

HCFA ADMINISTRATOR'S REPORT

Number 30

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TO ALL HCFA STAFF

On December 5, 1980, the President signed into law (Public Law 96-499), the "Omnibus Reconciliation Act of 1980." This is the most significant legislation enacted since 1972 which affects HCFA's programs; it contains over fifty provisions that impact upon Medicare, Medicaid, and PSROs.

Following is a summary of the health-related provisions of Public Law 96-499, which was prepared by the Office of Legislation and Congressional Affairs.



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Attachment

BENEFIT IMPROVEMENTS

Home Health Services (Section 930)

Provides for coverage under Medicare of unlimited home health visits; eliminates the 3-day prior-hospitalization requirement for home health services under part A; eliminates the \$60 deductible for home health services under part B; includes occupational therapy as qualifying criteria for home health benefits; and permits proprietary home health agencies to participate in States not having licensure laws.

Effective July 1, 1981

Preadmission Diagnostic Testing (Section 932)

Provides full reimbursement under Medicare for diagnostic services provided in a hospital's outpatient department and, to the extent practical (as determined by the Secretary), in a physician's office within 7 days prior to the patient's admission as an inpatient.

Effective on enactment

Outpatient Rehabilitation Facilities (Section 933)

Recognizes comprehensive outpatient rehabilitation facilities as Medicare "providers"; authorizes Medicare reimbursement for rehabilitation services provided in a certified outpatient rehabilitation facility.

Effective with accounting periods beginning July 1, 1981

Outpatient Physical Therapy (Section 935)

Increases annual limit from \$100 to \$500 for outpatient physical therapy services under Medicare.

Effective with expenses beginning calendar year 1982

Dental Services (Section 936)

Expands coverage under Medicare to include services provided by dentists which would be covered under current law when provided by a physician. Also covers hospital stays where they are warranted by the severity of the noncovered dental procedure.

Effective July 1, 1981

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BENEFIT IMPROVEMENTS

Optometrist Services (Section 937)

Provides Medicare coverage of optometrists for treatment of aphakia. Requires Secretary to submit legislative recommendations to Congress by January 1, 1982, for coverage of optometric services in connection with cataracts and other services authorized under licensure.

Effective July 1, 1981

Antigens (Section 938)

Covers antigens under Medicare prepared by one physician and forwarded to another for administering to the patient.

Effective January 1, 1981

Plantar Warts (Section 939)

Eliminates Medicare coverage exclusion of plantar warts.

Effective July 1, 1981

Enrollment in Part B of Medicare (Section 945)

Permits Medicare beneficiaries to enroll in part B at any time, with entitlement beginning on the third calendar month following the month of enrollment. Also provides for unlimited reenrollment in part B and in part A for those who purchase that protection.

Effective April 1, 1981

Buy-In Agreements (Section 945)

Provides that States which currently do not have part B buy-in agreements may enter into such agreements and permits States that now have buy-in agreements which cover only cash assistance recipients to cover other Medicaid eligibles.

Effective during calendar year 1981 only

Payment for Services Furnished to Deceased Beneficiaries (Section 954)

Provides that person with legal obligation to pay physician bill for deceased beneficiary may be reimbursed by Medicare, even for unassigned claims, prior to payment of the bill. The current system requires payment of the physician's bill before Medicare will reimburse for unassigned claims.

Effective with claims filed on or after January 1, 1981

BENEFIT IMPROVEMENTS

Payment Where Beneficiary Not At Fault (Section 956)

Requires the Secretary of HHS to make payment under the Medicare hospital insurance program for inpatient hospital or SNF services in those instances where a beneficiary requiring a higher level of care is erroneously placed in a part of the institution providing lower level of care.

Effective January 1, 1981

Nurse-Midwives (Section 965)

Mandates Medicaid coverage of services furnished by nurse-midwives which they are authorized to perform under State law.

Effective for calendar quarters beginning more than 120 days after enactment.

REIMBURSEMENT REFORM

State Cost-Containment Demonstrations (Section 903)

Authorizes Secretary of HHS to grant (or continue) Medicare waivers for State cost-control demonstrations until the State's reimbursement system is no longer applicable to all third-party payors or no longer meets the required tests of effectiveness in controlling costs. The Secretary is required to continue the Medicare reimbursement system in accord with these requirements for any State which has had a cost-containment demonstration project reimbursement system in continuous operation since July 1, 1977. No more than six statewide demonstration projects could be continued or implemented under this authority.

Effective on enactment

Coordinated Audits (Section 914)

Authorizes coordinated audits under Medicare, Medicaid, and the Maternal and Child Health programs. The Secretary also is directed to evaluate the feasibility of creating a single coordinated appeals process to adjudicate disputes arising under coordinated audits.

Effective under Medicaid for medical assistance provided on the first day of the calendar quarter beginning 30 days after enactment. Report to Congress required no later than December 31, 1981, on actions taken to implement this provision.

Reimbursement of Clinical Laboratories (Section 918)

Limits recognition of markup of bills from a physician, for services performed by an independent laboratory, to the lesser of the reasonable charge of the laboratory or the amount charged by the physician, plus a nominal fee for physician handling of the specimen. If the physician's bill does not identify who performed the test or give the amount charged, Medicare payment would be the lowest charge obtainable from a local laboratory. Any Medicaid payment for laboratory services billed for but not performed by a physician could not exceed the Medicare amount. Also, the Secretary would report to the Congress within 24 months on the effects of this provision.

Effective date: Medicare--no later than April 1, 1981; Medicaid--the first day of the calendar quarter which begins 6 months after enactment.

Outpatient Surgery (Section 934)

Provides for reimbursement for costs of certain surgical procedures (as determined by the Secretary) performed in ambulatory surgical centers and

REIMBURSEMENT REFORM

for certain procedures expenses associated with such surgery, including recognition of overhead in a physician's office. Such reimbursement would be made for surgery performed in a physician's office only if the physician is authorized to perform the procedures in a nearby hospital and if a PSRO has agreed to conduct review of the physician's performance of such procedures. Physicians would be paid 100 percent of reasonable charges if they accept assignment.

Effective on enactment

Payment to Providers of Services (Section 942)

Provides for Medicare reimbursement to providers under part B of Medicare on the basis of the reasonable cost of services minus the coinsurance amounts charged beneficiaries for outpatient services. The law inadvertently repeals the "lower of costs or charges" provision for providers under part B.

Effective on enactment

Hospital-Based Physician Reimbursement (Section 943)

Limits the special Medicare 100-percent reimbursement (with no deductible) for radiology and pathology services to physicians accepting assignment for all services furnished to hospital inpatients.

Effective for services provided after the sixth calendar month beginning after enactment.

Determination of Reasonable Charges (Section 946)

Provides that determination of Medicare reasonable charges for physician services will be based upon the date the medical service was rendered rather than the date on which the claim was processed.

Effective with bills submitted or requests for payment made on or after July 1, 1981

Secondary Liability of Medicare (Section 953)

Provides that Medicare would be the secondary payor in cases where care can be paid for under an automobile insurance plan or liability insurance, including self-insured plans. The Secretary may waive these provisions if he/she determines that the probability of recovery or the amount involved does not warrant pursuit of the claim. The Medicare program would ordinarily pay for the beneficiary's care in the usual manner and then seek reimbursement from the private insurance carrier after, and to the extent that, such carrier's liability under the private policy for the services has been determined.

Effective on enactment

REIMBURSEMENT REFORM

Temporary Delay in PIP (Section 959)

Provides for 3 weeks deferral of Periodic Interim Payments (PIP).

Effective last 3 weeks of September 1981

Expedited Recover of Disallowed Claims (Section 961)

Allows States to retain disallowed Medicaid expenditures until completion of the administrative appeals process, but requires States to offset these funds along with interest if the denial is upheld.

Effective for expenditures made on or after October 1, 1980, which are disallowed

ADMINISTRATIVE IMPROVEMENTS

Philanthropy (Section 901)

Enacts current Medicare policy regarding philanthropy into statute. This policy provides that the following items shall not be deducted from the operating costs of nonprofit hospitals in determining reimbursement amounts: 1) grants, gifts, or endowments and the income therefrom, which have not been designated by the donor for paying any specific operating costs; 2) governmental grants or similar payments, under the terms of which the grant or payment is not available for use as operating funds; and 3) the proceeds from the sale or mortgage of any real estate or other capital asset which the hospital acquired through gift or grant and which, under the terms of the gift or grant, are not available for use as operating funds (except for recovery of the appropriate share of depreciation when gains or losses are realized from the disposal of depreciable assets.)

Effective on enactment

Withholding of Medicaid Payments (Section 905)

Broadens Secretary's authority to withhold Federal matching funds under Medicaid to recover Medicare overpayments.

Effective on enactment

Quality Assurance Program for Clinical Laboratories (Section 911)

Extends Secretary's authority to conduct the proficiency testing program for clinical laboratory personnel (practical nurses, therapists, and certain other personnel) until December 31, 1981.

Reporting of Financial Interest (Section 912)

Amends title XI requirements concerning reporting of financial interest.

Effective on enactment

Exclusion of Health Care Professionals (Section 913)

Excludes from program participation all categories of health care professionals convicted of Medicare/Medicaid-related or title XX crimes.

Effective on enactment

ADMINISTRATIVE IMPROVEMENTS

Criminal Standards for Medicare/Medicaid-Related Crimes (Section 917)

Clarifies that criminal penalties apply only when conduct is "knowingly or willfully" undertaken.

Effective on enactment

Home Health Administration (Section 930)

Requires Secretary to take actions to achieve more effective administration of the Medicare home health benefit.

Effective on enactment

Bonding of Home Health Agencies (Section 930)

Requires Medicare home health agencies to meet additional requirements (including the establishment of bonding or escrow accounts) which the Secretary finds necessary to minimize financial risk, as a Medicare condition of participation.

Effective on enactment

Regional Intermediaries for Home Health Agencies (Section 930)

Requires Secretary to establish regional intermediaries for home health agencies.

Effective on enactment

Prohibition of Patient Certification by Physicians with Ownership Interest in Home Health Agencies (Section 930)

Prohibits physicians from certifying to the need for care or preparing the plan of care for patients of a home health agency in which the physician has an ownership interest or other financial connection.

Effective July 1, 1981

Payment for Home Health Agency Costs for Long-Term or Percentage-Based Contracts (Section 930)

Prohibits recognition of costs incurred by Medicare home health agencies which are for contracts exceeding 5 years, or for which payment is determined based on a percentage of the agency's billing.

Effective July 1, 1981

ADMINISTRATIVE IMPROVEMENTS

Training of Home Health Aides (Section 930)

Requires Medicare home health aides to have completed a training program approved by the Secretary.

Effective July 1, 1981

Repeal of Presumed Coverage Provisions (Section 941)

Repeals Medicare provisions authorizing, by type of diagnosis, presumed periods of coverage for skilled nursing facility and home health services.

Effective January 1, 1981

Plan of Treatment for Speech Pathology (Section 944)

Allows speech pathologists to establish the plan of treatment for outpatient speech pathology services under Medicare.

Effective January 1, 1981

Termination of Buy-In (Section 945)

Permits individual whose State buy-in coverage for part B of Medicare has ended to terminate coverage effective with the month HCFA is notified that such coverage is no longer wanted.

Effective third calendar month beginning after enactment

Payment to Teaching Hospitals (Section 948)

Repeals Section 227 of P.L. 92-603. Would permit reasonable charge reimbursement to physicians in teaching hospitals if the following specified conditions are met: the physician must exercise full personal control over the management of the patient's care; services are of the same character as those the physician furnishes to nonbeneficiaries; and at least 25 percent of hospital's non-Medicare patients must pay all or a substantial part of charges (including the Medicaid payments) for similar services rendered to them. Puts into statute current HCFA principles (Intermediary Letter 372) which provide that a physician must be the patient's attending physician if he is to be eligible for charge payments. Allows cost reimbursement to hospitals where all physicians elect it.

Effective with cost-accounting periods beginning January 1, 1981

ADMINISTRATIVE IMPROVEMENTS

Standards for Rural Hospitals (Section 949)

Authorizes Secretary to apply Medicare standards more flexibly to small rural hospitals (50 beds or less) where the health and safety of patients are not jeopardized. (Secretary could limit scope of services furnished by hospital.) Also extends Secretary's authority to waive the 24-hour nursing requirement for such hospitals.

Effective on enactment

Certification and Utilization Review by Podiatrists (Section 951)

Allows podiatrists, acting within the scope of their practice, to be recognized as physicians under Medicare for purposes of physician certification and utilization review requirements.

Effective January 1, 1981

Access to Books and Records of Subcontractors (Section 952)

Provides Medicare reimbursement to providers for services furnished under contracts (whose cost or value over 12 months is \$10,000 or more) to subcontractors unless the Secretary has access to books and records necessary to verify costs. The Secretary's request for access to books and records must be in writing, and the Secretary must specify in regulations the criteria and procedures for seeking and obtaining access to the relevant contracts, books, and records.

Effective for contracts entered into on or after the date of enactment

PRRB Jurisdiction (Section 955)

Requires Provider Reimbursement Review Board to determine within 30 days whether it has jurisdiction over an issue brought before it by a provider, and authorizes judicial review without further administrative review where the Board decides it lacks jurisdiction.

Effective on enactment

Technical ESRD Amendments (Section 957)

Authorizes Secretary to enter into agreements with approved nonprofit agencies which assist Medicare patients to dialyze at home.

Effective on enactment

ADMINISTRATIVE IMPROVEMENTS

ESRD Report (Section 957)

Changes reporting date for Renal Disease Annual Report to July 1.

Effective on enactment

Studies and Demonstrations (Section 958)

Requires studies on Medicare coverage for orthopedic shoes, respiratory therapy, second opinions for medical surgery, foot care, and home health services of dietitians; calls for demonstrations on coverage for clinical social workers and nutritional therapy for renal patients. Provides that, where relevant, any such study should include an evaluation of the effects of payment to independent practitioners on the coordination of care, cost, quality, organized settings, and utilization of services.

Effective on enactment

Funding for State Medicaid Fraud Control Units (Section 963)

Authorizes 90-percent Federal matching for establishing and operating State fraud control units for the initial 3-year period. After that period, Federal funding would be at the 75-percent level.

Effective on enactment

Utilization Control Penalties (Section 964)

Prohibits Secretary from assessing financial penalties against States for failure to conduct effective utilization review during periods prior to January 1979. (One State, Colorado, is affected.)

Demonstration Projects for Training AFDC Recipients (Section 966)

Requires Secretary to conduct demonstration projects in up to 12 States to train AFDC recipients as home health aides.

Effective on enactment

PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

PSRO Membership (Sections 921, 922, 923, 927)

Authorizes PSROs to offer membership to nonphysician health professionals who hold independent hospital admitting privileges (effective on enactment); provides that a registered nurse and dentist must be included in the advisory groups of each Statewide PSRO Council; expands membership of National Council to include a dentist, a registered nurse, and one other nonphysician health professional; eliminates requirement for formal advisory groups, and authorizes Secretary to establish more flexible guidelines to assure PSRO consultation with representatives of all health care disciplines.

Effective 180 days after enactment

Required Activities of PSRO (Section 924)

Permits a PSRO to become fully designated when it is satisfactorily reviewing hospital services; eliminates requirement that ambulatory care review be conducted within 2 years of receiving full designation. Requires Secretary to establish an evaluation program to determine the cost effectiveness of review of health care services in settings other than hospitals and alcohol detoxification facilities. Authorizes the Secretary to assign review responsibility to a PSRO other than the PSRO from the designated area.

Effective on enactment

Efficiency in Delegated Review by PSROs (Section 925)

Authorizes PSROs to delegate review functions to hospitals only if the hospital demonstrates capacity to carry out required reviews efficiently in addition to the current requirements that such reviews be carried out effectively and in timely fashion.

Effective on enactment

PSRO Review (Section 926)

Authorizes PSROs to focus preadmission review on elective hospital admissions and related services; authorizes Secretary to direct PSROs to conduct such reviews when they can be made on a timely and cost-effective basis.

Effective on enactment

PSROs

Response of PSROs to Freedom of Information Act (Section 928)

Provides that PSROs would not be required to release any records pursuant to a request under the Freedom of Information Act until the later of one year after a final court order for release, or the last day of the Congress during which the court order was entered.

Effective on enactment

Study of PSRO Norms (Section 929)

Requires Secretary, in consultation with National PSRO Council, to conduct a study of PSRO norms and criteria, including an assessment of the rationale for regional differences. Secretary shall report findings within one year of enactment.

Effective on enactment

LONG-TERM CARE FACILITIES

Differential Reimbursement (Section 902)

Authorizes reimbursement at the State Medicaid ICF or SNF rate where patient requiring lower level of care under Medicare and Medicaid is inappropriately placed in the hospital; reduced reimbursement does not apply for first 2 years where hospital's occupancy is over 80 percent.

Effective on date final regulations are issued (not later than first day of sixth month after month of enactment)

Swing Beds (Section 904)

Provides swing-bed reimbursement for small, rural hospitals which have been granted a certificate-of-need for provision of long-term care services. Provides swing-bed demonstration authority for larger hospitals.

Effective on date final regulations are issued (no later than first day of sixth month after month of enactment)

Life Safety Code (Section 915)

Authorizes Secretary to determine when SNFs would be required to meet provisions of revised editions of Life Safety Code. (Facilities meeting the 1973 or 1967 edition would be "grandfathered.")

Effective on enactment

Intermediate Sanctions for SNFs and ICFs (Section 916)

Authorizes Secretary to impose intermediate sanctions for SNFs or ICFs which are out of compliance with conditions of participation less severe than decertification; i.e., denial of reimbursement after a designated date to out-of-compliance SNFs until facility corrects deficiencies (if not corrected after one year, the Secretary may decertify the facility); authorizes Secretary to "look behind" State agency surveys on SNF and ICF compliance with conditions of participation in situations where the Secretary has cause to question the adequacy of the State's determination; allows States to impose intermediate sanctions, under Medicaid, upon SNFs and ICFs.

Effective on enactment

LONG-TERM CARE FACILITIES

Study of Dual Participation of SNFs (Section 919)

Requires Secretary to study the availability of SNFs under Medicare and Medicaid and the effect of requiring all SNFs which participate in Medicare to also participate in Medicaid (and vice-versa). Study and recommendations must be submitted to Congress within one year of enactment.

Alcohol Detoxification Facility Services (Section 931)

Provides for Medicare reimbursement of inpatient detoxification services (related to alcoholism) in free-standing facilities.

Effective April 1, 1981

Transfer From Hospital to SNF (Section 950)

Changes to Medicare requirement that patients be transferred from a hospital to a SNF from within 14 days of discharge to qualify for posthospital extended care benefits. New requirement is 30 days.

Effective on enactment

Medicaid Long-Term Care Reimbursement (Section 961)

Repeals the requirement that SNFs and ICFs under Medicaid be reimbursed on a reasonable cost-related basis. States can develop methods and standards on which rates of Medicaid reimbursement are based with the Secretary having 90 days to approve or disapprove. These rates must be reasonable and adequate to cover the costs of an efficiently operating facility. If not acted upon within 90 days, rates would take effect for the fiscal year for which they were proposed.

Effective October 1, 1980