to people convicted of killing a relative, and then claiming benefits based on the earnings record of the person they killed.

The data on the number of incarcerated persons receiving social security benefits is limited. Data from the 1970 census showed that approximately 4,000 prisoners in Federal, State and local penal institutions were receiving some form of social security benefits. A recent

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rough analysis of Federal prison inmates performed by GAO showed that 224 such inmates out of 17,000 who had known social security numbers were receiving benefits (approximately 1.5 percent). Another 5,000 inmates appeared not to have social security numbers, or their numbers were not known. Based on these data, the actuaries estimate that approximately 6,000 prisoners are now receiving social security benefits.

Committee amendment.—The committee believes that the basic purposes of the social security program are not served by the unrestricted payment of benefits to individuals who are in prison or whose eligibility arises from the commission of a crime. The disability program exists to provide a continuing source of monthly income to those whose earnings are cut off because they have suffered a severe disability. The need for this continuing source of income is clearly absent in the case of an individual who is being maintained at public expense in prison. The basis for his lack of other income in such circumstances must be considered to be marginally related to his impairment at best. The committee provision therefore would require the suspension of benefits to any individual who would otherwise be receiving them on the basis of disability while he is imprisoned by reason of a felony conviction. This suspension would apply except to the extent that a court of law specifically provides to the contrary as a part of its approval of a plan of vocational rehabilitation services for that individual, and only for so long as the individual continues to participate satisfactorily in an approved vocational rehabilitation program, which is expected to result in his return to substantial gainful employment. The committee amendment would also provide that an individual may not be considered to be a full-time student for purposes of social security student benefits while he is incarcerated. In addition, the amendment provides that disabilities to the extent that they arise from or are aggravated during the commission of a crime may not be considered in determining whether or not an individual qualifies for social security benefits. Impairments not arising from the commission of a crime but occurring while an individual is in prison could not be considered for purposes of disability eligibility so long as the individual remains in prison. This provision is estimated to reduce benefit costs by $16 million in fiscal year 1981.

F. Health Provisions

(Part F of Title VI)

CRITERIA FOR DETERMINING REASONABLE COST OF HOSPITAL SERVICES

(Section 651 of the Bill)

Expenditures for hospital care have been increasing at double-digit rates for many years. Preliminary estimates for calendar year 1978 indicate that hospital expenditures for that year were 12 percent higher than 1977. Expenditures for hospital care, $76 billion in 1978, represent 40 percent of all national health expenditures. Hospital expenditures is fiscal year 1978 represent 3.6 percent of the GNP and $341 per

capita. Historically, hospital costs per patient-day have risen much more rapidly than consumer prices in the economy as a whole.

This rapid growth in the costs of hospital care has focused increasing attention on hospitals and the present methods currently used to reimburse hospitals. Cost-based reimbursement in particular has been the subject of widespread criticism. There is little in the way of pressure on hospitals so paid to contain their costs, since any increases are simply passed along to the third parties that reimburse on a cost basis. The present "reasonable costs" procedures under the medicare program are not only inherently inflationary—because there are no effective limits on what costs will be recognized as reasonable—but also contain neither incentives for efficient performance nor true disincentives to inefficient operation.

In a nongovernmental attempt to moderate the rate of increase in overall hospital expenditures, the American Hospital Association, the American Medical Association, and the Federation of American Hospitals and other health care associations are leading a cost containment activity at the State level. This so-called "Voluntary Effort" should not be discouraged or impaired by Federal agencies through legal or other means before it has had reasonable opportunity to demonstrate success or failure.

The bill does not seek to replace the Voluntary Effort but rather to reform the method of reimbursement for hospitals under the medicare and medicaid programs. Under the new method, to 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 ancillary expenses such as laboratory, X-ray, pharmacy, etc.) would be related to a target rate based on similar costs incurred by comparable hospitals. Hospitals whose routine operating costs were below the average for comparable hospitals would be rewarded with incentive payments, and payments to hospitals with routine operating costs which are substantially above the average would be reduced.

This initial system, described more fully below, would be studied and extended on an as-ready basis. The committee expects that the new system will be extended to hospitals' ancillary costs and other costs that are excluded initially as soon as adjustments for patient-population differences and other methodological prerequisites are developed. Based on recommendations of a proposed Health Facilities Cost 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 Cost Commission on or before October 1, 1980. The Commission would consist of 15 persons who are expert in the health facilities reimbursement area. At least five of the members would be representatives of hospitals (and other providers which are subject to the new reimbursement method); at least five would be representatives

of public (Federal, State, and local) health benefits programs; and the remainder would be persons who, through training, experience or attainments, are particularly and exceptionally well qualified to serve in carrying out the Commission's functions.

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 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 approved education and training programs for health care personnel; 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. The Health Facilities Cost Commission should give priority to the development and evaluation of alternative definitions and classifications for this category of medical schools. The Commission should insure that the treatment of these medical center, tertiary care/teaching hospitals accurately reflects the hospital's role as a referral center for tertiary care patient services, as a source for the development and introduction of new diagnostic and treatment technologies, and/or as the source of care for a high concentration of patients needing unusually extensive or intensive patient care services provided in routine service cost centers. In addition, these hospitals generally provide a broad range of graduate medical education programs and undergraduate medical clerkships. The committee recognizes that some medical schools, because of their organization and objectives, have more than one primary affiliate, and the primary affiliate classification should provide for the possibility of including more than one hospital in unusual situations. The primary affiliates category should not include affiliated hospitals which are not primary affiliates within the meaning of the concept described above.

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 fully meet the 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 estimated 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.

The committee recognizes that all the data for precise determination of routine operating costs and the labor and nonlabor components of such costs may not be available from cost reports for accounting years that begin in and prior to, 1980. To the extent necessary, the Secretary will be expected to make reasonable estimates on the basis of the data available to him. That is reasonably related to actual hospital cost experience.

Hospitals whose actual routine operating costs fall below their target rate would receive their actual costs plus one-half of the difference between their costs and their target rate with the bonus payments limited to 5 percent of their target rate. In the first year, hospitals whose actual costs exceed their target rate, but are 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.

To ease transition of the program, only one-half of the bonuses and penalties would be applied during the first 2 years.

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. The target rate for hospitals which have average lengths-of-stay which are less than other hospitals in the same category could be calculated by multiplying the average reimbursement per patient stay for the hospital's category by the number of patient stays for that hospital, not to exceed its actual routine costs.

Adjustments would be made to the target rates of hospitals which demonstrate that their costs exceed their target rates because of (1) unusually high standby costs justified by low utilization in underserved areas; (2) atypical cost patterns of newly opened hospitals; (3) services changed for such reasons as consolidation, sharing, and approved addition of services (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 would

be recognized under the "intensity" exception provision, except where a hospital has had its target rate calculated on the cost-per-stay basis (to take into account shorter lengths of stay).

Hospitals would be exempted from the proposed cost limits if: (a) the hospital is located in a State which has established a hospital reimbursement control system which applies at least to the same hospitals and kinds of costs as are subject to the proposed Federal reimbursement reform system and (b) the State requests use of its own system and demonstrates to the satisfaction of the Secretary that, using the State's system, total medicare and medicaid reimbursement costs for hospitals in the State will be no greater than if the Federal system had been applicable. If the reimbursement system were not established by the State but in all other respects it meets the criteria for an exemption under the provisions of the bill, the reimbursement system would be considered to be established by the State if the State elects to have it so treated.

A State which exceeds, in the aggregate, the costs which would otherwise have been paid under the Federal programs for any two-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 the State incurs in 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 incurred by a State following approval of 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 expressed concern over the possibility that the new limits on reimbursement might lead to increased costs for other payors. The new Health Facilities Cost Commission should review the operation of the new medicare-medicaid hospital reimbursement system and report on the extent, if any, to which hospitals bill other payors to cover costs disallowed by medicare and medicaid.

The Commission is expected to also report to the Congress when, in its opinion, a State has, under its approved ratemaking system, established reimbursement under medicare and medicaid at levels so much below what would otherwise be payable in the absence of the State system, as to actually impair the ability of the hospitals to provide necessary care at reasonable cost.

If the HEW Secretary proposes to modify the method of reimbursement for reasonable costs under titles V, XVIII, and XIX of the Social Security Act, he must submit such proposals to the Health

Facilities Costs Commission. If the Commission disagrees with the proposals, regulations implementing such proposals must be submitted to the Congress and may not become effective for 60 days. In addition, section 660 of this bill requires the Commission to give priority to studying and recommending to the Secretary limits on reasonable costs and charges for outpatient services.

PAYMENTS TO PROMOTE CLOSING AND CONVERSION OF UNDERUTILIZED FACILITIES

(Section 652 of the Bill)

Studies have pointed to a national surplus of short-term general hospital beds ranging as high as 100,000 beds. Excess capacity contributes significantly to hospital costs since the initial construction and financing expenses have to be recovered by the hospital. In addition there are the continuing expenses associated with maintenance, and nonpatient services involved in keeping an empty bed ready for use. Surplus beds contribute to cost escalation in other less obvious ways. Unnecessary or underutilized hospital facilities can drain scarce manpower and generate scarcities of trained personnel, which in turn drive up salaries and may even threaten the quality of care. Coupled with the availability of hospitalization insurance, bed surpluses tend to generate pressures to use high cost hospital beds rather than less expensive alternative forms of care. The development of alternatives to inpatient facilities, such as primary care and community home care programs, suffers when investment is needlessly diverted to underutilized hospital bed capacity. Estimates of the savings that would accrue from closure or conversion of unused or underutilized facilities range from $2 billion to $4 billion annually, depending on whether the change involves closure or conversion of a particular service department as opposed to a whole hospital.

The bill 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 of underutilized bed capacity or services in nonprofit short-term hospitals. A hospital could apply for such payments *before or after* the conversion or closing takes place. 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 capital costs in the form of depreciation allowances, or reimbursement for interest payments which would ordinarily be applied toward payment of outstanding debt which had been 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. The Secretary of HHS is required to report to the Congress, on or before January 1, 1982, an evaluation of the effectiveness of the program and any recommendations.

The committee recognizes that a facility which is generally underutilized, and which would therefore be potentially eligible for a transitional allowance to finance a facility conversion, may be the sole or primary source of care for needed health services in the community. It is the intent of this committee that the availability of a transitional allowance not encourage the conversion of a facility that is needed in the community. Therefore, it will be necessary for the Hospital Transitional Allowance Board to determine that the facility conversion will not have an adverse impact on access to needed health care services before the Board may recommend that the Secretary establish a transitional allowance for the hospital. Only in those cases in which reasonable access to needed health care services will not be jeopardized may a transitional allowance be recommended.

COORDINATED AUDITS UNDER THE SOCIAL SECURITY ACT

(Section 653 of the Bill)

The bill provides for the coordinated use of audit findings in the administration of medicare, medicaid and the maternal and child health program.

The committee has been concerned that 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 a hospital, skilled nursing facility, or home health agency) participating in the program.

The committee bill therefore 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 Federal programs are to be coordinated through common audit procedures. Ordinarily, it is expected that the common audit would be performed for the purposes of reimbursement under title XVIII. However, in those cases where the Secretary finds, in the interest of efficiency and economy, that a State audit would be more appropriate, the State could, if it agrees to do so, perform the common audit for the three programs.

When a State declines to participate in a common audit, the Secretary is to reduce payments that would have been made to the State under title 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. The committee expects that the common audits will be carried out in timely fashion in order to expedite the inter-program coordination.

APPORTIONMENT OF PROVIDER COST

(Section 654 of the Bill)

Under a policy that medicare adopted in July 1969, hospitals are reimbursed for a disproportionately large share of the costs of routine nursing care on the theory that older hospital patients require an above-average amount of routine nursing services per day. This inpatient routine nursing salary cost differential is 8½ percent of the inpatient routine nursing salary cost. However, there was no objective, convincing evidence that this "plus factor" was warranted at that time, either in the case of individual hospitals or in the aggregate. Since July 1969, when the inpatient routine nursing salary cost differential became effective, there have been changes in medicare law, changes in the way services are furnished, and changes in the way medicare reimburses for routine services that make the cost differential even less tenable today. One argument against the cost differential is that the increase in the number of below-age-65 population beneficiaries has made an average routine per diem amount for all beneficiaries (excluding recognition of any differential) more appropriate. Also, with the growth of special-care beds (intensive care, coronary care, etc.), there has been a shift of the intensely ill from general routine-care areas to these special-care units. There has been greater utilization of these special-care units than of routine care areas by medicare beneficiaries. More intensive nursing care is now being given in these special-care units, making the nursing cost differential for routine services unnecessary.

The bill provides that no medicare payments may be made if the payment exceeds the proportional share of the cost, as measured by days of utilization or provider charges, until such time as evidence can be produced which, in the judgment of the Comptroller General, and concurred in by the Secretary of HHS, justifies a specific plus factor as warranted under particular circumstances for certain facilities.

Under the bill, the routine nursing cost differential would be retained through March 1981. During this time, GAO would conduct a study to determine which hospitals (classified, as appropriate, by type, size, location, patient characteristics, average length of stay, types and availability of nursing service, etc.) might be entitled to a nursing cost differential and the amount that was warranted. During the second half of fiscal year 1981, payment of the nursing cost differential would be suspended while the results of the GAO study are translated into new, more equitable nursing cost differential payment regulations. These new regulations would become effective in October 1981 and would apply not only prospectively but also retroactively, where applicable, to services furnished during the latter half of fiscal year 1981. It is the committee's intent that the Comptroller General will initiate the required studies without delay.

REIMBURSEMENT FOR INAPPROPRIATE INPATIENT HOSPITAL SERVICES

(Section 655 of the Bill)

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 home care programs 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.

To prevent this wasteful expenditure of public funds and encourage a more rational use of health resources, the bill provides that, effective October 1, 1980, medicare and medicaid payments to hospitals would be made at the average skilled nursing facility (SNF), intermediate care facility or detoxification facility payment rate (as may be appropriate) in the State, rather than the much higher hospital rate, for patients medically determined by PSRO reviewers to need care in such a lower-cost facility home care program. (In no case, however, could a facility that has a unit that can provide the appropriate level of care be paid more under this provision than it could be paid if it had placed the patient in the appropriate unit). For example, if the PSRO determined that a hospitalized medicare patient could more appropriately be cared for in a SNF, and that he would be eligible for medicare benefits if he were an inpatient in such a facility, medicare payments for his hospital care would be paid at the SNF rate. Days of care paid by medicare at the reduced, SNF rate 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 in those geographic areas where the appropriate State or local planning agencies certify that there is no general excess of hospital beds (adjusted for patients in hospital beds who do not need that level of care) and there is a shortage of long-term care beds.

In addition, the bill provides for payment to be made under medicare for inpatient detoxification services in a freestanding facility that is not a hospital. The "detoxification facility services" to be covered would be the same as those that are reimbursable when provided in a hospital. The term "detoxification facility" means a public or nonprofit facility other than a hospital which (a) is engaged in furnishing the above services to inpatients; (b) is either accredited by the Joint Commission on Accreditation of Hospitals as meeting its Accreditation Program for Psychiatric Facilities standards (1979 edition) or found by the Secretary to meet such standards; (c) has arrangements with one or more hospitals, having agreements in effect under section 1866, for the referral and admission of patients requiring services not available at the facility; and (d) meets such other requirements as the Secretary may find necessary in the interest of the health and safety of individuals who are furnished services by the facility.

A physician (qualified to make such determinations) who has examined the patient prior to initiation of detoxification must certify that he needs to be detoxified on an inpatient basis.

Reimbursement for detoxification services would be made under medicare—Part A, on a reasonable cost basis, with no deductible or coinsurance.

The Secretary shall study and make recommendations, within 18 months of enactment, concerning the appropriateness of extending coverage to post-detoxification rehabilitation and to outpatient detoxification. The Health Facilities Cost Commission would review and recommend a method of classifying and comparing detoxification facilities in time to permit application of the reimbursement methodology within 2 years of enactment.

PSRO's would be directed to review the appropriateness of the services furnished by detoxification facilities for which medicare reimbursement is claimed. The committee understands that 3–5 days will ordinarily be sufficient for patients to complete the detoxification process.

PSRO REVIEW OF HOSPITAL ADMISSIONS, ROUTINE TESTING AND PREOPERATIVE STAYS

(Section 656 of the Bill)

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. Because of inadequate appropriations, PSRO's have generally been unable to undertake the review of the ancillary and outpatient services that hospitals provide, as required by existing law. PSRO studies and testimony before the committee 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 (i.e., Friday and Saturday 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.

The bill directs PSRO's that are able to do so to give priority to reviewing 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 and weekend admissions 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 1 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 recognizes the need for additional funds for the PSRO program to engage in these reviews and expects that such funds will be made available.

CERTAIN SURGICAL PROCEDURES PERFORMED ON AN AMBULATORY BASIS

(Section 657 of the Bill)

Currently, medicare can reimburse the physician for his professional services in any setting. Also, the institutional costs of ambulatory surgery in a hospital outpatient department can be reimbursed. However, a charge for the use of special surgical facilities in a physician's private office or a free-standing surgical facility that is not hospital affiliated is not reimbursable.

Under the bill the physician performing certain listed surgical procedures in his office would be compensated for his special, surgical overhead through an all-inclusive rate if he accepts an assignment; there would be no deductible and coinsurance applied in such cases. Such procedures would include those which are often provided on an inpatient hospital basis but can, consistent with sound medical practice, be performed on an ambulatory basis. The rate would encompass reimbursement for the facility, physician 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.

Normal review of such claims by Professional Standards Review Organizations, carriers and other present review mechanisms should work to safeguard against inappropriate or indiscriminate performance of procedures on an ambulatory basis.

Similarly, reimbursement would be provided for the use of the facilities in an ambulatory surgical center, without deductible or coinsurance, where the center accepts assignment. In the case of an ambulatory surgical center the payment could take the form of an all-inclusive rate, covering the facility overhead and physicians' fees or, alternatively, the overhead allowance could be paid directly to the center and the professional fee could be paid directly to the surgeon and to other physicians who provide services in connection with the procedure. The deductible and coinsurance would also be waived for the physician fees for services performed in connection with listed surgical procedures in hospital outpatient departments and other ambulatory surgical centers where the physicians accept assignment.

The overhead factor is expected to be calculated on a prospective basis (and periodically updated) utilizing sample survey and similar techniques to develop reasonable estimated overhead allowances for each of the listed procedures which take account of volume (within reasonable limits). The committee does not intend that individual financial records be audited in order to determine a physician's or a center's specific overhead allowance. What is intended is a reasonable estimate of such costs of performing such procedures generally.

The committee expects that this provision will encourage performance of surgery in generally lower cost ambulatory settings, where appropriate, instead of the more expensive hospital inpatient setting.

It anticipates that States will want to monitor the effectiveness of the new benefit with a view toward making similar modifications in their medicaid programs.

The committee is concerned that 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 while in the hospital than prior to being admitted. The bill eliminates the financial incentives to unnecessarily utilize hospital care in cases where needed diagnostic services are provided in the hospital's outpatient department within the 7-day period prior to the patient's admission. The Secretary, in consultation with the National Professional Standards Review Council, would be required to specify those preoperative medical and other health services which could safely be performed on an outpatient as well as inpatient basis. A physician performing a listed service on an outpatient basis within the 7-day period prior to the patient's admission for surgery (to which the service relates) would receive reimbursement equal to 100 percent of medicare's reasonable charge if he agreed to accept such payment as payment in full.

CRITERIA FOR DETERMINING REASONABLE CHARGE FOR PHYSICIANS' SERVICES

(Section 658 of the Bill)

Medicare currently utilizes more than 200 different "localities" throughout the country for purposes of determining part B "reasonable" charges. For example, one State has 28 different localities. The committee notes that this has led in many instances to marked and unjustified disparities in areas of the same State in the prevailing charges for the same service. Additionally, under present law, increases in prevailing charges are limited to levels justified by changes in the costs of practice and wage levels. The committee is concerned that the effect of present law is to further widen the dollar gap between prevailing charges in different localities.

The bill provides 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.

Under existing law, medicare allows a new doctor to establish his customary charges at not greater than the 50th percentile of prevailing charges in the locality.

The bill would permit new physicians in localities which are designated by the Secretary as physician 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 fee levels.

PROCEDURES FOR DETERMINING REASONABLE COST AND REASONABLE CHARGE

(Section 659 of the Bill)

The bill 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) are based upon percentage arrangements.

Percentage arrangements can take several forms. For example, some involve business contracts for support services, such 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.

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.

The committee does not, however, intend this provision 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 Secretary finds that the arrangement contributes to efficient and economical operation.

For example, under some existing management contracts, the contractor receives both a percentage of operating expenses as a base management fee, and a share of the net revenues of the institution after all costs have been met. Where the contractor's percentage share of net revenues exceeds the percentage on which the base management fee is calculated, the contractor could have a strong incentive to contain operating expenses. Of course, under such circumstances, the reasonableness of the percentages applicable to the operating expenses would have to be considered in terms of comparison with the costs incurred in the management and/or operation of reasonably comparable facilities which do not utilize such contracts.

In the case of hospital-based physicians, on the other hand, the bill would permit recognition of percentage arrangements if the amount of reimbursement does not exceed an amount which would reasonably have been paid to the physician under relative value schedules approved for this purpose by the Secretary. Under such an approved relative value schedule, the charges of a given physician would be subject to a test of reasonableness in terms of that physician's usual contribution of time and effort in the provision of the services for which he bills.

Percentage arrangements entered into by hospitals and hospital-based physicians before January 1, 1979, could be recognized subject to the same tests of reasonableness as were prescribed by regulations in effect on such date until such time as the hospital is able to unilaterally terminate such arrangement, or January 1, 1982, whichever is earlier.

The bill directs the Secretary to conduct a study of hospital-based physician reimbursement and the impact of alternative reimbursement methods on providers, patients, physicians, and third-party payers. He must submit his findings, together with legislative recommendations within two years of enactment.

The committee recommends that HHS adopt as its policy under existing law those provisions relating to the reimbursement of anesthesiologists' services which were included in S. 505, which contained the predecessor of this provision. That provision would provide that full fees could be paid to an anesthesiologist only where he personally performed all the professionally appropriate pre- and post-anesthetic services and carried out the most demanding procedures in connection with administration of the anesthesia for no more than two patients. Payments equal to one-half of the full fee for each patient could be made where the anesthesiologist personally directed other individuals in carrying out the most demanding procedures, provided the anesthesiologist personally performed the other pre- and post-anesthetic services and was responsible for no more than four patients during the course of anesthesia administration.

LIMITATION ON REASONABLE COST AND REASONABLE CHARGE FOR OUTPATIENT SERVICES

(Section 660 of the Bill)

The bill requires the newly established Health Facilities Cost Commission to give priority to the development of limitations on hospital outpatient and clinic costs. Further, the Secretary is required to issue regulations providing for the establishment of such limitations.

As a result of various limits placed by public agencies and others on inpatient hospital expenditures, some hospitals have sought to have a disproportionately large share of their total costs financed by the revenues from their outpatient departments. In addition, reimbursement to community health centers and similar freestanding clinics which are presently paid on a cost-related basis, have, according to the General Accounting Office sometimes proved to be excessive.

The bill therefore requires the Health Facilities Cost Commission (established under Section 202 of this bill) to give immediate priority to making a study and submitting recommendations to the Secretary

with respect to setting limitations on costs or charges for outpatient services. Further, the Secretary is required to issue regulations establishing such limitations with respect to services provided on an outpatient basis by hospitals, community health centers, or clinics (other than rural health clinics) and by physicians using such facilities.

MEDICARE LIABILITY WHERE PAYMENTS CAN BE MADE UNDER LIABILITY INSURANCE

(Section 661 of the Bill)

The bill provides that medicare would not be the payor of first resort in cases where the patient is involved in an accident and his care can be paid for under liability insurance of the individual who was at fault or under a no-fault insurance plan.

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.

The bill provides that where the medicare patient is involved in an accident and his care can be paid for under the insurance of the individual who was at fault (or under a no-fault plan), medicare would have residual and not primary liability. Under this provision, medicare would pay for the patient's care in the usual manner and then seek to be reimbursed by private insurance after, and to the extent that, liability has been determined. The bill leaves to the discretion of the Secretary an evaluation of the probability of recovery and the minimum amounts estimated as recoverable, so as to avoid the administrative cost and effort of pursuing minor recoveries or situations where there is little likelihood of ultimate recovery.

ACCESS TO AND PURCHASE OF CERTAIN MEDICAID SERVICES

(Section 662 of the Bill)

The bill allows a State to arrange for a purchase services for its medicaid population through cost-effective arrangements, for services that meet applicable State and Federal laws, regulations and standards.

Under present law, medicaid recipients are permitted to choose from among hospitals and other suppliers of health care that are covered by the State program.

While this well-intentioned provision was designed to permit medicaid patients to choose among any qualified supplier of covered services, in the same manner as the patients, it has met with only partial success. On the other hand, it has in some instances led to the inefficient expenditure of often limited medicaid funds by depriving the State of discretion to purchase or arrange for medicaid services, equipment and supplies prudently and economically. In some cases, this inability to negotiate with the health care community has required States to pay

the top dollar for some services—especially institutional services—while at the same time shortages of funds makes it necessary for the State to impose harsh restrictions on the kinds of health services it covers and the number of low income people who can qualify for aid.

The bill would allow States greater discretion in arranging for hospital and other institutional services, clinic services, laboratory services and medical supplies and equipment for Medicaid recipients through cost-effective arrangements. However, the State could not pay less for inpatient hospital services under this provision than the cost that is found to be reasonable and necessary in the efficient delivery of hospital services in the geographic area where the hospital is located.

Provision would be made to assure that beneficiaries have reasonable access to services (including emergency services) that fully meet program standards of quality. In addition, provision would be made to avoid having a substantially adverse effect on appropriate and necessary use of hospitals with graduate medical education programs.

The Secretary is expected to carefully monitor the effects, if any, of operation of this section upon appropriate and necessary graduate medical education. If a pattern is found indicating serious impairment of such graduate education the Secretary is expected to require appropriate corrective modification by a State.

MEDICARE HOSPITAL PERIODIC INTERIM PAYMENTS (PIP)

(Section 663 of the Bill)

Medicare currently offers hospitals two payment procedures. First, there is a procedure under which payments are made to the hospital on the basis of bills which state what covered services have been furnished during the billing period. On the average, there is a 6 week lag between the rendition of a service and the receipt by the hospital of the payment. (Only about 10 to 14 days of this lag is attributable to time taken by the medicare intermediary in processing the bill.)

Under the alternative procedure, hospitals receive, "periodic interim payments" (PIP) which are not directly tied to the receipt of bills. On the average, this procedure produces only a three week lag between rendition of the service and receipt of payment.

The bill would amend the PIP payment procedure for hospitals by providing for payment to be withheld during September 1981 so that the lag would be increased to the average of about six weeks delay experienced by hospitals that use the standard method. The deferred payments would be paid to the hospitals in October 1981.

DISALLOWANCE OF STATE CLAIMS FOR FEDERAL MEDICAID FUNDS

(Section 664 of the Bill)

At present, when a State's claim for Medicaid matching funds is disallowed by the Federal Government, the State may appeal the decision and retain the funds that are in dispute until a final determina-

tion is made. A decision on an appealed disallowance can take as long as two years, and during this period the Federal Government loses interest on the disputed funds whether or not the appeal is settled in its favor.

The bill authorizes the Secretary of HHS to offset amounts in dispute from other Medicaid funds due the State until the appeals process has been exhausted. If the final decision is in the State's favor, the Federal Government would repay the money to the State with interest.

REIMBURSEMENT RATES UNDER MEDICAID FOR SKILLED NURSING AND INTERMEDIATE CARE FACILITIES

(Section 665 of the Bill)

Present law requires States participating in medicaid to pay skilled nursing facilities (SNFs) and intermediate care facilities (ICFs) on a reasonable cost-related basis. This requirement, added by Section 249(a) of the Social Security Amendments of 1972, was designed to assure that payment rates would more closely reflect the reasonable cost necessary to provide nursing home services of adequate quality. Section 249(a) gives States the option of using medicare's reasonable cost reimbursement formula for purposes of reimbursing SNFs and ICFs or developing other reasonable cost-related methods of reimbursement acceptable to the Secretary.

States have argued that the complex and long-delayed Federal regulations implementing the statutory requirement of section 249(a) have unduly restrained their administrative and fiscal discretion and that the Federal approval process has forced States to rely heavily on medicare principles of reimbursment. Neither of these consequences was intended when section 249(a) was enacted.

The committee continues to believe that States should have flexibility in developing methods of payment for their medicaid programs and that application of the reasonable cost reimbursement principals of the medicare program for long-term care facility services is not entirely satisfactory. These principals are inherently inflationary and contain no incentives for efficient performance.

The committee bill deletes the present language of section 1902 (a)(13)(E) of the act (which was added by section 249(a) of the 1972 legislation) and substitutes language which gives the States flexibility and discretion, subject to the statutory requirements of this section and the existing requirements of section 1902(a)(30) and section 1121 of the Act, to formulate their own methods and standards of payment.

Under the bill, States would be free to establish rates on a statewide or other geographic basis, a class basis, or an institution-by-institution basis, without reference to medicare principles of reimbursement. The flexibility given the States is not intended to encourage arbitrary reductions in payment that would adversely affect the quality of care. Under the bill, the State would be required to find, and make assurances satisfactory to the Secretary, that the payment rates, taking

into account projected economic conditions during the period for which the rates are set, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations and standards. The State would also be required to assure the Secretary that it has provided for the filing by the facilities of uniform cost reports and for their periodic audit by the State.

The Congress expects that the Secretary will keep regulatory and other requirements to that minimum necessary to assure proper accountability, and not to overburden the States and facilities with marginal but massive paperwork requirements. It is expected that the assurances made by the States will be considered satisfactory in the absence of a formal finding to the contrary by the Secretary.

In establishing rates, a State, at its option, could include incentive allowances designed to encourage cost containment through efficient performance, as well as incentives to attract investment where such investments would serve to alleviate demonstrated shortages of long-term care services. In addition, States would continue to have the option provided in current Federal Regulations to adjust rates downward for facilities with service deficiencies where facilities are classed by quality of service or level of care.

The Secretary would be expected to continue to apply current regulations which require that payments made under State plans do not exceed amounts which would be determined under the medicare principles of reimbursement. Since States would be free under the bill to establish payment rates without reference to medicare principles of reimbursement, the Secretary would only be expected to compare the average rates paid to SNFs participating in medicare with the average rates paid to SNFs participating in medicaid in applying this limitation.

LIMITS ON REIMBURSEMENT FOR HOME HEALTH VISITS UNDER MEDICARE

(Section 666 of the Bill)

On June 5, 1980, the Department of HHS published in the Federal Register the revised schedule of limits on home health agency costs that may be reimbursed under medicare for cost reporting periods that begin during the 12-month period that will begin July 1, 1980. The limits, which are authorized under legislation enacted in 1972, expressed as costs per visit. Although separate limits are established by type of service, they are applied to each agency as a single aggregate limit, based on the agency's number of visits for each type of service. The schedule of limits was based on (1) a classification of home health agencies according to their location within a Standard Metropolitan Statistical Area (SMSA), a New England County Metropolitan Area (NECMA) or a non-SMSA; (2) limits set at the 80th percentile; and (3) an estimated inflation factor. The limits, which are presented below, are adjusted to take account of local wage differentials when applied to the individual agency—

FREESTANDING AGENCIES

Type of visit	SMSA (NECMA) Location	Non-SMSA Location
Skilled nursing care	42.67	44.75
Physical therapy	42.42	49.62
Speech pathology	44.04	48.35
Occupational therapy	45.24	57.30
Medical social services	48.79	43.46
Home health aide	32.26	31.49

PROVIDER-BASED AGENCIES

Type of visit	SMSA (NECMA) Location	Non-SMSA Location
Skilled nursing care	54.17	47.23
Physical therapy	47.87	46.37
Speech pathology	47.52	[1]
Occupational therapy	49.94	[1]
Medical social services	54.54	[1]
Home health aide	47.36	42.95

[1] Insufficient data—Use basic services limits for free-standing non-SMSA agencies.

The committee believes that these limits are set at an unrealistically high level. In part, this is because the limits are based on unaudited cost reports which include inflated costs. More important, in averaging the costs per visit, the costs of a large agency were given no more weight than those of a small agency. The result of these problems in the calculation and others is that medicare is now prepared to pay more in some instances for a single visit to the patients home than is paid for an entire day of room and board and skilled care at a nursing home.

High payment ceilings are particularly troublesome in the home health area because many of the private agencies are organized primarily to serve medicare patients. For such agencies there is little incentive to hold down costs so long as they are reimbursable under medicare.

The bill would limit allowable costs for home health agency services under medicare to amounts not in excess of the 75th percentile of

weighted average audited costs. These limits would be applied separately to each type of visit, rather than on an aggregate basis, when revisions in the existing cost reporting procedures make this possible. (This methodology is similar to that used in calculating allowable charges for physicians' services.) In addition, the allowable cost of skilled nursing visits and home health aide visits would not exceed medicaid skilled nursing facility per diem rates, hospital-based facility rates in the case of hospital-based home health agencies and other skilled nursing facility rates in the case of nonhospital-related agencies.

The bill also makes changes of a technical nature that are intended only to make home health payment limits more equitable by assuring that nursing service costs and visits are properly accounted for. These changes would in no way affect beneficiaries' eligibility for home health benefits. One of these changes provides that visits that are required by regulation to assure that home health aides' services are being properly performed would be recognized for reimbursement purposes as visits. They are now treated as part of the agencies' overhead. Similar treatment would be provided for home health assessment visits which are necessary to determine whether a referred patient is suitable for home health services and eligible for medicare. For an assessment visit to qualify for visit status (even though the beneficiary was determined ineligible), the referral would have to be made by a hospital discharge planner, a physician or other person who has knowledge of the patient's health care needs and the home health benefit requirements and who believes that the patient should be eligible for covered services.

The committee is also concerned that a given home health agency may have to incur substantially more travel costs, compared to the agencies with which it is classified, in order to provide needed care to distant patients. The committee believes that the Secretary should provide for exceptions to be made for agencies that exceed the payment limits because of necessary, substantially atypical travel costs (including both transportation costs and the cost of salaries to personnel while traveling).

DETERMINATION OF REASONABLE CHARGES UNDER MEDICARE

(Section 667 of the Bill)

Medicare reasonable charges are updated in July of each year to keep pace with certain economic changes. All bills that the medicare carrier receives after the charges are updated are paid at the higher rate. In effect, the amount of the medicare payment often depends on how long the claimant delays billing rather than on the charge levels in effect when the medical service was provided. To eliminate this inequity, the bill includes a provision under which the medicare reasonable charges that are payable would depend on the date the medical service was rendered rather than the date the medicare claim was processed.

G. Fund Transfer Provision

(Part G of Title VI)

DEFERRED TRANSFER OF CERTAIN FUNDS TO TRUST FUNDS

(Section 671 of the Bill)

Present law.—The social security and medicare programs are funded through earmarked payroll taxes. These taxes are paid into the Treasury by employers, employees, and self-employed persons. Amounts exactly equal to the tax collections are then appropriated out of the general Treasury and into the social security and medicare trust funds under a permanent standing appropriation in the Social Security Act. Under the accounting system used for purposes of the Budget Act, budget authority for trust fund programs is considered to arise at the moment when the tax receipts are appropriated into the trust funds. As a result, the various savings provisions approved by the committee in trust fund programs will not result in a reduction in the 1981 budget authority for those programs although they do result in 1981 outlay reductions and do reduce the amount of budget authority that will ultimately be needed to operate the programs.

Committee amendment.—In order to meet the reconciliation requirements for fiscal 1981 budget authority reductions, the committee amendment provides that $0.6 billion in social security and medicare tax receipts which would otherwise be transferred to the trust funds at the end of September 1981 will instead be transferred to the trust funds after the end of that month. This will reduce budget authority for fiscal 1981 by that same amount.

III. Regulatory Impact of Finance Committee Amendments

In conformance with paragraph 11(b) of rule XXVI of the Standing Rules of the Senate the following Finance Committee evaluation is made of the regulatory impact which would be incurred in carrying out title VI of the bill.

A. UNEMPLOYMENT COMPENSATION PROVISIONS

The sections in Part A of title VI of the bill modify a number of aspects of the unemployeunt compensation programs. Sections 601 and 603, dealing with extended benefit trigger levels, should reduce the Federal regulatory impact on the States inasmuch as they increase State flexibility by removing an existing-law mandatory provision and increase the scope of flexibility under an existing-law optional provision. Ultimately the economic impact of these provisions is likely to be a reduction in the unemployment tax burden on employers reflecting a similar reduction in benefits to individuals. The level of this impact is indicated in the budgetary impact section of this report.

Section 602 is intended to affect State benefit rules concerning payment of benefits for the first week of unemployment. These rules may require some regulatory activity by the Department of Labor to explain and monitor the carrying out of these provisions. No significant amount of paperwork is anticipated.

Section 604 simply changes a qualifying service requirement from one period of time to another (90 days to one year).

Section 605 relates essentially to the method of accounting within Federal agencies for an existing expenditure item and except for the impact within those agencies should have no regulatory effects.

Sections 606 and 607 establish certain new limits on the payment of extended unemployment compensation benefits. As such, the provisions can be expected to (and are intended to) have an impact on individuals who would otherwise receive benefits under this program. However, those affected would be a relatively small proportion of the total population extended benefit recipients. The implementation of these provisions will involve some regulatory impact on applicants and on the State agencies that administer the program inasmuch as these provisions will require somewhat different eligibility rules for the extended benefit program than those that apply to the regular program (except to the extent that States choose to implement these rules in their regular programs). However, the regulatory impact is not expected to be excessive since States already receive information concerning non-resident beneficiaries and the prior wage history of applicants. The provision barring extended benefit payments to persons who have left jobs voluntarily or for misconduct is based on existing State findings and should therefore involve minimal new regulatory impact. The provision denying extended benefits to individuals refusing any reasonable job offer does differ from existing State programs in most jurisdictions and will therefore involve additional regulatory measures. However, an identical provision was previously in force under the now-expired Emergency Unemployment Compensation Act of 1974. Consequently, the procedures to carry out this provision should not be excessively difficult to develop and implement.

The Committee on Finance believes that none of the provisions of part A of title VI will have any substantial paperwork impact and that none of them can be expected to affect the personal privacy of individuals.

B. SSI PROVISION

Section 611 of the bill is intended to eliminate an abusive situation in which individuals with disqualifying assets intentionally divest themselves of those assets in order to qualify for cash and medical assistance. The provision will require some additional paperwork and some disclosure of personal information concerning property transactions which SSI applicants engaged in during the two years prior to application for benefits. This is, however, consistent with and similar in nature to other informational requirements of existing law con-

cerning the economic status and resources of applicants for assistance. The information will be utilized solely for purposes of program administration. For the great majority of SSI recipients, this requirement will have no economic impact. It will, however, have an adverse economic impact on those individuals who would otherwise attempt to qualify for benefits by disposing of assets.

C. TEMPORARY SUSPENSION OF DAY CARE REGULATIONS

Section 621 of the bill will postpone until October 1, 1981 the implementation of regulations recently promulgated by the Department of Health and Human Services governing child care for which Federal funding is claimed under title XX of the Social Security Act. This provision will defer the substantial regulatory impact of those regulations on providers and recipients in order to allow time for Congress to further examine that impact and to determine whether the regulations should be implemented and, if so, whether additional Federal resources are required.

D. PUBLIC ASSISTANCE PAYMENTS TO TERRITORIAL JURISDICTIONS

Section 631 of the bill will phase-in the increased funding for territorial public assistance programs which was provided for in Public Law 96-272 (H.R. 3434). Under this section, the additional funding for fiscal 1980 will be reduced from $52 to $13 million and for fiscal 1981 from $52 to $26 million. Thereafter, the permanent increase of $52 million will be effective. This should not affect the long-term economic situation of individuals although it will have some economic impact in fiscal years 1980 and 1981. The provision should require no additional regulatory activity and no impact on paperwork or privacy.

E. SOCIAL SECURITY PROVISIONS

Section 641 of the bill is an accounting transaction between two social security trust funds which has no impact of a regulatory nature. Section 642 simply reduces an existing law limit on the retroactivity of benefits from 12 months to 3 months prior to the month of application. It should have no impact of a regulatory, paperwork, or privacy nature and should affect only those relatively few applicants who do not file for benefits until some months after they have become eligible for them. Section 643 places limitations on the payment of benefits to prisoners and to persons who become disabled in the commission of criminal actions. Because of the relatively small number of individuals affected, the Committee believes that this provision has no significant regulatory impact. It is estimated that about 6,000 persons are now receiving benefits while in prison. For those affected, there will be some impact on economic status and on privacy (in that the Social Security Administration will be required to determine that they are in prison and that their disabilities arose in the commission of crimes.) The Finance Committee does not consider these impacts to be inappropriate.

F. HEALTH PROVISIONS

In implementing the various provisions of Part F of title VI there will be some increase in Federal regulatory activtiy. It is not anticipated, however, that the legislation would impose an unusual or burdensome regulatory effect. Several provisions will, in fact, decrease regulatory activity and associated paperwork.

Section 651 of the bill would generate the most significant new regulatory activity since a new method of reimbursement under medicare and medicaid is required. Revised regulations will be necessary to implement a procedure for determining hospital "target" rates, as well as implement a procedure for determining exceptions to those rates. In addition, the Secretary would be required to implement procedures to evaluate State ratemaking programs for the purpose of determining exemptions from the Federal program.

The authorization for payments under the legislation to promote closing and conversion of underutilized facilities establishes a new procedure that would also require implementing regulations.

A provision that directs PSRO's to review certain questitonable utilization practices would increase PSRO's review activities.

Provisions that will decrease regulations and paperwork include the provision for coordinated audits under titles V, XVIII, and XIX; and authority for States to arrange for the cost-effective purchase of certain services and certain medical devices under medicaid.

G. FUND TRANSFER PROVISION

Section 671 of the bill is an internal Treasury accounting provision which has no regulatory impact.

IV. Budgetary Impact of Finance Committee Amendments

In conformance with paragraph 11(a) of rule XXVI of the Standing Rules of the Senate and with sections 308 and 403 of the Congressional Budget Act of 1974, the following statements are made relative to the budgetary impact of the Finance Committee amendments included in title VI of the bill.

The Finance Committee estimates the budgetary impact of the provisions of title VI to be as shown in the following table. These estimates were made after consultation with the Congressional Budget Office.

The estimates of the Congressional Budget Office on the provisions of title VI appear in Appendix B.

OUTLAY REDUCTIONS UNDER FINANCE COMMITTEE PROPOSALS FOR RECONCILIATION PROCESS FOR FISCAL YEAR 1981 BUDGET RESOLUTION, FISCAL YEARS 1981-1985

[In millions of dollars]

	Fiscal year—				
	1981	1982	1983	1984	1985
Legislation already enacted: [1]					
Social security disability amendments (H.R. 3236)	−133	−374	−656	−972	−1,269
Social services amendments (H.R. 3434)	−92	−88	−96	−104	−112
A. Unemployment compensation:					
Sec. 601—Elimination of national trigger	([2])	−300	([2])	([2])	([2])
Sec. 602—Waiting period	−25	−27	−30	−32	−33
Sec. 603—Optional State trigger	−30	−30	−30	−30	−30
Sec. 604—Unemployment benefits for ex-servicemen	−43	−47	−51	−55	−57
Sec. 605—Unemployment benefits for Federal employees	−11	−12	−13	−14	−15
Sec. 606—Limit extended benefits for non-residents	−46	−30	−28	−19	−15
Sec. 607—Extended benefits:					
—Not payable on the basis of less than 20 weeks of employment	−120	−180	−90	−35	−20
—Not payable to persons who leave jobs voluntarily or for misconduct	−32	−49	−24	−10	−6
—Not payable to persons refusing any reasonable job	−94	−145	−72	−29	−16
B. Sec. 611—Limit SSI eligibility for individuals who dispose of resources	−15	−31	−40	−49	−55
C. Sec. 621—Temporary suspension of Federal day care regulations	−20				
D. Sec. 631—Public assistance payments to territorial jurisdictions	−26				
E. Social security provisions:					
Sec. 641—Reallocation of OASDI taxes between OASI and DI					

Provision					
Sec. 642—Three-month limit on retroactive benefits	−150	−250	−260	−270	−280
Sec. 643—Social security benefits for prisoners	−16	−17	−19	−21	−24
F. Health provisions:					
Sec. 651—Hospital routine cost limits	−70	+134	+46	−283	−521
Sec. 652—Closure/conversion of underutilized facilities	−2	−9	−23	−44	−72
Sec. 653—Coordinated audits	−4	−5	−6	−6	−7
Sec. 654—Apportionment of provider costs	−75	(3)	(3)	(3)	(3)
Sec. 655—Inappropriate hospital services	−151	−230	−262	−297	−239
Sec. 656—PSRO review of hospital admissions routine tests and preoperative stays	−25	−65	−86	−102	−119
Sec. 657—Ambulatory surgery	.....	−15	−20	−25	−25
Sec. 658—Criteria for determining reasonable charge for physician services	−15	−20	−25	−25	−25
Sec. 659—Procedures for determining reasonable cost/charge (hospital-based physician and business services)	−25	−70	−91	−114	−140
Sec. 660—Outpatient services charge limit	−23	−26	−31	−36	−41
Sec. 661—Medicare liability in accident cases	−14	−32	−75	−135	−156
Sec. 662—Access to and purchase of Medicaid services	−91	−227	−273	−314	−363
Sec. 663—Medicare hospital reimbursement: periodic interim payments (PIP)	−675	+682	.....	.....	.....
Sec. 664—Disallowance of certain State Medicaid claims	−147	−83	−16	−18	−20
Sec. 665—Reimbursement under medicaid for skilled nursing and intermediate care facilities	−2	−2	−2	−2	−2
Sec. 667—Home health agency reimbursement limits	−73	−86	−99	−114	−131
Sec. 668—Calculating medicare reasonable charges	−147	−226	−231	−250	−279
G. Sec. 671—Transfer of funds to trust funds	.....	.....	.....	.....	.....
Total	−2,397	−1,860	−2,603	−3,405	−4,172

[1] Consistent with the reconciliation accounting system, the amounts shown for H.R. 3236 and H.R. 3434 are the gross savings of benefit reduction provisions rather than the net budgetary impact of the bills.

[2] No savings under First Budget Resolution economic assumptions.

[3] No estimate available.

V. Changes in Existing Law Made by Finance Committee Amendments

In conformance with paragraph 12 of rule XXVI of the Standing Rules of the Senate, changes in existing law made by the Finance Committee amendments included in title VI of the bill are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic type, existing law in which no change is proposed is printed in roman type):

SOCIAL SECURITY ACT, AS AMENDED

* * * * * * *

TITLE II—FEDERAL OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE BENEFITS

Federal Old-Age and Survivors Insurance Trust Fund and Federal Disability Insurance Trust Fund

Section 201. (a) * * *

(b) There is hereby created on the books of the Treasury of the United States a trust fund to be known as the "Federal Disability Insurance Trust Fund". The Federal Disability Insurance Trust Fund shall consist of such gifts and bequests as may be made as provided in subsection (i)(1), and of such amounts as may be appropriated to, or deposited in, such fund as provided in this section. There is hereby appropriated to the Federal Disability Insurance Trust Fund for the fiscal year ending June 30, 1957, and for each fiscal year thereafter, out of any moneys in the Treasury not otherwise appropriated, amounts equivalent to 100 per centum of—

(1)(A) ½ of 1 per centum of the wages (as defined in section 3121 of the Internal Revenue Code of 1954) paid after December 31, 1956, and before January 1, 1966, and reported to the Secretary of the Treasury or his delegate pursuant to subtitle F of the Internal Revenue Code of 1954, (B) 0.70 of 1 per centum of the wages (as so defined) paid after December 31, 1965, and before January 1, 1968, and so reported, and (C) 0.95 of 1 per centum of the wages (as so defined) paid after December 31, 1967, and before January 1, 1970, and so reported, (D) 1.10 per centum of the wages (as so defined) paid after December 31, 1969, and before January 1, 1973, and so reported, (E) 1.1 per centum of the wages (as so defined) paid after December 31, 1972, and before January 1, 1974, and so reported, (F) 1.15 per centum of the wages (as so defined) paid after December 31, 1973, and before January 1, 1978, and so reported, (G) 1.55 per centum of the wages (as so defined) paid after December 31, 1977, and before January 1, 1979, and so reported, [(H) 1.50 per centum of the wages (as so defined) paid after December 31, 1978, and before January 1, 1981, and so reported, (I) 1.65 per centum of the wages (as so defined) paid after December 31, 1980, and before January 1, 1985, and so reported, (J) 1.90 per centum of the wages (as so defined) paid after December 31, 1984, and before January 1, 1990, and so reported, and (K) 2.20 per centum of the

wages (as so defined) paid after December 31, 1989, and so reported.] *(H) 1.50 per centum of the wages (as so defined) paid after December 31, 1978, and before January 1, 1980, and so reported, (I) 1.12 per centum of the wages (as so defined) paid after December 31, 1979, and before January 1, 1981, and so reported, (J) 1.30 per centum of the wages (as so defined) paid after December 31, 1980, and before January 1, 1982, and so reported, (K) 1.65 per centum of the wages (as so defined) paid after December 31, 1981, and before January 1, 1985, and so reported, (L) 1.90 per centum of the wages (as so defined) paid after December 31, 1984, and before January 1, 1990, and so reported, and (M) 2.20 per centum of the wages (as so defined) paid after December 31, 1989, and so reported,* which wages shall be certified by the Secretary of Health, Eduction, and Welfare on the basis of the records of wages established and maintained by such Secretary in accordance with such reports; and

(2)(A) ⅜ of 1 per centum of the amount of self-employment income (as defined in section 1402 of the Internal Revenue Code of 1954) reported to the Secretary of the Treasury or his delegate on tax returns under subtitle F of the Internal Revenue Code of 1954 for any taxable year beginning after December 31, 1956, and before January 1, 1966, (B) and 0.525 of 1 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1965, and before January 1, 1968, and (C) 0.7125 of 1 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1967, and before January 1, 1970, (D) 0.825 of 1 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1969, and before January 1, 1973, (E) 0.795 of 1 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1972, and before January 1, 1974, (F) 0.815 of 1 per centum of the amount of self-employment income (as so defined) as reported for any taxable year beginning after December 31, 1973, and before January 1, 1978, (G) 1.090 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1977, and before January 1, 1979, [(H) 1.0400 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1978, and before January 1, 1981, (I) 1.2375 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1980, and before January 1, 1985, (J) 1.4250 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1984, and before January 1, 1990, and (K) 1.650 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1989,] *(H) 1.0400 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1978, and before January 1, 1980, (I) 0.7775 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December*

31, 1979, and before January 1, 1981, (J) 0.9750 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1980, and before January 1, 1982, (K) 1.2375 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1981, and before January 1, 1985 (L) 1.4250 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1984, and before January 1990, and (M) 1.6500 per centum of the amount of self-employment income (as so defined) so reported for any taxable year beginning after December 31, 1989, which self-employment income shall be certified by the Secretary of Health, Education, and Welfare on the basis of the records of self-employment income established and maintained by the Secretary of Health, Education, and Welfare in accordance with such returns.

* * * * * * *

Old-Age and Survivors Insurance Benefit Payments

Old-Age Insurance Benefits

Sec. 202. (a) * * *

Child's Insurance Benefits

(d)(1) Every child (as defined in section 216(e)) of an individual entitled to old-age or disability insurance benefits, or of an individual who dies a fully or currently insured individual if such child—

(A) has filed application for child's insurance benefits,

(B) at the time such application was filed was unmarried and (i) either had not attained the age of 18 or was a full-time student and had not attained the age of 22, or (ii) is under a disability (as defined in section 223(d)) which began before he attained the age of 22, and

(C) was dependent upon such individual—

(i) if such individual is living, at the time such application was filed,

(ii) if such individual has died, at the time of such death, or

(iii) if such individual had a period of disability which continued until he became entitled to old-age or disability insurance benefits, or (if he has died) until the month of his death, at the beginning of such period of disability or at the time he became entitled to such benefits,

shall be entitled to a child's insurance benefit for each month, beginning with the first month after August 1950 in which such child becomes so entitled to such insurance benefits and ending with the month preceding which ever of the following first occurs—

(D) the month in which such child dies, or marries,

(E) the month in which such child attains the age of 18, but only if he (i) is not under a disability (as so defined) at the time he attains such age, and (ii) is not a full-time student during any part of such month.

(F) if such child was not under a disability (as so defined) at the time he attained the age of 18, the earlier of—

(i) the first month during no part of which he is a full-time student, or

(ii) the month in which he attains the age of 22,

but only if he was not under a disability (as so defined) in such earlier month; or

(G) if such child was under a disability (as so defined) at the time he attained the age of 18, or if he was not under a disability (as so defined) at such time but was under a disability (as so defined) at or prior to the time he attained (or would attain) the age of 22, or, subject to section 223(e), the termination month (and for purposes of this subparagraph, the termination month for any individual shall be the third month following the month in which his disability ceases; except that, in the case of an individual who has a period of trial work which ends as determined by application of section 222(c)(4)(A), the termination month shall be the earlier of (I) the third month following the earliest month after the end of such period of trial work with respect to which such individual is determined to no longer be suffering from a disabling physical or mental impairment, or (II) the third month following the earliest month in which such individual engages or is determined able to engage in substantial gainful activity, but in no event earlier than the first month occurring after the 15 months following such period of trial work in which he engages or is determined able to engage in substantial gainful activity, or (if later) the earlier of—

(i) the first month during no part of which he is a full-time student, or

(ii) the month in which he attains the age of 22,

but only if he was not under a disability (as so defined) in such earlier month.

Entitlement of any child to benefits under this subsection on the basis of the wages and self-employment income of an individual entitled to disability insurance benefits shall also end with the month before the first month for which such individual is not entitled to such benefits unless such individual is, for such later month, entitled to old-age insurance benefits or unless he dies in such month. No payment under this paragraph may be made to a child who would not meet the definition of disability in section 223(d) except for paragraph (1)(B) thereof for any month in which he engages in substantial gainful activity.

(2) Such child's insurance benefit for each month shall, if the individual on the basis of whose wages and self-employment income the child is entitled to such benefit has not died prior to the end of such month, be equal to one-half of the primary insurance amount of such individual for such month. Such child's insurance benefit for each month shall, if such individual has died in or prior to such month, be equal to three-fourths of the primary insurance amount of such individual.

(3) A child shall be deemed dependent upon his father or adopting father or his mother or adopting mother at the time specified in paragraph (1)(C) unless, at such time, such individual was not living with or contributing to the support of such child and—

(A) such child is neither the legitimate nor adopted child of such individual, or

(B) such child has been adopted by some other individual.

For purposes of this paragraph, a child deemed to be a child of a fully or currently insured individual pursuant to section 216(h)(2)(B) or section 216(h)(3) shall be deemed to be the legitimate child of such individual.

(4) A child shall be deemed dependent upon his stepfather or stepmother at the time specified in paragraph (1)(C) if, at such time, the child was living with or was receiving at least one-half of his support from such stepfather or stepmother.

(5) In the case of a child who has attained the age of eighteen and who marries—

(A) an individual entitled to benefits under subsection (a), (b), (e), (f), (g), or (h) of this section or under section 223 (a), or

(B) another individual who has attained the age of eighteen and is entitled to benefits under this subsection,

such child's entitlement to benefits under this subsection shall, notwithstanding the provisions of paragraph (1) but subject to subsection (s), not be terminated by reason of such marriage; except that, in the case of such a marriage to a male individual entitled to benefits under section 223(a) or this subsection, the preceding provisions of this paragraph shall not apply with respect to benefits for months after the last month for which such individual is entitled to such benefits under section 223(a) or this subsection unless (i) he ceases to be so entitled by reason of his death, or (ii) in the case of an individual who was entiled to benefits under section 223(a), he is entiled, for the month following such last month, to benefits under subsection (a) of this section.

(6) A child whose entitlement to child's insurance benefits on the basis of the wages and self-employment income of an insured individual terminated with the month preceding the month in which such child attained the age of 18, or with a subsequent month, may again become entitled to such benefits (provided no event specified in paragraph (1)(D) has occurred) beginning with the first month thereafter in which he—

(A)(i) is a full-time student or is under a disability (as defined in section 223(d)), and (ii) had not attained the age of 22, or

(B) is under a disability (as so defined) which began before the close of the 84th month following the month in which his most recent entitlement to child's insurance benefits terminated because he ceased to be under such disability.

but only if he has filed application for such reentitlement. Such reentitlement shall end with the month preceding whichever of the following first occurs:

(C) the first month in which an event specified in paragraph (1)(D) occurs;

(D) the earlier of (i) the first month during no part of which he is a full-time student, or (ii) the month in which he attains the age of 22, but only if he is not under a disability (as so defined) in such earlier month; or

(E) if he was under a disability (as so defined), the third month following the month in which he ceases to be under such disability or (if later) the earlier of—

(i) the first month during no part of which he is a full-time student, or

(ii) the month in which he attains the age of 22.

(7) For the purposes of this subsection—

(A) A "full-time student" is an individual who is in full-time attendance as a student at an educational institution, as determined by the Secretary (in accordance with regulations prescribed by him) in the light of the standards and practices of the institutions involved, except that no individual shall be considered a "full-time student" if he is paid by his employer while attending an educational institution at the request, or pursuant to a requirement, of his employer. *An individual shall not be considered a "full-time student" for the purpose of this section while that individual is confined in a jail, prison, or other penal institution or correctional facility, pursuant to his conviction of an offense (committed after the date of the enactment of this paragraph) which constituted a felony under applicable law.*

(B) Except to the extent provided in such regulations, an individual shall be deemed to be a full-time student during any period of nonattendance at an educational institution at which he has been in full-time attendance if (i) such period is 4 calendar months or less, and (ii) he shows to the satisfaction of the Secretary that he intends to continue to be in full-time attendance at an educational institution immeditely following such period. An individual who does not meet the requirement of clause (ii) with respect to such period of nonattendance shall be deemed to have met such requirement (as of the beginning of such period) if he is in full-time attendance at an educational institution immediately following such period.

(C) An "educational institution" is (i) a school or college or university operated or directly supported by the United States, or by any State or local government or political subdivision thereof, or (ii) a school or college or university which has been approved by a State or accredited by a State-recognized or nationally-recognized accrediting agency or body, or (iii) a nonaccredited school or college or university whose credits are accepted, on transfer, by not less than three institutions which are so accredited, for credit on the same basis as if transferred from an institution so accredited.

(D) A child who attains age 22 at a time when he is a full-time student (as defined in subparagraph (A) of this paragraph and without the application of subparagraph (B) of such paragraph) but has not (at such time) completed the requirements for, or received, a degree from a four-year college or university shall be deemed (for purposes of determining whether his en-

titlement to benefits under this subsection has terminated under paragraph (1)(F) and for purposes of determining his initial entitlement to such benefits under clause (i) of paragraph (1)(B)) not to have attained such age until the first day of the first month following the end of the quarter or semester in which he is enrolled at such time (or, if the educational institution (as defined in this paragraph) in which he is enrolled is not operated on a quarter or semester system, until the first day of the first month following the completion of the course in which he is so enrolled or until the first day of the third month beginning after such time, whichever first occurs).

(8) In the case of—

(A) An individual entitled to old-age insurance benefits (other than an individual referred to in subparagraph (B)), or

(B) an individual entitled to disability insurance benefits, or an individual entitled to old-age insurance benefits who was entitled to disability insurance benefits for the month preceding the first month for which he was entitled to old-age insurance benefits.

a child of such individual adopted after such individual became entitled to such old-age or disability insurance benefits shall be deemed not to meet the requirements of clause (i) or (iii) of paragraph (1)(C) unless such child—

(C) is the natural child or stepchild of such individual (including such a child who was legally adopted by such individual), or

(D)(i) was legally adopted by such individual in an adoption decreed by a court of competent jurisdiction within the United States,

(ii) was living with such individual in the United States and receiving at least one-half of his support from such individual (I) if he is an individual referred to in subparagraph (A), for the year immediately before the month in which such individual became entitled to old-age insurance benefits or, if such individual had a period of disability which continued until he had become entitled to old-age insurance benefits, the month in which such period of disability began, or (II) if he is an individual referred to in subparagraph (B), for the year immediately before the month in which began the period of disability of such individual which still exists as the time of adoption (or, if such child was adopted by such individual after such individual attained age 65, the period of disability of such individual which existed in the month preceding the month in which he attained age 65), or the month in which such individual became entitled to disability insurance benefit, or (III) if he is an individual referred to in either subparagraph (A) or subparagraph (B) and the child is the grandchild of such individual or his or her spouse, for the year immediately before the month in which such child files his or her application for child's insurance benefits, and

(iii) had not attained the age of 18 before he began living with such individual.

In the case of a child who was born in the one-year period during which such child must have been living with and receiving at least one-half of his support from such individual, such child shall be deemed to meet such requirements for such period if, as of the close of such period, such child has lived with such individual in the United States and received at least one-half of his support from such individual for substantially all of the period which begins on the date of birth of such child.

(9) (A) A child who is a child of an individual under clause (3) of the first sentence of section 216(e) and is not a child of such individual under clause (1) or (2) of such first sentence shall be deemed not to be dependent on such individual at the time specified in subparagraph (1)(C) of this subsection unless (i) such child was living with such individual in the United States and receiving at least one-half of his support from such individual (I) for the year immediately before the month in which such individual became entitled to old-age insurance benefits or disability insurance benefits or died, or (II) if such individual had a period of disability which continued until he had become entitled to old-age insurance benefits, or disability insurance benefits, or died, for the year immediately before the month in which such period of disability began, and (ii) the period during which such child was living with such individual began before the child attained age 18.

(B) In the case of a child who was born in the one-year period during which such child must have been living with and receiving at least one-half of his support from such individual, such child shall be deemed to meet such requirements for such period if, as of the close of such period, such child has lived with such individual in the United States and received at least one-half of his support from such individual for substantially all of the period which begins on the date of such child's birth.

* * * * * * *

Application for Monthly Insurance Benefits

(j)(1) Subject to the limitations contained in paragraph (4), an individual who would have been entitled to a benefit under subsection (a), (b), (c), (d), (e), (f), (g), or (h) for any month after August 1950 had he filed application therefor prior to the end of such month shall be entitled to such benefit for such month if he files application therefor prior to the end of the [twelfth] *third* month immediately succeeding such month. Any benefit under this title for a month prior to the month in which application is filed shall be reduced, to any extent that may be necessary, so that it will not render erroneous any benefit which, before the filing of such application, the Secretary has certified for payment for such prior month.

(2) An application for any monthly benefits under this section filed before the first month in which the applicant satisfies the requirements for such benefits shall be deemed a valid application (and shall be deemed to have been filed in such first month) only if the applicant satisfies the requirements for such benefits before the Secretary makes a final decision on the application and no request

under section 205(b) for notice and opportunity for a hearing thereon is made or, if such a request is made, before a decision based upon the evidence adduced at the hearing is made (regardless of whether such decision becomes the final decision of the Secretary).

(3) Notwithstanding the provisions of paragraph (1), an individual may, at his option, waive entitlement to any benefit referred to in paragraph (1) for any one or more consecutive months (beginning with the earliest month for which such individual would otherwise be entitled to such benefit) which occur before the month in which such individual files application for such benefit; and, in such case, such individual shall not be considered as entitled to such benefits for any such month or months before such individual filed such application. An individual shall be deemed to have waived such entitlement for any such month for which such benefit would, under the second sentence of paragraph (1), be reduced to zero.

(4)(A) Except as provided in subparagraph (B), no individual shall be entitled to a monthly benefit under subsection (a), (b), (c), (e), or (f) for any month prior to the month in which he or she files an application for benefits under that subsection if the effect of entitlement to such benefit would be to reduce, pursuant to subsection (q), the amount of the monthly benefit to which such individual would otherwise be entitled for the month in which such application is filed.

(B)(i) If the individual applying for retroactive benefits is applying for such benefits under subsection (a), and there are one or more other persons who would (except for subparagraph (A)) be entitled for any month, on the basis of the wages and self-employment income of such individual and because of such individual's entitlement to such retroactive benefits, to retroactive benefits under subsection (b), (c), or (d) not subject to reduction under subsection (q), then subparagraph (A) shall not apply with respect to such month or any subsequent month.

(ii) If the individual applying for retroactive benefits is a widow, surviving divorced wife, or widower and is under a disability (as defined in section 223(d)), and such individual would, except for subparagraph (A), be entitled to retroactive benefits as a disabled widow or widower or disabled surviving divorced wife for any month before attaining the age of 60, then subparagraph (A) shall not apply with respect to such months or any subsequent month.

(iii) If the individual applying for retroactive benefits has excess earnings (as defined in section 203 (f)) in the year in which he or she files an application for such benefits which could, except for subparagraph (A), be charged to months in such year prior to the month of application, then subparagraph (A) shall not apply to so many of such months immediately preceding the month of application as are required to charge such excess earnings to the maximum extent possible.

(iv) As used in this subparagraph, the term "retroactive benefits" means benefits to which an individual becomes entitled for a month prior to the month in which application for such benefits is filed.

Other Definitions

Sec. 216. * * *

Disability; Period of Disability

(i)(1) Except for purposes of section 202(d), 202(e), 202(f), 223, and 225, the term "disability" means (A) inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than 12 months, or (B) blindness; and the term "blindness" means central visual acuity of 20/200 or less in the better eye with the use of correcting lens. An eye which is accompanied by a limitation in the field of vision such that the widest diameter of the visual field subtends an angle no greater than 20 degrees shall be considered for purposes of this paragraph as having a central visual acuity of 20/200 or less. The provisions of paragraphs (2)(A), (3), (4), [and (5)] *(5), and (6)* of section 223(d) shall be applied for purposes of determining whether an individual is under a disability within the meaning of the first sentence of this paragraph in the same manner as they are applied for purposes of paragraph (1) of such section. Nothing in this title shall be construed as authorizing the Secretary or any other officer or employee of the United States to interfere in any way with the practice of medicine or with relationships between practitioners of medicine and their patients, or to exercise any supervision or control over the administration or operation of any hospital.

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Disability Insurance Benefit Payments

Disability Insurance Benefits

Sec. 223. (a) * * *

Definition of Disability

(d)(1) The term "disability" means—

(A) inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months; or

(B) in the case of an individual who has attained the age of 55 and is blind (within the meaning of "blindness" as defined in section 216(i)(1)), inability by reason of such blindness to engage in substantial gainful activity requiring skills or abilities comparable to those of any gainful activity in which he has previously engaged with some regularity and over a substantial period of time.

(2) For purposes of paragraph (1)(A)—

(A) an individual (except a widow, surviving divorced wife, or widower for purposes of section 202 (e) or (f) shall be deter-

mined to be under a disability only if his physical or mental impairment or impairments are of such severity that he is not only unable to do his previous work but cannot, considering his age, education, and work experience, engage in any other kind of substantial gainful work which exists in the national economy, regardless of whether such work exists in the immediate area in which he lives, or whether a specific job vacancy exists for him, or whether he would be hired if he applied for work. For purposes of the preceding sentence (with respect to any individual), "work which exists in the national economy" means work which exists in significant numbers either in the region where such individual lives or in several regions of the country;

(B) a widow, surviving divorced wife, or widower shall not be determined to be under a disability (for purposes of section 202 (e) or (f)) unless his or her physical or mental impairment or impairments are of a level of severity which under regulations prescribed by the Secretary is deemed to be sufficient to preclude an individual from engaging in any gainful activity.

(3) For purposes of this subsection, a "physical or mental impairment" is an impairment that results from anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques.

(4) The Secretary shall by regulations prescribe the criteria for determining when services performed or earnings derived from services demonstrate an individual's ability to engage in substantial gainful activity. No individual who is blind shall be regarded as having demonstrated an ability to engage in substantial gainful activity on the basis of earnings that do not exceed the exempt amount under section 203(f)(8) which is applicable to individuals described in subparagraph (D) thereof. Notwithstanding the provisions of paragraph (2), an individual whose services or earnings meet such criteria shall, except for purposes of section 222(c), be found not to be disabled. In determining whether an individual is able to engage in substantial gainful activity by reason of his earnings, where his disability is sufficiently severe to result in a functional limitation requiring assistance in order for him to work, there shall be excluded from such earnings an amount equal to the cost (to such individual) of any attendant care services, medical devices, equipment, prostheses, and similar items and services (not including routine drugs or routine medical services unless such drugs or services are necessary for the control of the dis-

abling condition) which are necessary (as determined by the Secretary in regulations) for that purpose, whether or not such assistance is also needed to enable him to carry out his normal daily functions; except that the amounts to be excluded shall be subject to such reasonable limits as the Secretary may prescribe.

(5) An individual shall not be considered to be under a disability unless he furnishes such medical and other evidence of the existence thereof as the Secretary may require.

Any non-Federal hospital, clinic, laboratory, or other provider of medical services, or physician not in the employ of the Federal Government, which supplies medical evidence required and requested by the Secretary under this paragraph shall be entitled to payment from the Secretary for the reasonable cost of providing such evidence.

* * * * * * *

(e) No benefit shall be payable under subsection (d)(1)(B)(ii), (e)(1)(B)(ii), or (f)(1)(B)(ii) of section 202 or under subsection (a)(1) of this section to an individual for any month, after the third month, in which he engages in substantial gainful activity during the 15-month period following the end of his trial work period determined by application of section 222(c)(4)(A).

Suspension of Benefits for Inmates of Penal Institutions

(f)(1) Notwithstanding any other provision of this title, no monthly benefits shall be paid under this section, or under section 202(d) by reason of being under a disability, to any individual for any month during which such individual is confined in a jail, prison, or other penal institution or correctional facility, pursuant to his conviction of an offense which constituted a felony under applicable law, unless such individual is actively and satisfactorily participating in a rehabilitation program which has been specifically approved for such individual by a court of law and, as detemined by the Secretary, is expected to result in such individual being able to engage in substantial gainful activity upon release and within a reasonable time.

(2) Benefits which would be payable to any individual (other than a confined individual to whom benefits are not payable by reason of paragraph (1)) under this title on the basis of the wages and self-employment income of such a confined individual but for the provisions of paragraph (1), shall be payable as though such confined individual were receiving such benefis under this section.

TITLE V—MATERNAL AND CHILD HEALTH AND CRIPPLED CHILDREN'S SERVICES

* * * * * * *

Approval of State Plans

Sec. 505. (a) * * *

(14) provides that acceptance of family planning services provided under the plan shall be voluntary on the part of the individual to whom such services are offered and shall not be a prerequisite to eligibility for or the receipt of any service under the plan; [and]

(15) provides—

(A) that the State health agency, or other appropriate State medical agency, shall be responsible for establishing a plan, consistent with regulations prescribed by the Secretary, for the review by appropriate professional health personnel of the appropriateness and quality of care and services furnished to recipients of services under the plan and, where applicable, for providing guidance with respect thereto to the other State agency referred to in paragraph (2); and

(B) that the State or local agency utilized by the Secretary for the purpose specified in the first sentence of section 1864(a), or, if such agency is not the State agency which is responsible for licensing health institutions, the State agency responsible for such licensing, will perform the function of determining whether institutions and agencies meet the requirements for participation in the program under the plan under this title[.]*; and*

(16) provides (A) that the records of any entity participating in the plan and providing services reimbursable on a cost-related basis will be audited as the Secretary determines to be necessary to insure that proper payments are made under the plan, (B) that such audits, for such entities also providing services under part A of title XVIII, will be coordinated and conducted jointly (to such extent and in such manner as the Secretary shall prescribe) with audits conducted for purposes of such part, and (C) for payment of the portion of costs of each such common audit of such an entity equal to the portion of of the cost of the common audit which is attributable to the program established under this title and which would not have otherwise been incurred in an audit of the program established under title XVIII.

(b) The Secretary shall approve any plan which meets the requirements of subsection (a).

Payments

Sec. 506. (a) From the sums appropriated therefor and the allotments available under section 503(1) or 504(1), as the case may be, the Secretary shall pay to each State which has a plan approved under this title, for each quarter, beginning with the quarter commencing July 1, 1968, an amount, which shall be used exclusively for carrying out the State plan, equal to one-half of the total sum expended during such quarter for carrying out such plan with respect to maternal and child health services and services for crippled children, respectively.

(b)(1) Prior to the beginning of each quarter, the Secretary shall estimate the amount to which a State will be entitled under subsection (a) for such quarter, such estimates to be based on (A) a report filed by the State containing its estimate of the total sum to be expended in such quarter in accordance with the provisions of such subsection, and stating the amount appropriated or made available by the State and its political subdivisions for such expenditures in such quarter, and if such amount is less than the State's proportionate share of the total sum of such estimated expenditures, the source or sources from which the difference is expected to be derived, and (B) such other investigation as the Secretary may find necessary.

(2) The Secretary shall then pay to the State, in such installments as he may determine, the amount so estimated, reduced or increased to the extent of any overpayment or underpayment which the Secretary determines was made under this section to such State for any prior quarter and with respect to which adjustment has not already been made under this subsection.

(3) Upon the making of an estimate by the Secretary under this subsection, any appropriations available for payments under this section shall be deemed obligated.

(c) The Secretary shall also from time to time make payments to the States from their respective allotments pursuant to section 503(2) or 504(2). Payments of grants under sections 503(2), 504(2), 508, 509, 510, and 511, and of grants, contracts, or other arrangements under section 512, may be made in advance or by way of reimbursement, and in such installments, as the Secretary may determine; and shall be made on such conditions as the Secretary finds necessary to carry out the purposes of the section involved.

(d) The total amount determined under subsections (a) and (b) and the first sentence of subsection (c) for any fiscal year ending after June 30, 1968, shall be reduced by the amount by which the sum expended (as determined by the Secretary) from non-Federal sources for maternal and child health services and services for crippled children for such year is less than the sum expended from such sources for such services for the fiscal year ending June 30, 1968. In the case of any such reduction, the Secretary shall determine the portion thereof which shall be applied, and the manner of applying such reduction, to the amounts otherwise payable from allotments under section 503 or section 504.

(e) Notwithstanding the preceding provisions of this section, no payment shall be made to any State thereunder from the allotments under section 503 or section 504 for any period after June 30, 1968, unless the State makes a satisfactory showing that it is extending the provisions of services, including services for dental care for children and family planning for mothers, to which such State's plan applies in the State with a view to making such services available by July 1, 1975 to children and mothers in all parts of the State.

(f) Notwithstanding the preceding provisions of this section, no payment shall be made to any State thereunder—

(1) with respect to any amount paid for items or services furnished under the plan after December 31, 1972, to the extent that such amount exceeds the charge which would be determined to

be reasonable for such items or services under [the fourth and fifth sentences of section 1842(b)(3)] *subparagraphs (B)(ii), (B)(iii), (C), and (F) of section 1842(b)(4)*; or

(2) with respect to any amount paid for services furnished under the plan after December 31, 1972, by a provider or other person during any period of time, if payment may not be made under title XVIII with respect to services furnished by such provider or person during such period of time solely by reason of a determination by the Secretary under section 1862(d)(1) or under clause (D), (E), or (F) of section 1866(b)(2); or

(3) with respect to any amount expended for inpatient hospital services furnished under the plan to the extent that such amount exceeds the hospital's customary charges with respect to such services or (if such services are furnished under the plan by a public institution free of charge or at nominal charges to the public) exceeds an amount determined on the basis of those items (specified in regulations prescribed by the Secretary) included in the determination of such payment which the Secretary finds will provide fair compensation to such institution for such services; or

(4) with respect to any amount expended for services furnished under the plan by a hospital unless such hospital has in effect a utilization review plan which meets the requirement imposed by section 1861(k) for purposes of title XVIII; and if such hospital has in effect such a utilization review plan for purposes of title XVIII, such plan shall serve as the plan required by this subsection (with the same standards and procedures and the same review committee or group) as a condition of payment under this title; the Secretary is authorized to waive the requirements of this paragraph in any State if the State agency demonstrates to his satisfaction that it has in operation utilization review procedures which are superior in their effectiveness to the procedures required under section 1861(k).

(g) For limitation on Federal participation for capital expenditures which are out of conformity with a comprehensive plan of a State or areawide planning agency, see section 1122.

(h) For additional exclusions from reasonable cost and reasonable charge see section 1134.

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TITLE IX—MISCELLANEOUS PROVISIONS RELATING TO EMPLOYMENT SECURITY

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Federal Advisory Council

Sec. 908. (a) The Secretary of Labor shall establish a Federal Advisory Council, of not to exceed 16 members including the chairman, for the purpose of reviewing the Federal-State program of unemployment compensation and making recommendations to him for improvement of the system.

(b) The Council shall be appointed by the Secretary without regard to the civil service laws and shall consist of men and women who shall be representatives of employers and employees in equal numbers, and the public.

(c) The Secretary may make available to the Council an Executive Secretary and secretarial, clerical, and other assistance, and such pertinent data prepared by the Department of Labor, as it may require to carry out its functions.

(d) Members of the Council shall, while serving on business of the Council, be entitled to receive compensation at rates fixed by the Secretary, but not exceeding $100 per day, including travel time; and while so serving away from their homes or regular places of business, they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by 5 U.S.C. 5703(b) for persons in government service employed intermittently.

(e) The Secretary shall encourage the organization of similar State advisory councils.

(f) There are hereby authorized to be appropriated for the fiscal year ending June 30, 1971, and for each fiscal year thereafter such sums, not to exceed $100,000, as may be necessary to carry out the purposes of this section.

Federal Employees Compensation Account

Sec. 909. There is hereby established in the Unemployment Trust Fund a Federal Employees Compensation Account which shall be used for the purposes specified in section 8509 of title 5, United States Code.

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TITLE XI—GENERAL PROVISIONS AND PROFESSIONAL STANDARDS REVIEW

Part A—General Provisions

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Limitation on Payments to Puerto Rico, the Virgin Islands, and Guam

Sec. 1108. (a) Except as provided in 2002(a)(2)(C), the total amount certified by the Secretary of Health, Education and Welfare under title I, X, XIV, and XVI, and under parts A and E of title IV (exclusive of any amounts on account of services and items to which subsection (b) applies)—

(1) for payment to Puerto Rico shall not exceed—

(A) $12,500,000 with respect to the fiscal year 1968,

(B) $15.000,000 with respect to the fiscal year 1969,

(C) $18,000,000 with respect to the fiscal year 1970,

(D) $21,000,000 with respect to the fiscal year 1971,

(E) $24,000,000 with respect to each of the fiscal year 1972 through 1978.

[(F) $72,000,000 with respect to the fiscal year 1979 and each fiscal year thereafter;]

(F) $72,000,000 with respect to the fiscal year 1979.

(G) $36,000,000 with respect to the fiscal year 1980.

(H) $48,000,000 with respect to the fiscal year 1981, or

(I) $72,000,000 with respect to the fiscal year 1982 and each fiscal year thereafter;

(2) for payment to the Virgin Islands shall not exceed—

(A) $425,000 with respect to the fiscal year 1968,

(B) $500,000 with respect to the fiscal year 1969,

(C) $600,000 with respect to the fiscal year 1970,

(D) $700,000 with respect to the fiscal year 1971,

(E) $800,000 with respect to each of the fiscal years 1972 through 1978, [or]

[(F) $2,400,000 with respect to the fiscal year 1979 and each fiscal year thereafter.]

(F) $2,400,000 with respect to the fiscal year 1979.

(G) $1,200,000 with respect to the fiscal year 1980.

(H) $1,600,000 with respect to the fiscal year 1981, or

(I) $2,400,000 with respect to the fiscal year 1982 and each fiscal year thereafter;

(3) for payment to Guam shall not exceed—

(A) $575,000 with respect to the fiscal year 1968,

(B) $690,000 with respect to the fiscal year 1969,

(C) $825,000 with respect to the fiscal year 1970,

(D) $960,000 with respect to the fiscal year 1971,

(E) $1,100,000 with respect to the fiscal year 1972 and each fiscal year thereafter other than the fiscal year 1979, [or]

[(F) $3,300,000 with respect to the fiscal year 1979.

(F) $3,300,000 with respect to the fiscal year 1979,

(G) $1,650,000 with respect to the fiscal year 1980,

(H) $2,200,000 with respect to the fiscal year 1981, or

(I) $3,300,000 with respect to the fiscal year 1982 and each fiscal year thereafter.

(b) The total amount certified by the Secretary under part A of title IV, on account of family planning services and services provided under section 402(a)(19) with respect to any fiscal year—

(1) for payment to Puerto Rico shall not exceed $2,000,000,

(2) for payment to the Virgin Islands shall not exceed $65,000, and

(3) for payment to Guam shall not exceed $90,000.

(c) The total amount certified by the Secretary under title XIX with respect to any fiscal year—

(1) for payment to Puerto Rico shall not exeed $30,000,000

(2) for payment to the Virgin Islands shall not exceed $1,000,000, and

(3) for payment to Guam shall not exceed $900,000.

(d) Notwithstanding the provisions of section 502(a) and 512(a) of this Act, and the provisions of sections 421, 503(1), and 504(1) of this Act as amended by the Social Security Amendments of 1967, and until such time as the Congress may by appropriation or other law otherwise provide, the Secretary shall, in lieu of the initail allotment specified in such sections, allot such smaller amounts to Guam,

American Samoa, and the Trust Territory of the Pacific Islands as he may deem appropirate.

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Adjustment of Retroactive Benefits Under Title II on Account of Supplemental Security Income Benefits

Sec. 1127. Notwithstanding any other provision of this Act in any case where an individual—

(1) makes application for benefits under title II and is subsequently determined to be entitled to those benefits, and

(2) was an individual with respect to whom supplemental security income benefits were paid under title XVI (including State supplementary payments which were made under an agreement pursuant to section 1616(a) or an administration agreement under section 212 of Public Law 93–66) for one or more months during the period beginning with the first month for which a benefit described in paragraph (1) is payable and ending with the month before the first month in which such benefit is paid pursuant to the application referred to in paragraph (1),

the benefits (described in paragraph (1)) which are otherwise retroactively payable to such individual for months in the period described in paragraph (2) shall be reduced by an amount equal to so much of such supplemental security income benefits (including State supplementary payments) described in paragraph (2) for such month or months as would not have been paid with respect to such individual or his eligible spouse if the individual had received the benefits under title II at the times they were regularly due during such period rather than retroactively; and from the amount of such reduction the Secretary shall reimburse the State on behalf of which such supplementary payments were made for the amount (if any) by which such State's expenditures on account of such supplementary payments for the period involved exceeded the expenditures which the State would have made (for such period) if the individual had received the benefits under title II at the times they were regularly due during such period rather than retroactively. An amount equal to the portion of such reduction remaining after reimbursement of the State under the preceding sentence shall be covered into the general fund of the Treasury.

Health Facilities Costs Commission

Sec. 1128. *(a) There is established a commission to be known as the Health Facilities Costs Commission (hereinafter in this section referred to as the "Commission").*

(b)(1) The Commission shall be composed of fifteen members appointed by the Secretary—

(A) at least five of whom shall be individuals who are representatives of providers;

(B) at least five of whom shall be individuals who represent public (including Federal, State, and local) health benefit programs; and

(C) the remainder of whom shall be, as a result of training, experience, or attainments, particularly and exceptionally well qualified to assist in serving and carrying out the functions of the Commission.

One of the members of the Commission, at the time of appointment, shall be designated as Chairman of the Commission. The Secretary shall first appoint members to the Commission not later than October 1, 1980.

(2) The Chairman of the Commission shall designate a member of the Commission to act as Vice Chairman of the Commission.

(3) A majority of the members of the Commission shall constitute a quorum, but a lesser number may conduct hearings.

(4) A vacancy in the Commission shall not affect its powers, but shall be filled in the same manner as that herein provided for the appointment of the member first appointed to the vacant position.

(5) Members of the Commission shall be appointed for a term of four years, except that the Secretary shall provide for such shorter terms for some of the members first appointed so as to stagger the date of expiration of members' terms of office.

(6) No individual may be appointed to serve more than two terms as a member of the Commission.

(7) Each member of the Commission shall be entitled to per diem compensation at rates fixed by the Secretary, but not more than the current per diem equivalent of the annual rate of basic pay in effect for grade GS-18 of the General Schedule for each day (including traveltime) during which the member is engaged in the actual performance of duties vested in the Commission, and all members of the Commission shall be allowed, while away from their homes or regular places of business in the performance of service for the Commission, travel expenses (including per diem in lieu of subsistence) in the same manner as persons employed intermittently in the Government service are allowed expenses under section 5703 of title 5, United States Code.

(8) The Commission shall meet at the call of the Chairman, or at the call of a majority of the members of the Commission; but meetings of the Commission shall be held not less frequently than once in each calendar month which begins after a majority of the authorized membership of the Commission has first been appointed.

(c)(1) It shall be the duty and function of the Commission to conduct a continuing study, investigation, and review of the reimbursement of hosiptals for care provided by them to individuals covered under title XVIII or under State plans approved under title XIX, with particular attention to the criteria established by section 1861 (bb) with a view to devising additional methods for reimbursing hospitals for all other costs, and for reimbursing all other entities which are reimbursed on the basis of reasonable cost. These methods shall provide for appropriate classification and reimbursement systems designed to ordinarily permit comparisons of (A) the cost centers of one entity, either individually or in the aggregate, with cost centers similar in terms of size and scale of operation, (B) prevailing wage levels, (C) the nature, extent, and appropriate volume of the services furnished, and (D) other factors which have a substantial impact on

hospital costs. The Commission shall also develop procedures for appropriate exceptions. The Commission shall submit to the Congress reports on its progress in addressing these issues at least once every six months during the three-year period following the date of the enactment of this section.

(2) The Commission shall study appropriate methods for classifying and comparing hospitals which, with respect to any accounting year, derive 75 percent or more (as estimated by the Secretary) of their inpatient care revenues from one or more health maintenance organizations. The Commission shall consider recommending the classification and comparison of such hospitals as a separate category in recognition of the differences in the nature of their operations as compared with other hospitals.

(3) The Secretary, taking account of the proposals and advice of the Commission, shall by regulation make appropriate modifications in the method of reimbursement under titles V, XVIII, and XIX for routine hospital costs, other hospital costs, and costs of other entities which are reimbursed on the basis of reasonable costs.

(B) In any case in which the Secretary proposes to make such modifications, he shall first submit such proposal to the Commission. If the Commission disagrees with such proposal, final regulations implementing such proposal shall be submitted to Congress by the Secretary, and such regulations may not become effective until at least 60 days after they were submitted to Congress.

(4) The Commission shall review and make recommendations with respect to a method of classifying and comparing detoxification facilities so as to provide that such method may be used for reimbursement purposes for such facilities within two years after the date of the enactment of this section.

(5) The Commission shall give immediate priority to making a study and submitting recommendations to the Secretary with respect to the setting of limitations on reasonable costs and reasonable charges for outpatient services as provided in section 1134(c).

(d) The Secretary shall provide such technical, secretarial, clerical, and other assistance as the Commission may need.

(e) The Commission may secure directly from any department or agency of the United States such data and information as may be necessary to enable it to carry out its duties under this section. Upon request of the Chairman of the Commission, any such department or agency shall furnish any such data or information to the Commission.

(f) There are authorized to be appropriated such sums as may be necessary to carry out this section.

(g) Section 14 of the Federal Advisory Committee Act shall not apply to the Commission.

Payments to Promote Closing and Conversion of Underutilized Facilities

Sec. 1129. *(a)(1)(A) Before the end of the third full month following the month in which this section is enacted, the Secretary shall establish a Hospital Transitional Allowance Board (hereinafter in this section referred to as the "Board"). The Board shall have five*

members, appointed by the Secretary without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, who are knowledgeable about hospital planning and hospital operations.

(B) Members of the Board shall be appointed for three-year terms, except some initial members shall be appointed for shorter terms to permit staggered terms of office.

(C) Members of the Board shall be entitled to per diem compensation at rates fixed by the Secretary, but not more than the current per diem equivalent at the time the service involved is rendered for grade GS-18 under section 5332 of title 5, United States Code.

(D) The Secretary shall provide such technical, secretarial, clerical, and other assistance as the Board may need.

(2) The Board shall receive and act upon applications by hospitals, certified for participation (other than as "emergency hospitals") under titles XVIII and XIX, for transitional allowances.

(b) For purposes of this section—

(1) The term "transitional allowance" means an amount which—

(A) shall, solely by reason of this section, be included in a hospital's reasonable cost for purposes of calculating payments under the programs authorized by titles V, XVIII, and XIX of this Act; and

(B) in accordance with this section, is established by the Secretary for a hospital in recognition of a reimbursement detriment (as defined in paragraph (3)) experienced because of a qualified facility conversion (as defined in paragraph (2)).

(2) The term "qualified facility conversion" means closing, modifying, or changing the usage of an underutilized hospital facility which is expected to benefit the programs authorized under title V, title XVIII, and title XIX by (A) eliminating excess bed capacity, (B) discontinuing an underutilized service for which there are adequate alternative sources, or (C) substituting for the underutilized service some other service which is needed in the area and which is consistent with the findings of an appropriate health planning agency.

(3) A hospital which has carried out a qualified facility conversion and which continues in operation will be regarded as having experienced a "reimbursement detrimental"—

(A) to the extent that, solely because of the conversion, there is a reduction in that portion of the hospital's costs attributable to capital assets which are taken into account in determining reasonable cost for purposes of determining amount of payment to the hospital under title V, title XVIII, or a State plan approved under title XIX;

(B) if the conversion results, on an interim basis, in increased operating costs, to the extent that operating costs exceed amounts ordinarily reimbursable under title V, title XVIII, and the State plan approved under title XIX; or

(C) in the case of complete closure of a private nonprofit hospital, or local governmental hospital, other than for re-

placement of the hospital, to the extent of actual debt obligations previously recognized as reasonable for reimbursement, where the debt remains outstanding, less any salvage value.

(c)(1) Any hospital may file an application with the Board (in such form and including such data and information as the Board, with the approval of the Secretary, may require) for a transitional allowance with respect to any qualified conversion which is formally initiated after September 30, 1980. The Board, with the approval of the Secretary, may also establish procedures, consistent with this section, by means of which a finding of a reimbursement detriment may be made prior to the actual conversion.

(2) The Board shall consider any application filed by a hospital, and if the Board finds that—

(A) the facility conversion is a qualified facility conversion, and

(B) the hospital is experiencing or will experience a reimbursement detriment because it carried out the qualified facility conversion,

the Board shall transmit to the Secretary its recommendation that the Secretary establish a transitional allowance for the hospital in amounts reasonably related to prior or prospective use of the facility under titles V and XVIII and the State plan approved under title XIX, for a period, not to exceed twenty years as specified by the Board, and, if the Board finds that the criteria in subparagraphs (A) and (B) are not met, it shall advise the Secretary not to establish a transitional allowance for that hospital. For an approved closure under subsection (b)(3)(C) the Board may recommend or the Secretary may approve, a lump-sum payment in lieu of periodic allowances, where such payment would constitute a more efficient and economic alternative.

(3)(A) The Board shall notify a hospital of its findings and recommendations.

(B) a hospital dissatisfied with a recommendation may obtain an informal or formal hearing, at the discretion of the Secretary by filing (in the form and within a time period established by the Secretary) and a request for a hearing.

(4)(A) Within thirty days after receiving a recommendation from the Board respecting a transitional allowance or, if later, within thirty days after a hearing, the Secretary shall make a final determination whether, and if so in what amount and for what period of time, a transitional allowance will be granted to a hospital. A final determination of the Secretary shall not be subject to judicial review.

(B) The Secretary shall notify a hospital and any other appropriate parties of the determination.

(C) Any transitional allowance shall take effect on a date prescribed by the Secretary, but not earlier than the date of completion of the qualified facility conversion. A transitional allowance shall be included as an allowable cost item in determining the reasonable cost incurred by the hospital in providing services for which payment is authorized under this Act, except that the transitional allowance shall not be considered in applying limits to costs recognized as reasonable pursuant to the third sentence of section 1861(v)(1) and sec-

tion 1861(bb) of this Act, or in determining the amount to be paid to a provider pursuant to section 1814(b), section 1833(a)(2), section 1903(i)(3), and section 506(f)(3) of this Act.

(d) In determining the reasonable cost incurred by a hospital with respect to which payment is authorized under a State plan approved under title V or title XIX, any transitional allowance shall be included as an allowable cost item.

(e)(1) The Secretary is authorized to establish transitional allowances only as provided in paragraphs (2) and (3).

(2) Prior to January 1, 1983, the Secretary is authorized to establish a transitional allowance for not more then fifty hospitals.

(3) On and after January 1, 1983, the Secretary is authorized to establish a transitional allowance for any hospital which qualifies for such an allowance under the provisions of this section.

(4) On or before January 1, 1982, the Secretary shall report to the Congress evaluating the effectiveness of the program established under this section including appropriate recommendations.

Coordinated Audits

Sec. 1130. *If an entity provides services reimbursable on a cost-related basis under title V or XIX, as well as services reimbursable on such a basis under title XVIII, the Secretary shall require, as a condition for payment to any State under title V or XIX with respect to administrative costs incurred in the performance of audits of the books, accounts, and records of that entity, that these audits be coordinated through common audit procedures with audits performed with respect to the entity for purposes of title XVIII. The Secretary shall apportion to the program established under title V or XIX that part of the cost of coordinated audits which is attributable to each such program and which would not have otherwise been incurred in an audit of the program established under title XVIII. Where the Secretary finds that a State has declined to participate in such a common audit with respect to title V or XIX, he shall reduce the payments otherwise due such State under such title by an amount which he estimates to be the amount that represents the duplication of costs resulting from such State's failure to participate in the common audit.*

* * * * * * *

Exclusion of certain items in determining reasonable cost and reasonable charge

Sec. 1134. *(a) Except as otherwise provided in subsection (b), in determining the amount of any payment under title XVIII, under a program established under title V, or under a State plan approved under title XIX of this Act, when the payment is based upon the reasonable cost or reasonable charge, no element comprising any part of the cost or charge shall be considered to be reasonable if, and to the extent that, such element is—*

(1) a commission, finder's fee, or for a similar arrangement, or

(2) an amount payable for any facility (or part or activity thereof) under any rental or lease arrangement,

which is, directly or indirectly, determined, wholly or in part as a

percentage, fraction, or portion of the charge or cost attributed to any health service (other than the element) or any health service including, but not limited to, the element.

(b)(1) The Secretary shall by regulations establish exceptions to the provisions of subsection (a) with respect to any element of cost or charge which consists of payments based on a percentage arrangement, if such element is otherwise reasonable and the percentage arrangement—

(A) is a customary commercial business practice, or

(B) provides incentives for the efficient and economical operation of the health service.

(2) The provisions of subsection (a) shall not be applicable to compensation payable to a physician under a percentage arrangement (including an arrangement that relates to compensation for supervisory, executive, educational, or research activity) between a physician and a hospital if the physician shows (to the satisfaction of the Secretary) that compensation under such arrangement does not exceed, on an annual basis, an amount which would reasonably have been paid to the physician under a relative value schedule which takes into consideration such physician's time and effort, consistent with the inherent complexity of the procedures and services.

(c) The Secretary shall issue regulations that provide for the establishment of limitations on the amount of any costs or charges that shall be considered reasonable with respect to services provided on an outpatient basis by hospitals, community health centers, or clinics (other than rural health clinics), which are reimbursed on a cost basis or on the basis of cost related charges, and by physicians utilizing such outpatient facilities. Such limitations shall be based upon the reasonableness of such costs or charges in relation to the reasonable charges of physicians in the same area for similar services provided in their offices.

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Part B—Professional Standards Review

Duties and Functions of Professional Standards Review Organizations

Sec. 1155. (a)(1) Notwithstanding any other provision of law, but consistent with the provisions of this part, it shall be the duty and function of each Professional Standards Review Organization for any area to assume, at the earliest date practicable, responsibility for the review of the professional activities in such area of physicians and other health care practitioners and institutional and noninstitutional providers of health care services (except as provided in paragraph (7)) in the provision of health care services and items for which payment may be made (in whole or in part) under this Act for the purpose of determining whether—

(A) such services and items are or were medically necessary;

(B) the quality of such services meets professionally recognized standards of health care; and

(C) in case such services and items are proposed to be provided in a hospital or other health care facility on an inpatient

basis, such services and items could, consistent with the provision of appropriate medical care, be effectively provided on an outpatient basis or more economically in an inpatient health care facility of a different type.

In carrying out the provisions of this paragraph such organization shall give priority to making such determinations with respect to routine hospital admission testing, preoperative hospital stays in excess of one day, and elective admissions on weekends or other times when services are not available.

(2) Each Professional Standards Review Organization shall have the authority to determine, in advance, in the case of—

(A) any elective admission to a hospital, or other health care facility, or

(B) any other health care service which will consist of extended or costly courses of treatment,

whether such service, if provided, or if provided by a particular health care practitioner or by a particular hospital or other health care facility, organization, or agency, would meet the criteria specified in clauses (A) and (C) of paragarph (1).

(3) Each Professional Standards Review Organization shall, in accordance with regulations of the Secretary, determine and publish, from time to time, the types and kinds of cases (whether by type of health care or diagnosis involved, or whether in terms of other relevant criteria relating to the provision of health care services) with respect to which such organization will, in order most effectively to carry out the purposes of this part, exercise the authority conferred upon it under paragraph (2).

(4) Each Professional Standards Review Organization shall be responsible for the arranging for the maintenance of and the regular review of profiles of care and services received and provided with respect to patients, utilizing to the greatest extent practicable in such patient profiles, methods of coding which will provide maximum confidentiality as to patient identity and assure objective evaluation consistent with the purposes of this part. Profiles shall also be regularly reviewed on an ongoing basis with respect to each health care practitioner and provider to determine whether the care and services ordered or rendered are consistent with the criteria specified in clauses (A), (B), and (C) of paragraph (1).

(5) Physicians assigned responsibility for the review of hospital care may be only those having active hospital staff privileges in at least one of the participating hospitals in the area served by the Professional Standards Review Organization.

(6) No physician shall be permitted to review—

(A) health care services provided to a patient if he was directly responsible for providing such services, or

(B) health care services provided in or by an institution, organization, or agency, if he or any member of his family has, directly or indirectly, a significant financial interest in such institution, organization, or agency.

For purposes of this paragraph, a physician's family includes only his spouse (other than a spouse who is legally separated from him under a decree of divorce or separate maintenance), children (including legally adopted children), grandchildren, parents, and grandparents.

(7)(A) Except as provided in subparagraph (B), a Professional Standards Review Organization located in a State has the function and duty to assume responsibility for the review under paragraph (1) of professional activities in intermediate care facilities (as defined in section 1905(c)) and in public institutions for the mentally retarded (described in section 1905(d)(1)) only if (i) the Secretary finds, on the basis of such documentation as he may require from the State, that the single State agency which administers or supervises the administration of the State plan approved under title XIX for that State is not performing effective review of the quality and necessity of health care services provided in such facilities and institutions, or (ii) the State requests such organization to assume such responsibility.

(B) A Professional Standards Review Organization located in a State has the function and duty to assume responsibility for the review under paragraph (1) of professional activities in intermediate care facilities in the State that are also skilled nursing facilities (as defined in section 1861(j)), to the extent that the Secretary finds that the performance of such function by the single State agency (described in subparagraph (A)) for that State is inefficient.

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(h) Any Professional Standards Review Organization which has assumed responsibility under this section for review of inpatient hospital services in an area shall also assume responsibility in such area for review of detoxification facility services.

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Requirement of Review Approval as Condition of Payment of Claims

Sec. 1158 (a) Except as provided for in section 1159 and [subsection (d)] *subsections (d) and (e)*, no Federal funds appropriated under any title of this Act (other than title V) for the provision of health care services or items shall be used (directly or indirectly) for the payment, under such title or any program established pursuant thereto, of any claim for the provision of such services or items, unless the Secretary, pursuant to regulation determines that the claimant is without fault if—

(1) the provision of such services or items is subject to review under this part by any Professional Standards Review Organization, or other agency; and

(2) such organization or other agency has, in the proper exercise of its duties and functions under or consistent with the purposes of this part, disapproved of the services or items giving rise to such claim, and has notified the practitioner or provider who provided or proposed to provide such services or items and the individual who would receive or was proposed to receive such services or items of its disapproval of the provision of such services or items.

(b) Whenever any Professional Standards Review Organization, in the discharge of its duties and functions as specified by or pursuant to this part, disapproves of any health care services or items furnished or to be furnished by any practitioner or provider, such organization shall, after notifying the practitioner, provider, or other organi-

zation or agency of its disapproval in accordance with subsection (a), promptly notify the agency or organization having responsibility for acting upon claims for payment for or on account of such services or items.

(c) Where a Professional Standards Review Organization (Whether designated on a conditional basis or otherwise) has been found competent by the Secretary to assume review responsibility with respect to specified types of health care services or specified providers or practitioners of such services and is performing such reviews, determinations made pursuant to paragraphs (1) and (2) of section 1155 (a) in connection with such reviews shall constitute the conclusive determination on those issues (subject to sections 1159, 1171(a)(1), and 1171(d)(3)) for purposes of payment under this Act, and no reviews with respect to those determinations shall be conducted, for purposes of payment, by agencies and organizations which are parties to agreements entered into by the Secretary pursuant to section 1816, carriers which are parties to contracts entered into by the Secretary pursuant to section 1842, or single State agenices administering or supervising the administration of State plans approved under title XIX.

(d) [In any case] *(1) Except as provided in subsection (e) and paragraph (2) of this subsection, in any case* in which a Professional Standards Review Organization disapproves (under subsection (a)) of inpatient hospital services or posthospital extended care services, payment may be made for such services furnished before the second day after the day on which the provider received notice of such disapproval, or, if such organization determines that more time is required in order to arrange postdischarge care, payment may be made for such services furnished before the fourth day after the day on which the provider received notice of such disapproval.

(2) A Professional Standards Review Organization shall not disapprove (under subsection (a)) of inpatient hospital services provided under a title of this Act to an individual on the grounds that such individual could receive appropriate and necessary medical nursing, or other care more economically in an inpatient facility or home care program of another type for which payment can be made under such title (but shall maintain and make public a quarterly report to the Secretary by hospital and area as to the number of cases and hospital days which, except for this paragraph, would have otherwise been disapproved) if—

(A) there is no excess of inpatient hospital beds adjusting for patients occupying hospital beds who do not need that level of care) in the geographic area in which the hospital is located (as certified by the State or local health planning agency or health systems agency); and

(B) there is no such other type of facility or home care program available to such individual to provide appropriate care for which payment can be made under such title.

(e)(1) If, for purposes of payment under a title of this Act as described in subsection (a), the Professional Standards Review Organization disapproves (under subsection (a)) of inpatient hospital services provided by a hospital to an individual on the grounds that such individual could receive appropriate and necessary medical, nurs-

ing, or other care more economically in an inpatient facility of another type or home care program, and such organization finds that—

(A) payment is authorized to be made under or pursuant to such title of this Act (as described in subsection (a)) with respect to services furnished to such individual in such other type of facility or home care program; and

(B) there is no such other type of facility or home care program available to such individual.

then payment, from funds described in subsection (a), to such hospital may continue to be made (but at a rate determined under paragraph (2)) for days (in a continuous period of days which begins with the day following the last day for which payment may be made, with application of subsection (d), for such inpatient hospital services furnished to such individual) with respect to which such individual meets the conditions specified in subparagraphs (A) and (B).

(2)(A) The rate at which payment may be continued under paragraph (1) shall be a rate equal to the estimated average rate per patient-day paid for services provided in such other type of facility under the State plan approved under title XIX of the State in which such hospital is located, or, if less, the reasonable reimbursement allowed to such hospital for services of the type provided in such other type of facility (if such hospital has a unit which provides such other type of services).

(B) In the case of a State that does not have a State plan approved under title XIX, the rate at which payment may be continued under paragraph (1) shall be a rate equal to the estimated average rate per patient-day for services provided in such other type of facility under title XVIII in the State in which such hospital is located, or, if less, the rate in effect for such hospital for services of the type provided in such other type of facility (if such hospital has a unit which provides such other type of services).

(3) Any day on which an individual receives inpatient hospital services for which payment is made at a lower rate on account of the provisions of this subsection shall, for purposes of this Act, be deemed to be a day on which he received the type of services provided by such other type of facility or home care program.

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TITLE XVI—SUPPLEMENTAL SECURITY INCOME FOR THE AGED, BLIND, AND DISABLED

* * * * * * *

Resources

Exclusions From Resources

Sec. 1613. (a) In determining the resources of an individual (and his eligible spouse, if any) there shall be excluded—

(1) the home (including the land that appertains thereto);

(2) household goods, personal effects, and an automobile, to the extent that their total value does not exceed such amount as the Secretary determines to be reasonable;

(3) other property which, as determined in accordance with and subject to limitations prescribed by the Secretary, is so essen-

tial to the means of self-support of such individual (and such spouse) as to warrant its exclusion;

(4) such resources of an individual who is blind or disabled and who has a plan for achieving self-support approved by the Secretary, as may be necessary for the fulfillment of such plan;

(5) in the case of Natives of Alaska, shares of stock held in a Regional or a Village Corporation, during the period of twenty years in which such stock is inalienable, as provided in section 7(h) and section 8(c) of the Alaska Native Claims Settlement Act; and

(6) assistance referred to in section 1612(b)(11) for the 9-month period beginning on the date such funds are received (or for such longer period as the Secretary shall by regulations prescribe in cases where good cause is shown by the individual concerned for extending such period); and, for purposes of this paragraph, the term "assistance" includes interest thereon which is excluded from income under section 1612(b)(12).

In determining the resources of an individual (or eligible spouse) an insurance policy shall be taken into account only to the extent of its cash surrender value; except that if the total face value of all life insurance policies on any person is $1,500 or less, no part of the value of any such policy shall be taken into account.

Disposition of Resources

(b) The Secretary shall prescribe the period or periods of time within which, and the manner in which, various kinds of property must be disposed of in order not to be included in determining an individual's eligibility for benefits. Any portion of the individual's benefits paid for any such period shall be conditioned upon such disposal; and any benefits so paid shall (at the time of the disposal) be considered overpayments to the extent they would not have been paid had the disposal occurred at the beginning of the period for which such benefits were paid.

Disposal of Resource for Less Than Fair Market Value

(c) (1) In determining the resources of an individual (and his eligible spouse, if any) there shall be included (but subject to the exclusions under subsection (a)) any resource (or interest therein) owned by such individual or eligible spouse within the preceding 24 months if such individual or eligible spouse gave away or sold such resource or interest at less than the fair market value of such resource or interest for the purpose of establishing eligibility for benefits or assistance under this Act.

(2) Any transaction described in paragraph (1) shall be presumed to have been for the purpose of establishing eligibility for benefits or assistance under this Act unless such individual or eligible spouse furnishes convincing evidence to establish that the transaction was exclusively for some other purpose.

(3) For purposes of paragraph (1) the value of such a resource or interest shall be the fair market value of such resource or interest at the time it was sold or given away, less the amount of compensation received for such resource or interest, if any.

TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND DISABLED

* * * * * * *

Part A—Hospital Insurance Benefits for the Aged and Disabled

Description of Program

Sec. 1811. The insurance program for which entitlement is established by sections 226 and 226A provides basic protection against the costs of hospital and related post-hospital services in accordance with this part for (1) individuals who are age 65 or over and are entitled to retirement benefits under title II of this Act or under the railroad retirement system, (2) individuals under age 65 who have been entitled for not less than 24 months to benefits under title II of this Act or under the railroad retirement system on the basis of a disability, and (3) certain individuals who do not meet the conditions specified in either clause (1) or (2) but who are medically determined to have end stage renal disease.

Scope of Benefits

Sec. 1812. (a) The benefits provided to an individual by the insurance program under this part shall consist of entitlement to have payment made on his behalf or, in the case of payments referred to in section 1814(d)(2) to him (subject to the provisions of this part) for—

(1) inpatient hospital services for up to 150 days during any spell of illness minus one day for each day of inpatient hospital services in excess of 90 received during any preceding spell of illness (if such individual was entitled to have payment for such services made under this part unless he specifies in accordance with regulations of the Secretary that he does not desire to have such payment made);

(2) post-hospital extended care services for up to 100 days during any spell of illness: [and]

(3) post-hospital home health services for up to 100 visits (during the one-year period described in section 1861(n)) after the beginning of one spell of illness and before the beginning of the next[.]; *and*

(*4*) *detoxification facility services.*

* * * * * * *

Conditions of and Limitations on Payment for Services

Requirement of Requests and Certifications

Sec. 1814. (a) Except as provided in subsections (d) and (g) and in section 1876, payment for services furnished an individual may be made only to providers of services which are eligible therefor under section 1866 and only if—

(1) written request, signed by such individual, except in cases in which the Secretary finds it impracticable for the individual to do so, is filed for such payment in such form, in such manner,

and by such person or persons as the Secretary may by regulation prescribe, no later than the close of the period of 3 calendar years following the year in which such services are furnished (deeming any services furnished in the last 3 calendar months of any calendar year to have been furnished in the succeeding calendar year) except that where the Secretary deems that efficient administration so requires, such period may be reduced to not less than 1 calendar year;

(2) physician certifies (and recertifies, where such services are furnished over a period of time, in such cases, with such frequency, and accompanied by such supporting material, appropriate to the case involved, as may be provided by regulations, except that the first of such recertifications shall be required in each case of inpatient hospital services not later than the 20th day of such period) that—

(A) in the case of inpatient psychiatric hospital services, such services are or were required to be given on an inpatient basis, by or under the supervision of a physician, for the psychiatric treatment of an individual; and (i) such treatment can or could reasonably be expected to improve the condition for which such treatment is or was necessary or (ii) inpatient diagnostic study is or was medically required and such services are or were necessary for such purposes;

(B) in the case of inpatient tuberculosis hospital services, such services are or were required to be given on an inpatient basis, by or under the supervision of a physician, for the treatment of an individual for tuberculosis; and such treatment can or could reasonably be expected to (i) improve the condition for which such treatment is or was necessary or (ii) render the condition noncommunicable;

(C) in the case of post-hospital extended care services, such services are or were required to be given because the individual needs or needed on a daily basis skilled nursing care (provided directly by or requiring the supervision of skilled nursing personnel) or other skilled rehabilitation services, which as a practical matter can only be provided in a skilled nursing facility on an inpatient basis, for any of the conditions with respect to which he was receiving inpatient hospital services (or services which would constitute inpatient hospital services if the institution met the requirements of paragraphs (6) and (9) of section 1861(e)) prior to transfer to the skilled nursing facility or for a condition requiring such extended care services which arose after such transfer and while he was still in the facility for treatment of the condition or conditions for which he was receiving such inpatient hospital services;

(D) in the case of post-hospital home health services, such services are or were required because the individual is or was confined to his home (except when receiving items and services referred to in section 1861(m)(7)) and needed skilled nursing care on an intermittent basis, or physical or speech therapy, for any of the conditions with respect to which he

was receiving inpatient hospital services (or services which would constitute inpatient hospital services if the institution met the requirements of paragraphs (6) and (9) of section 1861(e)) or post-hospital extended care services; a plan for furnishing such services to such individual has been established and is periodically reviewed by a physician; and such services are or were furnished while the individual was under the care of a physician; [or]

(E) in the case of inpatient hospital services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth, the individual, because of his underlying medical condition and clinical status, requires hospitalization in connection with the provision of such dental services; *or*

(F) in the case of detoxification facility services, such services are required on an inpatient basis (based upon an examination by such certifying physician made prior to initiation of detoxification);

(3) with respect to inpatient hospital services (other than inpatient physchiatric hospital services and inpatient tuberculosis hospital services) which are furnished over a period of time, a physician certifies that such services are required to be given on an inpatient basis for such individual's medical treatment, or that inpatient diagnostic study is medically required and such services are necessary for such purpose, except that (A) such certification shall be furnished only in such cases, with such frequency, and accompanied by such supporting material, appropriate to the cases involved, as may be provided by regulations, and (B) the first such certification required in accordance with clause (A) shall be furnished no later than the 20th day of such period;

(4) in the case of inpatient psychiatric hospital services, the services are those which the records of the hospital indicate were furnished to the individual during periods when he was receiving (A) intensive treatment services, (B) admission and related services necessary for a diagnostic study, or (C) equivalent services;

(5) in the case of inpatient tuberculosis hospital services, the services are those which the records of the hospital indicate were furnished to the individual during periods when he was receiving treatment which could reasonably be expected to (A) improve his condition or (B) render it noncommunicable;

(6) with respect to inpatient hospital services furnished such individual after the 20th day of a continuous period of such services and with respect to post-hospital extended care services furnished after such day of a continuous period of such services as may be prescribed in or pursuant to regulations, there was not in effect, at the time of admission of such individual to the hospital or skilled nursing facility, as the case may be, a decision under section 1866(d) (based on a finding that utilization review of long-stay cases is not being made in such hospital or facility); and

(7) with respect to inpatient hospital services or post-hospital extended care services furnished such individual during a con-

tinuous period, a finding has not been made (by the physician members of the committee or group, as described in section 1861(k)(4), including any finding made in the course of a sample or other review of admissions to the institution) pursuant to the system of utilization to review that further inpatient hospital services or further post-hospital extended care services, as the case may be, are not medically necessary; except that, if such a finding has been made, payment may be made for such services furnished before the 4th day after the day on which the hospital or skilled nursing facility, as the case may be, received notice of such finding.

To the extent provided by regulations, the certification and recertification requirements of paragraph (2) shall be deemed satisfied where, at a later date, a physician makes certification of the kind provided in subparagraph (A), (B), (C), (D), or (E) of paragraph (2) (whichever would have applied), but only where such certification is accompanied by such medical and other evidence as may be required by such regulations.

* * * * * * *

Use of Carriers for Administration of Benefits

Sec. 1842. (a) * * *

(b)(1) * * *

(3) Each such contract shall provide that the carrier—

(A) will take such action as may be necessary to assure that, where payment under this part for a service is on a cost basis, the cost is reasonable cost (as determined under section 1861(v));

(B) will take such action as may be necessary to assure that, where payment under this part for a service is on a charge basis, such charge will be reasonable and not higher than the charge applicable, for a comparable service and under comparable circumstances, to the policyholders and subscribers of the carrier, and such payment will (except as otherwise provided in section 1870(f)) be made—

(i) on the basis of an itemized bill; or

(ii) on the basis of an assignment under the terms of which (I) the reasonable charge is the full charge for the service (except in the case of physicians' services and ambulance service furnished as described in section 1862(a)(4), other than for purposes of section 1870(f) and (II) the physician or other person furnishing such service agrees not to charge for such service if payment may not be made therefor by reason of the provisions of paragraph (1) of section 1862, and if the individual to whom such service was furnished was without fault in incurring the expenses of such service, and if the Secretary's determination that payment (pursuant to such assignment) was incorrect and was made subsequent to the third year following the year in which notice of such payment was sent to such individual; except that the Secretary may reduce such three-year period to not less than one year if he finds such reduction is consistent with the objectives of this title;

but (in the case of bills submitted, or requests for payment made, after March 1968) only if the bill is submitted, or a written request for payment is made in such other form as may be permitted under regulations, no later than the close of the calendar year following the year in which such service is furnished (deeming any service furnished in the last 3 months of any calendar year to have been furnished in the succeeding calendar year);

(C) will establish and maintain procedures pursuant to which an individual enrolled under this part will be granted an opportunity for a fair hearing by the carrier, in any case where the amount in controversy is $100 or more when requests for payment under this part with respect to services furnished him are denied or are not acted upon with reasonable promptness or when the amount of such payment is in controversy;

(D) will furnish to the Secretary such timely information and reports as he may find necessary in performing his functions under this part; [and]

(E) will maintain such records and afford such access thereto as the Secretary finds necessary to assure the correctness and verification of the information and reports under subparagraph (D) and otherwise to carry out the purposes of this part: *and*

(F) will take such action as may be necessary to assure that where payment under this part for a service rendered in a particular month is on a charge basis, such payment shall be determined on the basis of the charge that is determined to be reasonable for such month in accordance with this part (except that in the case of a service which was rendered prior to the beginning of the calendar year preceding the year in which the bill is submitted, or request for payment is made, with respect to such service, payment shall be determined on the basis of the charge that is determined to be reasonable in accordance with this part for the first month of such preceding year;

and shall contain such other terms and conditions not inconsistent with this section as the Secretary may find necessary or appropriate. In determining the reasonable charge for services for purposes of this paragraph, there shall be taken into consideration the customary charges for similar services generally made by the physician or other person furnishing such services, as well as the prevailing charges in the locality for similar services.

[No charge may be determined to be reasonable in the case of bills submitted or requests for payment made under this part after December 31, 1970, if it exceeds the higher of (i) the prevailing charge recognized by the carrier and found acceptable by the Secretary for similar services in the same locality in administering this part on December 31, 1970, or (ii) the prevailing charge level that, on the basis of statistical data and methodology acceptable to the Secretary, would cover 75 percent of the customary charges made for similar services in the same locality during the last preceding calendar year elapsing prior to the start of the twelve-month period (beginning July 1 of each year) in which the bill is submitted or the request for payment is made. In the case of physician services the prevailing charge level determined for purposes of clause (ii) of the preceding sentence

for any twelve-month period (beginning after June 30, 1973) specified in clause (ii) of such sentence may not exceed (in the aggregate) the level determined under such clause for the fiscal year ending June 30, 1973. except to the extent that the Secretary finds, on the basis of appropriate economic index data, that such higher level is justified by economic changes. With respect to power-operated wheelchairs for which payment may be made in accordance with section 1861(s)(6), charges determined to be reasonable may not exceed the lowest charge at which power-operated wheelchairs are available in the locality. In the case of medical services, supplies, and equipment (including equipment servicing) that, in the judgment of the Secretary, do not generally vary significantly in quality from one supplier to another, the charges incurred after December 31, 1972, determined to be reasonable may not exceed the lowest charge levels at which such services, supplies, and equipment are widely and consistently available in a locality except to the extent and under the circumstances specified by the Secretary. The requirement in subparagraph (B) that a bill be submitted or request for payment be made by the close of the following calendar year shall not apply if (i) failure to submit the bill or request the payment by the close of such year is due to the error or misrepresentation of an officer, employee. fiscal intermediary, carrier, or agent of the Department of Health, Education, and Welfare performing functions under this title and acting within the scope of his or its authority, and (ii) the bill is submitted or the payment is requested promptly after such error or misrepresentation is eliminated or corrected. Notwithstanding the provisions of the third and fourth sentences preceding this sentence, the prevailing charge level in the case of a physician service in a particular locality determined pursuant to such third and fourth sentences for the twelve-month period beginning on July 1 in any calendar year after 1974 shall, if lower than the prevailing charge level for the fiscal year ending June 30, 1975, in the case of a similar physician service in the same locality by reason of the application of economic index data, be raised to such prevailing charge level for the fiscal year ending June 30, 1975.]

(4)(A) In determining the reasonable charge for services for purposes of paragraph (3) (including the services of any hospital-associated physicians), there shall be taken into consideration the customary charges for similar services generally made by the physician or other person furnishing such services, as well as the prevailing charges in the locality for similar services.

(B)(i) Except as otherwise provided in clause (iii), no charge may be determined to be reasonable in the case of bills submitted or requests for payment made under this part after December 31, 1970, if it exceeds the higher of (I) the prevailing charge recognized by the carrier and found acceptable by the Secretary for similar services in the same locality in administering this part on December 31, 1970, or (II) the prevailing charge level that, on the basis of statistical data and methodology acceptable to the Secretary, would cover 75 percent of the customary charges made for similar services in the same locality during the last preceding calendar year elapsing prior to the start of the fiscal year in which the service is rendered.

(ii) In the case of physician services, the prevailing charge level determined for purposes of clause (i)(II) for any fiscal year beginning after June 30, 1973, may not (except as otherwise provided in clause (iii)) exceed (in the aggregate) the level determined under such clause for the fiscal year ending June 30, 1973, except to the extent that the Secretary finds, on the basis of appropriate economic index data, that such higher level is justified by economic changes. Moreover, for any twelve-month period beginning on July 1 of any year (beginning with 1980), no prevailing charge level for physicians' services shall be increased to the extent that it would exceed by more than one-third the statewide prevailing charge level (as determined under subparagraph (E)) for that service.

(iii) Notwithstanding the provisions of clauses (i) and (ii) of this subparagraph, the prevailing charge level in the case of a physician service in a particular locality determined pursuant to such clauses for the fiscal year beginning July 1, 1975, shall, if lower than the prevailing charge level for the fiscal year ending June 30, 1975, in the case of a similar physician service in the same locality by reason of the application of economic index data, be raised to such prevailing charge level for the fiscal year ending June 30, 1975.

(C) In the case of medical services, supplies, and equipment (including equipment servicing) that, in the judgment of the Secretary, do not generally vary significantly in quality from one supplier to another, the charges incurred after December 31, 1972, determined to be reasonable may not exceed the lowest charge levels at which such services, supplies, and equipment are widely and consistently available in a locality except to the extent and under circumstances specified by the Secretary. With respect to power-operated wheelchairs for which payment may be made in accordance with section 1861(s)(6), charges determined to be reasonable may not exceed the lowest charge at which power-operated wheelchairs are available in the locality.

(D) The requirement in paragraph (3)(B) that a bill be submitted or request for payment be made by the close of the following calendar year shall not apply if (i) failure to submit the bill or request the payment by the close of such year is due to the error or misrepresentation of an officer, employee, fiscal intermediary, carrier, or agent of the Department of Health and Human Services performing functions under this title and acting within the scope of his or its authority, and (ii) the bill is submitted or the payment is requested promptly after such error or misrepresentation is eliminated or corrected.

(E) The Secretary shall determine separate statewide prevailing charge levels for each State that, on the basis of statistical data and methodology acceptable to the Secretary, would cover 50 percent of the customary charges made for similar services in the State during the last preceding calendar year elapsing prior to the sart of the fiscal year in which the service is rendered. In States with more than one carrier, the statewide prevailing charge level shall be the weighted average of the fiftieth percentiles of the customary charges of each carrier.

(F) Notwithstanding any other provision of this paragraph, any charge for any particular service or procedure performed by a doctor of medicine or osteopathy shall be regarded as a reasonable charge if—

(i) the service or procedure is performed in an area which the Secretary has designated as a physician shortage area,

(ii) the physician has a regular practice in the physician shortage area,

(iii) the charge does not exceed the prevailing charge level as determined under subparagraph (B), and

(iv) the charge does not exceed the amount generally charged by such physician for similar services.

(G) For additional exclusions from reasonable cost and reasonable charge see section 1134.

[(4)] *(5)* Each contract under this section shall be for a term of at least one year, and may be made automatically renewable from term to term in the absence of notice by either party of intention to terminate at the end of the current term; except that the Secretary may terminate any such contract at any time (after such reasonable notice and opportunity for hearing to the carrier involved as he may provide in regulations) if he finds that the carrier has failed substantially to carry out the contract or is carrying out the contract in a manner inconsistent with the efficient and effective administration of the insurance program established by this part.

[(5)] *(6)* No payment under this part for a service provided to any individual shall (except as provided in section 1870) be made to anyone other than such individual or (pursuant to an assignment described in subparagraph (B)(ii) of paragraph (3)) the physician or other person who provided the service, except that payment may be made (A) to the employer of such physician or other person if such physician or other person is required as a condition of his employment to turn over his fee for such service to his employer, or (B) (where the service was provided in a hospital, clinic, or other facility) to the facility in which the service was provided if there is a contractual arrangement between such physician or other person and such facility under which such facility submits the bill for such service. No payment which under the preceding sentence may be made directly to the physician or other person providing the service involved (pursuant to an assignment described in subparagraph (B)(ii) of paragraph (3)) shall be made to anyone else under a reassignment or power of attorney (except to an employer or facility as described in clause (A) or (B) of such sentence); but nothing in this subsection shall be construed (i) to prevent the making of such a payment in accordance with an assignment from the individual to whom the service was provided or a reassignment from the physician or other person providing such service if such assignment or reassignment is made to a governmental agency or entity or is established by or pursuant to the order of a court of competent jurisdiction, or (ii) to preclude an agent of the physician or other person providing the service from receiving any such payment if (but only if) such agent does so pursuant to an agency agreement under which the compensation to be paid to the agent for his services for or in connection with the billing or collection of payments due such physician or other person under this title is unrelated (directly or indirectly) to the amount of such payments or the billings therefor, and is not dependent upon the actual collection of any such payment.

Appropriations To Cover Government Contributions and Contingency Reserve

Sec. 1844. (a) There are authorized to be appropriated from time to time out of any moneys in the Treasury not otherwise appropriated, to the Federal Supplementary Medical Insurance Trust Fund—

(1)(A) A Government contribution equal to the aggregate premiums payable for a month for enrollees age 65 and over under this part and deposited in the Trust Fund, multiplied by the ratio of—

(i) twice the dollar amount of the actuarially adequate rate per enrollee age 65 and over as determined under section 1839(c)(1) for such month, minus the dollar amount of the premium per enrollee for such month as determined under section 1839(c)(3), to

(ii) the dollar amount of the premium per enrollee for such month, plus

(B) a Government contribution equal to the aggregate premiums payable for a month for enrollees under age 65 under this part and deposited in the Trust Fund, multiplied by the ratio of—

(i) twice the dollar amount of the actuarially adequate rate per enrollee under age 65 as determined under section 1839 (c)(4) for such month, minus the dollar amount of the premium per enrollee for such month, as determined under section 1839(c)(3), to

(ii) the dollar amount of the premium per enrollee for such month.

(2) such sums as the Secretary deems necessary to place the Trust Fund, at the end of any fiscal year occurring after June 30, 1967, in the same position in which it would have been at the end of such fiscal year if (A) a Government contribution representing the excess of the premiums deposited in the Trust Fund during the fiscal year ending June 30, 1967, over the Government contribution actually appropriated to the Trust Fund during such fiscal year had been appropriated to it on June 30, 1967, and (B) the Government contribution for premiums deposited in the Trust Fund after June 30, 1967, had been appropriated to it when such premiums were deposited.

(b) In order to assure prompt payment of benefits provided under this part and the administrative expenses thereunder during the early months of the program established by this part, and to provide a contingency reserve, there is also authorized to be appropriated, out of any moneys in the Treasury not otherwise appropriated, to remain available through the calendar year 1969 for repayable advances (without interest) to the Trust Fund, an amount equal to $18 multiplied by the number of individuals (as estimated by the Secretary) who could be covered in July 1966 by the insurance program established by this part if they had theretofore enrolled under this part.

Special Provisions Relating to Certain Surgical and Preoperative Procedures Performed on an Ambulatory Basis

Sec. 1845. *(a) The Secretary shall in consultation with the National Professional Standards Review Council and appropriate medical or-*

ganizations, specify those surgical procedures which can be safely and appropriately performed either in a hospital on an inpatient basis or on an ambulatory basis—

(1) in a physician's office; or

(2) in an ambulatory surgical center or hospital.

(b)(1) If a physician performs in his office a surgical procedure specified by the Secretary pursuant to subsection (a)(1) on an individual insured for benefits under this part, he shall, notwithstanding any other provision of this part, be entitled to have payment made under this part equal to—

(A) 100 percent of the reasonable charge for the services involved with the performance of such procedure (including all pre- and post-operative physicians' services performed in connection therewith), plus

(B) the amount established by the Secretary pursuant to paragraph (2),

but only if the physician agrees with such individual to be paid on the basis of an assignment under the terms of which the reasonable charge for such services is the full charge therefor.

(2) The Secretary shall establish with respect to each surgical procedure specified pursuant to subsection (a)(1), an amount established with a view to according recognition to the special costs, in excess of usual overhead, which physicians incur which are attributable to securing, maintaining, and staffing the facilities and ancillary services appropriate for the performance of such procedure in the physician's office, and to assuring that the performance of such procedure in the physician's office will involve substantially less total cost than would be involved if the procedure were performed on an inpatient basis in a hospital. The amount so established with respect to any surgical procedure periodically shall be reviewed and revised and may be adjusted, when appropriate, by the Secretary to take account of varying conditions in different areas.

(c)(1) Payment under this part may be made to an ambulatory surgical center for ambulatory facility services furnished in connection with any surgical procedure, specified by the Secretary pursuant to subsection (a)(2), which is performed on an individual insured for benefits under this part in an ambulatory surgical center, which meets such health, safety, and other standards as the Secretary shall by regulations prescribe, if such surgical center agrees to accept, in full payment of all services furnished by it in connection with such procedure, the amount established for such procedure pursuant to paragraph (2).

(2) The Secretary shall establish with respect to each surgical procedure specified pursuant to subsection (a)(2), a reimbursement amount which is payable to an ambulatory surgical center for its services furnished in connection with such procedure. The amount established for any such surgical procedure shall be established with a view to according recognition to the costs incurred by such centers generally in providing the services involved in connection with such procedure, and to assuring that the performance of such procedure in such a center involves less cost than would be involved if such procedure were performed on an inpatient basis in a hospital. The amount so established with respect to any surgical procedure shall periodi-

cally be reviewed and revised and may be adjusted by the Secretary, when appropriate, to take account of varying conditions in different areas.

(3) If the physician, performing a surgical procedure (specified by the Secretary under subsection (a)(2)), in a hospital on an outpatient basis or in an ambulatory surgical center with respect to which payment is authorized under the preceding provisions of this subsection, or a physician performing physicians' services in such center or hospital directly related to such surgical procedure, agrees to accept as full payment for all services performed by him in connection with such procedure (including pre- and post-operative services) an amount equal to 100 percent of the reasonable charge for such services, he shall be paid under this part for such services an amount equal to 100 percent of the reasonable charge for such services.

(d)(1) The Secretary is authorized by regulations to provide that in case a surgical procedure specified by the Secretary pursuant to subsection (a)(2) is performed on an individual insured for benefits under this part in an ambulatory surgical center which meets such health, safety, and other standards as the Secretary shall by regulations prescribe, there shall be paid with respect to the services furnished by such center and with respect to all related services (including physicians' services, laboratory, X-ray, and diagnostic services) a single all-inclusive fee established pursuant to paragraph (2), if all parties furnishing all such services agree to accept such fee (to be divided among the parties involved in such manner as they shall have previously agreed upon) as full payment for the services furnished.

(2) In implementing this subsection, the Secretary shall establish with respect to each surgical procedure specified pursuant to subsection (a)(2) the amount of the all-inclusive fee for such procedure, taking into account such factors as may be appropriate. The amount so established with respect to any surgical procedure shall periodically be reviewed and revised and may be adjusted, when appropriate, to take account of varying conditions in different areas.

(e)(1) The Secretary shall, in consultation with the National Professional Standards Review Council and appropriate medical organizations, specify those preoperative medical and other health services which can be safely and appropriately performed in a hospital on both an inpatient and outpatient basis.

(2) If a physician, performing a preoperative service (specified by the Secretary under paragraph (1)) in a hospital on an outpatient basis, within seven days prior to admission on an inpatient basis for the surgery to which such service relates, agrees to accept as full payment for such service an amount equal to 100 percent of the reasonable charge for such service, he shall be paid under this part for such service an amount equal to 100 percent of the reasonable charge for such service.

(f) The provisions of sections 1833 (a) and (b) shall not be applicable to expenses attributable to services to which subsection (b) is applicable, to ambulatory facility services (furnished by an ambulatory surgical center) to which the provisions of subsections (c)(1) and (2) are applicable, or to services to which the provisions of subsection (c)(3), (d), or (e) are applicable.

Part C—Miscellaneous Provisions

Definition of Services, Institutions, etc.

Sec. 1861. * * *

Provider of Services

(u) The term "provider of services" means a hospital, skilled nursing facility, home health agency, *detoxification facility* or, for purposes of section 1814(g) and section 1835(e), a fund.

Reasonable Cost

(v)(1)(A) [The] *Subject to subsection (bb), the* reasonable cost of any services shall be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services; except that in any case to which paragraph (2) or (3) applies, the amount of the payment determined under such paragraph with respect to the services involved shall be considered the reasonable cost of such services. In prescribing the regulations referred to in the preceding sentence, the Secretary shall consider, among other things, the principles generally applied by national organizations or established prepayment organizations (which have developed such principles) in computing the amount of payment, to be made by persons other than the recipients of services, to providers of services on account of services furnished to such recipients by such providers. Such regulations may provide for determination of the costs of services on a per diem, per unit, per capita, or other basis, may provide for using different methods in different circumstances, may provide for the use of estimates of costs of particular items or services, may provide for the establishment of limits on the direct or indirect overall incurred costs or incurred costs of specific items or services or groups of items or services to be recognized as reasonable based on estimates of the costs necessary in the efficient delivery of needed health services to individuals covered by the insurance programs established under this title, and may provide for the use of charges or a percentage of charges where this method reasonably reflects the costs. Such regulations shall (i) take into account both direct and indirect costs of providers of services (excluding therefrom any such costs, including standby costs, which are determined in accordance with regulations to be unnecessary in the efficient delivery of services covered by the insurance programs established under this title) in order that, under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this title will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs, and (ii) provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive.

(B) Such regulations in the case of extended care services furnished by proprietary facilities shall include provision for specific recognition of a reasonable return on equity capital, including necessary working capital, invested in the facility and used in the furnishing of such services, in lieu of other allowances to the extent that they reflect similar items. The rate of return recognized pursuant to the preceding sentence for determining the reasonable cost of any services furnished in any fiscal period shall not exceed one and one-half times the average of the rates of interest, for each of the months any part of which is included in such fiscal period, on obligations issued for purchase by the Federal Hospital Insurance Trust Fund.

(C) Where a hospital has an arrangement with a medical school under which the faculty of such school provides services at such hospital, an amount not in excess of the reasonable cost of such services to the medical school shall be included in determining the reasonable cost to the hospital of furinshing services—

(i) for which payment may be made under part A, but only if

(I) payment for such services as furnished under such arrangement would be made under part A to the hospital had such services been furnished by the hospital, and

(II) such hospital pays to the medical school at least the reasonable cost of such services to the medical school, or

(ii) for which payment may be made under part B, but only if such hospital pays to the medical school at least the reasonable cost of such services to the medical school.

(D) Where (i) physicians furnish services which are either inpatient hospital services (including services in conjunction with the teaching programs of such hospital) by reason of paragraph (7) of subsection (b) or for which entitlement exists by reason of clause (II) of section 1832(a)(2)(B) (i) and (ii) such hospital (or medical school under arrangement with such hospital) incurs no actual cost in the furnishing of such services, the reasonable cost of such services shall (under regulations of the Secretary) be deemed to be the cost such hospital or medical school would have incurred had it paid a salary to such physicians rendering such services approximately equivalent to the average salary paid to all physicians employed by such hospital (or if such employment does not exist, or is minimal in such hospital, by similar hospitals in a geographic area of sufficient size to assure reasonable inclusion of sufficient physicians in development of such average salary).

(E) Such regulations may, in the case of skilled nursing facilities in any State, provide for the uses of rates, developed by the State in which such facilities are located, for the payment of the cost of skilled nursing facility services furnished under the State's plan approved under title XIX (and such rates may be increased by the Secretary on a class or size of institution or on a geographical basis by a percentage factor not in excess of 10 percent to take into account determinable items or services or other requirements under this title not otherwise included in the computation of such State rates), if the Secretary finds that such rates are reasonably related to (but not necessarily limited to) analyses undertaken by such State of costs of care in comparable facilities in such State; except that the foregoing pro-

visions of this subparagraph shall not apply to any skilled nursing facility in such State if—

(i) such facility is a distinct part of or directly operated by a hospital, or

(ii) such facility operates in a close, formal satellite relationship (as defined in regulations of the Secretary) with a participating hospital or hospitals.

Notwithstanding the previous provisions of this paragraph in the case of a facility specified in clause (ii) of this subparagraph, the reasonable cost of any services furnished by such facility as determined by the Secretary under this subsection shall not exceed 150 percent of the costs determined by the application of this subparagraph (without regard to such clause (ii)).

(F) Such regulations shall require each provider of services (other than a fund) to make reports to the Secretary of information described in section 1121(a) in accordance with the uniform reporting system (established under such section) for that type of provider.

(G) No payment with respect to a cost attributable to the program established by this title shall be made to a provider of services to the extent that such payment exceeds the proportional share of such cost, as measured by days of utilization or provider charges, until such time as evidence can be produced which, in the judgment of the Comptroller General and concurred in by the Secretary, justifies payment of such a higher proportional share as warranted under particular circumstances for certain facilities, and such payments may then be made only to the extent so justified.

(H)(i) Such regulations shall require that the amount of the costs incurred by a home health agency shall not be considered reasonable to the extent that such costs exceed, in the aggregate, an amount equal to 75 percent of the average costs after settlement for home health agencies, appropriately weighted on the basis of the number of different types of visits and services rendered by such agency. As soon as is feasible, based upon costs reporting procedures developed by the Secretary, such regulations shall provide that the limitation under the preceding sentence shall be modified so as to require that the amount of the costs incurred by a home health agency shall not be considered reasonable to the extent that such costs exceed, on a per visit basis, an amount equal to 75 percent of the audited costs for that type to visit.

(ii) Such regulations shall require that in the case of visits by a skilled nurse or home health aide, the costs incurred by a health agency for such visits shall not be considered reasonable to the extent that the cost of any such visit exceeds the per diem rate paid, in the State where such agency is located, under the State's plan approved under title XIX of this Act for skilled nursing facility services in the area. In making such determination, in the case of a hospital-based home health agency, the comparison shall be made to the per diem rate for hospital-based skilled nursing facilities, and in the case of other home health agencies the comparison shall be made to the per diem rate for non-hospital-based skilled nursing facilities. In the case of a State which does not have a plan approved under title XIX, the per diem rate for skilled nursing facilities under this title shall be used in lieu of the per diem rate under such a State plan.

(iii) Any supervisory nursing visit which is specifically required by regulation shall be reimbursable as a home health aide visit (but shall not count as a visit for purposes of determining a particular beneficiary's eligibility for visits). Any initial patient assessment visit shall be a reimbursable visit notwithstanding a determination of ineligibility following such visit, if there was a reasonable basis for assuming potential eligibility, such as referral from a discharge planner, physician, or other source qualified as being knowledgeable with respect to the beneficiary and the program under this title.

(iv) Such regulations may provide for appropriate exceptions and adjustments on an agency by agency basis where warranted by unusual circumstances.

Certification and Approval of Skilled Nursing Facilities

(2) (A) If the bed and board furnished as part of inpatient hospital services (including inpatient tuberculosis hospital services and inpatient psychiatric hospital services) or post-hospital extended care services is in accommodations more expensive than semi-private accommodations, the amount taken into account for purposes of payment under this title with respect to such services may not exceed an amount equal to the reasonable cost of such services if furnished in such semi-private accommodations unless the more expensive accommodations were required for medical reasons.

(B) Where a provider of services which has an agreement in effect under this title furnishes to an individual items or services which are in excess of or more expensive than the items or services with respect to which payment may be made under part A or part B, as the case may be, the Secretary shall take into account for purposes of payment to such provider of services only the equivalent of the reasonable cost of the items or services with respect to which such payment may be made.

(3) If the bed and board furnished as part of inpatient hospital services (including inpatient tuberculosis hospital services and inpatient psychiatric hospital services) or post-hospital extended care services is in accommodations other than, but not more expensive than, semi-private accommodations and the use of such other accommodations rather than semi-private accommodations was neither at the request of the patient nor for a reason which the Secretary determines is consistent with the purposes of this title, the amount of the payment with respect to such bed and board under part A shall be the reasonable cost of such bed and board furnished in semi-private accommodations (determined pursuant to paragraph (1)) minus the difference between the charge customarily made by the hospital or skilled nursing facility for bed and board in semi-private accommodations and the charge customarily made by it for bed and board in the accommodations furnished.

(4) If a provider of services furnishes items or services to an individual which are in excess of or more expensive than the items or services determined to be necessary in the efficient delivery of needed health services and charges are imposed for such more expensive items or services under the authority granted in section 1866(a)(2)(B)(ii),

the amount of payment with respect to such items or services otherwise due such provider in any fiscal period shall be reduced to the extent that such payment plus such charges exceed the cost actually incurred for such items or services in the fiscal period in which such charges are imposed.

(5)(A) Where physical therapy services, occupational therapy services, speech therapy services, or other therapy services or services of other health-related personnel (other than physicians) are furnished under an arrangement with a provider of services or other organizations, specified in the first sentence of section 1861(p) the amount included in any payment to such provider or other organization under this title as the reasonable cost of such services (as furnished under such arrangements) shall not exceed an amount equal to the salary which would reasonably have been paid for such services (together with any additional costs that would have been incurred by the provider or other organization) to the person performing them if they had been performed in an employment relationship with such provider or other organization (rather than under such arrangement) plus the cost of such other expenses (including a reasonable allowance for traveltime and other reasonable types of expense related to any differences in acceptable methods of organization for the provision of such therapy) incurred by such person, as the Secretary may in regulations determine to be appropriate.

(B) Notwithstanding the provisions of subparagraph (A), if a provider of services or other organization specified in the first sentence of section 1861(p) requires the services of a therapist on a limited part-time basis, or only to perform intermittent services, the Secretary may make payment on the basis of a reasonable rate per unit of service, even though such rate is greater per unit of time than salary related amounts, where he finds that such greater payment is, in the aggregate, less than the amount that would have been paid if such organization had employed a therapist on a full- or part-time salary basis.

(6) For purposes of this subsection, the term "semi-private accommodations" means two-bed, three-bed, or four-bed accommodations.

(7) For limitation on Federal participation for capital expenditures which are out of conformity with a comprehensive plan of a State or areawide planning agency, see section 1122.

(8) For additional requirements applicable to determination of reasonable cost, see subsection (bb) and section 1128(c)(3).

(9) For additional exclusions from reasonable cost and reasonable charge see section 1134.

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Criteria for Determining Reasonable Cost of Hospital Services

(bb)(1) It is the purpose of this subsection to set forth initial methods and criteria for determining reimbursement based upon reasonable cost, but such methods and criteria shall be subject to appropriate modification by the Secretary as provided in section 1128. In order more fairly and effectively to determine reasonable costs incurred in providing hospital services, the Secretary shall, not later

than September 1, 1980, after consulting with appropriate national organizations, establish a system of hospital classification under which hospitals furnishing services will be classified on a national basis initially—

(A) by size, with each of the following groups of hospitals being classified in separate categories: (i) those having more than 5, but fewer than 25, beds, (ii) those having more than 24 but fewer than 50, beds, (iii) those having more than 49, but fewer than 100, beds, (iv) those having more than 99, but fewer than 200, beds, (v) those having more than 199, but fewer than 300, beds, (vi) those having more than 299, but fewer than 400, beds, (vii) those having more than 399, but fewer than 500, beds, and (viii) those having more than 499 beds;

(B) by type of hospital with (i) short-term general hospitals being in a separate category, (ii) hospitals which are primary affiliates of accredited medical schools being in one separate category, and (iii) psychiatric, geriatric, maternity, pediatric, or other specialty hospitals being in the same or separate categories, as the Secretary may determine appropriate, in light of any differences in specialty which significantly affect the routine costs of the different types of hospitals;

(C) as rural or urban; and

(D) according to such other criteria as the Secreary finds appropriate, including modification of bed-size categories;

but the system of hospital classification shall not differentiate between hospitals on the basis of ownership.

(2) The term "routine operating costs" used in this subsection does not include—

(A) capital and related costs,

(B) direct personnel and supply costs of approved hospital education and training programs,

(C) costs of interns, residents, and nonadministrative physicians,

(D) energy costs,

(E) malpractice insurance expense, or

(F) ancillary service costs.

(3)(A) During the calendar quarter beginning on January 1 of each year, beginning with 1981 (and in the case of 1980, as soon as possible), the Secretary shall determine, for the hospitals in each category of the system established under paragraph (1), an average per diem routine operating cost amount which shall (except as otherwise provided in this subsection) be used in determining payments to hospitals.

(B) The determination shall be based upon the amount of the hospitals' rountine operating costs for the most recent accounting year ending prior to October 1 of the calendar year preceding the calendar year in which the determination is made. If, for any accounting year which starts on or after July 1, 1980, a hospital's actual routine operating costs are in excess of the amount allowed for purposes of determining payment to the hospital pursuant to this subsection and subsection (v), only one-half of such excess shall be taken into account in making any determination which the Secretary shall make under this para-

graph. Such amount as determined under the preceding sentences of this subparagraph shall be adjusted to reflect the percentage increase in the cost of the mix of goods and services (including personnel and nonpersonnel costs) comprising routine operating costs, based on an index composed of appropriately weighted indicators of changes in the economy in wages and prices which are representative of services and goods included in routine operating costs, during the period from the end of the accounting year referred to in the first sentence of this subparagraph to the end of the quarter in which the determination is being made.

(C) In making a determination, the routine operating costs of hospitals in each category shall be divided into personnel and nonpersonnel components.

(D)(i) The personnel and nonpersonnel components of routine operating costs for hospitals in each category (other than for those excluded under clause (ii)) shall be divided by the total number of days of routine care provided by such hospitals to determine the average per diem routine operating cost for such category.

(ii) In making the calculations required by subparagraph (A) the Secretary shall exclude any newly opened hospital (as defined in the second sentence of paragraph (4)(F)), and any hospital which he determines is experiencing significant cost differentials resulting from failure of the hospital fully to meet the standards and conditions of participation as a provider of services.

(E) There shall be determined for each hospital in each category a per diem target rate for routine operating costs. Such target rate shall equal the average per diem routine operating cost amount for the category in which the hospital is expected to be classified during the subsequent accounting year, except that the personnel component shall be adjusted using a wage index based upon general wage levels for reasonably comparable work in the areas in which the hospitals are located. If the Secretary finds that, in an area where a hospital in any category is located for the most recent twelve-month period for which data with respect to such wage levels are available, the wage level for such hospital is significantly higher than such general wage level in that area (relative to the relationship within the same hospital group between hospital wages and such general wages in other areas), then such general wage level in the area shall be deemed equal to the wage level for such hospital, but only with respect to the hospital's first accounting year beginning on or after July 1, 1980 and prior to July 1, 1981.

(4)(A)(i) The term "adjusted per diem target rate for routine operating costs" means the per diem target rate for routine operating costs plus the percentage increase in costs determined under the succeeding provisions of this subparagraph.

(ii) In determining the adjusted per diem target rate, the Secretary shall add an estimated percentage increase in the cost of the mix of goods and services (including personnel and nonpersonnel costs) comprising routine operating costs, based on an index composed of appropriately weighted indicators of changes in the economy in wages and prices which are representative of services and goods included in routine operating costs, during the period from the end of the quarter in

which the determination is made under paragraph (3)(A) to the end of the hospital's accounting year. Where actual changes in such weighted index are significantly different (at least one-half of 1 percentage point) from those estimated, the Secretary shall issue corrected target rates on a quarterly basis. At the end of the hospital's accounting year, the target rate shall be adjusted to reflect the actual changes in such weighted index. Adjustments shall also be made to take account of changes in the hospital's classification.

(B) For purposes of payment, the amount of routine operating cost incurred by a hospital for any accounting year which begins on or after July 1, 1980, shall be deemed to be equal—

(i) in the case of a hospital which has actual routine operating costs equal to or greater than that hospital's adjusted per diem target rate for routine operating costs, to the greater of—

(I) the hospital's actual routine operating costs, but not exceeding—

(a) in the case of the first accounting year of any hospital which begins on or after July 1, 1980, and prior to July 1, 1981, an amount equal to the aggregate of (1) 100 percent of the hospital's adjusted per diem target rate for routine operating costs, plus (2) 15 percent of the amount described in clause (1), plus (3) one-half of the difference between the hospital's actual routine operating costs and the sum of the amounts determined under clauses (1) and (2),

(b) in the case of the first accounting year of any hospital which begins on or after July 1, 1981, and prior to July 1, 1982 (or if earlier, the second accounting year of such hospital which begins on or after July 1, 1980, and prior to July 1, 1982), an amount equal to the aggregate of (1) 100 percent of the hospital's adjusted per diem target rate for routine operating costs for such year, plus (2) a dollar amount equal to the dollar amount determined under clause (a)(2) for the category of such hospital, plus (3) one-half of the difference between the hospital's actual routine operating costs and the sum of the amounts determined under clauses (1) and (2), and

(c) in the case of any accounting year after the accounting year described in clause (b), an amount equal to the aggregate of (1) 100 percent of the hospital's adjusted per diem target rate for routine operating costs for such year, plus (2) a dollar amount equal to the dollar amount determined under clause (b)(2) for the category of such hospital, or

(II) the amounts determined for the hospital under division (I) if it had been classified in the bed-size category which contains hospitals closest in bed-size to such hospital's bed-size (with a hospital which has a bed-size that falls halfway between two such categories being considered in the category which contains hospitals with the greater number of beds), but not exceeding the hospital's actual routine operating costs; or

(III) in the case of a hospital having an average length-of-stay per patient which is less than the average length-of-stay per patient for hospitals classified in the same category, for any accounting year, an amount equal to the average reimbursement for routine operating costs per patient stay for hospitals in the same category, multiplied by the number of patient stays for such hospital during that accounting year, but not exceeding the actual routine operating costs for such hospital; and

(ii) in the case of a hospital which has actual routine operating costs which are less than that hospital's adjusted per diem target rate for routine operating costs, to (I) the amount of the hospital's actual routine operating costs, plus (II) the smaller of (a) 5 percent (or 2.5 percent with respect to any accounting year which begins on or after July 1, 1980, and prior to July 1, 1982) of the hospital's adjusted per diem target rate for routine operating costs, or (b) 50 percent (or 25 percent with respect to any accounting year which begins on or after July 1, 1980, and prior to July 1, 1982) of the amount by which the hospital's adjusted per diem target rate for routine operating costs exceeds the hospital's actual routine operating costs.

(C) Any hospital (other than a newly opened hospital) excluded by the Secretary under paragraph (3)(D)(ii), shall be reimbursed for routine operating costs on the basis of the lesser of (i) actual costs or (ii) the reimbursement determined under this subsection.

(D) On or before April 1 (or in the case of 1980, as soon as possible) of the year in which the Secretary determines the amount of the average per diem operating cost for each hospital category and the adjusted per diem target rate for each hospital, the Secretary shall publish the determinations, and he shall notify the hospital administrator and the administrative governing body of each hospital with respect to all aspects of the determination which affect the hospital.

(E) If a hospital is determined by the Secretary to be—

(i) located in an underserved area where hospital services are not otherwise available,

(ii) certified as being currently necessary by an appropriate planning agency, and

(iii) underutilized,

the adjusted per diem target rate shall not apply to that portion of the hospital's routine operating costs attributable to the underutilized capacity.

(F) If a newly opened hospital is determined by the Secretary to have greater routine operating costs as a result of the cost patterns associated with newly opened hospitals, the adjusted per diem target rate shall not apply to that portion of the hospital's routine operating costs attributable to such patterns. For purposes of this subparagraph a "newly opened hospital" means a hospital which has not satisfied the requirements of paragraphs (1) and (7) of subsection (e) of this section (under present or previous ownership) for at least twenty-four months prior to the start of such hospital's accounting year.

(G) If a hospital is determined by the Secretary to have greater

routine operating costs as a result of changes in service on account of consolidation, sharing, or addition of services, where such consolidation, sharing, or addition has been approved by the appropriate State health planning and development agency or agencies, the adjusted per diem target rate shall not apply to that portion of the hospital's routine operating costs attributable to such changes in service.

(H)(i) If a hospital satisfactorily demonstrates to the Secretary that, in the aggregate, its patients require a substantially greater intensity of care than generally is provided by the other hospitals in the same category, resulting in unusually greater routine operating costs, then the adjusted per diem target rate shall not apply to that portion of the hospital's routine operating costs attributable to the greater intensity of care required.

(ii) To the extent that a hospital can demonstrate that it experiences routine operating costs in excess of such costs for hospitals having a reasonably similar mix of patients on account of consistently shorter lengths-of-stay in such hospital, which result from the greater intensity of care provided by such hospital, the excess routine operating costs shall be considered attributable to the greater intensity of care required, but this clause shall not apply in the case of a hospital whose routine operating costs are determined under subparagraph (B)(i)(III).

(I) The Secretary may further increase the adjusted per diem target rate applicable in Alaska and Hawaii to reflect the higher prices prevailing in such States.

(J) Where the Secretary finds that a hospital has manipulated its patient mix, or patient flow, or provides less than the normal range and extent of patient services, or that an unusually large proportion of routine nursing service is provided by private-duty nurses, the routine operating costs of that hospital shall be deemed equal to the lesser of (i) the amount determined without regard to this subsection, or (ii) the amount determined under subparagraph (B).

(5) Where any provisions of this subsection are inconsistent with subsection (v), this subsection supersedes subsection (v).

(6)(A) Notwithstanding any other provision of this Act, in the case of any State which has established a reimbursement system for hospitals, hospital reimbursement in that State under this title and under the State plan approved under title XIX shall, with respect to the services covered by such system, be based on that State system, if the Secretary finds that—

(i) the State has a reimbursement system and it at least applies to the same hospitals in the State, and to the same costs, as the Federal reimbursement reform program established by this subsection;

(ii) every hospital in the State with which there is a provider agreement under this title or under the State plan approved under title XIX conforms to the accounting and uniform reporting requirements of section 1121 of this Act, and furnishes any appropriate reports that the Secretary may require; and

(iii) such State demonstrates to his satisfaction that the total amount payable, with respect to inpatient hospital costs, in the

State under this title and under the State plan approved under title XIX will be equal to or less than an amount equal to (I) the amount which would otherwise be payable for such costs under this title and such State plan without regard to the incentive payments provided by subparagraph (B)(ii) of paragraph (4), plus (II) the amount of any incentive payments which are allowed under the State's reimbursement system in recognition of demonstrated efficiencies (but not to exceed the amount of the incentive payments which would be allowed under paragraph (4)(B)(ii)). If the Secretary finds that any of the above conditions in a State which previously met them have not been met for a two-year period, the Secretary shall, after due notice, reimburse hospitals in that State according to the provisions of this Act (other than this paragraph) unless he finds that unusual, justifiable, and nonrecurring circumstances led to the failure to comply.

(B) If the Secretary finds that, during any two-year period during which hospital reimbursement under this title and under the State plan approved under title XIX was based on a State system as provided in subparagraph (A), the amount payable by the Federal Government under such titles for inpatient hospital costs in such State was in excess of the amount which would have been payable for such costs in such State if reimbursement had not been based on the State system (as estimated by the Secretary), the adjusted per diem target rate for routine operating costs (as determined under the preceding paragraphs of this subsection) for hospitals in such State shall be reduced (by not more than 1 percent in any year) until the Federal Government has recouped an amount equal to such excess payment amount.

(C)(i) The Secretary shall pay to any State in which hospital reimbursement under this title is based on a State system as provided in subparagraph (A), an amount which bears the same ratio to the total cost incurred by such State of administering the approved State system (including the cost of initially putting the system into operation) as the amount paid by the Federal Government under this title in such State for inpatient hospital costs bears to the total amount of inpatient hospital costs in such State which are subject to the State system.

(ii) Payments under clause (i) shall be made from funds in the Federal Hospital Insurance Trust Fund.

(iii) An amount which bears the same ratio to the total cost incurred by such State of administering the approved State system (including the cost of initially putting the system into operation) as the amount paid under the State plan approved under title XIX in such State for inpatient hospital costs bears to the total amount of inpatient hospital costs in such State which are subject to the State system, shall, for purposes of title XIX, be considered to be an amount expended for the administration of such State plan.

(D) If there is in effect in a State a reimbursement system for hospitals which the Secretary finds meets the criteria prescribed in subparagraph (A) except that such system was not established by the State, at the election of the State, such system shall for purposes of this paragraph be considered to be a reimbursement system for hospitals established by such State.

Detoxification Facility Services

(cc)(1) The term "detoxification facility services" means services provided by a detoxification facility in order to reduce or eliminate the amount of a toxic agent in the body, but only to the extent that such services would be covered under subsection (b) if furnished as an inpatient service by a hospital, or are physician services covered under subsection (s).

(2) The term "detoxification facility" means a public or voluntary community based nonprofit facility, other than a hospital, which—

(A) is engaged in furnishing to inpatients the services described in paragraph (1);

(B) is accredited by the Joint Commission on the Accreditation of Hospitals as meeting the Accreditation Program for Psychiatric Facilities standards (1979 edition), or is found by the Secretary to meet such standards;

(C) has arrangements with one or more hospitals, having agreements in effect under section 1866, for the referral and admission of patients requiring services not available at the facility; and

(D) meets such other requirements as the Secretary may find necessary in the interest of the health and safety of individuals who are furnished services by the facility.

Exclusions From Coverage

Sec. 1862. (a) * * *

(b) Payment under this title may not be made with respect to any item or service to the extent that payment has been made, or can reasonably be expected to be made (as determined in accordance with regulations), with respect to such item or service, under a workmen's compensation law or plan of the United States or a State, *or under liability insurance of the person at fault, or under no-fault liability insurance.* Any payment under this title with respect to any item or service shall be conditioned on reimbursement to the appropriate Trust Fund established by this title when notice or other information is received that payment for such item or service has been made under such a law a plan, *or under such liability insurance.*

The Secretary may waive the provisions of this subsection with respect to liability insurance if he determines that the probability of recovery or amount involved does not warrant the pursuing of the claim.

* * * * * * *

Agreements With Providers of Services

Sec. 1866. (a)(1) Any provider of services (except a fund designated for purposes of section 1814(g) and section 1835(e)) shall be qualified to participate under this title and shall be eligible for payments under this title if it files with the Secretary an agreement—

(A) not to charge, except as provided in paragraph (2), any individual or any other person for items or services for which such individual is entitled to have payment made under this title (or

for which he would be so entitled if such provider of services had complied with the procedural and other requirements under or pursuant to this title or for which such provider is paid pursuant to the provisions of section 1814(e)), and

(B) not to charge any individual or any other person for items or services for which such individual is not entitled to have payment made under this title because payment for expenses incurred for such items or services may not be made by reason of the provisions of paragraph (1) or (9), but only if (i) such individual was without fault in incurring such expenses and (ii) the Secretary's determination that such payment may not be made for such items and services was made after the third year following the year in which notice of such payment was sent to such individual; except that the Secretary may reduce such three-year period to not less than one year if he finds such reduction is consistent with the objectives of this title, and

(C) to make adequate provision for return (or other disposition, in accordance with regulations) or any moneys incorrectly collected from such individual or other person, and

(D) to promptly notify the Secretary of its employment of an individual who, at any time during the year preceding such employment, was employed in a managerial, accountng, auditing, or similar capacity (as determined by the Secretary by regulation) by an agency or organization which serves as a fiscal intermediary or carrier (for purposes of part A or part B, or both, of this title) with respect to the provider[.], *and*

(E) not to increase amounts due from any individual, organization, or agency in order to offset reductions made under section 1861(bb) in the amount paid, or expected to be paid, under this title.

* * * * * * *

TITLE XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

* * * * * * *

State Plans for Medical Assistance

Sec. 1902. (a) A State plan for medical assistance must—

* * * * * * *

(13) provide—

(A)(i) for the inclusion of some institutional and some noninstitutional care and services, and

(ii) for the inclusion of home health services for any individual who, under the State plan, is entitled to skilled nursing facility services, and

(B) in the case of individuals receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, or with respect to whom supplemental security income benefits are being paid under title XVI, for the inclusion of at least the care and services listed in clauses (1) through (5) of section 1905(a), and

(C) in the case of individuals not included under subparagraph (B) for the inclusion of at least—

(i) the care and services listed in clauses (1) through (5) of section 1905(a) or

(ii)(I) the care and services listed in any 7 of the clauses numbered (1) through (16) of such section and (II) in the event the care and services provided under the State plan include hospital or skilled nursing facility services, physicians' services to an individual in a hospital or skilled nursing facility during any period he is receiving hospital services from such hospital or skilled nursing facility services from such home, and

[(D) for payment of the reasonable cost of inpatient hospital services provided under the plan, as determined in accordance with methods and standards, consistent with section 1122, which shall be developed by the State and reviewed and approved by the Secretary and (after notice of approval by the Secretary) included in the plan, except that the reasonable cost of any such services as determined under such methods and standards shall not exceed the amount which would be determined under section 1861(v) as the reasonable cost of such services for purposes of title XVIII; and]

(D) for payment of the reasonable cost of inpatient hospital services provided under the plan, applying the methods specified in section 1861(v) and section 1861(bb), which are consistent with section 1122; and

[(E) effective July 1, 1976, for payment of the skilled nursing facility and intermediate care facility services provided under the plan on a reasonable cost related basis, as determined in accordance with methods and standards which shall be developed by the State on the basis of cost-finding methods approved and verified by the Secretary; and]

(E) for payment of the skilled nursing facility and intermediate care facility services provided under the plan through the use of rates, determined in accordance with methods and standards developed by the State, which the State finds, and make assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards; and such State makes further assurances, satisfactory to the Secretary, for the filing of uniform cost reports; and

(F) for payment for services described in section 1905(a)(2)(B) provided by a rural health clinic under the plan of 100 percent of costs which are reasonable and related to the cost of furnishing such services or based on such other tests of reasonableness, as the Secretary may prescribe in regulations under section 1833(a)(3), or, in the case of services to which those regulations do not apply, on such tests of reasonableness as the Secretary may prescribe in regulations under this subparagraph;

* * * * * * *

[(23) except in the case of Puerto Rico, the Virgin Islands, and Guam, provide that any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required (including an organization which provides such services, or arranges for their availability, on a prepayment basis), who undertakes to provide him such services; and a State plan shall not be deemed to be out of compliance with the requirements of this paragraph or paragraph (1) or (10) solely by reason of the fact that the State (or any political subdivision thereof) has entered into a contract with an organization which has agreed to provide care and services in addition to those offered under the State plan to individuals eligible for medical assistance who reside in the geographic area served by such organization and who elect to obtain such care and services from such organization, or by reason of the fact that the plan provides for payment for rural health clinic services only if those services are provided by a rural health clinic;]

(23) provide that limitations or restrictions elected by a State with respect to choice by recipients of medical assistance provided for by the State—

(A) may apply only to institutional providers (including clinics), laboratory services, and medical devices;

(B) must be cost-effective arrangements which provide for reasonable payment based upon comparisons of costs at which services of proper quality may be obtained and are actually available (and for this purpose the plan may provide that such arrangements need not be in effect in all political subdivisions of the State notwithstanding the provisions of paragraph (1)), and must provide that in the case of inpatient hospital services, payment to a hospital shall not be deemed to be reasonable for purposes of paragraph (13)(D) if it is less than the cost that is found reasonable and necessary in the efficient and economical delivery of such needed services in the geographic area in which such hospital is located;

(C) must assure that such recipients shall have reasonable access to services for which they are eligible (including emergency services and provision for timely referral and transfer to other providers when medically appropriate) through providers which meet all applicable standards under the State plan and where services are available to such recipients; and

(D) must provide that there will not be a resulting substantially adverse effect on the appropriate and necessary use of hospitals having graduate medical education programs;

* * * * * * *

(27) provide for agreements with every person or institution providing services under the State plan under which such person or institution agrees (A) to keep such records as are necessary fully to disclose the extent of the services provided to individuals receiving assistance under the State plan, [and] (B) to furnish

the State agency or the Secretary with such information, regarding any payments claimed by such person or institution for providing services under the State plan, as the State agency or the Secretary may from time to time request, *and (C) not to increase amounts due from any individual, organization, or agency in order to offset reductions made pursuant to the requirements contained in section 1902(a)(13)(D) in the amount paid, or expected to be paid under the State plan;*

* * * * * * *

(39) provide that, subject to subsection (g), whenever the single State agency which administers or supervises the administration of the State plan is notified by the Secretary under section 1862(e)(2)(A) that a physician or other individual practioner has been suspended from participation in the program under title XVIII, the agency shall promptly suspend such physician or practitioner from participation in the plan for not less than the period specified in such notice, and no payment may be made under the plan with respect to any item or service furnished by such physician or practioner during the period of the suspension under this title;

(40) require each health services facility or organization which receives payments under the plan and of a type for which a uniform reporting system has been established under section 1121(a) to make reports to the Secretary of information described in such section in accordance with the uniform reporting system (established under such section) for that type of facility or organization; and

(41) provide that whenever a provider of services or any other person is terminated, suspended, or otherwise sanctioned or prohibited from participating under the State plan, the State agency shall promptly notify the Secretary of such action.

(42) provide (A) that the records of any entity participating in the plan and providing services reimbursable on a cost-related basis will be audited as the Secretary determines to be necessary to insure that proper payments are made under the plan, (B) that such audits, for such entities also providing services under part A of title XVIII, will be coordinated and conducted jointly (to such extent and in such manner as the Secretary shall prescribe) with audits conducted for purposes of such title, and (C) for payment of the portion of the costs of each such common audit of such an entity equal to the portion of the cost of the common audit which is attributable to the program established under this title and which would not have otherwise been incurred in an audit of the program established under title XVIII; and

(43) provide that any laboratory services (other than such services provided in a physician's office) paid for under such plan must be provided by a laboratory which meets the requirements of section 1861(e)(9) and paragraphs (10) and (11) of section 1861 (s), or in the case of a rural health clinic, section 1861(aa)(2) (G).

* * * * * * *

Payment to States

Sec. 1903. (a) * * *.

(d)(1) Prior to the beginning of each quarter, the Secretary shall estimate the amount to which a State will be entitled under subsections (a) and (b) for such quarter, such estimates to be based on (A) a report filed by the State containing its estimate of the total sum to be expended in such quarter in accordance with the provisions of such subsections, and stating the amount appropriated or made available by the State and its political subdivisions for such expenditures in such quarters, and if such amount is less than the State's proportionate share of the total sum of such estimated expenditures, the source or sources from which the difference is expected to be derived, and (B) such other investigation as the Secretary may find necessary.

(2) The Secretary shall then pay to the State, in such installments as he may determine, the amounts so estimated, reduced or increased to the extent of any overpayment or underpayment which the Secretary determines was made under this section to such State for any prior quarter and with respect to which adjustment has not already been made under this subsection. Expenditures for which payments were made to the State under subsection (a) shall be treated as an overpayment to the extent that the State or local agency administering such plan has been reimbursed for such expenditures by a third party pursuant to the provisions of its plan in compliance with section 1902(a)(25).

(3) The pro rata share to which the United States is equitably entitled, as determined by the Secretary, of the net amount recovered during any quarter by the State or any political subdivision thereof with respect to medical assistance furnished under the State plan shall be considered an overpayment to be adjusted under this subsection.

(4) Upon the making of an estimate by the Secretary under this subsection, any appropriations available for payments under this section shall be deemed obligated.

(5)(A) *In any case in which the Secretary estimates that there has been an overpayment to a State on the basis of a claim by such State that has been disallowed by the Secretary, and such State disputes such disallowance, the amount of the Federal payment in controversy shall not be paid to such State until such time as a final determination has been made with respect to such amount. If such final determination is to the effect that an amount is owed to such State, such amount shall be increased by an amount equal to the amount which would have been paid on the amount otherwise owed, at the rates of interest on obligations issued for purchase by the Federal Hospital Insurance Trust Fund, during the period beginning on the date that the State disputed such disallowance and ending on the date that payment is made to the State.*

* * * * * * *

(i) Payment under the preceding provisions of this section shall not be made—

(1) with respect to any amount paid for items or services furnished under the plan after December 31, 1972, to the extent

that such amount exceeds the charge which would be determined to be reasonable for such items or services under [the fourth and fifth sentences of section 1842(b)(3)] *subparagraphs (B)(ii), (B)(iii), (C), and (F) of section 1842(b)(4)*; or

(2) with respect to any amount paid for services furnished under the plan after December 31, 1972, by a provider or other person during any period of time, if payment may not be made under title XVIII with respect to services furnished by such provider or person during such period of time solely by reason of a determination by the Secretary under section 1862(d)(1) or under clause (D), (E), or (F) of section 1866(b)(2), or by reason of noncompliance with a request made by the Secretary under clause (C)(ii) of such section 1866(b)(2) or under section 1902(a)(38); or

(3) with respect to any amount expended for inpatient hospital services furnished under the plan to the extent that such amount exceeds the hospital's customary charges with respect to such services or (if such services are furnished under the plan by a public institution free of charge or at nominal charges to the public) exceeds an amount determined on the basis of those items (specified in regulations prescribed by the Secretary) included in the determination of such payment which the Secretary finds will provide fair compensation to such institution for such services; or

(4) with respect to any amount expended for care or services furnished under the plan by a hospital or skilled nursing facility unless such hospital or skilled nursing facility has in effect a utilization review plan which meets the requirements imposed by section 1861(k) for purposes of title XVIII; and if such hospital or skilled nursing facility has in effect such a utilization review plan for purposes of title XVIII, such plan shall serve as the plan required by this subsection (with the same standards and procedures and the same review committee or group) as a condition of payment under this title; the Secretary is authorized to waive the requirements of this paragraph if the State agency demonstrates to his satisfaction that it has in operation utilization review procedures which are superior in their effectiveness to the procedures required under section 1861(k).

* * * * * * *

(q) For the purposes of this section, the term "State medicaid fraud control unit" means a single identifiable entity of the State government which the Secretary certifies (and annually recertifies) as meeting the following requirements:

(1) The entity (A) is a unit of the office of the State Attorney General or of another department of State government which possesses statewide authority to prosecute individuals for criminal violations, (B) is in a State the constitution of which does not provide for the criminal prosecution of individuals by a statewide authority and has formal procedures, approved by the Secretary, that (i) assure its referral of suspected criminal violations relating to the program under this title to the appropriate authority

or authorities in the State for prosecution and (ii) assure its assistance of, and coordination with, such authority or authorities in such prosecutions, or (C) has a formal working relationship with the office of the State Attorney General and has formal procedures (including procedures for its referral of suspected criminal violations to such office) which are approved by the Secretary and which provide effective coordination of activities between the entity and such office with respect to the detection, investigation, and prosecution of suspected criminal violations relating to the program under this title.

(2) The entity is separate and distinct from the single State agency that administers or supervises the administration of the State plan under this title.

(3) The entity's function is conducting a statewide program for the investigation and prosecution of violations of all applicable State laws regarding any and all aspects of fraud in connection with any aspect of the provision of medical assistance and the activities of providers of such assistance under the State plan under this title.

(4) The entity has procedures for reviewing complaints of the abuse and neglect of patients of health care facilities which receive payments under the State plan under this title, and, where appropriate, for acting upon such complaints under the criminal laws of the State or for referring them to other State agencies for action.

(5) The entity provides for the collection, or referral for collection to a single State agency, of overpayments that are made under the State plan to health care facilities and that are discovered by the entity in carrying out its activities.

(6) The entity employs such auditors, attorneys, investigators, and other necessary personnel and is organized in such a manner as is necessary to promote the effective and efficient conduct of the entity's activities.

(7) The entity submits to the Secretary an application and annual reports containing such information as the Secretary determines, by regulation, to be necessary to determine whether the entity meets the other requirements of this subsection.

(*r*) *For additional exclusions from reasonable cost and reasonable charge see section 1134.*

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TITLE XX—GRANTS TO STATES FOR SERVICES

* * * * * * *

Payments to States

Sec. 2002. (a) (1) * * *

(9) (A) No payment may be made under this section with respect to any expenditure in connection with the provision of any child day care service, unless—

(i) in the case of care provided in the child's home, the care meets standards established by the State which are reasonably in

accord with recommended standards of national standard-setting organizations concerned with the home care of children, or

(ii) in the case of care provided outside the child's home, the care meets the Federal interagency day care requirements as approved by the Department of Health, Education, and Welfare and the Office of Economic Opportunity on September 23, 1968; except that (I) subdivision III of such requirements with respect to educational services shall be recommended to the States and not required, and staffing standards for school-age children in day care centers may be revised by the Secretary, (II) the staffing standards imposed with respect to such care in the case of children under age 3 shall conform to regulations prescribed by the Secretary, (III) the staffing standards imposed with respect to such care in the case of children aged 10 to 14 shall require at least one adult for each 20 children, and in the case of school-aged children under age 10 shall require at least one adult for each 15 children, (IV) the State agency may waive the staffing standards otherwise applicable in the case of a day care center or group day care home in which not more than 20 per centum of the children in the facility (or, in the case of a day care center, not more than 5 children in the center) are children whose care is being paid for (wholly or in part) from funds made available to the State under this title, if such agency finds that it is not feasible to furnish day care for the children, whose care is so paid for, in a day care facility which complies with such staffing standards, and if the day care facility providing care for such children complies with applicable State standards, and (V) in determining whether applicable staffing standards are met in the case of day care provided in a family day care home, the number of children being cared for in such home shall include a child of the mother who is operating the home only if such child is under age 6,

except as provided in subparagraph (B).

(B) The Secretary shall submit to the President of the Senate and the Speaker of the House of Representatives, after December 31, 1976, and prior to April 1, 1978, an evaluation of the appropriateness of the requirements imposed by subparagraph (A), together with any recommendations he may have for modification of those requirements. No earlier than ninety days after the submission of that report, the Secretary may, by regulation, make such modifications in the requirements imposed by subparagraph (A) as he determines are appropriate.

(C) The requirements imposed by this paragraph are in lieu of any requirements that would otherwise be applicable under section 522(d) of the Economic Opportunity Act of 1964 to child day care services with respect to which payment is made under this section.

(D) The requirements imposed by this paragraph or by any regulations promulgated by the Department of Health and Human Services to carry out this paragraph shall be inapplicable to child day care services provided after June 30, 1980 and prior to October 1, 1981 which meet applicable standards of State and local law.

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EXCERPTS FROM

TITLE 5 U.S.C.—GOVERNMENT ORGANIZATION AND EMPLOYEES

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CHAPTER 85.—UNEMPLOYMENT COMPENSATION

SUBCHAPTER I—EMPLOYEES GENERALLY

* * * * * * *

§ 8509. FEDERAL EMPLOYEES COMPENSATION ACCOUNT.

(a) The federal Employees Compensation account (as established lished by section 909 of the Social Security Act, and hereafter in this section referred to as the 'Account') in the Unemployment Trust Fund (as established by section 904 of such Act) shall consist of—

(1) funds appropriated to or transferred thereto, and

(2) amounts deposited therein pursuant to susbection (c).

(b) Moneys in the Account shall be available only for the purpose of making payments to States pursuant to agreements entered into under this chapter and making payments of compensation under this chapter in States which do not have in effect such an agreement.

(c)(1) Each employing agency shall deposit into the Account amounts equal to the expenditures incurred under this chapter on account of Federal service performed by employees and former employees of that agency.

(2) Deposits required by paragraph (1) shall be made during each calendar quarter and the amount of the deposit to be made by any employing agency during any quarter shall be based on a determination by the Secretary of Labor as to the amounts of payments, made prior to such quarter from the account based on Federal service performed by employees of such agency after September 30, 1980, with respect to which deposit has not previously been made. The amount to be deposited by any employing agency during any calendar quarter shall be adjusted to take account of any overpayment or underpayment of deposit during any previous quarter for which adjustment has not already been made.

(d) The Secretary of Labor shall certify to the Secretary of the Treasury the amount of the deposit which each employing agency is required to make to the Account during any calendar quarter, and the Secretary of the Treasury shall notify the Secretary of Labor as to the date and amount of any deposit made to such Account by any such agency.

(e) Prior to the beginning of each fiscal year (commencing with the fiscal year which begins October 1, 1980) the Secretary of Labor shall estimate—

(1) the amount of expenditures which will be made from the Account during such year, and

(2) the amount of funds which will be available during such year for the making of such expenditures,

and if, on the basis of such estimate, he determines that the amount described in clause (2) is in excess of the amount necessary—

(3) to meet the expenditures described in paragraph (1), and
(4) to provide a reasonable contingency fund so as to assure that there will, during all times in such year, be sufficient sums available in the Account to meet the expenditures described in paragraph (1),
he shall certify the amount of such excess to the Secretary of the Treasury and the Secretary of the Treasury shall transfer, from the Account to the general fund of the Treasury, an amount equal to such excess.

(f) The Secretary of Labor is authorized to establish such rules and regulations as may be necessary or appropriate to carry out the provisions of this section.

(g) Any funds appropriated after the establishment of the Account, for the making of payments for which expenditures are authorized to be made from moneys in the Account, shall be made to the Account; and there are hereby authorized to be appropriated to the Account, from time to time, such sums as may be necessary to assure that there will, at all times, be sufficient sums available in the Account to meet the expenditures authorized to be made from moneys therein.

SUBCHAPTER II—EX-SERVICEMEN

§ 8521. DEFINITIONS; APPLICATION.

(a) For the purpose of this subchapter—

(1) "Federal service" means active service, including active duty for training purposes, in the armed forces which either began after January 31, 1955, or terminated after October 27, 1958, if—

(A) that service was continuous for [90 days] *one year* or more, or was terminated earlier because of an actual service-incurred injury or disability; and

(B) with respect to that service, the individual—

(i) was discharged or released under conditions other than dishonorable; and

(ii) was not given a bad conduct discharge, or, if an officer, did not resign for the good of the service;

(2) "Federal wages" means all pay and allowances, in cash and in kind, of Federal service, computed on the basis of the pay and allowances for the pay grade of the individual at the time of his latest discharge or release from Federal service as specified in the schedule applicable at the time he files his first claim of compensation for the benefit year. The Secretary of Labor shall issue, from time to time, after consultation with the Secretary of Defense, schedules specifying the pay and allowances for each pay grade of servicemen covered by this subchapter, which reflect representative amounts for appropriate elements of the pay and allowances whether in cash or in kind; and

(3) "State" means the several States, the District of Columbia, the Commonwealth of Puerto Rico, and the Virgin Islands.[1]

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[1] Paragraph (3) was amended by section 116(e)(4) of Public Law 94-566.

(b) The provisions of subchapter I of this chapter, subject to the modifications made by this subchapter, apply to individuals who have had Federal service as defined by subsection (a) of this section.

* * * * * * *

Federal-State Extended Unemployment Compensation Act, as Amended

Excerpt From Public Law 91-373, August 10, 1970

* * * * * * *

Title II—Federal-State Extended Unemployment Compensation Program

Short Title

Sec. 201. This title may be cited as the "Federal-State Extended Unemployment Compensation Act of 1970".

Payment of Extended Compensation

State Law Requirements

Sec. 202. (a) (1) For purposes of section 3304(a) (11) of the Internal Revenue Code of 1954, a State law shall provide that payment of extended compensation shall be made, for any week of unemployment which begins in the individual's eligibility period, to individuals who have exhausted all rights to regular compensation under the State law and who have no rights to regular compensation with respect to such week under such law or any other State unemployment compensation law or to compensation under any other Federal law and are not receiving compensation with respect to such week under the unemployment compensation law of Canada. For purposes of the preceding sentence, an individual shall have exhausted his rights to regular compensation under a State law (A) when no payments of regular compensation can be made under such law because such individual has received all regular compensation available to him based on employment or wages during his base period, or (B) when his rights to such compensation have terminated by reason of the expiration of the benefit year with respect to which such rights existed.

(2) Except where inconsistent with the provisions of this title, the terms and conditions of the State law which apply to claims for regular compensation and to the payment thereof shall apply to claims for extended compensation and to the payment thereof.

(3) Notwithstanding the provisions of paragraph (2), payment of extended compensation shall not be made to an individual for any week of unemployment in such individual's eligibility period (as defined in section 203(c)) during which such individual resides in a State in which there is not a State "on" indicator for such week, if such individual took up residence in such State after the beginning of the period of unemployment with respect to which extended benefits would otherwise be payable; except that the preceding provisions of

this paragraph shall not apply with respect to the first two weeks during which such individual resides in such State.

(4)(A) Notwithstanding the provisions of paragraph (2), payment of extended compensation under this Act shall not be made to any individual for any week of unemployment in his eligibility period—

(i) if such individual had less than 20 weeks of covered employment during his base period;

(ii) if such individual is unemployed because he voluntarily left employment, was discharged for misconduct, or refused suitable employment as determined under State law;

(iii) during which he fails to accept any offer of suitable work (as defined in subparagraph (B)) or fails to apply for any suitable work to which he was referred by the State agency; or

(iv) during which he fails to actively engage in seeking work.

(B) If any individual is ineligible for extended compensation for any week by reason of a failure described in clause (iii) or (iv) of subparagraph (A), the individual shall be ineligible to receive extended compensation for any week which begins during a period which—

(i) begins with the week following the week in which such failure occurs, and

(ii) does not end until such individual has been employed during at least 4 weeks which begin after such failure and the total of the remuneration earned by the individual for being so employed is not less than the product of 4 multiplied by the individual's average weekly benefit amount (as determined for purposes of subsection (b)(1)(C) for his benefit year.

(C) For purposes of this paragraph, the term "suitable work" means, with respect to any individual, any work which is within such individual's capabilities; except that, if the individual furnishes evidence satisfactory to the State agency that such individual's prospects for obtaining work in his customary occupation within a reasonably short period are good, the determination of whether any work is suitable work with respect to such individual shall be made in accordance with the applicable State law.

(D) Extended compensation shall not be denied under clause (iii) of subparagraph (A) to any individual for any week by reason of a failure to accept an offer of, or apply for, suitable work—

(i) if the gross average weekly remuneration payable to such individual for the position does not exceed the sum of—

(I) the individual's average weekly benefit amount (as determined for purposes of subsection (b)(1)(C)) for his benefit year, plus

(II) the amount (if any) of supplemental unemployment compensation benefits (as defined in section 501(c)(17)(D) of the Internal Revenue Code of 1954) payable to such individual for such week;

(ii) if the position was not offered to such individual in writing and was not listed with the State employment service;

(iii) if such failure would not result in a denial of compensation under the provisions of the applicable State law to the extent that

such provisions are not inconsistent with the provisions of subparagraphs (C) and (E); or

(iv) if the position pays wages less than the higher of—

(I) the minimum wage provided by section 6(a)(1) of the Fair Labor Standards Act of 1938, without regard to any exemption; or

(II) any applicable State or local minimum wage.

(E) For purposes of this paragraph, an individual shall be treated as actively engaged in seeking work during any week if—

(i) the individual has engaged in a systematic and sustained effort to obtain work during such week, and

(ii) the individual provides tangible evidence to the State agency that he has engaged in such an effort during such week.

(F) For purposes of section 3304(a)(11) of the Internal Revenue Code of 1954, a State law shall provide for referring applicants for benefits under this Act to any suitable work to which clauses (i), (ii), (iii), and (iv) of subparagraph (D) would not apply.

Individuals' Compensation Accounts

(b)(1) The State law shall provide that the State will establish, for each eligible individual who files an application therefor, an extended compensation account with respect to such individual's benefit year. The amount established in such account shall be not less than whichever of the following is the least:

(A) 50 per centum of the total amount of regular compensation (including dependents' allowances) payable to him during such benefit year under such law,

(B) thirteen times his average weekly benefit amount, or

(C) thirty-nine times his average weekly benefit amount, reduced by the regular compensation paid (or deemed paid) to him during such benefit year under such law;

except that the amount so determined shall (if the State law so provides) be reduced by the aggregate amount of additional compensation paid (or deemed paid) to him under such law for prior weeks of unemployment in such benefit year which did not begin in an extended benefit period.

(2) For purposes of paragraph (1), an individual's weekly benefit amount for a week is the amount of regular compensation (including dependents' allowances) under the State law payable to such individual for such week for total unemployment.

Extended Benefit Period

Beginning and Ending

Sec. 203. (a) For purposes of this title in the case of any State, an extended benefit period—

[(1) shall begin with the third week after whichever of the following weeks first occurs:

[(A) a week for which there is a national "on" indicator, or

[(B) a week for which there is a State "on" indicator; and

[(2) shall end with the third week after the first week for which there is both a national "off" indicator and a State "off" indicator.]

(1) shall begin with the third week after the week for which there is a State "on" indicator; and

(2) shall end with the third week after the first week for which there is a State "off" indicator.

Special Rules

(b) (1) In the case of any State—

(A) no extended benefit period shall last for a period of less than thirteen consecutive weeks, and

(B) no extended benefit period may begin by reason of a State "on" indicator before the fourteenth week after the close of a prior extended benefit period with respect to such State.

(2) When a determination has been made that an extended benefit period is beginning or ending with respect to a State [(or all the States)], the Secretary shall cause notice of such determination to be published in the Federal Register.

Eligibility Period

(c) For purposes of this title, an individual's eligibility period under the State law shall consist of the weeks in his benefit year which begin in an extended benefit period and, if his benefit year ends within such extended benefit period, any weeks thereafter which begin in such extended benefit period.

National "On" and "Off" Indicators

[(d) For purposes of this section—

[(1) There is a national "on" indicator for a week if, for the period consisting of such week and the immediately preceding twelve weeks, the rate of insured unemployment (seasonally adjusted) for all States equaled or exceeded 4.5 per centum (determined by reference to the average monthly covered employment for the first four of the most recent six calendar quarters ending before the close of such period).

[(2) There is a national "off" indicator for a week if, for the period consisting of such week and the immediately preceding twelve weeks, the rate of insured unemployment (seasonally adjusted) for all States was less than 4.5 per centum (determined by reference to the average monthly covered employment for the first four of the most recent six calendar quarters ending before the close of such period).]

State "On" and "Off" Indicators

(e) For purposes of this section—

(1) There is a State "on" indicator for a week if the rate of insured unemployment under the State law for the period consisting of such week and the immediately preceding twelve weeks—

(A) equaled or exceeded 120 per centum of the average of such rates for the corresponding thirteen-week period ending in each of the preceding two calendar years, and

(B) equaled or exceeded 4 per centum.

(2) There is a State "off" indicator for a week if, for the period consisting of such week and the immediately preceding twelve weeks, either subparagraph (A) or subparagraph (B) of paragraph (1) is not satisfied.

Effective with respect to compensation for weeks of unemployment beginning after March 30, 1977 (or, if later, the date established pursuant to State law) the State may by law provide that the determination of whether there has been a State "on" or "off" indicator beginning or ending any extended benefit period shall be made under this subsection as if (i) paragraph (1) did not contain subparagraph (A) thereof, and [(ii) the figure "4" contained in subparagraph (B) thereof were "5"; except] *(ii) the figure "4" contained in subparagraph (B) thereof were "5" (or such number, or percentage of a number, which exceeds 5, as is specified by the State law); except* that, notwithstanding any such provision of State law, any week for which there would otherwise be a State "on" indicator shall continue to be such a week and shall not be determined to be a week for which there is a State "off" indicator. For purposes of this subsection, the rate of insured unemployment for any thirteen-week period shall be determined by reference to the average monthly covered employment under the State law for the first four of the most recent six calendar quarters ending before the close of such period.

Rate of Insured Unemployment; Covered Employment

(f)(1) For purposes of [subsections (d) and (e)] *subsection (e)*, the term "rate of insured unemployment" means the percentage arrived at by dividing--

(A) the average weekly number of individuals filing claims for weeks of unemployment with respect to the specified period, as determined on the basis of the reports made by [all State agencies (or, in the case of subsection (e), by the State agency)] *the State agency* to the Secretary, by

(B) the average monthly covered employment for the specified period.

[(2) Determinations under subsection (d) shall be made by the Secretary in accordance with regulations prescribed by him.]

[(3)] *(2)* Determinations under subsection (e) shall be made by the State agency in accordance with regulations prescribed by the Secretary.

Payments to States

Amount Payable

Sec. 204. (a)(1) There shall be paid to each State an amount equal to one-half of the sum of—

(A) the sharable extended compensation, and

(B) the sharable regular compensation,

paid to individuals under the State law.

(2) No payment shall be made to any State under this subsection in respect to compensation (*A*) for which the State is entitled to reimbursement under the provisions of any Federal law other than this Act, *or* (*B*) *paid for the first week of compensable unemployment in an individual's eligibility period, if the State law of such State provides for payment* (*at any time or under any circumstances*) *of regular compensation to an individual for his first week of otherwise compensable unemployment.*

[(3) In the case of compensation which is sharable extended compensation or sharable regular compensation by reason of the provision contained in the last sentence of section 203(d), the first paragraph of this subsection shall be applied as if the words "one-half of" read "100 per centum of" but only with respect to compensation that would not have been payable if the State law's provisions as to the State "on" and "off" indicators omitted the 120 percent factor as provided for by Public Law 93-368 and by section 106 of this Act.]

[(4] (*3*) The amount which, but for this paragraph, would be payable under this subsection to any State in respect of any compensation paid to an individual whose base period wages include wages for services to which section 3306(c)(7) of the Internal Revenue Code of 1954 applies shall be reduced by an amount which bears the same ratio to the amount which, but for this paragraph, would be payable under this subsection to such State in respect of such compensation as the amount of the base period wages attributable to such services bears to the total amount of the base period wages.

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APPENDIX A

Text of Finance Committee Amendments Recommended Under Reconciliation Process

[FINANCE COMMITTEE PRINT]

JUNE 25, 1980

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1 TITLE VI—PROVISIONS REDUCING SPENDING IN
2 PROGRAMS WITHIN JURISDICTION OF
3 SENATE COMMITTEE ON FINANCE

4 PART A—UNEMPLOYMENT COMPENSATION PROVISIONS

5 ELIMINATION OF "NATIONAL TRIGGER" UNDER THE
6 EXTENDED BENEFITS PROGRAM

7 SEC. 601. (a)(1) Paragraphs (1) and (2) of section 203(a)
8 of the Federal-State Extended Unemployment Compensation
9 Act of 1970 are amended to read as follows:
10 "(1) shall begin with the third week after the
11 week for which there is a State 'on' indicator; and
12 "(2) shall end with the third week after the first
13 week for which there is a State 'off' indicator.".
14 (2) Section 203(b)(2) of such Act is amended by striking
15 out "(or all the States)".
16 (3) Section 203 of such Act is further amended by strik-
17 ing out subsection (d) thereof.
18 (4) Section 203(f) of such Act is amended—
19 (A) in paragraph (1), by—

1 (i) striking out "subsections (d) and (e)" and
2 inserting in lieu thereof "subsection (e)", and
3 (ii) striking out "all State agencies (or, in the
4 case of subsection (e), by the State agency)" and
5 inserting in lieu thereof "the State agency",
6 (B) by striking out paragraph (2), and
7 (C) by redesignating paragraph (3) as paragraph
8 (2).
9 (b)(1) Section 204(a) of such Act is amended—
10 (A) by striking out paragraph (3), and
11 (B) by redesignating paragraph (4) as paragraph
12 (3).
13 (c) The amendments made by this section shall take
14 effect on October 1, 1980.
15 WAITING PERIOD FOR BENEFITS
16 SEC. 602. (a) Section 204(a)(2) of the Federal-State
17 Extended Unemployment Compensation Act of 1970 is
18 amended—
19 (1) by inserting "(A)" after "compensation", and
20 (2) by inserting immediately before the period the
21 following: ", or (B) paid for the first week of com-
22 pensable unemployment in an individual's eligibility
23 period, if the State law of such State provides for pay-
24 ment (at any time or under any circumstances) of regu-

1 lar compensation to an individual for his first week of
2 otherwise compensable unemployment".
3 (b) The amendments made by this section shall be
4 applicable in the case of extended compensation paid to
5 individuals during eligibility periods beginning on or after
6 October 1, 1980.

7 STATE OPTION AS TO CRITERIA FOR STATE "ON" AND
8 "OFF" INDICATORS

9 SEC. 603. (a) Section 203(e) of the Federal-State Ex-
10 tended Unemployment Compensation Act of 1970 is amend-
11 ed, in the first sentence following paragraph (2) thereof, by
12 striking out the matter beginning with "(ii)" and ending with
13 "except", and inserting in lieu thereof the following: "(ii) the
14 figure '4' contained in subparagraph (B) thereof were '5' (or
15 such number, or percentage of a number, which exceeds 5, as
16 is specified by the State law); except".
17 (b) The amendment made by this section shall be effec-
18 tive with respect to weeks of unemployment beginning after
19 October 1, 1980.

20 FEDERAL SERVICE OF EX-SERVICEMEN

21 SEC. 604. (a) Section 8521(a)(1)(A) of title 5, United
22 States Code, is amended by striking out "90 days" and in-
23 serting in lieu thereof "one year".
24 (b) The amendment made by this subsection shall be
25 applicable with respect to determinations of Federal service

1 in the case of individuals filing claims for unemployment com-
2 pensation on or after October 1, 1980.

3 BENEFITS ON ACCOUNT OF FEDERAL SERVICE TO BE PAID
4 BY EMPLOYING FEDERAL AGENCY

5 SEC. 605. (a) Title IX of the Social Security Act is
6 amended by adding at the end thereof the following new
7 section:

8 "FEDERAL EMPLOYEES COMPENSATION ACCOUNT

9 "SEC. 909. There is hereby established in the Unem-
10 ployment Trust Fund a Federal Employees Compensation
11 Account which shall be used for the purposes specified in
12 section 8509 of title 5, United States Code.".

13 (b) Subchapter I of chapter 85, title 5, United States
14 Code, is amended by adding at the end thereof the following
15 new section:

16 **"§ 8509. Federal Employees Compensation Account**

17 "(a) The Federal Employees Compensation Account (as
18 established by section 909 of the Social Security Act, and
19 hereafter in this section referred to as the 'Account') in the
20 Unemployment Trust Fund (as established by section 904 of
21 such Act) shall consist of—

22 "(1) funds appropriated to or transferred thereto,
23 and

24 "(2) amounts deposited therein pursuant to sub-
25 section (c).

1 "(b) Moneys in the Account shall be available only for
2 the purpose of making payments to States pursuant to agree-
3 ments entered into under this chapter and making payments
4 of compensation under this chapter in States which do not
5 have in effect such an agreement.

6 "(c)(1) Each employing agency shall deposit into the
7 Account amounts equal to the expenditures incurred under
8 this chapter on account of Federal service performed by em-
9 ployees and former employees of that agency.

10 "(2) Deposits required by paragraph (1) shall be made
11 during each calendar quarter and the amount of the deposit
12 to be made by any employing agency during any quarter
13 shall be based on a determination by the Secretary of Labor
14 as to the amounts of payments, made prior to such quarter
15 from the Account based on Federal service performed by em-
16 ployees of such agency after September 30, 1980, with re-
17 spect to which deposit has not previously been made. The
18 amount to be deposited by any employing agency during any
19 calendar quarter shall be adjusted to take account of any
20 overpayment or underpayment of deposit during any previous
21 quarter for which adjustment has not already been made.

22 "(d) The Secretary of Labor shall certify to the Secre-
23 tary of the Treasury the amount of the deposit which each
24 employing agency is required to make to the Account during
25 any calendar quarter, and the Secretary of the Treasury shall

1 notify the Secretary of Labor as to the date and amount of
2 any deposit made to such Account by any such agency.
3 "(e) Prior to the beginning of each fiscal year (com-
4 mencing with the fiscal year which begins October 1, 1980)
5 the Secretary of Labor shall estimate—
6 "(1) the amount of expenditures which will be
7 made from the Account during such year, and
8 "(2) the amount of funds which will be available
9 during such year for the making of such expenditures,
10 and if, on the basis of such estimate, he determines that the
11 amount described in clause (2) is in excess of the amount
12 necessary—
13 "(3) to meet the expenditures described in para-
14 graph (1), and
15 "(4) to provide a reasonable contingency fund so
16 as to assure that there will, during all times in such
17 year, be sufficient sums available in the Account to
18 meet the expenditures described in paragraph (1),
19 he shall certify the amount of such excess to the Secretary of
20 the Treasury and the Secretary of the Treasury shall trans-
21 fer, from the Account to the general fund of the Treasury, an
22 amount equal to such excess.
23 "(f) The Secretary of Labor is authorized to establish
24 such rules and regulations as may be necessary or appropri-
25 ate to carry out the provisions of this section.

1 "(g) Any funds appropriated after the establishment of
2 the Account, for the making of payments for which expendi-
3 tures are authorized to be made from moneys in the Account,
4 shall be made to the Account; and there are hereby author-
5 ized to be appropriated to the Account, from time to time,
6 such sums as may be necessary to assure that there will, at
7 all times, be sufficient sums available in the Account to meet
8 the expenditures authorized to be made from moneys
9 therein.".

10 (c) All funds, appropriated for the fiscal year beginning
11 October 1, 1979, and which are available for the making of
12 payments to States after September 30, 1980, pursuant to
13 agreements entered into under chapter 85 of title 5, United
14 States Code, or for the making of payments after such date of
15 compensation under such chapter in States which do not
16 have in effect such an agreement, shall be transferred on Oc-
17 tober 1, 1980 to the Federal Employees Compensation Ac-
18 count established by section 909 of the Social Security Act.
19 On and after such date, all payments described in the preced-
20 ing sentence shall be made from such Account as provided by
21 section 8509 of title 5, United States Code.

1 CESSATION OF EXTENDED BENEFITS WHEN INDIVIDUAL
2 MOVES TO STATE IN WHICH TRIGGER IS NOT "ON"

3 SEC. 606. (a) Section 202(a) of the Federal-State Ex-
4 tended Unemployment Compensation Act of 1970 is amend-
5 ed by adding at the end thereof the following new paragraph:
6 "(3) Notwithstanding the provisions of paragraph (2),
7 payment of extended compensation shall not be made to an
8 individual for any week of unemployment in such individual's
9 eligibility period (as defined in section 203(c)) during which
10 such individual resides in a State in which there is not a
11 State 'on' indicator for such week, if such individual took up
12 residence in such State after the beginning of the period of
13 unemployment with respect to which extended benefits would
14 otherwise be payable; except that the preceding provisions of
15 this paragraph shall not apply with respect to the first two
16 weeks during which such individual resides in such State.".
17 (b) The amendment made by this section shall be effec-
18 tive with respect to weeks of unemployment beginning on or
19 after October 1, 1980.

20 LIMITATION ON EXTENDED UNEMPLOYMENT
21 COMPENSATION PROGRAM

22 SEC. 607. (a) Section 202(a) of the Federal-State Ex-
23 tended Unemployment Compensation Act of 1970 is amend-
24 ed by adding at the end thereof the following new paragraph:

1 "(4)(A) Notwithstanding the provisions of paragraph (2),
2 payment of extended compensation under this Act shall not
3 be made to any individual for any week of unemployment in
4 his eligibility period—
5 "(i) if such individual had less than 20 weeks of
6 covered employment during his base period;
7 "(ii) if such individual is unemployed because he
8 voluntarily left employment, was discharged for mis-
9 conduct, or refused suitable employment as determined
10 under State law;
11 "(iii) during which he fails to accept any offer of
12 suitable work (as defined in subparagraph (B)) or fails
13 to apply for any suitable work to which he was re-
14 ferred by the State agency; or
15 "(iv) during which he fails to actively engage in
16 seeking work.
17 "(B) If any individual is ineligible for extended compen-
18 sation for any week by reason of a failure described in clause
19 (iii) or (iv) of subparagraph (A), the individual shall be ineligi-
20 ble to receive extended compensation for any week which
21 begins during a period which—
22 "(i) begins with the week following the week in
23 which such failure occurs, and
24 "(ii) does not end until such individual has been
25 employed during at least 4 weeks which begin after

1 such failure and the total of the remuneration earned
2 by the individual for being so employed is not less than
3 the product of 4 multiplied by the individual's average
4 weekly benefit amount (as determined for purposes of
5 subsection (b)(1)(C) for his benefit year.

6 "(C) For purposes of this paragraph, the term 'suitable
7 work' means, with respect to any individual, any work which
8 is within such individual's capabilities; except that, if the in-
9 dividual furnishes evidence satisfactory to the State agency
10 that such individual's prospects for obtaining work in his cus-
11 tomary occupation within a reasonably short period are good,
12 the determination of whether any work is suitable work with
13 respect to such individual shall be made in accordance with
14 the applicable State law.

15 "(D) Extended compensation shall not be denied under
16 clause (iii) of subparagraph (A) to any individual for any week
17 by reason of a failure to accept an offer of, or apply for,
18 suitable work—

19 "(i) if the gross average weekly remuneration
20 payable to such individual for the position does not
21 exceed the sum of—

22 "(I) the individual's average weekly benefit
23 amount (as determined for purposes of subsection
24 (b)(1)(C)) for his benefit year, plus

1 "(II) the amount (if any) of supplemental un-
2 employment compensation benefits (as defined in
3 section 501(c)(17)(D) of the Internal Revenue
4 Code of 1954) payable to such individual for such
5 week;
6 "(ii) if the position was not offered to such indi-
7 vidual in writing and was not listed with the State em-
8 ployment service;
9 "(iii) if such failure would not result in a denial of
10 compensation under the provisions of the applicable
11 State law to the extent that such provisions are not in-
12 consistent with the provisions of subparagraphs (C) and
13 (E); or
14 "(iv) if the position pays wages less than the
15 higher of—
16 "(I) the minimum wage provided by section
17 6(a)(1) of the Fair Labor Standards Act of 1938,
18 without regard to any exemption; or
19 "(II) any applicable State or local minimum
20 wage.
21 "(E) For purposes of this paragraph, ar individual shall
22 be treated as actively engaged in seeking work during any
23 week if—

1 "(i) the individual has engaged in a systematic
2 and sustained effort to obtain work during such week,
3 and

4 "(ii) the individual provides tangible evidence to
5 the State agency that he has engaged in such an effort
6 during such week.

7 "(F) For purposes of section 3304(a)(11) of the Internal
8 Revenue Code of 1954, a State law shall provide for refer-
9 ring applicants for benefits under this Act to any suitable
10 work to which clauses (i), (ii), (iii), and (iv) of subparagraph
11 (D) would not apply.".

12 (h) The amendments made by this section shall be effec-
13 tive with respect to weeks of unemployment beginning on or
14 after October 1, 1980.

15 CERTIFICATION OF STATE UNEMPLOYMENT LAWS

16 SEC. 608. On October 31 of any taxable year after
17 1979, the Secretary of Labor shall not certify any State, as
18 provided in section 3304(c) of the Internal Revenue Code of
19 1954, which, after reasonable notice and opportunity for a
20 hearing to the State agency, the Secretary of Labor finds has
21 failed to amend its law so that it contains each of the provi-
22 sions required by reason of the enactment of the preceding
23 provisions of this part to be included therein, or has with
24 respect to the 12-month period ending on such October 31,
25 failed to comply substantially with any such provision.

1 PART B—PROVISIONS RELATING TO SSI

2 DISPOSAL OF RESOURCES FOR LESS THAN FAIR MARKET
3 VALUE

4 SEC. 611. (a) Section 1613 of the Social Security Act is
5 amended by adding at the end thereof the following new sub-
6 section:

7 "DISPOSAL OF RESOURCE FOR LESS THAN FAIR MARKET
8 VALUE

9 "(c)(1) In determining the resources of an individual
10 (and his eligible spouse, if any) there shall be included (but
11 subject to the exclusions under subsection (a)) any resource
12 (or interest therein) owned by such individual or eligible
13 spouse within the preceding 24 months if such individual or
14 eligible spouse gave away or sold such resource or interest at
15 less than the fair market value of such resource or interest
16 for the purpose of establishing eligibility for benefits or assist-
17 ance under this Act.

18 "(2) Any transaction described in parag. aph (1) shall be
19 presumed to have been for the purpose of establishing eligi-
20 bility for benefits or assistance under this Act unless such
21 individual or eligible spouse furnishes convincing evidence to
22 establish that the transaction was exclusively for some other
23 purpose.

24 "(3) For purposes of paragraph (1) the value of such a
25 resource or interest shall be the fair market value of such

1 resource or interest at the time it was sold or given away,
2 less the amount of compensation received for such resource
3 or interest, if any.".
4 (b) The amendment made by subsection (a) shall be
5 effective with respect to applications for benefits under title
6 XVI of the Social Security Act filed on or after October 1,
7 1980.

8 PART C—PROVISIONS RELATING TO SOCIAL SERVICES

9 FEDERAL DAY CARE REGULATIONS

10 SEC. 621. Section 2002(a)(9) of the Social Security Act
11 is amended by adding at the end thereof the following new
12 subparagraph:
13 "(D) The requirements imposed by this paragraph or by
14 any regulations promulgated by the Department of Health
15 and Human Services to carry out this paragraph shall be
16 inapplicable to child day care services provided after June
17 30, 1980 and prior to October 1, 1981, which meet applica-
18 ble standards of State and local law.".
19 (b) The provisions of section 3(f) of Public Law 93-647
20 shall not apply with respect to child day care services pro-
21 vided after June 30, 1980 and prior to October 1, 1981
22 which meet applicable standards of State and local law.

1 PART D—PUBLIC ASSISTANCE PAYMENTS TO
2 TERRITORIAL JURISDICTIONS

3 SEC. 631. (a) Section 1108(a)(1) of the Social Security
4 Act is amended—
5 (1) by striking out "or" at the end of subpara-
6 graph (E); and
7 (2) by striking out subparagraph (F) and inserting
8 in lieu thereof the following:
9 "(F) $72,000,000 with respect to the fiscal year
10 1979,
11 "(G) $36,000,000 with respect to the fiscal year
12 1980,
13 "(H) $48,000,000 with respect to the fiscal year
14 1981, or
15 "(I) $72,000,000 with respect to the fiscal year
16 1982 and each fiscal year thereafter;".
17 (b) Section 1108(a)(2) of such Act is amended—
18 (1) by striking out "or" at the end of subpara-
19 graph (E); and
20 (2) by striking out subparagraph (F) and inserting
21 in lieu thereof the following:
22 "(F) $2,400,000 with respect to the fiscal year
23 1979,
24 "(G) $1,200,000 with respect to the fiscal year
25 1980,

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1 "(H) $1,600,000 with respect to the fiscal year
2 1981, or
3 "(I) $2,400,000 with respect to the fiscal year
4 1982 and each fiscal year thereafter;".
5 (c) Section 1108(a)(3) of such Act is amended—
6 (1) by striking out "or" at the end of subpara-
7 graph (E); and
8 (2) by striking out subparagraph (F) and inserting
9 in lieu thereof the following:
10 "(F) $3,300,000 with respect to the fiscal
11 year 1979,
12 "(G) $1,650,000 with respect to the fiscal
13 year 1980,
14 "(H) $2,200,000 with respect to the fiscal
15 year 1981, or
16 "(I) $3,300,000 with respect to the fiscal
17 year 1982 and each fiscal year thereafter.".
18 PART E—PROVISIONS RELATING TO OASDI
19 REALLOCATION OF OASDI TAXES
20 SEC. 641. (a) Section 201(b)(1) of the Social Security
21 Act is amended by striking out clauses (H) through (K) and
22 inserting in lieu thereof the following: "(H) 1.50 per centum
23 of the wages (as so defined) paid after December 31, 1978,
24 and before January 1, 1980, and so reported, (I) 1.12 per
25 centum of the wages (as so defined) paid after December 31,

1 1979, and before January 1, 1981, and so reported, (J) 1.30
2 per centum of the wages (as so defined) paid after December
3 31, 1980, and before January 1, 1982, and so reported, (K)
4 1.65 per centum of the wages (as so defined) paid after
5 December 31, 1981, and before January 1, 1985, and so
6 reported, (L) 1.90 per centum of the wages (as so defined)
7 paid after December 31, 1984, and before January 1, 1990,
8 and so reported, and (M) 2.20 per centum of the wages (as so
9 defined) paid after December 31, 1989, and so reported,".
10 (b) Section 201(b)(2) of such Act is amended by striking
11 out clauses (H) through (K) and inserting in lieu thereof the
12 following: "(H) 1.0400 per centum of the amount of self-
13 employment income (as so defined) so reported for any tax-
14 able year beginning after December 31, 1978, and before
15 January 1, 1980, (I) 0.7775 per centum of the amount of
16 self-employment income (as so defined) so reported for any
17 taxable year beginning after December 31, 1979, and before
18 January 1, 1981, (J) 0.9750 per centum of the amount of
19 self-employment income (as so defined) so reported for any
20 taxable year beginning after December 31, 1980, and before
21 January 1, 1982, (K) 1.2375 per centum of the amount of
22 self-employment income (as so defined) so reported for any
23 taxable year beginning after December 31, 1981, and before
24 January 1, 1985, (L) 1.4250 per centum of the amount of
25 self-employment income (as so defined) so reported for any

1 taxable year beginning after December 31, 1984, and before
2 January 1, 1990, and (M) 1.6500 per centum of the amount
3 of self-employment income (as so defined) so reported for any
4 taxable year beginning after December 31, 1989,".

5 LIMIT ON RETROACTIVE BENEFITS

6 SEC. 642. (a) Section 202(j)(1) of the Social Security
7 Act is amended by striking out "twelfth" and inserting in lieu
8 thereof "third".

9 (b) The amendment made by subsection (a) shall be
10 effective with respect to applications filed on or after Septem-
11 ber 1, 1980.

12 BENEFITS FOR CERTAIN PRISONERS

13 SEC. 643. (a)(1) Section 223(d) of the Social Security
14 Act is amended by adding at the end thereof the following
15 new paragraph:

16 "(6)(A) Notwithstanding any other provision of this
17 title, any physical or mental impairment which arises in con-
18 nection with the commission of a crime by an individual
19 (committed after the date of the enactment of this paragraph)
20 for which such individual is subsequently convicted, or which
21 is aggravated in connection with such a crime (but only to
22 the extent so aggravated), shall not be considered in deter-
23 mining whether an individual is under a disability.

24 "(B) Notwithstanding any other provision of this title,
25 any physical or mental impairment which arises in connection

1 with an individual's confinement in a jail, prison, or other
2 penal institution or correctional facility pursuant to such indi-
3 vidual's conviction of an offense (committed after the date of
4 the enactment of this paragraph) constituting a felony under
5 applicable law, or which is aggravated in connection with
6 such a confinement (but only to the extent so aggravated),
7 shall not be considered in determining whether such individu-
8 al is under a disability for purposes of benefits payable for
9 any month during which such individual is so confined.".
10 (2) The third sentence of section 216(i)(1) of such Act is
11 amended by striking out "and (5)" and inserting in lieu there-
12 of "(5), and (6)".
13 (b) Section 202(d)(7)(A) of such Act is amended by
14 adding at the end thereof the following: "An individual shall
15 not be considered a 'full-time student' for the purpose of this
16 section while that individual is confined in a jail, prison, or
17 other penal institution or correctional facility, pursuant to his
18 conviction of an offense (committed after the date of the en-
19 actment of this paragraph) which constituted a felony under
20 applicable law.".
21 (c) Section 223 of such Act is amended by adding at the
22 end thereof the following new subsection:

1 "SUSPENSION OF BENEFITS FOR INMATES OF PENAL
2 INSTITUTIONS

3 "(f)(1) Notwithstanding any other provision of this title,
4 no monthly benefits shall be paid under this section, or under
5 section 202(d) by reason of being under a disability, to any
6 individual for any month during which such individual is con-
7 fined in a jail, prison, or other penal institution or correc-
8 tional facility, pursuant to his conviction of an offense which
9 constituted a felony under applicable law, unless such indi-
10 vidual is actively and satisfactorily participating in a rehabili-
11 tation program which has been specifically approved for such
12 individual by a court of law and, as determined by the Secre-
13 tary, is expected to result in such individual being able to
14 engage in substantial gainful activity upon release and within
15 a reasonable time.

16 "(2) Benefits which would be payable to any individual
17 (other than a confined individual to whom benefits are not
18 payable by reason of paragraph (1)) under this title on the
19 basis of the wages and self-employment income of such a
20 confined individual but for the provisions of paragraph (1),
21 shall be payable as though such confined individual were re-
22 ceiving such benefits under this section.".

23 (d) The amendments made by this section shall be effec-
24 tive with respect to benefits payable for months beginning on
25 or after October 1, 1980.

PART F—PROVISIONS RELATING TO MEDICARE AND MEDICAID

CRITERIA FOR DETERMINING REASONABLE COST OF HOSPITAL SERVICES

SEC. 651. (a)(1) The first sentence of section 1861(v)(1)(A) of the Social Security Act is amended by striking out "The" and inserting "Subject to subsection (bb), the".

(2) Section 1861(v) of such Act is further amended by adding at the end thereof the following new paragraph:

"(8) For additional requirements applicable to determination of reasonable cost, see subsection (bb) and section 1128(c)(3).".

(b) Section 1861 of such Act is amended by adding after subsection (aa) the following new subsection:

"Criteria for Determining Reasonable Cost of Hospital Services

"(bb)(1) It is the purpose of this subsection to set forth initial methods and criteria for determining reimbursement based upon reasonable cost, but such methods and criteria shall be subject to appropriate modification by the Secretary as provided in section 1128. In order more fairly and effectively to determine reasonable costs incurred in providing hospital services, the Secretary shall, not later than September 1, 1980, after consulting with appropriate national orga-

1 nizations, establish a system of hospital classification under
2 which hospitals furnishing services will be classified on a na-
3 tional basis initially—
4 "(A) by size, with each of the following groups of
5 hospitals being classified in separate categories: (i)
6 those having more than 5, but fewer than 25, beds, (ii)
7 those having more than 24, but fewer than 50, beds,
8 (iii) those having more than 49, but fewer than 100,
9 beds, (iv) those having more than 99, but fewer than
10 200, beds, (v) those having more than 199, but fewer
11 than 300, beds, (vi) those having more than 299, but
12 fewer than 400, beds, (vii) those having more than
13 399, but fewer than 500, beds, and (viii) those having
14 more than 499 beds;
15 "(B) by type of hospital, with (i) short-term gener-
16 al hospitals being in a separate category, (ii) hospitals
17 which are primary affiliates of accredited medical
18 schools being in one separate category, and (iii) psychi-
19 atric, geriatric, maternity, pediatric, or other specialty
20 hospitals being in the same or separate categories, as
21 the Secretary may determine appropriate, in light of
22 any differences in specialty which significantly affect
23 the routine costs of the different types of hospitals;
24 "(C) as rural or urban; and

1 "(D) according to such other criteria as the Secre-
2 tary finds appropriate, including modification of bed-
3 size categories;
4 but the system of hospital classification shall not differentiate
5 between hospitals on the basis of ownership.
6 "(2) The term 'routine operating costs' used in this sub-
7 section does not include—
8 "(A) capital and related costs,
9 "(B) direct personnel and supply costs of ap-
10 proved hospital education and training programs,
11 "(C) costs of interns, residents, and nonadminis-
12 trative physicians,
13 "(D) energy costs,
14 "(E) malpractice insurance expense, or
15 "(F) ancillary service costs.
16 "(3)(A) During the calendar quarter beginning on Janu-
17 ary 1 of each year, beginning with 1981 (and in the case of
18 1980, as soon as possible), the Secretary shall determine, for
19 the hospitals in each category of the system established under
20 paragraph (1), an average per diem routine operating cost
21 amount which shall (except as otherwise provided in this sub-
22 section) be used in determining payments to hospitals.
23 "(B) The determination shall be based upon the amount
24 of the hospitals' routine operating costs for the most recent
25 accounting year ending prior to October 1 of the calendar

1 year preceding the calendar year in which the determination
2 is made. If, for any accounting year which starts on or after
3 July 1, 1980, a hospital's actual routine operating costs are
4 in excess of the amount allowed for purposes of determining
5 payment to the hospital pursuant to this subsection and sub-
6 section (v), only one-half of such excess shall be taken into
7 account in making any determination which the Secretary
8 shall make under this paragraph. Such amount as determined
9 under the preceding sentences of this subparagraph shall be
10 adjusted to reflect the percentage increase in the cost of the
11 mix of goods and services (including personnel and nonper-
12 sonnel costs) comprising routine operating costs, based on an
13 index composed of appropriately weighted indicators of
14 changes in the economy in wages and prices which are repre-
15 sentative of services and goods included in routine operating
16 costs, during the period from the end of the accounting year
17 referred to in the first sentence of this subparagraph to the
18 end of the quarter in which the determination is being made.
19 "(C) In making a determination, the routine operating
20 costs of hospitals in each category shall be divided into per-
21 sonnel and nonpersonnel components.
22 "(D)(i) The personnel and nonpersonnel components of
23 routine operating costs for hospitals in each category (other
24 than for those excluded under clause (ii)) shall be divided by
25 the total number of days of routine care provided by such

1 hospitals to determine the average per diem routine operating
2 cost for such category.
3 "(ii) In making the calculations required by subpara-
4 graph (A) the Secretary shall exclude any newly opened hos-
5 pital (as defined in the second sentence of paragraph (4)(F)),
6 and any hospital which he determines is experiencing signifi-
7 cant cost differentials resulting from failure of the hospital
8 fully to meet the standards and conditions of participation as
9 a provider of services.
10 "(E) There shall be determined for each hospital in each
11 category a per diem target rate for routine operating costs.
12 Such target rate shall equal the average per diem routine
13 operating cost amount for the category in which the hospital
14 is expected to be classified during the subsequent accounting
15 year, except that the personnel component shall be adjusted
16 using a wage index based upon general wage levels for rea-
17 sonably comparable work in the areas in which the hospitals
18 are located. If the Secretary finds that, in an area where a
19 hospital in any category is located for the most recent
20 twelve-month period for which data with respect to such
21 wage levels are available, the wage level for such hospital is
22 significantly higher than such general wage level in that area
23 (relative to the relationship within the same hospital group
24 between hospital wages and such general wages in other
25 areas), then such general wage level in the area shall be

1 deemed equal to the wage level for such hospital, but only
2 with respect to the hospital's first accounting year beginning
3 on or after July 1, 1980 and prior to July 1, 1981.

4 "(4)(A)(i) The term 'adjusted per diem target rate for
5 routine operating costs' means the per diem target rate for
6 routine operating costs plus the percentage increase in
7 costs determined under the succeeding provisions of this
8 subparagraph.

9 "(ii) In determining the adjusted per diem target rate,
10 the Secretary shall add an estimated percentage increase in
11 the cost of the mix of goods and services (including personnel
12 and nonpersonnel costs) comprising routine operating costs,
13 based on an index composed of appropriately weighted indi-
14 cators of changes in the economy in wages and prices which
15 are representative of services and goods included in routine
16 operating costs, during the period from the end of the quarter
17 in which the determination is made under paragraph (3)(A) to
18 the end of the hospital's accounting year. Where actual
19 changes in such weighted index are significantly different (at
20 least one-half of 1 percentage point) from those estimated,
21 the Secretary shall issue corrected target rates on a quarterly
22 basis. At the end of the hospital's accounting year, the target
23 rate shall be adjusted to reflect the actual changes in such
24 weighted index. Adjustments shall also be made to take ac-
25 count of changes in the hospital's classification.

1 "(B) For purposes of payment, the amount of routine
2 operating cost incurred by a hospital for any accounting year
3 which begins on or after July 1, 1980, shall be deemed to be
4 equal—
5 "(i) in the case of a hospital which has actual rou-
6 tine operating costs equal to or greater than that hos-
7 pital's adjusted per diem target rate for routine operat-
8 ing costs, to the greater of—
9 "(I) the hospital's actual routine operating
10 costs, but not exceeding—
11 "(a) in the case of the first accounting
12 year of any hospital which begins on or after
13 July 1, 1980, and prior to July 1, 1981, an
14 amount equal to the aggregate of (1) 100
15 percent of the hospital's adjusted per diem
16 target rate for rcutine operating costs, plus
17 (2) 15 percent of the amount described in
18 clause (1), plus (3) one-half of the difference
19 between the hospital's actual routine operat-
20 ing costs and the sum of the amounts deter-
21 mined under clauses (1) and (2),
22 "(b) in the case of the first accounting
23 year of any hospital which begins on or after
24 July 1, 1981, and prior to July 1, 1982 (or
25 if earlier, the second accounting year of such

1 hospital which begins on or after July 1,
2 1980, and prior to July 1, 1982), an amount
3 equal to the aggregate of (1) 100 percent of
4 the hospital's adjusted per diem target rate
5 for routine operating costs for such year,
6 plus (2) a dollar amount equal to the dollar
7 amount determined under clause (a)(2) for
8 the category of such hospital, plus (3) one-
9 half of the difference between the hospital's
10 actual routine operating costs and the sum of
11 the amounts determined under clauses (1)
12 and (2), and
13 "(c) in the case of any accounting year
14 after the accounting year described in clause
15 (b), an amount equal to the aggregate of (1)
16 100 percent of the hospital's adjusted per
17 diem target rate for routine operating costs
18 for such year, plus (2) a dollar amount equal
19 to the dollar amount determined under clause
20 (b)(2) for the category of such hospital, or
21 "(II) the amounts determined for the hospital
22 under division (I) if it had been classified in the
23 bed-size category which contains hospitals closest
24 in bed-size to such hospital's bed-size (with a hos-
25 pital which has a bed-size that falls halfway be-

1 tween two such categories being considered in the
2 category which contains hospitals with the greater
3 number of beds), but not exceeding the hospital's
4 actual routine operating costs; or
5 "(III) in the case of a hospital having an
6 average length-of-stay per patient which is less
7 than the average length-of-stay per patient for
8 hospitals classified in the same category, for any
9 accounting year, an amount equal to the average
10 reimbursement for routine operating costs per pa-
11 tient stay for hospitals in the same category, mul-
12 tiplied by the number of patient stays for such
13 hospital during that accounting year, but not ex-
14 ceeding the actual routine operating costs for such
15 hospital; and
16 "(ii) in the case of a hospital which has actual
17 routine operating costs which are less than that hospi-
18 tal's adjusted per diem target rate for routine operating
19 costs, to (I) the amount of the hospital's actual routine
20 operating costs, plus (II) the smaller of (a) 5 percent
21 (or 2.5 percent with respect to any accounting year
22 which begins on or after July 1, 1980, and prior to
23 July 1, 1982) of the hospital's adjusted per diem target
24 rate for routine operating costs, or (b) 50 percent (or
25 25 percent with respect to any accounting year which

1 begins on or after July 1, 1980, and prior to July 1,
2 1982) of the amount by which the hospital's adjusted
3 per diem target rate for routine operating costs exceeds
4 the hospital's actual routine operating costs.

5 "(C) Any hospital (other than a newly opened hospital)
6 excluded by the Secretary under paragraph (3)(D)(ii), shall be
7 reimbursed for routine operating costs on the basis of the
8 lesser of (i) actual costs or (ii) the reimbursement determined
9 under this subsection.

10 "(D) On or before April 1 (or in the case of 1980, as
11 soon as possible) of the year in which the Secretary deter-
12 mines the amount of the average per diem operating cost for
13 each hospital category and the adjusted per diem target rate
14 for each hospital, the Secretary shall publish the determina-
15 tions, and he shall notify the hospital administrator and the
16 administrative governing body of each hospital with respect
17 to all aspects of the determination which affect the hospital.

18 "(E) If a hospital is determined by the Secretary to
19 be—

20 "(i) located in an underserved area where hospital
21 services are not otherwise available,

22 "(ii) certified as being currently necessary by an
23 appropriate planning agency, and

24 "(iii) underutilized,

1 the adjusted per diem target rate shall not apply to that por-
2 tion of the hospital's routine operating costs attributable to
3 the underutilized capacity.

4 "(F) If a newly opened hospital is determined by the
5 Secretary to have greater routine operating costs as a result
6 of the cost patterns associated with newly opened hospitals,
7 the adjusted per diem target rate shall not apply to that por-
8 tion of the hospital's routine operating costs attributable to
9 such patterns. For purposes of this subparagraph a 'newly
10 opened hospital' means a hospital which has not satisfied the
11 requirements of paragraphs (1) and (7) of subsection (e) of
12 this section (under present or previous ownership) for at least
13 twenty-four months prior to the start of such hospital's ac-
14 counting year.

15 "(G) If a hospital is determined by the Secretary to
16 have greater routine operating costs as a result of changes in
17 service on account of consolidation, sharing, or addition of
18 services, where such consolidation, sharing, or addition has
19 been approved by the appropriate State health planning and
20 development agency or agencies, the adjusted per diem
21 target rate shall not apply to that portion of the hospital's
22 routine operating costs attributable to such changes in
23 service.

24 "(H)(i) If a hospital satisfactorily demonstrates to the
25 Secretary that, in the aggregate, its patients require a sub-

1 stantially greater intensity of care than generally is provided
2 by the other hospitals in the same category, resulting in un-
3 usually greater routine operating costs, then the adjusted per
4 diem target rate shall not apply to that portion of the hospi-
5 tal's routine operating costs attributable to the greater inten-
6 sity of care required.

7 "(ii) To the extent that a hospital can demonstrate that
8 it experiences routine operating costs in excess of such costs
9 for hospitals having a reasonably similar mix of patients on
10 account of consistently shorter lengths-of-stay in such hospi-
11 tal, which result from the greater intensity of care provided
12 by such hospital, the excess routine operating costs shall be
13 considered attributable to the greater intensity of care
14 required, but this clause shall not apply in the case of a hos-
15 pital whose routine operating costs are determined under
16 subparagraph (B)(i)(III).

17 "(I) The Secretary may further increase the adjusted
18 per diem target rate applicable in Alaska and Hawaii to re-
19 flect the higher prices prevailing in such States.

20 "(J) Where the Secretary finds that a hospital has ma-
21 nipulated its patient mix, or patient flow, or provides less
22 than the normal range and extent of patient services, or that
23 an unusually large proportion of routine nursing service is
24 provided by private-duty nurses, the routine operating costs
25 of that hospital shall be deemed equal to the lesser of (i) the

1 amount determined without regard to this subsection, or (ii)
2 the amount determined under subparagraph (B).
3 "(5) Where any provisions of this subsection are incon-
4 sistent with subsection (v), this subsection supersedes subsec-
5 tion (v).
6 "(6)(A) Notwithstanding any other provision of this Act,
7 in the case of any State which has established a reimburse-
8 ment system for hospitals, hospital reimbursement in that
9 State under this title and under the State plan approved
10 under title XIX shall, with respect to the services covered by
11 such system, be based on that State system, if the Secretary
12 finds that—
13 "(i) the State has a reimbursement system and it
14 at least applies to the same hospitals in the State, and
15 to the same costs, as the Federal reimbursement
16 reform program established by this subsection;
17 "(ii) every hospital in the State with which there
18 is a provider agreement under this title or under the
19 State plan approved under title XIX conforms to the
20 accounting and uniform reporting requirements of sec-
21 tion 1121 of this Act, and furnishes any appropriate
22 reports that the Secretary may require; and
23 "(iii) such State demonstrates to his satisfaction
24 that the total amount payable, with respect to inpatient
25 hospital costs, in the State under this title and under

1 the State plan approved under title XIX will be equal
2 to or less than an amount equal to (I) the amount
3 which would otherwise be payable for such costs under
4 this title and such State plan without regard to the in-
5 centive payments provided by subparagraph (B)(ii) of
6 paragraph (4), plus (II) the amount of any incentive
7 payments which are allowed under the State's re-
8 imbursement system in recognition of demonstrated
9 efficiencies (but not to exceed the amount of the incen-
10 tive payments which would be allowed under para-
11 graph (4)(B)(ii).
12 If the Secretary finds that any of the above conditions in a
13 State which previously met them have not been met for a
14 two-year period, the Secretary shall, after due notice, reim-
15 burse hospitals in that State according to the provisions of
16 this Act (other than this paragraph) unless he finds that un-
17 usual, justifiable, and nonrecurring circumstances led to the
18 failure to comply.
19 "(B) If the Secretary finds that, during any two-year
20 period during which hospital reimbursement under this title
21 and under the State plan approved under title XIX was
22 based on a State system as provided in subparagraph (A), the
23 amount payable by the Federal Government under such titles
24 for inpatient hospital costs in such State was in excess of the
25 amount which would have been payable for such costs in

1 such State if reimbursement had not been based on the State
2 system (as estimated by the Secretary), the adjusted per diem
3 target rate for routine operating costs (as determined under
4 the preceding paragraphs of this subsection) for hospitals in
5 such State shall be reduced (by not more than 1 percent in
6 any year) until the Federal Government has recouped an
7 amount equal to such excess payment amount.

8 "(C)(i) The Secretary shall pay to any State in which
9 hospital reimbursement under this title is based on a State
10 system as provided in subparagraph (A), an amount which
11 bears the same ratio to the total cost incurred by such State
12 of administering the approved State system (including the
13 cost of initially putting the system into operation) as the
14 amount paid by the Federal Government under this title in
15 such State for inpatient hospital costs bears to the total
16 amount of inpatient hospital costs in such State which are
17 subject to the State system.

18 "(ii) Payments under clause (i) shall be made from funds
19 in the Federal Hospital Insurance Trust Fund.

20 "(iii) An amount which bears the same ratio to the total
21 cost incurred by such State of administering the approved
22 State system (including the cost of initially putting the
23 system into operation) as the amount paid under the State
24 plan approved under title XIX in such State for inpatient
25 hospital costs bears to the total amount of inpatient hospital

1 costs in such State which are subject to the State system,
2 shall, for purposes of title XIX, be considered to be an
3 amount expended for the administration of such State plan.
4 "(D) If there is in effect in a State a reimbursement
5 system for hospitals which the Secretary finds meets the cri-
6 teria prescribed in subparagraph (A) except that such system
7 was not established by the State, at the election of the State,
8 such system shall for purposes of this paragraph be consid-
9 ered to be a reimbursement system for hospitals established
10 by such State.".
11 (c) Part A of title XI of the Social Security Act is
12 amended by adding after section 1127 the following new
13 section:
14 "HEALTH FACILITIES COSTS COMMISSION
15 "SEC. 1128. (a) There is established a commission to be
16 known as the Health Facilities Costs Commission (herein-
17 after in this section referred to as the 'Commission').
18 "(b)(1) The Commission shall be composed of fifteen
19 members appointed by the Secretary—
20 "(A) at least five of whom shall be individuals
21 who are representatives of providers;
22 "(B) at least five of whom shall be individuals
23 who represent public (including Federal, State, and
24 local) health benefit programs; and

1 "(C) the remainder of whom shall be, as a result
2 of training, experience, or attainments, particularly and
3 exceptionally well qualified to assist in serving and car-
4 rying out the functions of the Commission.
5 One of the members of the Commission, at the time of ap-
6 pointment, shall be designated as Chairman of the Commis-
7 sion. The Secretary shall first appoint members to the Com-
8 mission not later than October 1, 1980.
9 "(2) The Chairman of the Commission shall designate a
10 member of the Commission to act as Vice Chairman of the
11 Commission.
12 "(3) A majority of the members of the Commission shall
13 constitute a quorum, but a lesser number may conduct
14 hearings.
15 "(4) A vacancy in the Commission shall not affect its
16 powers, but shall be filled in the same manner as that herein
17 provided for the appointment of the member first appointed to
18 the vacant position.
19 "(5) Members of the Commission shall be appointed for
20 a term of four years, except that the Secretary shall provide
21 for such shorter terms for some of the members first ap-
22 pointed so as to stagger the date of expiration of members'
23 terms of office.
24 "(6) No individual may be appointed to serve more than
25 two terms as a member of the Commission.

1 "(7) Each member of the Commission shall be entitled
2 to per diem compensation at rates fixed by the Secretary, but
3 not more than the current per diem equivalent of the annual
4 rate of basic pay in effect for grade GS–18 of the General
5 Schedule for each day (including traveltime) during which the
6 member is engaged in the actual performance of duties vested
7 in the Commission, and all members of the Commission shall
8 be allowed, while away from their homes or regular places of
9 business in the performance of service for the Commission,
10 travel expenses (including per diem in lieu of subsistence) in
11 the same manner as persons employed intermittently in the
12 Government service are allowed expenses under section
13 5703 of title 5, United States Code.

14 "(8) The Commission shall meet at the call of the Chair-
15 man, or at the call of a majority of the members of the Com-
16 mission; but meetings of the Commission shall be held not
17 less frequently than once in each calendar month which
18 begins after a majority of the authorized membership of the
19 Commission has first been appointed.

20 "(c)(1) It shall be the duty and function of the Commis-
21 sion to conduct a continuing study, investigation, and review
22 of the reimbursement of hospitals for care provided by them
23 to individuals covered under title XVIII or under State plans
24 approved under title XIX, with particular attention to the
25 criteria established by section 1861(bb) with a view to devis-

1 ing additional methods for reimbursing hospitals for all other
2 costs, and for reimbursing all other entities which are reim-
3 bursed on the basis of reasonable cost. These methods shall
4 provide for appropriate classification and reimbursement sys-
5 tems designed to ordinarily permit comparisons of (A) the
6 cost centers of one entity, either individually or in the aggre-
7 gate, with cost centers similar in terms of size and scale of
8 operation, (B) prevailing wage levels, (C) the nature, extent,
9 and appropriate volume of the services furnished, and (D)
10 other factors which have a substantial impact on hospital
11 costs. The Commission shall also develop procedures for ap-
12 propriate exceptions. The Commission shall submit to the
13 Congress reports on its progress in addressing these issues at
14 least once every six months during the three-year period fol-
15 lowing the date of the enactment of this section.
16 "(2) The Commission shall study appropriate methods
17 for classifying and comparing hospitals which, with respect to
18 any accounting year, derive 75 percent or more (as estimated
19 by the Secretary) of their inpatient care revenues from one or
20 more health maintenance organizations. The Commission
21 shall consider recommending the classification and compari-
22 son of such hospitals as a separate category in recognition of
23 the differences in the nature of their operations as compared
24 with other hospitals.

1 "(3)(A) The Secretary, taking account of the proposals
2 and advice of the Commission, shall by regulation make ap-
3 propriate modifications in the method of reimbursement under
4 titles V, XVIII, and XIX for routine hospital costs, other
5 hospital costs, and costs of other entities which are reim-
6 bursed on the basis of reasonable costs.

7 "(B) In any case in which the Secretary proposes to
8 make such modifications, he shall first submit such proposal
9 to the Commission. If the Commission disagrees with such
10 proposal, final regulations implementing such proposal shall
11 be submitted to Congress by the Secretary, and such regula-
12 tions may not become effective until at least 60 days after
13 they were submitted to Congress.

14 "(d) The Secretary shall provide such technical, secre-
15 tarial, clerical, and other assistance as the Commission may
16 need.

17 "(e) The Commission may secure directly from any de-
18 partment or agency of the United States such data and infor-
19 mation as may be necessary to enable it to carry out its
20 duties under this section. Upon request of the Chairman of
21 the Commission, any such department or agency shall furnish
22 any such data or information to the Commission.

23 "(f) There are authorized to be appropriated such sums
24 as may be necessary to carry out this section.

1 "(g) Section 14 of the Federal Advisory Committee Act
2 shall not apply to the Commission.".
3 (d)(1) Section 1866(a)(1) of the Social Security Act is
4 amended—
5 (A) by striking out the period at the end of sub-
6 paragraph (D) and inserting in lieu thereof ", and";
7 and
8 (B) by inserting after subparagraph (D) the follow-
9 ing new subparagraph:
10 "(E) not to increase amounts due from any indi-
11 vidual, organization, or agency in order to offset reduc-
12 tions made under section 1861(bb) in the amount paid,
13 or expected to be paid, under this title.".
14 (2) Section 1902(a)(27) of the Social Security Act is
15 amended by striking out "and" at the end of clause (A) and
16 by inserting before the semicolon at the end of clause (B) the
17 following: ", and (C) not to increase amounts due from any
18 individual, organization, or agency in order to offset reduc-
19 tions made pursuant to the requirements contained in section
20 1902(a)(13)(D) in the amount paid, or expected to be paid
21 under the State plan".
22 (e) Section 1902(a)(13)(D) of the Social Security Act is
23 amended to read as follows:
24 "(D) for payment of the reasonable cost of inpa-
25 tient hospital services provided under the plan,

1 applying the methods specified in section 1861(v) and
2 section 1861(bb), which are consistent with section
3 1122; and".

4 PAYMENTS TO PROMOTE CLOSING AND CONVERSION OF
5 UNDERUTILIZED FACILITIES

6 SEC. 652. (a) Part A of title XI of the Social Security
7 Act is amended by adding after section 1128 (as added by
8 section 651 of this Act) the following new section:

9 "PAYMENTS TO PROMOTE CLOSING AND CONVERSION OF
10 UNDERUTILIZED FACILITIES

11 "SEC. 1129. (a)(1)(A) Before the end of the third full
12 month following the month in which this section is enacted,
13 the Secretary shall establish a Hospital Transitional Allow-
14 ance Board (hereinafter in this section referred to as the
15 'Board'). The Board shall have five members, appointed by
16 the Secretary without regard to the provisions of title 5,
17 United States Code, governing appointments in the competi-
18 tive service, who are knowledgeable about hospital planning
19 and hospital operations.

20 "(B) Members of the Board shall be appointed for three-
21 year terms, except some initial members shall be appointed
22 for shorter terms to permit staggered terms of office.

23 "(C) Members of the Board shall be entitled to per diem
24 compensation at rates fixed by the Secretary, but not more
25 than the current per diem equivalent at the time the service

1 involved is rendered for grade GS-18 under section 5332 of
2 title 5, United States Code.
3 "(D) The Secretary shall provide such technical, secre-
4 tarial, clerical, and other assistance as the Board may need.
5 "(2) The Board shall receive and act upon applications
6 by hospitals, certified for participation (other than as 'emer-
7 gency hospitals') under titles XVIII and XIX, for transition-
8 al allowances.
9 "(b) For purposes of this section—
10 "(1) The term 'transitional allowance' means an
11 amount which—
12 "(A) shall, solely by reason of this section,
13 be included in a hospital's reasonable cost for pur-
14 poses of calculating payments under the programs
15 authorized by titles V, XVIII, and XIX of this
16 Act; and
17 "(B) in accordance with this section, is es-
18 tablished by the Secretary for a hospital in recog-
19 nition of a reimbursement detriment (as defined in
20 paragraph (3)) experienced because of a qualified
21 facility conversion (as defined in paragraph (2)).
22 "(2) The term 'qualified facility conversion' means
23 closing, modifying, or changing the usage of an under-
24 utilized hospital facility which is expected to benefit
25 the programs authorized under title V, title XVIII,

1 and title XIX by (A) eliminating excess bed capacity,
2 (B) discontinuing an underutilized service for which
3 there are adequate alternative sources, or (C) substitut-
4 ing for the underutilized service some other service
5 which is needed in the area and which is consistent
6 with the findings of an appropriate health planning
7 agency.

8 "(3) A hospital which has carried out a qualified
9 facility conversion and which continues in operation
10 will be regarded as having experienced a 'reimburse-
11 ment detriment'—

12 "(A) to the extent that, solely because of the
13 conversion, there is a reduction in that portion of
14 the hospital's costs attributable to capital assets
15 which are taken into account in determining rea-
16 sonable cost for purposes of determining amount
17 of payment to the hospital under title V, title
18 XVIII, or a State plan approved under title XIX;

19 "(B) if the conversion results, on an interim
20 basis, in increased operating costs, to the extent
21 that operating costs exceed amounts ordinarily re-
22 imbursable under title V, title XVIII, and the
23 State plan approved under title XIX; or

24 "(C) in the case of complete closure of a pri-
25 vate nonprofit hospital, or local governmental hos-

1 pital, other than for replacement of the hospital,
2 to the extent of actual debt obligations previously
3 recognized as reasonable for reimbursement,
4 where the debt remains outstanding, less any sal-
5 vage value.

6 "(c)(1) Any hospital may file an application with the
7 Board (in such form and including such data and information
8 as the Board, with the approval of the Secretary, may re-
9 quire) for a transitional allowance with respect to any quali-
10 fied conversion which is formally initiated after September
11 30, 1980. The Board, with the approval of the Secretary,
12 may also establish procedures, consistent with this section,
13 by means of which a finding of a reimbursement detriment
14 may be made prior to the actual conversion.

15 "(2) The Board shall consider any application filed by a
16 hospital, and if the Board finds that—

17 "(A) the facility conversion is a qualified facility
18 conversion, and

19 "(B) the hospital is experiencing or will experi-
20 ence a reimbursement detriment because it carried out
21 the qualified facility conversion,

22 the Board shall transmit to the Secretary its recommendation
23 that the Secretary establish a transitional allowance for the
24 hospital in amounts reasonably related to prior or prospective
25 use of the facility under titles V and XVIII and the State

1 plan approved under title XIX, for a period, not to exceed
2 twenty years as specified by the Board, and, if the Board
3 finds that the criteria in subparagraphs (A) and (B) are not
4 met, it shall advise the Secretary not to establish a transi-
5 tional allowance for that hospital. For an approved closure
6 under subsection (b)(3)(C) the Board may recommend or the
7 Secretary may approve, a lump-sum payment in lieu of peri-
8 odic allowances, where such payment would constitute a
9 more efficient and economic alternative.

10 "(3)(A) The Board shall notify a hospital of its findings
11 and recommendations.

12 "(B) A hospital dissatisfied with a recommendation may
13 obtain an informal or formal hearing, at the discretion of the
14 Secretary by filing (in the form and within a time period
15 established by the Secretary) a request for a hearing.

16 "(4)(A) Within thirty days after receiving a recommen-
17 dation from the Board respecting a transitional allowance or,
18 if later, within thirty days after a hearing, the Secretary shall
19 make a final determination whether, and if so in what amount
20 and for what period of time, a transitional allowance will be
21 granted to a hospital. A final determination of the Secretary
22 shall not be subject to judicial review.

23 "(B) The Secretary shall notify a hospital and any other
24 appropriate parties of the determination.

1 "(C) Any transitional allowance shall take effect on a
2 date prescribed by the Secretary, but not earlier than the
3 date of completion of the qualified facility conversion. A tran-
4 sitional allowance shall be included as an allowable cost item
5 in determining the reasonable cost incurred by the hospital in
6 providing services for which payment is authorized under this
7 Act, except that the transitional allowance shall not be con-
8 sidered in applying limits to costs recognized as reasonable
9 pursuant to the third sentence of section 1861(v)(1) and sec-
10 tion 1861(bb) of this Act, or in determining the amount to be
11 paid to a provider pursuant to section 1814(b), section
12 1833(a)(2), section 1903(i)(3), and section 506(f)(3) of this
13 Act.

14 "(d) In determining the reasonable cost incurred by a
15 hospital with respect to which payment is authorized under a
16 State plan approved under title V or title XIX, any transi-
17 tional allowance shall be included as an allowable cost item.

18 "(e)(1) The Secretary is authorized to establish transi-
19 tional allowances only as provided in paragraphs (2) and (3).

20 "(2) Prior to January 1, 1983, the Secretary is author-
21 ized to establish a transitional allowance for not more than
22 fifty hospitals.

23 "(3) On and after January 1, 1983, the Secretary is
24 authorized to establish a transitional allowance for any hospi-

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1 tal which qualifies for such an allowance under the provisions
2 of this section.
3 "(4) On or before January 1, 1982, the Secretary shall
4 report to the Congress evaluating the effectiveness of the
5 program established under this section including appropriate
6 recommendations.".
7 (b) The amendments made by subsection (a) shall apply
8 only to services furnished by a hospital during any account-
9 ing year beginning on or after October 1, 1980.
10 COORDINATED AUDITS UNDER THE SOCIAL SECURITY ACT
11 SEC. 653. (a) Title XI of the Social Security Act is
12 amended by inserting after section 1129 (as added by section
13 652 of this Act) the following new section:
14 "COORDINATED AUDITS
15 "SEC. 1130. If an entity provides services reimbursable
16 on a cost-related basis under title V or XIX, as well as serv-
17 ices reimbursable on such a basis under title XVIII, the Sec-
18 retary shall require, as a condition for payment to any State
19 under title V or XIX with respect to administrative costs
20 incurred in the performance of audits of the books, accounts,
21 and records of that entity, that these audits be coordinated
22 through common audit procedures with audits performed with
23 respect to the entity for purposes of title XVIII. The Secre-
24 tary shall apportion to the program established under title V
25 or XIX that part of the cost of coordinated audits which is

1 attributable to each such program and which would not have
2 otherwise been incurred in an audit of the program estab-
3 lished under title XVIII. Where the Secretary finds that a
4 State has declined to participate in such a common audit with
5 respect to title V or XIX, he shall reduce the payments oth-
6 erwise due such State under such title by an amount which
7 he estimates to be the amount that represents the duplication
8 of costs resulting from such State's failure to participate in
9 the common audit.".

10 (b) Section 1902(a) of the Social Security Act is
11 amended—

12 (A) by striking out "and" at the end of paragraph
13 (40);

14 (B) by striking out the period at the end of para-
15 graph (41) and inserting in lieu thereof "; and"; and

16 (C) by inserting after paragraph (41) the following
17 new paragraph:

18 "(42) provide (A) that the records of any entity
19 participating in the plan and providing services reim-
20 bursable on a cost-related basis will be audited as the
21 Secretary determines to be necessary to insure that
22 proper payments are made under the plan, (B) that
23 such audits, for such entities also providing services
24 under part A of title XVIII, will be coordinated
25 and conducted jointly (to such extent and in such

1 manner as the Secretary shall prescribe) with audits
2 conducted for purposes of such title, and (C) for pay-
3 ment of the portion of the costs of each such common
4 audit of such an entity equal to the portion of the cost
5 of the common audit which is attributable to the pro-
6 gram established under this title and which would not
7 have otherwise been incurred in an audit of the pro-
8 gram established under title XVIII.".
9 (c) Section 505(a) of the Social Security Act is
10 amended—
11 (A) by striking out "and" at the end of paragraph
12 (14);
13 (B) by striking out the period at the end of para-
14 graph (15) and inserting in lieu thereof "; and"; and
15 (C) by inserting after paragraph (15) the following
16 new paragraph:
17 "(16) provides (A) that the records of any entity
18 participating in the plan and providing services reim-
19 bursable on a cost-related basis will be audited as the
20 Secretary determines to be necessary to insure that
21 proper payments are made under the plan, (B) that
22 such audits, for such entities also providing services
23 under part A of title XVIII, will be coordinated and
24 conducted jointly (to such extent and in such manner
25 as the Secretary shall prescribe) with audits conducted

1 for purposes of such part, and (C) for payment of the
2 portion of costs of each such common audit of such an
3 entity equal to the portion of the cost of the common
4 audit which is attributable to the program established
5 under this title and which would not have otherwise
6 been incurred in an audit of the program established
7 under title XVIII.".
8 (d)(1) The amendments made by subsections (b) and (c)
9 shall (except as otherwise provided in paragraph (2)) apply to
10 medical assistance provided, under a State plan approved
11 under title V or title XIX of the Social Security Act, on or
12 after the first day of the first calendar quarter which begins
13 more than 30 days after the date of enactment of this Act.
14 (2) In the case of a State plan under title V or title XIX
15 of the Social Security Act which the Secretary determines
16 requires State legislation in order for the plan to meet the
17 additional requirements imposed by the amendments made by
18 subsection (b) or (c), the State plan shall not be regarded as
19 failing to comply with the requirements of such title solely on
20 the basis of its failure to meet these additional requirements
21 before the first day of the first calendar quarter beginning
22 after the close of the first regular session of the State legisla-
23 ture which begins after the date of enactment of this Act.
24 (e) The Secretary shall report to Congress, not later
25 than March 31, 1981, on actions the Secretary has taken (1)

1 to coordinate the conduct of institutional audits and inspec-
2 tions which are required under the programs funded under
3 title V, XVIII, or XIX of the Social Security Act and (2) to
4 coordinate such audits and inspections with those conducted
5 by other cost payers, and he shall include in such report rec-
6 ommendations for such legislation as he deems appropriate to
7 assure the maximum feasible coordination of such institu-
8 tional audits and inspections.

9 APPORTIONMENT OF PROVIDER COSTS

10 SEC. 654. (a) Section 1861(v)(1) of the Social Security
11 Act is amended by adding at the end thereof the following
12 new subparagraph:
13 "(G) No payment with respect to a cost attributable to
14 the program established by this title shall be made to a pro-
15 vider of services to the extent that such payment exceeds the
16 proportional share of such cost, as measured by days of utili-
17 zation or provider charges, until such time as evidence can be
18 produced which, in the judgment of the Comptroller General
19 and concurred in by the Secretary, justifies payment of such
20 a higher proportional share as warranted under particular cir-
21 cumstances for certain facilities, and such payments may
22 then be made only to the extent so justified.".
23 (b)(1) The amendment made by this section shall be ef-
24 fective with respect to costs attributable to services provided
25 on or after April 1, 1981.

1 (2) The Comptroller General shall undertake a study to
2 determine those providers (classified, as appropriate, on the
3 basis of type, size, location, patient characteristics, average
4 length of stay, types of nursing services, or other relevant
5 criteria) for which payment of any differential is justified
6 under section 1861(v)(1)(G) of the Social Security Act, and
7 the extent to which such payments are justified. The Comp-
8 troller General shall submit the results of such study to the
9 Secretary of Health and Human Services prior to April 1,
10 1981, and the Secretary shall issue regulations with respect
11 to such payments prior to October 1, 1981.

12 (3) In the case of any provider with respect to which it
13 is determined under the regulations issued under paragraph
14 (2) that such payments are justified, reimbursement to such
15 provider shall include such payments, and retroactive reim-
16 bursement of such payments shall be made, after October 1,
17 1981, for services provided on or after April 1, 1981 and
18 before October 1, 1981.

19 REIMBURSEMENT FOR INAPPROPRIATE INPATIENT
20 HOSPITAL SERVICES

21 SEC. 655. (a)(1) Section 1158 of the Social Security Act
22 is amended by adding at the end thereof the following new
23 subsection:

24 "(e)(1) If, for purposes of payment under a title of this
25 Act as described in subsection (a), the Professional Standards

1 Review Organization disapproves (under subsection (a)) of in-
2 patient hospital services provided by a hospital to an individ-
3 ual on the grounds that such individual could receive appro-
4 priate and necessary medical, nursing, or other care more
5 economically in an inpatient facility of another type or home
6 care program, and such organization finds that—
7 "(A) payment is authorized to be made under or
8 pursuant to such title of this Act (as described in sub-
9 section (a)) with respect to services furnished to such
10 individual in such other type of facility or home care
11 program; and
12 "(B) there is no such other type of facility or
13 home care program available to such individual,
14 then payment, from funds described in subsection (a), to such
15 hospital may continue to be made (but at a rate determined
16 under paragraph (2)) for days (in a continuous period of days
17 which begins with the day following the last day for which
18 payment may be made, with application of subsection (d), for
19 such inpatient hospital services furnished to such individual)
20 with respect to which such individual meets the conditions
21 specified in subparagraphs (A) and (B).
22 "(2)(A) The rate at which payment may be continued
23 under paragraph (1) shall be a rate equal to the estimated
24 average rate per patient-day paid for services provided in
25 such other type of facility under the State plan approved

1 under title XIX of the State in which such hospital is
2 located, or, if less, the reasonable reimbursement allowed to
3 such hospital for services of the type provided in such other
4 type of facility (if such hospital has a unit which provides
5 such other type of services).
6 "(B) In the case of a State that does not have a State
7 plan approved under title XIX, the rate at which payment
8 may be continued under paragraph (1) shall be an amount
9 equal to the estimated average allowable costs per patient-
10 day for services provided in such other type of facility under
11 title XVIII in the State in which such hospital is located, or,
12 if less, the allowable costs in effect for such hospital for serv-
13 ices of the type provided in such other type of facility (if such
14 hospital has a unit which provides such other type of
15 services).
16 "(3) Any day on which an individual receives inpatient
17 hospital services for which payment is made at a lower
18 amount on account of the provisions of this subsection shall,
19 for purposes of this Act, be deemed to be a day on which he
20 received the type of services provided by such other type of
21 facility or home care program.".
22 (2) Section 1158(a) of such Act is amended by striking
23 out "subsection (d)" and inserting in lieu thereof "subsections
24 (d) and (e)".
25 (3) Section 1158(d) of such Act is amended—

1 (A) by striking out "In any case" and inserting in
2 lieu thereof "(1) Except as provided in subsection (e)
3 and paragraph (2) of this subsection, in any case"; and
4 (B) by adding at the end thereof the following
5 new paragraph:
6 "(2) A Professional Standards Review Organization
7 shall not disapprove (under subsection (a)) of inpatient hospi-
8 tal services provided under a title of this Act to an individual
9 on the grounds that such individual could receive appropriate
10 and necessary medical, nursing, or other care more economi-
11 cally in an inpatient facility or home care program of another
12 type for which payment can be made under such title (but
13 shall maintain and make public a quarterly report to the Sec-
14 retary by hospital and area as to the number of cases and
15 hospital days which, except for this paragraph, would have
16 otherwise been disapproved) if—
17 "(A) there is no excess of inpatient hospital beds
18 (adjusting for patients occupying hospital beds who do
19 not need that level of care) in the geographic area in
20 which the hospital is located (as certified by the State
21 or local health planning agency or health systems
22 agency); and
23 "(B) there is no such other type of facility or
24 home care program reasonably available to such indi-

1 vidual to provide appropriate care for which payment
2 can be made under such title.".
3 (b)(1) Section 1812(a) of such Act is amended—
4 (A) by striking out "and" at the end of paragraph
5 (2);
6 (B) by striking out the period at the end of para-
7 graph (3) and inserting in lieu thereof "; and"; and
8 (C) by adding after paragraph (3) the following
9 new paragraph:
10 "(4) detoxification facility services.".
11 (2) Section 1814(a)(2) of such Act is amended—
12 (A) by striking out "or" at the end of subpara-
13 graph (D);
14 (B) by inserting "or" at the end of subparagraph
15 (E); and
16 (C) by adding after subparagraph (E) the follow-
17 ing new subparagraph:
18 "(F) in the case of detoxification facility services,
19 such services are required on an inpatient basis (based
20 upon an examination by such certifying physician made
21 prior to initiation of detoxification);".
22 (3) Section 1861(u) of such Act is amended by inserting
23 "detoxification facility," after "home health agency,".

1 (4) Section 1861 of such Act is amended by adding after
2 subsection (bb) (as added by section 651 of this Act) the fol-
3 lowing new subsection:

4 "Detoxification Facility Services

5 "(cc)(1) The term 'detoxification facility services' means
6 services provided by a detoxification facility in order to
7 reduce or eliminate the amount of a toxic agent in the body,
8 but only to the extent that such services would be covered
9 under subsection (b) if furnished as an inpatient service by a
10 hospital, or are physician services covered under subsection
11 (s).

12 "(2) The term 'detoxification facility' means a public or
13 voluntary community-based nonprofit facility, other than a
14 hospital, which—

15 "(A) is engaged in furnishing to inpatients the
16 services described in paragraph (1);

17 "(B) is accredited by the Joint Commission on the
18 Accreditation of Hospitals as meeting the Accreditation
19 Program for Psychiatric Facilities standards (1979
20 edition), or is found by the Secretary to meet such
21 standards;

22 "(C) has arrangements with one or more hospi-
23 tals, having agreements in effect under section 1866,
24 for the referral and admission of patients requiring
25 services not available at the facility; and

1 "(D) meets such other requirements as the Secre-
2 tary may find necessary in the interest of the health
3 and safety of individuals who are furnished services by
4 the facility.".
5 (c) The amendments made by the preceding provisions
6 of this section shall become effective on October 1, 1980.
7 (d) The Secretary of Health and Human Services shall
8 conduct a study and make recommendations, within 18
9 months after the date of the enactment of this Act, concern-
10 ing the appropriateness of extending coverage to postdetoxifi-
11 cation rehabilitation and to outpatient detoxification.
12 (e) Section 1128(c) of the Social Security Act (as added
13 by section 651 of this Act) is amended by adding at the end
14 thereof the following new paragraph:
15 "(4) The Commission shall review and make recommen-
16 dations with respect to a method of classifying and comparing
17 detoxification facilities so as to provide that such method may
18 be used for reimbursement purposes for such facilities within
19 two years after the date of the enactment of this section.".
20 (f) Section 1155 of such Act is amended by adding at
21 the end thereof the following new subsection:
22 "(h) Any Professional Standards Review Organization
23 which has assumed responsibility under this section for
24 review of inpatient hospital services in an area shall also

1 assume responsibility in such area for review of detoxification
2 facility services.".

3 PSRO REVIEW OF HOSPITAL ADMISSIONS, ROUTINE
4 TESTING, AND PREOPERATIVE STAYS

5 SEC. 656. Section 1155(a)(1) of the Social Security Act
6 is amended by adding at the end thereof (after and below
7 subparagraph (C)) the following new sentence: "In carrying
8 out the provisions of this paragraph such organization shall
9 give priority to making such determinations with respect to
10 routine hospital admission testing, preoperative hospital stays
11 in excess of one day, and elective admissions on weekends or
12 other times when services are not available.".

13 CERTAIN SURGICAL PROCEDURES PERFORMED ON AN
14 AMBULATORY BASIS

15 SEC. 657. Part B of title XVIII of the Social Security
16 Act is amended by adding at the end thereof the following
17 new section:

18 "SPECIAL PROVISIONS RELATING TO CERTAIN SURGICAL
19 AND PREOPERATIVE PROCEDURES PERFORMED ON AN
20 AMBULATORY BASIS

21 "SEC. 1845. (a) The Secretary shall, in consultation
22 with the National Professional Standards Review Council
23 and appropriate medical organizations, specify those surgical
24 procedures which can be safely and appropriately performed

1 either in a hospital on an inpatient basis or on an ambulatory
2 basis—
3 "(1) in a physician's office; or
4 "(2) in an ambulatory surgical center or hospital.
5 "(b)(1) If a physician performs in his office a surgical
6 procedure specified by the Secretary pursuant to subsection
7 (a)(1) on an individual insured for benefits under this part, he
8 shall, notwithstanding any other provision of this part, be
9 entitled to have payment made under this part equal to—
10 "(A) 100 percent of the reasonable charge for the
11 services involved with the performance of such proce-
12 dure (including all pre- and postoperative physicians'
13 services performed in connection therewith), plus
14 "(B) the amount established by the Secretary pur-
15 suant to paragraph (2),
16 but only if the physician agrees with such individual to be
17 paid on the basis of an assignment under the terms of which
18 the reasonable charge for such services is the full charge
19 therefor.
20 "(2) The Secretary shall establish with respect to each
21 surgical procedure specified pursuant to subsection (a)(1), an
22 amount established with a view to according recognition to
23 the special costs, in excess of usual overhead, which physi-
24 cians incur which are attributable to securing, maintaining,
25 and staffing the facilities and ancillary services appropriate

1 for the performance of such procedure in the physician's
2 office, and to assuring that the performance of such proce-
3 dure in the physician's office will involve substantially less
4 total cost than would be involved if the procedure were per-
5 formed on an inpatient basis in a hospital. The amount so
6 established with respect to any surgical procedure periodi-
7 cally shall be reviewed and revised and may be adjusted,
8 when appropriate, by the Secretary to take account of vary-
9 ing conditions in different areas.

10 "(c)(1) Payment under this part may be made to an am-
11 bulatory surgical center for ambulatory facility services fur-
12 nished in connection with any surgical procedure, specified
13 by the Secretary pursuant to subsection (a)(2), which is per-
14 formed on an individual insured for benefits under this part in
15 an ambulatory surgical center, which meets such health,
16 safety, and other standards as the Secretary shall by regula-
17 tions prescribe, if such surgical center agrees to accept, in
18 full payment of all services furnished by it in connection with
19 such procedure, the amount established for such procedure
20 pursuant to paragraph (2).

21 "(2) [illegible] Secretary shall establish with respect to each
22 surgical procedure specified pursuant to subsection (a)(2), a
23 reimbursement amount which is payable to an ambulatory
24 surgical center for its services furnished in connection with
25 such procedure. The amount established for any such surgical

1 procedure shall be established with a view to according rec-
2 ognition to the costs incurred by such centers generally in
3 providing the services involved in connection with such pro-
4 cedure, and to assuring that the performance of such proce-
5 dure in such a center involves less cost than would be in-
6 volved if such procedure were performed on an inpatient
7 basis in a hospital. The amount so established with respect to
8 any surgical procedure shall periodically be reviewed and re-
9 vised and may be adjusted by the Secretary, when appropri-
10 ate, to take account of varying conditions in different areas.
11 "(3) If the physician, performing a surgical procedure
12 (specified by the Secretary under subsection (a)(2)), in a hos-
13 pital on an outpatient basis or in an ambulatory surgical
14 center with respect to which payment is authorized under the
15 preceding provisions of this subsection, or a physician per-
16 forming physicians' services in such center or hospital
17 directly related to such surgical procedure, agrees to accept
18 as full payment for all services performed by him in connec-
19 tion with such procedure (including pre- and postoperative
20 services) an amount equal to 100 percent of the reasonable
21 charge for such services, he shall be paid under this part for
22 such services an amount equal to 100 percent of the reason-
23 able charge for such services.
24 "(d)(1) The Secretary is authorized by regulations to
25 provide that in case a surgical procedure specified by the

1 Secretary pursuant to subsection (a)(2) is performed on an
2 individual insured for benefits under this part in an ambula-
3 tory surgical center which meets such health, safety, and
4 other standards as the Secretary shall by regulations pre-
5 scribe, there shall be paid with respect to the services fur-
6 nished by such center and with respect to all related services
7 (including physicians' services, laboratory, X-ray, and diag-
8 nostic services) a single all-inclusive fee established pursuant
9 to paragraph (2), if all parties furnishing all such services
10 agree to accept such fee (to be divided among the parties
11 involved in such manner as they shall have previously agreed
12 upon) as full payment for the services furnished.

13 "(2) In implementing this subsection, the Secretary
14 shall establish with respect to each surgical procedure speci-
15 fied pursuant to subsection (a)(2) the amount of the all-inclu-
16 sive fee for such procedure, taking into account such factors
17 as may be appropriate. The amount so established with re-
18 spect to any surgical procedure shall periodically be reviewed
19 and revised and may be adjusted, when appropriate, to take
20 account of varying conditions in different areas.

21 "(e)(1) The Secretary shall, in consultation with the Na-
22 tional Professional Standards Review Council and appropri-
23 ate medical organizations, specify those preoperative medical
24 and other health services which can be safely and appropri-

1 ately performed in a hospital on both an inpatient and outpa-
2 tient basis.

3 "(2) If a physician, performing a preoperative service
4 (specified by the Secretary under paragraph (1)) in a hospital
5 on an outpatient basis, within seven days prior to admission
6 on an inpatient basis for the surgery to which such service
7 relates, agrees to accept as full payment for such service an
8 amount equal to 100 percent of the reasonable charge for
9 such service, he shall be paid under this part for such service
10 an amount equal to 100 percent of the reasonable charge for
11 such service.

12 "(f) The provisions of sections 1833 (a) and (b) shall not
13 be applicable to expenses attributable to services to which
14 subsection (b) is applicable, to ambulatory facility services
15 (furnished by an ambulatory surgical center) to which the
16 provisions of subsections (c) (1) and (2) are applicable, or to
17 services to which the provisions of subsection (c)(3), (d), or (e)
18 are applicable.".

19 CRITERIA FOR DETERMINING REASONABLE CHARGE FOR
20 PHYSICIANS' SERVICES

21 SEC. 658. (a) Section 1842(b) of the Social Security Act
22 is amended—

23 (1) by redesignating paragraphs (4) and (5) as
24 paragraphs (5) and (6);

1 (2) by striking out so much of paragraph (3) as
2 follows the first sentence; and
3 (3) by inserting after paragraph (3) the following
4 new paragraph:
5 "(4)(A) In determining the reasonable charge for serv-
6 ices for purposes of paragraph (3) (including the services of
7 any hospital-associated physicians), there shall be taken into
8 consideration the customary charges for similar services gen-
9 erally made by the physician or other person furnishing such
10 services, as well as the prevailing charges in the locality for
11 similar services.
12 "(B)(i) Except as otherwise provided in clause (iii), no
13 charge may be determined to be reasonable in the case of
14 bills submitted or requests for payment made under this part
15 after December 31, 1970, if it exceeds the higher of (I) the
16 prevailing charge recognized by the carrier and found accept-
17 able by the Secretary for similar services in the same locality
18 in administering this part on December 31, 1970, or (II) the
19 prevailing charge level that, on the basis of statistical data
20 and methodology acceptable to the Secretary, would cover
21 75 percent of the customary charges made for similar serv-
22 ices in the same locality during the last preceding calendar
23 year elapsing prior to the start of the fiscal year in which the
24 bill is submitted or the request for payment is made.

1 "(ii) In the case of physician services, the prevailing
2 charge level determined for purposes of clause (i)(II) for any
3 fiscal year beginning after June 30, 1973, may not (except as
4 otherwise provided in clause (iii)) exceed (in the aggregate)
5 the level determined under such clause for the fiscal year
6 ending June 30, 1973, except to the extent that the Secre-
7 tary finds, on the basis of appropriate economic index data,
8 that such higher level is justified by economic changes. More-
9 over, for any twelve-month period beginning on July 1 of any
10 year (beginning with 1980), no prevailing charge level for
11 physicians' services shall be increased to the extent that it
12 would exceed by more than one-third the statewide prevail-
13 ing charge level (as determined under subparagraph (E)) for
14 that service.

15 "(iii) Notwithstanding the provisions of clauses (i) and
16 (ii) of this subparagraph, the prevailing charge level in the
17 case of a physician service in a particular locality determined
18 pursuant to such clauses for the fiscal year beginning July 1,
19 1975, shall, if lower than the prevailing charge level for the
20 fiscal year ending June 30, 1975, in the case of a similar
21 physician service in the same locality by reason of the appli-
22 cation of economic index data, be raised to such prevailing
23 charge level for the fiscal year ending June 30, 1975.

24 "(C) In the case of medical services, supplies, and
25 equipment (including equipment servicing) that, in the judg-

1 ment of the Secretary, do not generally vary significantly in
2 quality from one supplier to another, the charges incurred
3 after December 31, 1972, determined to be reasonable may
4 not exceed the lowest charge levels at which such services,
5 supplies, and equipment are widely and consistently available
6 in a locality except to the extent and under circumstances
7 specified by the Secretary. With respect to power-operated
8 wheelchairs for which payment may be made in accordance
9 with section 1861(s)(6), charges determined to be reasonable
10 may not exceed the lowest charge at which power-operated
11 wheelchairs are available in the locality.

12 "(D) The requirement in paragraph (3)(B) that a bill be
13 submitted or request for payment be made by the close of the
14 following calendar year shall not apply if (i) failure to submit
15 the bill or request the payment by the close of such year is
16 due to the error or misrepresentation of an officer, employee,
17 fiscal intermediary, carrier, or agent of the Department of
18 Health and Human Services performing functions under this
19 title and acting within the scope of his or its authority,
20 and (ii) the bill is submitted or the payment is requested
21 promptly after such error or misrepresentation is eliminated
22 or corrected.

23 "(E) The Secretary shall determine separate statewide
24 prevailing charge levels for each State that, on the basis of
25 statistical data and methodology acceptable to the Secretary,

1 would cover 50 percent of the customary charges made for
2 similar services in the State during the last preceding calen-
3 dar year elapsing prior to the start of the fiscal year in which
4 the bill is submitted or the request for payment is made. In
5 States with more than one carrier, the statewide prevailing
6 charge level shall be the weighted average of the fiftieth per-
7 centiles of the customary charges of each carrier.

8 "(F) Notwithstanding any other provision of this para-
9 graph, any charge for any particular service or procedure
10 performed by a doctor of medicine or osteopathy shall be re-
11 garded as a reasonable charge if—

12 "(i) the service or procedure is performed in an
13 area which the Secretary has designated as a physician
14 shortage area,

15 "(ii) the physician has a regular practice in the
16 physician shortage area,

17 "(iii) the charge does not exceed the prevailing
18 charge level as determined under subparagraph (B),
19 and

20 "(iv) the charge does not exceed the amount gen-
21 erally charged by such physician for similar services.".

22 (b) Sections 506(f)(1) and 1903(i)(1) of the Social Secu-
23 rity Act are each amended by striking out "the fourth and
24 fifth sentences of section 1842(b)(3)" and inserting in lieu

1 thereof in each instance "subparagraphs (B)(ii), (B)(iii), (C),
2 and (F) of section 1842(b)(4)".
3 (c) The amendments made by this section shall become
4 effective on July 1, 1980.

5 PROCEDURES FOR DETERMINING REASONABLE COST AND
6 REASONABLE CHARGE

7 SEC. 659. (a) Part A of title XI of the Social Security
8 Act is amended by adding after section 1133 the following
9 new section:

10 "EXCLUSION OF CERTAIN ITEMS IN DETERMINING
11 REASONABLE COST AND REASONABLE CHARGE

12 "SEC. 1134. (a) Except as otherwise provided in sub-
13 section (b), in determining the amount of any payment under
14 title XVIII, under a program established under title V, or
15 under a State plan approved under title XIX of this Act,
16 when the payment is based upon the reasonable cost or rea-
17 sonable charge, no element comprising any part of the cost or
18 charge shall be considered to be reasonable if, and to the
19 extent that, such element is—
20 "(1) a commission, finder's fee, or for a similar ar-
21 rangement, or
22 "(2) an amount payable for any facility (or part or
23 activity thereof) under any rental or lease arrangement,
24 which is, directly or indirectly, determined, wholly or in part
25 as a percentage, fraction, or portion of the charge or cost

1 attributed to any health service (other than the element) or
2 any health service including, but not limited to, the element.
3 "(b)(1) The Secretary shall by regulations establish ex-
4 ceptions to the provisions of subsection (a) with respect to
5 any element of cost or charge which consists of payments
6 based on a percentage arrangement, if such element is other-
7 wise reasonable and the percentage arrangement—
8 "(A) is a customary commercial business practice,
9 or
10 "(B) provides incentives for the efficient and eco-
11 nomical operation of the health service.
12 "(2) The provisions of subsection (a) shall not be appli-
13 cable to compensation payable to a physician under a per-
14 centage arrangement (including an arrangement that relates
15 to compensation for supervisory, executive, educational, or
16 research activity) between a physician and a hospital if the
17 physician shows (to the satisfaction of the Secretary) that
18 compensation under such arrangement does not exceed, on
19 an annual basis, an amount which would reasonably have
20 been paid to the physician under a relative value schedule
21 which takes into consideration such physician's time and
22 effort, consistent with the inherent complexity of the proce-
23 dures and services.".
24 (b) Section 506 of such Act is amended by adding at the
25 end thereof the following new subsection:

1 "(h) For additional exclusions from reasonable cost and
2 reasonable charge see section 1134.".
3 (c) Section 1842(b)(4) of such Act (as amended by sec-
4 tion 158 of this Act) is further amended by adding at the end
5 thereof the following new subparagraph:
6 "(G) For additional exclusions from reasonable cost and
7 reasonable charge see section 1134.".
8 (d) Section 1861(v) of such Act is amended by adding
9 after paragraph (8) (as added by section 151 of this Act) the
10 following new paragraph:
11 "(9) For additional exclusions from reasonable cost and
12 reasonable charge see section 1134.".
13 (e) Section 1903 of such Act is amended by adding at
14 the end thereof the following new subsection:
15 "(r) For additional exclusions from reasonable cost and
16 reasonable charge see section 1134.".
17 (f) The Secretary of Health and Human Services shall
18 conduct a study of the hospital-based physician compensation
19 and the impact of alternative reimbursement methods on pro-
20 viders, patients, physicians, and third party payors, and shall
21 submit to the Congress a full and complete report thereon,
22 together with recommendations for such legislation as he
23 deems appropriate, within two years after the date of the
24 enactment of this Act.

1 (g) The amendments made by this section shall become
2 effective on October 1, 1980, except that a percentage ar-
3 rangement entered into prior to January 1, 1980, shall be
4 recognized for reimbursement purposes under the Social Se-
5 curity Act, subject to the same tests of reasonableness as
6 were prescribed by such Act or regulations thereunder on
7 January 1, 1980, until such time as the facility is able to
8 unilaterally terminate such arrangement, or until December
9 31, 1981, whichever is earlier.

10 LIMITATION ON REASONABLE COST AND REASONABLE
11 CHARGE FOR OUTPATIENT SERVICES

12 SEC. 660. (a) Section 1134 of the Social Security Act
13 (as added by section 659 of this Act) is amended by adding at
14 the end thereof the following new subsection:
15 "(c) The Secretary shall issue regulations that provide
16 for the establishment of limitations on the amount of any
17 costs or charges that shall be considered reasonable with re-
18 spect to services provided on an outpatient basis by hospitals,
19 community health centers, or clinics (other than rural health
20 clinics), which are reimbursed on a cost basis or on the basis
21 of cost related charges, and by physicians utilizing such out-
22 patient facilities. Such limitations shall be based upon the
23 reasonableness of such costs or charges in relation to the
24 reasonable charges of physicians in the same area for similar
25 services provided in their offices.".

1 (b) Section 1128(c) of the Social Security Act (as added
2 by sections 661 and 655 of this Act) is amended by adding at
3 the end thereof the following new paragraph:
4 "(5) The Commission shall give immediate priority to
5 making a study and submitting recommendations to the Sec-
6 retary with respect to the setting of limitations on reasonable
7 costs and reasonable charges for outpatient services as pro-
8 vided in section 1134(c).".
9 MEDICARE LIABILITY WHERE PAYMENT CAN BE MADE
10 UNDER LIABILITY INSURANCE
11 SEC. 661. (a) Section 1862(b) of the Social Security Act
12 is amended—
13 (1) by inserting before the period at the end of the
14 first sentence the following: ", or under liability insur-
15 ance of the person at fault, or under no-fault liability
16 insurance";
17 (2) by inserting before the period at the end of the
18 last sentence ", or under such liability insurance"; and
19 (3) by adding at the end thereof the following new
20 sentence: "The Secretary may waive the provisions of
21 this subscction with respect to liability insurance if he
22 determines that the probability of recovery or amount
23 involved does not warrant the pursuing of the claim.".

1 ACCESS TO AND PURCHASE OF MEDICAID SERVICES

2 SEC. 662. (a) Section 1902(a)(23) of the Social Security
3 Act is amended to read as follows:
4 "(23) provide that limitations or restrictions
5 elected by a State with respect to choice by recipients
6 of medical assistance provided for by the State—
7 "(A) may apply only to institutional pro-
8 viders (including clinics), laboratory services, and
9 medical devices;
10 "(B) must be cost-effective arrangements
11 which provide for reasonable payment based upon
12 comparisons of costs at which services of proper
13 quality may be obtained and are actually available
14 (and for this purpose the plan may provide that
15 such arrangements need not be in effect in all po-
16 litical subdivisions of the State notwithstanding
17 the provisions of paragraph (1)), and must provide
18 that in the case of inpatient hospital services, pay-
19 ment to a hospital shall not be deemed to be rea-
20 sonable for purposes of paragraph (13)(D) if it is
21 less than the cost that is found reasonable and
22 necessary in the efficient and economical delivery
23 of such needed services in the geographic area in
24 which such hospital is located;

1 have reasonable access to services (taking into
2 account geographic location and reasonable travel
3 time) for which they are eligible (including emergen-
4 cy services and provisions for timely referral and
5 transfer to other providers when medically appropri-
6 ate) through providers which meet all applicable
7 standards under the State plan and whose services
8 are available to such recipients; and
9 "(D) must provide that, subject to the provisions
10 of subparagraph (B) there will not be a resulting
11 substantially adverse effect on the access of recipi-
12 ents to qualified hospitals having graduate medical
13 education programs that undertake to provide such
14 care;".
15 (b) Section 1902(a) of such Act (as amended by section
16 653 of this Act) is amended—
17 (1) by striking out "and" at the end of paragraph
18 (41);
19 (2) by striking out the period at the end of para-
20 graph (42) and inserting "; and"; and
21 (3) by adding after paragraph (42) the following
22 new paragraph:
23 "(43) provide that any laboratory services (other
24 than such services provided in a physician's office) paid
25 for under such plan must be provided by a laboratory
26 which meets the requirements of section 1861(e)(9) and

1 paragraphs (10) and (11) of section 1861(s), or, in the
2 case of a rural health clinic, section 1861(aa)(2)(G).".
3 (c)(1) The amendments made by subsection (b) shall
4 (except as otherwise provided in paragraph (2)) apply to
5 medical assistance provided, under a State plan approved
6 under title XIX of the Social Security Act, on or after the
7 first day of the first calendar quarter that begins more than
8 30 days after the date of enactment of this Act.
9 (2) In the case of a State plan for medical assistance
10 under title XIX of the Social Security Act which the Secre-
11 tary determines requires State legislation in order for the
12 plan to meet the additional requirements imposed by the
13 amendments made by subsection (b), the State plan shall not
14 be regarded as failing to comply with the requirements of
15 such title solely on the basis of its failure to meet these addi-
16 tional requirements before the first day of the first calendar
17 quarter beginning after the close of the first regular session of
18 the State legislature that begins after the date of enactment
19 of this Act.
20 (3) The amendment made by subsection (a) shall become
21 effective on the date of the enactment of this Act.
22 SUSPENSION OF PERIODIC INTERIM PAYMENT METHOD OF
23 REIMBURSEMENT
24 SEC. 663. Effective September 1, 1981, the Secretary
25 of Health and Human Services shall withhold payments to

1 hospitals under title XVIII of the Social Security Act under
2 the periodic interim payment method of reimbursement to the
3 extent necessary to provide that the lag time between the
4 date services are rendered and the date of payment under
5 such method of reimbursement is equal to the lag time in
6 such payments under this title to hospitals not being reim-
7 bursed under such method.

8 WITHHOLDING OF DISPUTED PAYMENTS

9 SEC. 664. Section 1903(d) of the Social Security Act is
10 amended by adding at the end thereof the following new
11 paragraph:

12 "(5)(A) In any case in which the Secretary esti-
13 mates that there has been an overpayment to a State
14 on the basis of a claim by such State that has been
15 disallowed by the Secretary, and such State disputes
16 such disallowance, the amount of the Federal payment
17 in controversy shall not be paid to such State until
18 such time as a final determination has been made with
19 respect to such amount. If such final determination is
20 to the effect that an amount is owed to such State,
21 such amount shall be increased by an amount equal to
22 the amount which would have been paid on the amount
23 otherwise owed, at the rates of interest on obligations
24 issued for purchase by the Federal Hospital Insurance
25 Trust Fund, during the period beginning on the date

1 that the State disputed such disallowance and ending
2 on the date that payment is made to the State.".

3 REIMBURSEMENT RATES UNDER MEDICAID FOR SKILLED
4 NURSING AND INTERMEDIATE CARE FACILITIES

5 SEC. 665. (a) Section 1902(a)(13)(E) of the Social Se-
6 curity Act is amended to read as follows:
7 "(E) for payment of the skilled nursing facility
8 and intermediate care facility services provided under
9 the plan through the use of rates, determined in ac-
10 cordance with methods and standards developed by the
11 State, which the State finds, and make assurances sat-
12 isfactory to the Secretary, are reasonable and adequate
13 to meet the costs which must be incurred by efficiently
14 and economically operated facilities in order to provide
15 care and services in conformity with applicable State
16 and Federal laws, regulations, and quality and safety
17 standards; and such State makes further assurances,
18 satisfactory to the Secretary, for the filing of uniform
19 cost reports; and".
20 (b) The amendment made by subsection (a) shall
21 become effective on October 1, 1980.

22 HOME HEALTH AGENCY REIMBURSEMENT LIMITS

23 SEC. 666. (a) Section 1861(v)(1) of the Social Security
24 Act is amended by adding after subparagraph (G) (as added
25 by section 654 of this Act) the following new subparagraph:

1 "(H)(i) Such regulations shall provide that the cost per visit
2 for each of the different types of visits a home health agency
3 provides shall not be considered to be reasonable to the extent
4 that it exceeds an amount that would cover 75 percent of the
5 average per visit costs for such visits (weighted on the basis of
6 the number of visits rendered) incurred by home health agencies
7 which are determined to be comparable by the Secretary.
8 "(ii) Such regulations shall require that in the case of
9 visits by a skilled nurse or home health aide, the costs
10 incurred by a health agency for such visits shall not be con-
11 sidered reasonable to the extent that the cost of any such
12 visit exceeds the per diem rate paid, in the State where such
13 agency is located, under the State's plan approved under title
14 XIX of this Act for skilled nursing facility services in the
15 area. In making such determination, in the case of a hospital-
16 based home health agency, the comparison shall be made to
17 the per diem rate for hospital-based skilled nursing facilities,
18 and in the case of other home health agencies the comparison
19 shall be made to the per diem rate for nonhospital-based
20 skilled nursing facilities. In the case of a State which does
21 not have a plan approved under title XIX, the per diem rate
22 for skilled nursing facilities under this title shall be used in
23 lieu of the per diem rate under such a State plan.

1 "(iii) Any supervisory visit which is specifically required
2 by regulati- shall be reimbursable as a home health aide
3 visit (but shall not count as a visit for purposes of deter-
4 mining a particular beneficiary's eligibility for visits). Any
5 initial patient assessment visit shall be a reimbursable visit
6 notwithstanding a determination of ineligibility following
7 such visit, if there was a reasonable basis for assuming poten-
8 tial eligibility, such as a referral from a discharge planner,
9 physician, or other source qualified as being knowledgeable
10 with respect to the beneficiary and the program under this
11 title.
12 "(iv) Such regulations may provide for appropriate ex-
13 ceptions and adjustments on an agency-by-agency basis
14 where warranted by unusual circumstances.".
15 (b) The amendment made by this section shall become
16 effective on October 1, 1980.
17 DETERMINATION OF REASONABLE CHARGE
18 SEC. 667. (a) Section 1842(b)(4)(B)(i) of the Social Se-
19 curity Act (as added by section 658 of this Act) is amended
20 by striking out "fiscal year in which the bill is submitted or
21 the request for payment is made" and inserting in lieu thereof
22 "fiscal year in which the service is rendered".
23 (b) Section 1842(b)(4)(E) of such Act (as added by sec-
24 tion 658 of this Act) is amended by striking out "fiscal year

1 in which the bill is submitted or the request for payment is
2 made" and inserting in lieu thereof "fiscal year in which the
3 service is rendered".

4 (c) Section 1842(b)(3) of such Act is amended by strik-
5 ing out "and" at the end of subparagraph (D), by adding
6 "and" at the end of subparagraph (E), and by inserting after
7 subparagraph (E) the following new subparagraph:

8 "(F) will take such action as may be necessary to
9 assure that where payment under this part for a serv-
10 ice rendered in a particular month is on a charge basis,
11 such payment shall be determined on the basis of the
12 charge that is determined to be reasonable for such
13 month in accordance with this part (except that in the
14 case of a service which was rendered prior to the be-
15 ginning of the calendar year preceding the year in
16 which the bill is submitted, or request for payment is
17 made, with respect to such service, payment shall be
18 determined on the basis of the charge that is deter-
19 mined to be reasonable in accordance with this part for
20 the first month of such preceding year;".

21 (d) The amendments made by this section shall become
22 effective on October 1, 1980.

23 (e) In any case in which the Secretary of Health and
24 Human Services is required to issue regulations on or before

1 a specified date by reason of any amendment made by this
2 part, the Secretary shall (and is authorized to) waive or
3 modify any requirement of section 553 of title 5, United
4 States Code, to the extent necessary (as determined by the
5 Secretary) in order to issue such regulations in a timely
6 manner.

7 PART G—TRANSFER OF FUNDS

8 SEC. 671. The Secretary of the Treasury shall delay
9 transfer, until on or after October 1, 1981, of $600,000,000
10 which would otherwise be transferred during September
11 1981 from the general fund in the Treasury into the Federal
12 Old-Age and Survivors Insurance Trust Fund, the Federal
13 Disability Insurance Trust Fund, or the Federal Hospital In-
14 surance Trust Fund. In delaying such transfer the Secretary
15 shall insure that the funds are withheld from any or all of
16 such trust funds in such amounts so as not to adversely affect
17 the ability of the Secretary of Health and Human Services to
18 make payments out of such trust funds as required under the
19 Social Security Act. The Secretary shall, at the time of such
20 transfer, also transfer to the appropriate trust funds an
21 amount equal to the amount of interest which he estimates
22 would have accrued to such trust funds if the transfer had not
23 been delayed as provided by this section.

APPENDIX B

Congressional Budget Office Estimates of Budgetary Impact of Finance Committee Amendments

(Note.—The totals in the CBO estimates do not reflect the savings from already-enacted legislation (H.R. 3434 and H.R. 3236). These amounts are included in the committee estimates as shown in the table in Chapter IV of this report. The committee estimates are otherwise consistent with those of CBO.)

CONGRESSIONAL BUDGET OFFICE
U.S. CONGRESS
WASHINGTON, D.C. 20515

Alice M. Rivlin
Director

June 24, 1980

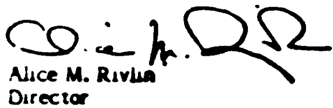
The Honorable Russell B. Long
Chairman
Committee on Finance
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

Pursuant to Section 202 of the Congressional Budget Act of 1974, the Congressional Budget Office has prepared the attached cost estimate for Title VI, Senate Resolution on Budget Reconciliation.

Should the Committee so desire, we would be pleased to provide further details on the attached cost estimate.

Sincerely,



Alice M. Rivlin
Director

64-262 O - 80 - 14

CONGRESSIONAL BUDGET OFFICE

COST ESTIMATE

June 24, 1980

1. BILL TITLE: Title VI, Senate Resolution on Budget Reconciliation

2. BILL STATUS:

   As transmitted by the Senate Committee on Finance to the Senate Committee on the Budget, June 25, 1980.

3. BILL PURPOSE:

   To bring the expenditures authorized by the Senate Committee on Finance within the target for that Committee established by the First Concurrent Resolution on the Budget for fiscal year 1981.

4. COST ESTIMATE:

   (by fiscal years, in millions of dollars)

	1980	1981	1982	1983	1984	1985
Budget Authority	-39	-839	279	-359	-387	-372
Outlays	-39	-2,172	-1,398	-1,851	-2,329	-2,791

   The savings resulting from this bill fall within budget functions 550 and 600.

5. BASIS OF ESTIMATE:

   Since much of the final language of the bill was not available at the time this estimate was prepared, the attached section-by-section cost analysis is based on CBO's understanding of the provisions of the bill from press releases and conversations with Committee staff.

6. ESTIMATE COMPARISON: None.

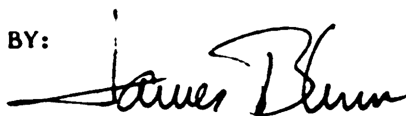
7. PREVIOUS CBO ESTIMATE:

   Where applicable, previous CBO estimates are discussed by section under "Basis of Estimate."

8. ESTIMATE PREPARED BY:

   Human Resources Cost Estimates Unit, Charles Seagrave, Chief (225-7766)

9. ESTIMATE APPROVED BY:



James L. Blum
Assistant Director
for Budget Analysis

Sec. 601: Elimination of National Trigger

COST ESTIMATE:

	(by fiscal years, in millions of dollars)				
	1981	1982	1983	1984	1985
Estimated Outlays	0	-300	0	0	0

BASIS OF ESTIMATE:

Under current CBO economic assumptions, the unemployment rate is expected to trigger a national extended benefit program during one quarter of fiscal year 1982. Elimination of this national trigger is estimated to save $300 million in fiscal year 1982. CBO is in the process of revising its economic assumptions. It is likely that a revised set of economic assumptions will show savings from this provision in 1981.

PREVIOUS CBO ESTIMATE:

An estimate of the savings from this provision was included in CBO's December 10, 1979 estimate of H.R. 4612, as ordered reported by the Senate Finance Committee. The previous estimate has been updated for economic assumptions.

Sec. 602: Waiting Period for Benefits

COST ESTIMATE:

	(by fiscal years, in millions of dollars)				
	1981	1982	1983	1984	1985
Estimated Outlays	-25	-27	-30	-32	-33

BASIS OF ESTIMATE:

Currently, 12 states do not require unemployed individuals to wait one week before receiving unemployment insurance benefits. Another 9 states require a one week waiting period, but pay for that week retroactively after a certain period of unemployment. This provision would eliminate federal matching for the first week of extended benefits in states with no waiting period. The estimate assumes that 10 percent of the states that either have no waiting period or pay retroactively, would institute a one week waiting period or eliminate retroactive payments as a result of this provision.

PREVIOUS CBO ESTIMATE:

An estimate of the savings from this provision was included in CBO's December 10, 1979 estimate of H.R. 4612, as ordered reported by the Senate Finance Committee. The previous estimate has been updated for economic assumptions.

Sec. 603: Optional State Trigger

	(by fiscal years, in millions of dollars)				
	1981	1982	1983	1984	1985
Estimated Outlays	-30	-30	-30	-30	-30

BASIS OF ESTIMATE:

Under current law, states are required to participate in the extended benefit program (1) when the national trigger is "on" because the national insured unemployment rate is 4.5 percent or higher or (2) when the state insured unemployment rate is both at least 4 percent and 20 percent above the comparable state insured unemployment rate for the last two years. States which are not required to participate under the above criterion may participate, if the insured unemployment rate is at least 5 percent. This bill would permit states to select a higher unemployment rate to initiate the extended benefit program. It is not known how many states would change the 5 percent trigger rate or what new trigger rate they would select. The estimate assumes that 25 percent of the states that currently use the 5 percent rule will adopt a 6 percent trigger point.

PREVIOUS CBO ESTIMATE:

An estimate of the savings from this provision was included in CBO's December 10, 1979 estimate of H.R. 4612, as ordered reported by the Senate Finance Committee. The previous estimate has been updated for economic assumptions.

Sec. 604: Unemployment Benefits for Ex-Servicemen

COST ESTIMATE:

	(by fiscal years, in millions of dollars)				
	1981	1982	1983	1984	1985
Required Budget Authority	-43	-47	-51	-55	-57
Estimated Outlays	-43	-47	-51	-55	-57

BASIS OF ESTIMATE:

Under current law, unemployment insurance benefits are payable to ex-servicemen who have served at least 90 days. This bill would extend the minimum period of service to one year. The cost estimate is based on Department of Defense data on the length of service of enlistees from 1975 to 1977.

PREVIOUS CBO ESTIMATE:

An estimate of the savings from this provision was included in CBO's December 10, 1979 estimate of H.R. 4612, as ordered reported by the Senate Finance Committee. The previous estimate has been updated to reflect new data on average benefits and lengths of receipt for this population.

Sec. 605: Unemployment Benefits for Federal Employees

COST ESTIMATE:

	(by fiscal years, in millions of dollars)				
	1981	1982	1983	1984	1985
Required Budget Authority	-11	-12	-13	-14	-15
Estimated Outlays	-11	-12	-13	-14	-15

BASIS OF ESTIMATE:

Under current law, unemployed former federal employees receive unemployment insurance payments financed from a general appropriation. This provision would require each agency to reimburse claims for former employees out of the agency appropriation. The provision is expected to save 5 percent of total benefit payments to former federal employees in the outyears.

PREVIOUS CBO ESTIMATE:

An estimate of the savings from this provision was included in CBO's December 10, 1979 estimate of H.R. 4612, as ordered reported by the Senate Finance Committee. The previous estimate has been updated for economic assumptions.

Sec. 606: Limitation on Extended Benefits for Nonresidents

COST ESTIMATE:

	(by fiscal years, in millions of dollars)				
	1981	1982	1983	1984	1985
Estimated Outlays	-46	-30	-28	-19	-15

BASIS OF ESTIMATE:

For extended unemployment benefit recipients moving to a state where no extended benefit program currently exists, only two weeks of extended benefit payments could be made. Based on Department of Labor data on the number of extended benefit claimants applying for benefits outside of their original state, CBO estimates a fiscal year 1981 savings of 2 percent of extended benefit payments.

Sec. 607(A): Extended Benefits Not Payable on the Basis of Less Than 20 Weeks of Unemployment

COST ESTIMATE:

(by fiscal years, in millions of dollars)

	1981	1982	1983	1984	1985
Estimated Outlays	-120	-180	-90	-35	-20

BASIS OF ESTIMATE:

Eighteen states and the District of Columbia do not make extended benefit payments to persons with less than 20 weeks of employment. In the remaining states, Department of Labor data shows a saving of between 5 and 10 percent. This estimate assumes a savings of 7½ percent of extended benefit payments in the remaining states. The savings are reduced in 1983 through 1985 due to an improved economic forecast.

Sec. 607(B): Extended Benefit Not Payable to Persons Who Leave Jobs Voluntarily or for Misconduct

COST ESTIMATE:

(by fiscal years, in millions of dollars)

	1981	1982	1983	1984	1985
Estimated Outlays	-32	-49	-24	-10	-6

BASIS OF ESTIMATE:

The 1981 estimate was provided by the Department of Labor. The outyear estimates assume the savings are a constant ratio of total estimated extended benefit payments.

Sec. 607(C): Extended Benefits Not Payable to Persons Refusing Any Reasonable Job Offer

COST ESTIMATE:

	(by fiscal years, in millions of dollars)				
	1981	1982	1983	1984	1985
Estimated Outlays	-94	-145	-72	-29	-16

BASIS OF ESTIMATE:

An SRI study of the job requirement in the now expired federal supplemental benefits program found a savings of approximately 4 percent from requiring acceptance of any job which meets minimum standards of acceptability. This estimate assumes a 4 percent savings from total extended benefit payments.

Sec. 611: Limit Supplemental Security Income (SSI) Eligibility for Individuals who Dispose of Resources

COST ESTIMATE:

	(by fiscal years, in millions of dollars)				
	1981	1982	1983	1984	1985
Required Budget Authority	-15	-31	-40	-49	-55
Estimated Outlays	-15	-31	-40	-49	-55

BASIS OF ESTIMATE:

Under current law, the disposal or transfer of a resource prior to the filing of an SSI application does not preclude program eligibility, eventhough the individual would be ineligible if he retained the resource. This provision would delay SSI eligibility in the case of applicants who dispose of resources for less than current market value, if retaining such resources would make them ineligible for benefits. The cost estimate is based on Social Security Administration data on the proportion of all new program applicants who dispose of assets. The estimate includes medicaid savings.

PREVIOUS CBO ESTIMATE:

An estimate of the savings from this provision was contained in CBO's September 20, 1979 cost estimate of H.R. 4904. The savings estimate has been modified to reflect a different implementation date.

Sec. 621: Federal Day Care Regulations

COST ESTIMATE:

	(by fiscal years, in millions of dollars)				
	1981	1982	1983	1984	1985
Required Budget Authority	-20	0	0	0	0
Estimated Outlays	-20	0	0	0	0

BASIS OF ESTIMATE:

The Department of Health and Human Services has issued final regulations for day care provided under state social services plans (Title XX), to be effective September 19, 1980. Some states have expressed concern about the cost of implementing the new standards, indicating that they believe that their enforcement would result in reducing the available supply of care, particularly for low income families, the primary recipients of HHS-funded care. To the extent that AFDC families are denied day care services at these facilities as a result of the new regulations, they would be eligible for additional AFDC monies to purchase day care elsewhere. This provision would postpone the implementation of the new standards one year until October 1, 1981, thereby postponing the increased AFDC costs, as well.

CBO estimates that in fiscal year 1981, without the new regulations, $100 million in federal expenditures will go to pay for day care costs incurred by AFDC parents who work. This might be expected to rise about $20 million when AFDC parents purchase child care services outside of Title XX funded institutions. Postponing the implementation date of the regulations would, thus, save the $20 million.

Sec. 631: Public Assistance Payments to Territorial Jurisdictions

COST ESTIMATE:

	(by fiscal years, in millions of dollars)					
	1980	1981	1982	1983	1984	1985
Budget Authority	-39	-26	0	0	0	0
Outlays	-39	-26	0	0	0	0

BASIS OF ESTIMATE:

H.R. 3434, as recently enacted, raised the federal payments to the trust territories (Puerto Rico, Guam and the Virgin Islands) from $26 million to $78 million. This provision would cut payment level to $39 million in fiscal year 1980 (saving $39 million) and $52 million in fiscal year 1981 (saving $26 million).

Sec. 641: Reallocation of OASDI Taxes Between OASI and DI Trust Funds

COST ESTIMATE:

No cost.

Sec. 642: Three Month Limit on Retroactive Benefits

COST ESTIMATE:

(by fiscal years, in millions of dollars)

	1981	1982	1983	1984	1985
Budget Authority	5	20	40	62	86
Outlays	-150	-250	-260	-270	-280

BASIS OF ESTIMATE:

Cutting the retroactive period during which OASI and DI beneficiaries can receive benefits from 12 to 3 months will save approximately $150 million in fiscal year 1981. We accept the actuaries estimates at this time, although it is possible that people's behavior patterns will result in their more prompt application for benefits, and thus the savings might be slightly lower. Available evidence, however, does not indicate that this faster application for benefits has occurred in the past when similar provisions went into effect.

Sec. 643: Cut Social Security Benefits for Prisioners

COST ESTIMATE:

(by fiscal years, in millions of dollars)

	1981	1982	1983	1984	1985
Budget Authority	1	2	3	5	7
Outlays	-16	-17	-19	-21	-24

BASIS OF ESTIMATE:

This provision will withhold benefit payments for all disabled and student prisoners, and their dependents.

A GAO study of federal benefits received by prison inmates shows that there are approximately 3,750 prisoners in receipt of Social Security benefits. Assuming an average 1981 benefit of $4,400 (including dependents), there will be $16 million in savings for fiscal year 1981.

Sec. 651: Hospital Routine Cost Limits

COST ESTIMATE:

(by fiscal years, in millions of dollars)

	1981	1982	1983	1984	1985
Hospital Routine Cost Limits					
Estimated Outlays	-70	130	40	-290	-530
Budget Authority	-10	10	-20	-60	-60
Payments for State Programs					
Estimated Outlays	*	4	6	7	9
Budget Authority	*	1	1	1	1

*Less than $500,000.

BASIS OF ESTIMATE:

The estimate is derived from two CBO microsimulation models using medicare cost reports of 5,800 hospitals. The cost reports, the most recent available as of July 18, 1978, were updated using actual and projected aggregate increases in patient days and routine costs. Because section 651 would replace the regulations promulgated under section 223 of the 1972 Social Security Amendments, it was necessary to simulate both programs in order to determine the net effect of section 651.

Over the next five years the limits on routine hospital costs would reduce federal medicare and medicaid outlays by approximately $720 million, assuming the limits are effective July 1, 1980, as stated in the bill. The penalities, net of section 223 savings 1/, would save about $1,420 million over five years; whereas, bonus payments would cost about $700 million (see Table 1).

Although the limits under section 651 appear to be similar to those in effect under section 223, the section 651 limits are more restrictive for several reasons. First, the section 651 limits for any one year are based on data that are two to three years old. The data would be updated by an index of the prices hospitals pay for the goods and services used in providing the care covered by the bill, called a hospital "market basket", rather than by projected costs. Because actual cost increases usually exceed the increases in the market basket due to growth in the intensity of services, the use of the market basket index in updating the data would result in lower limits than if an index of routine costs were used. The section 223 regulations, on

1/ Estimates of section 223 savings include estimates of the impact of revised regulations included in President's Fiscal Year 1981 Budget.

TABLE 1. COMPONENTS OF IMPACT OF ROUTINE COST LIMITS ON FEDERAL MEDICARE AND MEDICAID OUTLAYS, FISCAL YEARS 1981-1985: IN MILLIONS OF DOLLARS

	1981 a/	1982	1983	1984	1985	1981 1985
Gross Impact of Limits	-340	-350 b/	-520 b/	-1,030	-1,340	-3,580
Effect of Eliminating Section 223 c/	270	370	440	510	570	2,160
Net Impact of Limits	-70	20	-80	-520	-770	-1,420
Bonus Payments	--	110	120	230	240	700
Total Costs	-70	130	40	-290	-530	-720

a/ The new reimbursement system would be phased in during fiscal year 1981, beginning with hospital accounting years starting July 1, 1980.

b/ Figures include excess penalities returned to hospitals at final settlement.

c/ Figures include estimates of impact of revised regulations included in President's Fiscal Year 1981 Budget.

the other hand, are based on more recent data that is updated to some extent by an index of total routine costs, not only market basket increases. As a result, the section 651 limits would be more restrictive than the section 223 limits. Furthermore, the section 651 limits become much more restrictive over time.

The unusual pattern of savings and costs over the 1981 to 1985 period results from assumptions about the administration of the bill by HHS. Based on discussions with staff of the Health Care Financing Administration, CBO made the following assumptions:

(1) Although the bill would reduce penalities by one-half during the first two years, full penalities would be deducted from interim payments for all years. The extra one-half of penalities assessed during the first two years would be returned to hospitals at final settlement. This procedure would be necessary since one would not know the amount of one-half of the penalities until the year was completed.

(2) Bonuses would be paid at the time of final settlement, or about six months after the end of the hospitals' accounting years.

These assumptions maximize the cash savings in fiscal year 1981. All the savings would show up during the hospital's first fiscal year under the new controls, while the costs (bonuses plus one-half of penalities for first two years) would not show up until the hospital's next fiscal year.

Section 651 would also establish a Health Facilities Cost Commission that could recommend to the Secretary of HHS expansion of the controls to cover all (routine, special care, and ancillary) costs. No savings are attributed to this particular provision.

Finally, this section would provide funds totaling approximately $26 million for the administrative costs of state hospital cost commissions. The commissions would be reimbursed by the federal government for a portion of their administrative costs equal to the proportion that medicare and medicaid hospital expenditures represent of all hospital expenditures covered by the state commissions.

Further details on the estimate of this section are available on request.

PREVIOUS CBO ESTIMATE:

In October, 1979, CBO estimated that the same provisions contained in H.R. 934, Section 202, would increase federal outlays by $450 million. The primary reason for the substantial change in the estimate was the development of the simulation model that greatly improved CBO's ability to analyze the impact of the provisions. In particular, the model indicated that the provision of the bill that allows hospitals with below average lengths-of-stay per patient to have different limits does not reduce the savings by as much as previously estimated. In addition, CBO now assumes that the penalities would be deducted from interim payments, rather than assessed at final settlement as was assumed in the last estimate. This assumption shifts estimated savings forward by one year.

Sec. 652: Closure/Conversion of Underutilized Facilities

COST ESTIMATE:

(by fiscal years, in millions of dollars)

	1981	1982	1983	1984	1985
Budget Authority	0	-2	-2	-4	-6
Outlays - Medicare	-2	-7	-19	-36	-58
Outlays - Medicaid	0	-2	-4	-8	-14
Total Outlays	-2	-9	-23	-44	-72

BASIS OF ESTIMATE:

The estimate assumes that the conversion of acute care facilities to lesser levels of care will be the predominant activity resulting from the provision. In fiscal years 1981 and 1982, 49 hospitals are assumed to receive payments, and 50 hospitals in each fiscal year thereafter. Only hospitals with less than 400 beds are assumed to undertake conversion projects. Fifteen beds out of an average of 120 beds per hospital are assumed to be converted since this would raise the acute care occupancy rate from an average of 65 percent to 74 percent. The conversion cost is assumed to be $30,000 per bed in fiscal year 1981 dollars, amortized over 20 years. Savings are generated by recouping one-half the cost of an occupied acute care bed, offset by the costs for the long-term care patients that would fill the converted beds.

PREVIOUS CBO ESTIMATE:

This estimate is identical to that provided to the Committee on October 25, 1979 for section 205 of H.R. 934, except that it has been extended to fiscal year 1985. Since the assumed enactment date for this estimate is later than for the earlier estimate, it is implicitly assumed that the conversion program will become operational more quickly than was previously assumed.

Sec. 653: Coordinated Audits

COST ESTIMATE:

(by fiscal years, in millions of dollars)

	1981	1982	1983	1984	1985
Required Budget Authority	-4	-5	-6	-6	-7
Estimated Outlays	-4	-5	-6	-6	-7

BASIS OF ESTIMATE:

This provision would require that audits of providers performed for the purposes of medicaid or of Title V programs be coordinated with medicare audits whenever a provider participates in medicare and in one or both of the other programs. Federal reimbursements for state expenditures for medicaid or for maternal and child health programs would be reduced for any state not conducting common audits. The amount paid to the state would be reduced to the amount that would have been paid for auditing expenses had the state conducted common audits.

Eliminating duplicative audits should reduce administrative costs for providers, states, and the federal government. A rough estimate of potential federal savings is derived in the following manner.

HCFA estimates that medicare audits will cost about $63 million in fiscal year 1980. This figure includes the costs of coordinated medicaid audits in the more than 30 states that already perform such audits. A comparable HCFA estimate of the costs of medicaid audits is unavailable because states do not routinely report such costs. Assuming that audit costs per participating provider are identical for medicare and medicaid, however, CBO estimates that, in the absence of any coordinated audits, medicaid audits would cost about $47 million in fiscal year 1980. The 16 states and territories that were not performing common audits on June 30, 1977 accounted for about 25 percent of total medicaid administrative expenditures that year. Thus, medicaid audit costs for those states that would be affected by Section 21 are estimated to be about $12 million in fiscal year 1980 and $13 million in fiscal year 1981. The federal share of these expenditures is $7 million. Assuming arbitrarily that 80 percent of this amount would be saved through coordinated audits, over $5 million would be saved by the federal government during fiscal year 1981. Because the provision is assumed to be effective for just three-quarters of the year, however, the estimated savings shown have been reduced to $4 million. Savings in future years are assumed to increase according to CBO's projections of the Consumer Price Index.

PREVIOUS CBO ESTIMATE:

This estimate is consistent with earlier CBO estimates of similar provisions included in H.R. 4000 as reported by the House Committee on Interstate and Foreign Commerce (estimate dated March 28, 1980). This estimate is considerably lower than CBO's estimate of the provision included in H.R. 934 as reported by the Senate Committee on Finance (estimate dated October 25, 1979). The reestimate is based on more complete information regarding current audit costs than was previously available.

Sec. 654: Apportionment of Provider Costs

COST ESTIMATE:

(by fiscal years, in millions of dollars)

	1981	1982	1983	1984	1985
Budget Authority	3	1/	1/	1/	1/
Outlays-Medicare	-75	1/	1/	1/	1/

1/ Estimate not available.

BASIS OF ESTIMATE:

This proposal is a modification of Section 210 of H.R. 934 as ordered reported on June 28, 1979. In effect, the 8.5 percent nursing differential would be retained during the first half of fiscal year 1981 and suspended during the second half, pending the results of a GAO study. The Office of Financial and Actuarial Analysis of the Health Care Financing Administration has estimated that complete elimination of the nursing differential would save $191 million in fiscal year 1981. CBO has verified this estimate and has adjusted it to account for the proposal being effective only during the latter half of fiscal year 1981. An estimate for subsequent fiscal years is not possible until the results of the GAO study are known.

PREVIOUS CBO ESTIMATE:

See "Basis of Estimate" section above.

Sec. 655: Inappropriate Hospital Services

COST ESTIMATE:

(by fiscal years, in millions of dollars)

	1981	1982	1983	1984	1985
Medicare					
Estimated Outlays	-118	-179	-204	-231	-263
Medicaid					
Required Budget Authority	-33	-51	-58	-66	-76
Estimated Outlays	-33	-51	-58	-66	-76

BASIS OF ESTIMATE:

The provision would restrict medicare and medicaid reimbursements for inpatient hospital services furnished to beneficiaries who do not require hospital care but who are hospitalized because necessary long-term care services are unavailable. Reimbursement would be limited to the average skilled nursing facility, intermediate care facility, or detoxification facility payment rate, as appropriate.

Currently, under medicare, inpatient hospital care provided only because necessary long-term care services are unavailable is reimbursed at normal medicare rates for inpatient hospital services. Consequently, the provision would reduce medicare payments for such care. Under medicaid, most states follow current medicare practices regarding such care, but some already limit reimbursement to skilled nursing or intermediate care facility rates, and still others do not pay for such care at all. Thus, for medicaid, the effect of the provision would be reduced somewhat.

One study of medicare and medicaid hospital patients indicates that approximately 3 percent of medicare and medicaid hospital days (about four million days) are provided only because required long-term care services are unavailable. Based on the results of the study, CBO estimates that 20 percent of these medically unnecessary hospital days would escape PSRO review altogether (because of the periodic nature of that review). CBO assumes that 90 percent of reviewed days would be reimbursed at the special rate. On the basis of current payment data, fiscal year 1980 savings of $80 are estimated for each day reimbursed at the lower rate. Thus, gross first-year savings (federal and state) would be about $230 million. Exemption of hospitals in areas not having excess hospital beds is estimated to reduce gross savings by about 10 percent to $207 million.

The assumed six-month delay in implementation would cut estimated net savings in fiscal year 1981 to $177 million. Two-thirds of this amount ($118 million) is estimated to accrue to medicare. Of the medicaid portion, about $33 million would be federal savings. Savings in subsequent years grow according to CBO's projections of increases in total annual hospital days and in savings per day.

PREVIOUS CBO ESTIMATE:

This estimate is consistent with earlier CBO estimates of similar provisions included in H.R. 4000, as reported by the House Committee on Ways and Means (estimate dated November 20, 1979), and as reported by the House Committee on Interstate and Foreign Commerce (estimate dated March 28, 1980). This estimate is considerably higher than CBO's estimate of the provision included in H.R. 934, as reported by the Senate Committee on Finance (estimate dated October 25, 1979). The reestimate is based on additional information about unnecessary hospital days and the PSRO review process.

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Sec. 656: PSRO Review of Hospital Admissions, Routine Tests, and Preoperative Stays

(by fiscal years, in millions of dollars)

	1981	1982	1983	1984	1985
Budget Authority	-1	-6	-5	-1	4
Outlays-Medicare	-23	-55	-72	-85	-99
Medicare	-2	-10	-14	-17	-20

Savings from eliminating unnecessary routine tests are estimated on the assumption that a battery of six tests costing about $70 would be involved per admission. It is estimated on the basis of HI discharge data that 65 percent of HI admissions are for non-surgical procedures. Based on a study by Blue Cross, it is assumed that, in 75 percent of these admissions, the affected tests are done routinely. It is further assumed that 10 percent of these tests would be eliminated by the increased priority placed by the provision on the review by PSROs of their necessity. The foregoing assumptions yield, through a multiplicative relationship, first-year savings in HI of outlays of $38 million in fiscal year 1981. These are assumed to be reduced in half in fiscal year 1981 due to delays in implementation. Outyear savings are projected to increase by both the rate of growth in medicare hospital admissions (5 percent per year) and by CBO's latest projections in the rate of growth in the medical care services component of the Consumer Price Index.

On the basis of findings by a CBO study of PSROs, it is assumed that 2 percent of medicare preop days for elective procedures could be eliminated by PSRO efforts in this area. At an assumed $148 in routine costs per day, first year savings would be $22 million. The savings are partially offset by $5 million for administative costs. Due to delays in implementation, first-year savings are assumed to be reduced by two-thirds. Out-year savings are projected to increase by both the rate of growth in HI surgical admissions (7 percent per year) and by CBO's latest projections of the rate of increase in hospital expense per day.

Medicaid savings are assumed to be 20 percent of total medicare savings, based on the relative shares of total hospital expenditures financed by these two programs. Out-year savings are projected to grow at the same rate as total medicaid outlays.

PREVIOUS CBO ESTIMATE:

The estimate is similar to the one of section 213 of H.R. 934 with some minor changes in assumptions.

Sec. 657: Ambulatory Surgery

COST ESTIMATE:

(by fiscal years, in millions of dollars)

	1981	1982	1983	1984	1985
Budget Authority	--	1	2	4	6
Outlays - Medicare	-5	-15	-20	-25	-25

BASIS OF ESTIMATE:

The parts of this proposal which provide for reimbursement for surgery done on an ambulatory basis will result in both savings and costs to the medicare program. Savings are generated by the lower cost of minor surgery done in an ambulatory rather than an inpatient setting. Costs are generated by the likely increase in the number of minor operations done because of the greater convenience to patients of an ambulatory setting. The estimate of costs is based on a three-year study of the costs and quality of surgery performed in different settings which was done by the Orkand Corporation for DHHS. This study showed that the total costs of minor surgery done in an ambulatory setting is about 25 percent less than that performed in an inpatient setting. CBO assumes that minor operations cost 60 percent of the average cost for all surgical procedures financed by medicare. It is further assumed that 0.5 percent of all medicare-financed operations will be done in an ambulatory setting in fiscal year 1981 and that this figure will increase to 4 percent in fiscal year 1985. These assumptions, combined with a 25 percent savings rate per operation and CBO's projections of the growth in HI outlays, produce an estimated savings to the medicare program of $8 million in fiscal year 1981. The savings rise to $122 million in fiscal year 1984. CBO expects these savings to be reduced slightly by HI's share in the costs produced by an assumed 40 percent refilling of the empty hospital beds created by the shift of minor operations out of hospitals. The savings are further offset by the costs of the additional demand for minor operations. These are estimated under the assumption that the number of medicare-financed operations that can be performed on an ambulatory basis will increase by one percent in fiscal year 1981, increasing to 10 percent in fiscal year 1984. The proposal also provides incentives for presurgical diagnostic tests to be done on an outpatient basis seven days prior to admission for a surgical procedure. The bulk of the savings resulting from this provision would be achieved by the similar provision in Section 656.

PREVIOUS CBO ESTIMATE:

This estimate is essentially the same as that for section 234 of H.R. 934. There are some slight differences in the assumptions underlying the estimate of savings from ambulatory surgery. In addition, necessary modifications have been made for a shift in the assumed enactment date.

Sec. 658: Criteria for determining Reasonable Charge for Physicians' Services

(by fiscal years, in millions of dollars)

	1981	1982	1983	1984	1985
Budget Authority	1	2	4	6	8
Outlays-Medicare	-15	-20	-25	-25	-25

BASIS OF ESTIMATE:

The cost estimates included here were developed by the Office of Financial and Actuarial Analysis of DHHS. The provision affects physicians' fees in two ways. First, it limits the difference between local prevailing fees and the statewide median fee for a procedure to one-third of the latter. The savings estimate is generated by a computer simulation of the effect of the limitation using data on 1976 medicare prevailing charges for the 50 most commonly performed physician services. The second effect of the provision is to raise the allowable prevailing charge from the 50th to the 75th percentile for new and established physicians practicing in designated physician-shortage areas. The estimate is derived from data on prevailing charges and the number of physicians practicing in physician-shortage areas.

PREVIOUS CBO ESTIMATE:

This is identical to the estimate shown for section 235 of H.R. 934, except for a change in the enactment date.

Sec. 659: Procedures for Determining Reasonable Cost and Charge

COST ESTIMATE:

	(by fiscal years, in millions of dollars)				
	1981	1982	1983	1984	1985
Budget Authority	-3	-7	-5	-1	3
Outlays - Medicare	-21	-59	-76	-96	-117
Outlays - Medicaid	-4	-11	-15	-18	-23

BASIS OF ESTIMATE:

This section provides that payments to contractors, subcontractors, employees, or consultants that are based upon percentage arrangements not be recognized for purposes of reimbursement by medicare. Savings are estimated separately for limitations on percentage reimbursement arrangements for hospital-based physicians (HBPs) and for limitations on percentage-based contracts for business services. Savings in medicare reimbursements to HBPs were estimated by assuming that payments would be reduced by the difference between what HBPs are paid on a percentage basis and what they would be paid as salaried employees. It is estimated on the basis of data from the American Medical Association, Health Care Financing Administration (HCFA), and a recent study of HBPs done by the Arthur Andersen Company for HCFA, which indicate that approximately 1,000 radiologists and 1,600 pathologists would be affected by this provision. The Andersen study also provided data for 1975 on the difference in income between percentage-basis and salaried physicians in hospitals. This difference was adjusted for the overhead expenses assumed to be generated by the salaried physicians and inflated to account for the growth in total hospital expenditures and physicians' incomes from 1975 to 1981. It was further assumed that only half of the apparent savings would be realized because of various adjustments likely to occur in the arrangements between the affected physicians and their hospitals. Half-year savings are assumed for fiscal year 1981 and full-year savings thereafter. Savings in medicare reimbursement for business services are assumed not to occur until fiscal year 1982 due to the complexity of the regulations that would have to be written. About 2 percent of hospitals' total expenses are for business services. CBO assumes that the average amount of overcharge resulting from percentage arrangements is 2 percent. One half of this amount is assumed to be saved in medicare reimbursements to hospitals during fiscal year 1982, 75 percent in fiscal year 1983, and 100 percent in succeeding fiscal years. Medicaid savings in all years are estimated to bear about the same relationship to medicare savings as medicaid hospital expenditures do to medicare hospital expenditures.

PREVIOUS CBO ESTIMATE:

This estimate is the same as that done for section 252 of H.R. 934, in the area of HBP reimbursement. The estimate for business services was done previously and, thus, represents additional savings.

Sec. 660: Outpatient Services Charge Limit

(by fiscal years, in millions of dollars)

	1981	1982	1983	1984	1985
Budget Authority	-2	0	1	2	5
Outlays-Medicare	-20	-23	-27	-31	-36
Medicaid	-3	-3	-4	-5	-5

BASIS OF ESTIMATE:

The estimate is based on the assumption that all charges for outpatient visits that exceed by 80 percent charges for similar procedures performed in a physician's office would be reduced to the average charge per physician visit. About five percent of SMI outpatient charges are estimated to be reduced by 25 percent as a result of this provision. The first-year savings to SMI are about 1.3 percent of total SMI outpatient expenditures. Federal medicaid savings are estimated to bear the same relationship to SMI savings as total federal medicaid outpatient expenditures do to SMI outpatient expenditures. Outyear savings are expected to increase at the same rate as total SMI and medicaid expenditures.

PREVIOUS CBO ESTIMATE:

This estimate is similar in most respects to the estimate of section 249 of H.R. 934. In that estimate, the reduction in excessive charges was assumed to be 50 percent, whereas in this estimate that has been changed to 25 percent. Adjustments have also been made for changes in the assumed enactment date.

Sec. 661: Medicare Liability in Accident Cases

COST ESTIMATE:

(by fiscal years, in millions of dollars)

	1981	1982	1983	1984	1985
Budget Authority	1	2	7	16	28
Outlays-Medicare	-14	-32	-75	-135	-156

BASIS OF ESTIMATE:

Medicare hospital discharge data show that 10 percent of all HI discharges are for diagnoses involving accidents of all types. Similar data from the National Ambulatory Medical Care Survey show that about 5 percent of all physician office visits by persons aged 65 or older are for accident-related conditions. It is assumed, therefore, that 10 percent of HI outlays and 5 percent of SMI outlays are for injuries resulting from accidents. Data from the Health Interview Survey show that about 50 percent of accidents occurring in the 65 and older population at home, about 10 percent are related to automobile accidents, and 30 percent are due to all other causes. Accidents occurring at home are unlikely to involve situations where liability insurance claims can be made. Similarly, accidents occurring in the workplace are likely to be covered by workers' compensation. It is assumed, therefore, that recoveries from liability insurance policies would be possible for all accidents except those occurring in the home or at work. The proportion of total medicare outlays spent for medical services related to each type of accident is assumed to be the same as the proportion each represents of all accidents. For automobile accidents, it is assumed for both HI and SMI that 95 percent of the accidents involving medicare beneficiaries occur where insurance coverage is present and that 50 percent of these have the potential for recovery of medical insurance payments. For all other accidents, it is similarly assumed that 25 percent occur in circumstances in which liability insurance is present and that 50 percent of these have the potential for recoveries. For both types of accidents, it is further assumed that the actual volume of recoveries will be 5 percent of the potential level in fiscal year 1981, 10 percent in fiscal year 1982, and 20 percent in fiscal year 1983, and thereafter.

PREVIOUS CBO ESTIMATE:

This estimate is similar to the earlier one of section 255 of H.R. 934, although some assumptions have changed. It is now assumed that 50, rather than 80 percent of automobile accidents involving medicare beneficiaries have the potential for recovery of medical insurance payments. Similarly, it is assumed for all other accidents that 25, rather than 60, percent occur where liability insurance is present, and that 50, rather than 80, percent have the potential for recoveries. For both types of accidents the volume of recoveries in the affected fiscal years is assumed to be 5, 10, 20, 20, and 20 percent respectively rather than 15, 20, 25, 25, and 25 percent.

Sec. 662: Access to and Purchase of Medicaid Services

COST ESTIMATE:

(by fiscal years, in millions of dollars)

	1981	1982	1983	1984	1985
Budget Authority	-91	-227	-273	-314	-363
Outlays	-91	-227	-273	-314	-363

BASIS OF ESTIMATE:

CBO has tried to assess the possible impact of this provision through discussions with officials of state medicaid agencies. We have assumed that states responsible for one-half of medicaid spending will restrict choice of provider in 1981, with the proportion growing to two-thirds by 1985. First-year savings are assumed to be reduced by one-half because of implementation delays. We have further assumed that choice of provider will be restricted only in metropolitan areas and that restriction will not be effective in nursing hom because of capacity constraints. Within metropolitan area hospitals in states restricting choice, we assume a savings of 8 percent of expenditures.

The estimate of savings under competitive bidding arrangements for clinical laboratory services amd medical devices is based on studies done in New York, New Jersey, and California. We assume a savings rate of 20 percent. First-year savings are assumed to be halved due to delays in implementation.

PREVIOUS CBO ESTIMATE:

The part of the section on payment for clinical laboratories was previously estimated by CBO for section 258 of H.R. 934. Fiscal year 1981 savings have been reduced to reflect delays in passage of the legislation.

Sec. 663: Medicare Hospital Reimbursement; Periodic Interim Payments (PIP)

COST ESTIMATE:

	(by fiscal years, in millions of dollars)				
	1981	1982	1983	1984	1985
Budget Authority	2	—	—	—	—
Outlays - Medicare	-675	682	—	—	—

BASIS OF ESTIMATE:

This section mandates that the Secretary of HHS modify the Hospital Insurance (HI) periodic interim payment (PIP) system during September 1981 in such a manner that hospitals on PIP experience a three-week interruption in reimbursements. The effect would be similar to eliminating the PIP system entirely, which would presumably result in a three-week interruption in the flow of nearly one-half of all HI reimbursements. Conceivably, the providers of PIP could build up their cash positions with respect to HI by shortening the period under regular billing procedures between hospital discharge and receipt of payment. On the basis of discussions with knowledgable individuals within HCFA and the hospital industry, it appears that this could occur only to a very limited extent. CBO therefore assumes that only a two-day gain could occur in the billing cycle. The affected providers' cash shortfall could be met by increased payments under the PIP system prior to its discontinuance. This, of course, would substantially reduce the savings. CBO, therefore, assumes that neither increased payments under the PIP system nor any other special accelerated payments will be made prior to the end of fiscal year 1981. The interruption of payments to the affected hospitals is assumed to occur during September 1981. It is further assumed that the PIP system would be reestablished on October 1, 1981, and that accelerated payments equal to the cash shortfall experienced by the affected providers would be made during the first week of October. The accelerated payments would appear as an additional cost to the HI program in fiscal year 1982. There would be a small additional interest cost to the program resulting from the short-term borrowing that hospitals would have to undertake to meet the anticipated cash shortfall in September 1981.

PREVIOUS CBO ESTIMATE:

This estimate updates an informal estimate provided to the Committee on October 3, 1979, for a proposal to eliminate PIP in September 1980. The estimate has been adjusted for the change in effective date and for the fact that the change would occur at the end of the fiscal year. A further adjustment has been made to take into account the higher level of HI reimbursements at the end of the fiscal year as compared to the average level during the fiscal year.

Sec. 664: Disallowance of State Claims for Federal Medicaid Funds

COST ESTIMATE:

	(by fiscal years, in millions of dollars)				
	1981	1982	1983	1984	1985
Medicaid					
Required Budget Authority	0	0	0	0	0
Estimated Outlays	-147	-83	-16	-18	-20

BASIS OF ESTIMATE:

This provision is designed to expedite recovery of federal payments for certain disallowed medicaid claims. Under current policy, if a state appeals a disallowance, the amount disallowed by HHS is not recovered until the appeal has been resolved. The proposal would allow HHS to recover amounts disallowed immediately upon notice of disallowance, without regard to any pending appeal. The proposal would affect disallowances after September 30, 1980.

On the basis of information provided by HCFA, it is estimated that about $140 million in medicaid claims will be disallowed by HHS and appealed by the affected states in fiscal year 1981. That figure includes $25 million of such disallowances for which recovery is assumed to be delayed until fiscal year 1981 from the last quarter of fiscal year 1980 as a consequence of active consideration of this proposal by the Congress. Current experience and the large backlog of unresolved appeals suggest that, during the next several years, the typical appeal will take 18 months. Under current law, then, that $140 million would not begin to be recovered by HHS until the third quarter of fiscal year 1982. Under the proposal, however, that amount would be offset against federal medicaid outlays in fiscal year 1981. In terms of the federal budget, therefore, the proposal would directly reduce federal medicaid outlays in fiscal year 1981 and in the first half of fiscal year 1982 and would yield interest savings thereafter. The proposal would have no effect on required budget authority.

Estimate assumes effective date of October 1, 1980 medicaid only.

Sec. 665: Reimbursement Under Medicaid for Skilled Nursing and Intermediate Care Facilities

COST ESTIMATE:

	(by fiscal years, in millions of dollars)				
	1981	1982	1983	1984	1985
Budget Authority	-2	-2	-2	-2	-2
Outlays - Medicaid	-2	-2	-2	-2	-2

BASIS OF ESTIMATE

This proposal is identical to section 227 of H.R. 934, which would substitute new language for section 1902(a)(13)(E) of the Social Security Act relating to reimbursement of nursing homes under medicaid on a reasonable cost-related basis. The new wording would modify the Secretary's approval authority over state medicaid plans in order to give states more flexibility in setting nursing home reimbursement rates. Based on conversations with medicaid officials in several states, knowledgeable individuals within the nursing home industry, and HCFA officials, CBO has concluded that the new wording will result in some modest cost savings. Most states probably would not significantly alter their rate-setting methodologies in response to passage of this section. One state, Oklahoma, has informed CBO that it would change its rate-setting methods in order to realize $3 million in savings. Of this $3 million savings, the federal share would be $2 million. At this time, CBO cannot estimate more reliably the magnitude of the savings because of the uncertainty concerning state actions and concerning the outcome of court actions initiated by state nursing home associations in response to changes in rate-setting methodologies made by state medicaid agencies.

PREVIOUS CBO ESTIMATE:

In its original cost estimate of the budgetary impact of H.R. 934, CBO estimated that this proposal would have a negligible cost impact. That estimate was based on a draft of the bill dated August 23, 1979, that differed substantively from the language contained in the final printed version of H.R. 934 dated December 10, 1979. The new estimate corrects this discrepancy.

Sec. 666: Home Health Agency Reimbursement Limits

	(by fiscal years, in millions of dollars)				
	1981	1982	1983	1984	1985
Budget Authority	3	10	17	27	37
Outlays-Medicare	-73	-86	-99	-114	-131

BASIS OF ESTIMATE:

The average medicaid skilled nursing per diem rate in calendar year 1978 was estimated by CBO using data from the National Center for Health Statistics. This figure was supplied to analysts within the Bureau of Program Policy of the Health Care Financing Administration for use in a computer simulation of the impact of limiting home health aide and skilled nursing visit reimbursement to no more than medicaid per diem SNF rate in a state. The simulation also calculated the impact of changing application of the percentiles to a descending array of visits rather than providers and the impact of lowering the percentile to be applied from the 80th to the 75th. The resulting fiscal year 1981 savings estimate was extrapolated to the outyears by applying CBO's latest estimates of the growth rate of medicare home health care expenditures.

Sec. 667: Calculating Medicare Reasonable Charges

COST ESTIMATE:

	(by fiscal years, in millions of dollars)				
	1981	1982	1983	1984	1985
Budget Authority	6	21	41	62	84
Outlays	-147	-226	-231	-250	-279

BASIS OF ESTIMATE:

The estimates for all years were provided by the Office of Financial and Actuarial Analysis of DHHS. The estimate for fiscal year 1981 is composed of $173 million in savings offset by $26 million in implementation costs. The implementation costs are assumed to occur only in fiscal year 1981.

Sec. 671: Delay Transfer of Funds From the Treasury to Trust Funds

COST ESTIMATE:

(by fiscal years, in millions of dollars)

	1981	1982	1983	1984	1985
Budget Authority	-600	+600	--	--	--

BASIS OF ESTIMATE:

The effect of specifying a $600 million delay in transfers to the trust fund from the Treasury's general fund is to reduce budget authority by that amount in fiscal year 1981, and increase it by $600 million in 1982. (There could also be $.5 million in interest loss in 1981 and regained in 1982, depending on the amount of time this transfer is delayed.) It is assumed that the entire delay in the transfer from the Treasury occurs from only one trust fund, and that the fund will be either the OASI or DI fund.