1977-05-20

P/S/R/O update: May 20, 1977 no. 32

P/S/R/O Update

Boston University Medical Center

May 20/77
Number 32

The Medical Cost/Quality Newsletter

PSRO program's management described by House panel as big barrier to effectiveness

An oversight subcommittee of the House Ways and Means Committee has found, after two days of hearings on PSROs in April, that "generally, the PSRO program has enormous potential," but that the biggest impediment to its effectiveness so far is found in the management of the program.

LACK OF REGS HIT

Specifically, the brief report by Rep. Fortney H. Stark, Jr. (D-Cal.), who chaired the hearings, cites the lack of regulations as a cause of "confusion and apprehension" for PSRO personnel, who have had to learn DHEW policy through a transmittal system. He says transmittals "are characteristically vague, are often revised and are not legally binding."

Stark asserts that "regulations governing the program have been lethargically promulgated: seven out of 17 mandatory regulations have yet to be proposed."

Also, he points out there have been conflicts within DHEW in enunciating policy to PSRO, with at least three agencies disseminating conflicting policy statements to PSROs, he says.

One less familiar criticism leveled at DHEW by the subcommittee is that, "for those areas adamantly opposed to the PSRO concept,

(Continued on pg. 3)

INSIDE STORIES

Forthcoming BQA transmittal will make Medicare coverage a key to level-of-care action

Next month, PSROs should receive a set of final instructions on level-of-care determinations that will make it clear that the PSRO is responsible for knowing the guidelines Medicare uses to determine coverage of its beneficiaries. In practice, this means that in certain cases the PSRO's determination of medical necessity for continued stay will depend on a coverage rule.

MOST CONTROVERSIAL

These level-of-care instructions will come in the form of a final transmittal due to be sent out by the Bureau of Quality Assurance in June after more than a year in draft. The subject of level of care, according to BQA Director Michael J. Goran, M.D., has raised "more controversy than any other aspect of the program." He made the remark to the National PSR Council in March when that body was asked to--and did--approve the final draft of the level-of-care transmittal. (The transmittal concerns Medicare only; instructions for Medicaid level-of-care determinations have not been drafted.)

Much of the controversy stems from what PSROs see as a conflict in their mandate--on one hand to determine the level of care on the basis of medical necessity, and on the other to conform to Medicare coverage rules when making that determination. Most physicians feel that a medical decision about the best level of care for a patient ought to be made without having to consider whether Medicare pays for it.

(Continued on pg. 2)

PSRO Update, which covers the federally mandated Professional Standards Review Organization program and the broader field of medical cost and quality, is published monthly by Boston University Medical Center Address editorial inquiries to **PSRO Update,** 720 Harrison Avenue, Suite 300, Boston, MA 02118. Telephone (617) 247-5606. Address subscription inquiries to **PSRO Update,** 306 Dartmouth Street, Boston, MA 02116, Telephone (617) 267-7100. Executive Editor/Donald R. Giller. Managing Editor/Owen J. McNamara. News Editor/Barbara Mackey. Contributing Editors/Nancy Haslam, Lorraine Loviglio, John Blum. Correspondents throughout the nation. Staff assistants/Carol Bernbaum, Rose Razzino.

Forthcoming BQA transmittal will make Medicare coverage a key to level-of-care action

(Continued from pg. 1)

The issue focuses on this situation: Medicare covers care in skilled-nursing facilities but not in intermediate-care facilities. When no bed is available in an SNF, and the SNF has been determined to be the proper level for a patient, the PSRO may certify the patient's continued stay at the acute-care institution. If, however, the ICF is the correct level of placement for the patient and there is no bed available, the PSRO may not certify a continuation of stay.

The reasoning is that if the patient cannot be sent to a bed that Medicare pays for, Medicare would still pay for his continued hospitalization while he waits for the proper level bed. Likewise, if the patient is awaiting a bed for which Medicare does not pay, then Medicare will not pay for the patient's continued hospitalization.

3 SEPARATE ASPECTS

The transmittal, which was prepared by BQA in cooperation with the Bureau of Health Insurance, states that the three aspects of PSRO review--determining the medical necessity of care, the quality of services and the appropriateness of the level of care--should be viewed separately by the PSRO. Following this approach, the PSRO must keep Medicare coverage guidelines in mind and first, distinguish between medically necessary and medically unnecessary hospitalization, and second, look at the medically necessary care, distinguishing that which is covered from that which is not covered.

Some examples of a PSRO's not being permitted to certify a continued stay are given in the transmittal:

--A hospitalized senile patient with uncomplicated diabetes needs supervision to assure he's getting medication and eating properly. His attending physician orders an ICF but, there is no ICF bed for him. The PSRO is not permitted to certify the patient's continuation in the acute-care hospital.

--Delays in discharge of a patient are caused by paperwork inefficiencies or the patient's or his family's dissatisfaction with the available bed at the prescribed level. The PSRO cannot certify that patient's continued stay.

BHI's POINT OF VIEW

From the point of view of BHI, these are entirely reasonable determinations because Medicare, being a health insurance program, should not be expected to cover care that is not essentially health related; ICFs fall into that category of care. They provide simple nursing care and, perhaps, a variety of social services. A patient in an ICF has to be seen by a physician only once every three months. ICFs are usually staffed by licensed practical nurses instead of registered nurses. Much of the care provided to Medicare patients by an ICF is available to Medicare patients through home-health benefits.

The Bureau of Health Insurance sees ICFs primarily as serving financial needs rather than medical or health needs, and, as such, ICFs fall outside the scope of a health insurance program but into the area of welfare, which is covered by the Medicaid program. The argument is that it is the lack of financial resources that requires a patient to enter an ICF; people with the financial means would provide for themselves basic nursing and social services.

Further, if a Medicare beneficiary were to use up his limited number of paid hospital days in an ICF, he might incur a needless financial burden if he later needed acute-hospital care and had no benefit days left.

Thus, BHI tends to see the issue as one in which the PSROs, if they could get the policy changed to their liking, would be rewriting the benefit package to include care in an intermediate-care facility, care that is not primarily medical care.

GOVERNMENT'S 'SCAPEGOATS'

Physicians who run PSROs tend to see this as a bind which makes them scapegoats when the government applies its unpopular rules. "The PSRO becomes a villain," said Irving Burka, M.D., president of the National Capital Medical Foundation, "and the profession is left holding the bag." He is one of about half a dozen representatives from the American Association of PSROs that met several times with BQA and BHI on the issue. The final transmittal was still unacceptable to the group, Burka said.

But he pointed up one factor contributing to the problem, saying, "Most doctors don't know the difference between skilled-nursing facilities and intermediate-care facilities. Someone has to determine what intermediate care is; we know what's custodial, but we don't know what intermediate care is."

He expresses one of the problems facing physicians: They are being asked to deal

with new rules and administrative procedures without having learned the nomenclature. Most physicians have little need in their practices to know about levels of care; thus, they haven't had to learn the distinctions.

DIFFERING DEFINITIONS

A further complication is that there exist no standard definitions of level of care that are acceptable in all 50 states as well as in the Medicare and Medicaid programs.

It is actually discharge planners, social service personnel and review coordinators who are most knowledgeable about the distinctions between levels of care. Physicians haven't had to know about this area. However, when new rules and administrative procedures--such as pour out from the PSRO program in profusion--demand that physicians know about levels of care, these directives often are greeted with annoyance that covers confusion. ■

PSRO program's management described by House panel as big barrier to effectiveness

(Continued from pg. 1)

HEW has not impressed upon those areas that the program is not volunary."

Stark then addresses the persistent question of cost versus quality as an objective of PSRO activities, saying it was discussed often at the hearings and that "some clarification" of the purpose of PSRO is in order.

PROGRAM GOAL CONFUSION

"It is obvious that cost control was intended to be the main emphasis of PSRO review, yet when selling the program to the medical profession, HEW distorted the intent. Dr. Henry Simmons, the deputy secretary for health, told the American Medical Association that 'utilization review is probably the smallest part of what PSROs will be doing;' and 'total cost is not the key issue with PSROs.' The product of these mixed views has been a disjointed and uncoordinated review system," Stark says.

The subcommittee has linked the ambiguity about the purpose (of PSRO) to PSROs' attempt to use "three very broad review systems" to "cover all health-care settings."

"Unfortunately," Stark asserts, "the present review format cannot properly monitor health care outside of conventional acute-care facilities. Outpatient care, physician therapy, home health, etc., cannot be reviewed by the same program that reviews inpatient admissions. Therefore, once it is decided that cost or quality in a specific health-care setting is the review target, PSROs will be more capable of being effective. Review is presently developed before the target is known. As it exists now, program development works in reverse," his report says.

CONFIDENTIALITY CONCERNS

The subcommittee has also discussed concerns about the confidentiality of medical records and urged that DHEW "be made continually aware of the vulnerability within federal health programs to abuse of such confidentiality."

As another finding, the subcommittee sees the lack of uniformity among PSROs as a bar to the development of national and regional norms and comparisons between PSROs.

"Finally," the report says, "the subcommittee would like PSROs to recognize Congress' desire to see impact data. If HEW, doctors, hospitals, etc., believe that PSROs are working, then there should be a move towards determining exact cost-savings, cost-benefit and quality improvement." ■

Carter's hospital cost lid draws praise and criticism; congressional outlook cloudy

WASHINGTON, D.C.--Although inevitable, the strong and immediate opposition of providers to President Carter's proposed 9-percent-a-year lid on hospital costs cannot easily be dismissed. The proposal faces an uncertain future in Congress.

Two key House health subcommittees began joint hearings on the President's proposed Hospital Cost Containment Act of 1977 on May 11.

PRESIDENT'S APPEAL

Carter on April 25 urged Congress to halt "runaway costs of hospital care" by imposing a 9-percent-a-year limit on increases in patient bills for 6,000 acute-care hospitals. He predicted a $2-billion saving in the first year, through limits on revenue increases and capital expenditures. The proposal does not cover nursing homes, health maintenance organizations, Veterans Administration and Public Health Service hospitals, although VA and PHS hospitals could and would have cost controls imposed directly by the President under existing authority, according to DHEW Secretary

Joseph A. Califano, Jr.

The limit on hospital revenues would be enforced by punitive taxation of 150 percent of the amount in violation of the allowed limit, and would be an average figure based on the total annual charges by each hospital. Through a formula reflecting general price trends in the economy, allowing for some improvements in quality of care, the bill would restrain increases in the reimbursements hospitals receive from all sources--Medicare, Medicaid, Blue Cross, commercial insurers and the 10 percent of patients who pay their bills directly.

Carter described his plan as transitional, a step on the road to national health insurance. "It is intended to flow directly into a long-term prospective reimbursement system, which will not accept a hospital's base cost as given," he said in a message to Congress. "The long-term system will be able to analyze and compare base costs and provide greater incentives to those hospitals which are most efficient."

HOSPITALS CALLED 'OBESE'

He said hospital costs have been increasing at a rate of 15 percent a year and must be controlled. Califano described the hospital system as one lacking competition. "Hospitals have become, many of them, quite obese," said Califano. "We are asking them to cut out waste."

Criticism came quickly, heavily, and from expected sources--the American Hospital Association, the American Medical Association and the Federation of American Hospitals. But the Blue Cross Association, the private health insurance industry, the American Association for Comprehensive Health Planning, the Physicians National Housestaff Association and not a few newspaper editorials had nicer things to say of the proposal.

Doctors and hospitals will join to fight the proposal, said AHA President J. Alexander McMahon. He flatly predicted its demise in Congress. "We will tell Congress right out why hospitals costs have risen," McMahon said at a news conference. Of the 15-percent annual increase in hospital costs in recent years, 10 percent is due to inflation and the rest to improved patient care, McMahon said. "To comply with the 9-percent restriction, the first thing that would have to be done away with would be those quality improvements," he said.

'SCARE TACTICS' CITED

McMahon accused Califano of using "scare tactics" in saying that hospitals have become obese. Because 90 percent of the hospital patients are isolated from their bills by third-party payments, public demands are spurring the increase in hospital costs, he told reporters. "We can't bring it to a halt or markedly cut it back overnight. That's the trouble with this (the administration) proposal."

Blue Cross Association President Walter J. McNerney commended the proposed limit on new capital expenditures "because the capital structure in many ways dictates the use and efficiency of health-care services." The Health Insurance Association of America, in a statement by its president, Robert F. Froehlke, said: "We endorse the President's efforts because health-care costs must be contained. As purely an interim measure we can support his program."

It was the interim aspect that troubled Sen. Herman Talmadge (D-Ga.), who reintroduced his Medicare-Medicaid reform bill on May 5. Talmadge expressed reservations over the administration "cap" on hospitals, saying that with all the exceptions allowed, the cap might be ineffective as a ceiling, and that a ceiling "by its very nature is arbitrary and tends to penalize those who have been efficient in the past and reward those who have been inefficient."

LONG-TERM APPROACH

Talmadge said his restructured bill represents a long-term approach to controlling hospital costs. He is uncertain, he said, about the merits of the administration's proposal for an interim cap. "But I do share their concern and will strongly support redoubled efforts at effective application of presently authorized controls and interim measures--such as broad public disclosure of hospital costs and charges and whatever appropriate jawboning activities the administration might engage in," said Talmadge, chairman of a Senate health subcommittee.

Despite his stated preference for public disclosure, Talmadge added a provision to his bill to amend the Freedom of Information Act to preclude DHEW's releasing information on payments to Medicare doctors. Secretary Califano apologized recently to the AMA, expressing "our deep regret at the significant number of errors" in a March 14 listing of doctors who had generated at least $100,000 worth of business among elderly Medicare patients in 1975. A Michigan doctor listed as having received $115,000 actually received $15,000 and said, "My wife must think I have an apartment on the side and a mistress as well." ■

Bill maps possible course to guide PSROs and state Medicaid agency relations

A possible pathway through the thorny field of PSRO and state Medicaid relations has been mapped out in a compromise written into House bill H.R. 3, which deals with controlling fraud and abuse in Medicare and Medicaid. The legislation is still far from being law of the land, however, because it has only just been reported out of two House health subcommittees and now must compete for legislative attention with energy, tax and welfare packages.

The problem in some states, particularly those with large Medicaid populations, has been increased pressure to control rampant welfare expenses. To this end, the states view the control of hospital utilization as offering some hope. From the point of view of some states, the PSRO, through its concurrent review of hospital care, has not proven--or may never prove--its ability to control costs.

COMPROMISE POINTS

Essentially, the legislative compromise asserts the PSROs' authority over review of Medicaid patients, but it also gives the state leverage through a system of monitoring PSRO review. The compromise includes these points:

--The secretary of DHEW would be required to give a state governor 30 days in which to comment before a PSRO enters each of four phases: conditional status, operational status, ambulatory-care review and long-term care review. If the governor and the secretary disagree on what action to take, the secretary would allow another 30 days for comment from the governor.

--As a prerequisite to starting binding Medicaid review, the PSRO would be required to sign a memorandum of understanding with the state Medicaid agency, except if the state agency chose not to, in which case, the secretary may authorize the PSRO to begin binding review without it. The Bureau of Quality Assurance has been requiring an MOU as an administrative measure; this amendment would give that requirement the force of law.

SPELLING OUT GOALS

--For the first time, a state agency may request that a PSRO specify its review goals and methods in an MOU. If the PSRO refuses, the secretary could require that the review goals and methods be spelled out as long as they were consistent with both PSRO purposes and the Medicaid plan and did not "seriously impact on the effectiveness and uniformity of the organization's review of health-care services." As an example, one state agency wanted a PSRO to look at Friday hospital admissions and was told that that judgment was one for the PSRO to make. The provision in the bill would give that state agency the power to have Friday admissions scrutinized by the PSRO.

--The state agency could contract with the PSRO for types of Medicaid review beyond what would be covered in the MOU. For example, the state may want the PSRO to do review of ambulatory services and would be able to contract for it under this provision.

STATE MONITORING

--The state could set up a system to monitor PSRO review and if, over time, the state believed that PSRO review decisions had had been adversely affecting quality or total expenditures of the state for health care under Medicaid, and if it documented that contention for the secretary, the secretary could suspend the binding authority of PSRO Medicaid review for 30 days. The secretary would then investigate further and decide whether to reinstate the PSRO's binding review.

--Finally, there is provision for periodic consultation between the secretary and the state agencies. This would include having the PSROs supply to the state agencies, on request, routine data sent periodically to the secretary and other data if the secretary so authorizes.■

PSRO-state feud in New York gets public, congressional airing, but still simmers unresolved

NEW YORK--The long-running battle between the New York State Department of Health and the state PSROs on the question of hospital review of Medicaid patients received public attention last month in at least two forums--the New York daily press and a congressional hearing. No full resolution of the central issues involved has yet emerged.

CHAPTER 76 AT ISSUE

The relations between the state of New York and the PSROs over utilization control for hospitalization under Medicaid are perhaps the worst in the nation.

The state medical society has said in congressional testimony that under the controversial state law known as Chapter 76, passed in 1976, the state has been "refusing to pay Medicaid claims where a local PSRO has certified the care as being medically necessary and appropriate."

The deputy state health commissioner,

Roger Herdman, M.D., on the other hand, has said, "In New York, the utilization review program is a cost-control program." Chapter 76 was passed last year to control hospital utilization in the Medicaid program. Herdman says that New York had the longest length of stay in the nation and that the state was spending $1 billion on Medicaid. From the start of the state utilization-control program last September until February, the state had saved $1.5 million, he told an audience Feb. 25.

Articles published in April quoted spokespersons for the state as charging that PSROs had allegedly failed to reduce costs in hospitals with peer review programs. In particular, the utilization-review director of the state health department, John Eadie, declared that a pilot study by state Medicaid inspectors revealed that the PSRO in three major New York City hospitals had failed to reduce unnecessary admissions or to cut questionable surgery. Eadie was quoted as saying, "We determined that our review monitors would have cut 17 percent of the costs and procedures approved by the federal review organizations."

HERDMAN CHALLENGED

In a letter of rebuttal to Herdman, Eleanore Rothenberg, executive director of the New York County Health Services Review Organization, challenged the state's version of the PSRO's monitoring at seven hospitals.

Rothenberg contended that the state's Medicaid analysis was not accurate and was biased. She called the state "irresponsible" for saying that the PSRO had not adequately performed its peer review responsibilities.

Later, Herdman sent a letter of apology to Rothenberg for the story's appearance in the media prior to the "appropriate" time. Rothenberg told PSRO Update, "I got angry because the story should not have been leaked." She noted that the story also involved a 60-day pilot project at three major New York City hospitals, which was launched last Nov. 7 by agreement between Herdman and Rothenberg. This project was designed to create a "nonduplicative and cost-effective review system to simplify and coordinate the hospital review process."

Rothenberg said that the "allegation" in the newspapers was that "the PSRO doesn't work in terms of cost containment and performance of review, and we felt that was a premature determination."

(Although Rothenberg refused to name the three major hospitals involved in the pilot study by the PSRO group, Herdman named them as Mt. Sinai and Beth Israel, voluntary hospitals, and Metropolitan Hospital, a municipal institution.)

FED IN THE MIDDLE?

As matters stand now, the state and the PSROs are in a "confrontational" situation, with both sides, in effect, urging the federal government to settle the dispute. In testimony before a House oversight subcommittee hearing in Washington, the Medical Society of the State of New York criticized both the state health department and DHEW, the latter for failure to issue guidelines and to provide needed funds.

Charles N. Aswad, M.D., of Binghamton, N.Y., chairman of the statewide support center for PSRO, testified for the state medical society in Washington before the oversight subcommittee. "It was self-evident to the Congress, as well as organized medicine in New York State, that previous mechanisms for utilization review and quality control--namely the fiscal intermediaries and state Medicaid agency--were ineffective as either quality or cost-control agents," he testified. "It was their inability to control constantly rising Medicare and Medicaid costs and the absence of documentation concerning quality of care delivered which led to enactment of P.L. 92-603 [the PSRO law]."

Aswad charged that New York State has consistently sought to "thwart the intention of Congress," and thus this could result in the hospitals being faced with "the prospect of performing duplicative and costly review systems on Medicaid patients."

He said he was concerned that the federal government "may not have the determination to prevent the state of New York from implementing such duplicative review," and chided the federal government for not providing funds to enable PSRO processing of hospital review data.

STATE SITTING TIGHT

Herdman told PSRO Update last month that he had recently visited Washington to meet with DHEW people and with other state representatives on the PSRO situation. "DHEW said they would be thinking through the issues we discussed and get back to us, but they haven't done so yet," he said. "In the meantime, we're sitting tight with the policy we have had, still doing reviews with our on-site staff. It's up to DHEW to come to a policy decision.

"I never got completely specific with DHEW, but I did tell them of our problem with the PSRO in general. We have a major cost-control need and a major cost-control problem in New York. We have some programs that are dedicated to controlling cost,

which conflict with PSRO. Our problem is that we need to be assured in some definitive, convincing, concrete way that PSROs are going to control costs and not going to inhibit cost-control measures the state might have."

He added that the state had some "good data" in nine hospitals where the PSRO had been "in place" for one year, and "we didn't see any change in length of stay as compared with preceding years."

The state has shown its determination to carry on the cost-control battle by circumventing a preliminary injunction on deferrable surgery handed down by a federal judge Jan. 18 (see PSRO Update, Feb. 1977). In that decision, the state was enjoined from enforcing the provision of Chapter 76 that defined certain surgical procedures as being deferrable for Medicaid patients unless two surgical opinions said otherwise. Through a change in language, the state, in March, directed that these types of surgery have "prior authorization" in order to be considered necessary, according to Herdman's projections when speaking to a group of review coordinators in Massachusetts Feb. 25. This language, he noted, satisfied the requirement of the injunction. It thus enabled the state to continue acting as a gatekeeper for patients entering surgery under Medicaid.

QUESTION OF COMPLIANCE

Both the state and the PSROs acknowledge that there is a real question of whether New York's Medicaid plan is out of compliance with federal law. The state medical society would like to see that question put to a test. One way to do it, according to Morton Chalef, director of the PSRO state support center, would be for the federal government to call a "compliance hearing." He acknowledged, however, that it is a serious step because if the state were found to be out of compliance, it could lose all its federal Medicaid funds. ■

Draft on ancillary review seeks to encourage demonstration projects in difficult area

One of the more difficult-to-deal-with areas of PSRO activities has been opened by the issuance this month of a draft transmittal from the Bureau of Quality Assurance on ancillary-services review. BQA acknowledges that "no one we could find knows how to do ancillary-services review," and that this transmittal is a start by which to encourage some PSROs to launch demonstration projects, said Mary Tierney, M.D., of the Division of Peer Review.

PATTERNS OF ANALYSIS

The draft transmittal, which was presented to the National PSR Council in March, outlines a general approach to reviewing ancillaries that calls for analyzing patterns of ancillary use through a variety of means--reviewing existing claims forms, doing medical care evaluation studies, examining profiles and reviewing other hospital data.

The overriding problems of undertaking ancillary-services review are that ancillaries are difficult to define, there are no widely tried methodologies available for a PSRO, and any review methods used are likely to produce extensive data simply because ancillary services are so numerous and so widely used in hospitals. ■

Proposed bill would mandate ambulatory-care review and push for confidentiality regs

After holding hearings and mark-up sessions last month on a major House bill containing PSRO provisions, two health subcommittees finally agreed to make ambulatory-care review mandatory for PSROs and to encourage DHEW to issue regulations on confidentiality of data. Most of the bill's other provisions had been made final early last month (see PSRO Update, April 1977).

The measure, H.R. 3, is essentially a Medicare and Medicaid anti-fraud and anti-abuse bill, but it contains a package of provisions affecting PSROs (see PSRO Upate, April 1977).

AMBULATORY-CARE SECTION

Ambulatory-care review, which is not required of PSROs now, is acknowledged as being at a rudimentary stage and in need of experimentation using a variety of methodologies. The bill thus would require the DHEW secretary to develop ambulatory-review methodologies within two years after enactment of the legislation. Secondly, it would give the secretary authority to require a PSRO to undertake ambulatory-care review within two years of the organization's becoming operational.

Since the operational phase of a PSRO may be delayed (according to another provision of the bill) as long as four--and in some cases six--years after a PSRO is first funded, ambulatory-care review would not have to be undertaken for six or even eight years.

Under another provision of the final

bill, PSROs would be prohibited from delegating review to skilled nursing facilities; the practice of delegating review has become widely accepted for acute-care hospitals.

CONFIDENTIALITY PROVISIONS

Finally, the area of confidentiality of records is addressed in two provisions. One would put a ban on the release by a PSRO of data on "private" patients (those not paid for by the federal government). The second provision would require the DHEW secretary to submit a detailed report to Congress containing specific recommendations for procedures to be used to guard the confidentiality of medical records, including a means to protect those records from unwarranted inspection and disclosure by a PSRO or its employees. The report would be due within 90 days after the Privacy Commission submits its report to Congress, which is expected to be June 10. This provision reflects the concern expressed at several congressional hearings over the fact that DHEW has not issued regulations on confidentiality.

The current version of the bill, H.R. 3, agreed to in a sequence of mark-ups by the health subcommittees of the Ways and Means and the Interstate and Foreign Commerce Committees, will go next to the full committees, where a single, final version must be approved before it can be reported to the floor of the House for a vote. To be enacted, it must then be approved by the Senate and signed by the President.

It had been thought that the bill would proceed quickly through the Congress. However, it has collided with a bundle of reform legislation (on energy, taxation and Welfare) introduced by the administration, that must be funneled through just two congressional committees--the House Ways and Means and the Senate Finance. It now appears the bill will not reach a final vote until later in the year. ■

Quality assurance is theme of June 4-5 PSRO symposium

A symposium to be sponsored by the California Area 22 (Los Angeles) PSRO June 4-5 will examine a variety of topics under the theme "Quality Assurance--The Cutting Edge?"

Among the speakers are researchers Paul J. Sanazaro, M.D., and Robert Brook, M.D.; Wallace Bennett, retired senator from Utah and sponsor of the original PSRO legislation; and Abbott Goldberg, the judge who heard the precedent-setting case of Gonzalez v. Nork, which established for California a hospital's obligation to implement a quality-assurance program.

The symposium, which will be held at the Pacifica Hotel, Culver City, Calif., is underwritten by Area 22 PSRO from its contract funds and is free to participants. ■

UR coordinators and AHA sponsoring regional workshops

The California-based National Association of Utilization Review Coordinators, together with the American Hospital Association, in June will sponsor a series of regional workshops geared to broadening the coordinator's knowledge of PSROs, of requirements of the Joint Commission on Accreditation of Hospitals and of utilization review itself.

The workshops scheduled are in: Atlanta, June 6-7, Peachtree Plaza Hotel; Cherry Hill, N.J., June 9-10, Cherry Hill Hyatt; Boston, June 13-14, Hyatt Regency Cambridge; Chicago, June 16-17, Hyatt Regency; Kansas City, Mo., June 20-21, Crown Center Hotel; Albuquerque, N. Mex., June 23-24, Airport Marina Hotel; and Lake Tahoe, Nev., June 27-28, Lake Tahoe Resort.

Registration forms are available from the National Association of Utilization Review Coordinators, P.O. Box 2221, 31244 Palos Verdes Drive West, Rancho Palos Verdes, CA 90274. The workshop fee is $95 for non-members. For registration forms received after May 25 there is an additional charge of $15. ■

Revamped Talmadge bill to be heard from June 7-10

The Senate Finance Committee has scheduled four days of hearings June 7-10 on a Medicare and Medicaid reform bill introduced by Sen. Herman E. Talmadge (D-Ga.) May 5.

Talmadge called the bill (S. 1470) "an improved version of...a similar proposal introduced in the last Congress." It is designed "to deal with, among other things, the problem of the continued explosion in the costs of Medicare-Medicaid programs. ■