Calendar No. 1066

99TH CONGRESS
2d Session

SENATE

REPORT
99-520

MEDICARE AND MEDICAID PATIENT AND PROGRAM PROTECTION ACT OF 1986

OCTOBER 2 (legislative day, SEPTEMBER 24), 1986.—Ordered to be printed

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

REPORT

[To accompany H.R. 1868]

[Including cost estimate of the Congressional Budget Office]

The Committee on Finance, to which was referred the bill (H.R. 1868), to amend the Social Security Act to protect beneficiaries under the health care programs of that Act from unfit practitioners, and to otherwise improve the antifraud provisions of that Act, having considered the same, reports favorably thereon with an amendment in the nature of a substitute to the text, and recommends that the bill as amended do pass.

I. LEGISLATIVE BACKGROUND

H.R. 1868 was passed by the House of Representatives on June 4, 1985. It was ordered favorably reported by the Committee on Finance on September 10, 1986, with an amendment in the nature of a substitute.

COMMITTEE HEARINGS

The health subcommittee held a public hearing on H.R. 1868 on July 12, 1985.

63-780 O

II. TABLE OF CONTENTS

III. BRIEF DESCRIPTION OF THE BILL

Title I of the Committee amendment to H.R. 1868, the Medicare and Medicaid Patient and Program Protection Act of 1986, would recodify certain provisions of law relating to Medicare and Medicaid fraud and abuse and extend them to the maternal and child health program and the title XX social services program. The bill as amended would also add several new provisions. It would require a minimum exclusion of five years for individuals or entities convicted of a program-related crime. It would also mandate the exclusion of any individual or entity convicted of a crime related to patient neglect or abuse for at least five years. In addition, it would authorize the Secretary to exclude from Medicare, Medicaid, the maternal and child health program and the title XX social services program any individual or entity convicted of certain crimes related to the provision of health services, to financial integrity, to the obstruction of certain investigations or to controlled substance violations and would authorize the exclusion from Medicare, Medicaid and the State health care programs in all States a person whose license had been revoked or suspended by any State licensing authority.

The purpose of the recodification is to organize, clarify and simplify current provisions related to offenses for fraud and abuse under Medicare and Medicaid. Further, the additional authority for the Secretary to exclude certain practitioners who have committed crimes or lost their licenses is intended to fill in gaps in the current ability of the Department of Health and Human Services to protect Medicare, Medicaid and other program beneficiaries from incompetent practitioners and receiving inappropriate care.

The bill as amended would clarify the Secretary's authority to impose civil monetary and criminal penalties. New authority would be added for the Secretary to assess civil monetary penalties against hospitals paid under the prospective payment system (PPS)

who establish certain physician incentive plans that inappropriately reward reduction in patient care or against hospitals that improperly charge or discharge beneficiaries. Civil monetary penalties could also be assessed against (HMOs) Health Maintenance Organizations and (CMPs) Competitive Medical Plans who violate certain requirements.

The bill as amended would require States to establish a system to report to the Secretary all formal proceedings concluded against a health care practitioner by a State licensing authority, including loss of license because the license was surrendered or the individual or entity left the State. The Secretary would be required to assure that this information was provided to appropriate health and law enforcement officials nationwide.

Clarifications would be made to the provisions in the Deficit Reduction Act requiring a moratorium on the imposition of fiscal penalties against State Medicaid programs that fail to meet certain eligibility requirements.

The bill as amended would permit the Secretary to assess intermediate sanctions consisting of denial of certain payments against Medicare and Medicaid providers, suppliers, HMOs and CMPs who violate the terms of their agreements or contracts when there is no immediate jeopardy to the health or safety of the patients.

The bill as amended would eliminate criminal penalties for certain providers who participate in group purchasing organizations or who waive Medicare part A cost-sharing requirements provided that specified conditions are met. The Secretary would have the authority to exempt other competitive activities from criminal penalties as kickbacks through regulations.

The bill as amended make other miscellaneous changes related to the implementation of the fraud and abuse provisions in the Social Security Act.

The bill as amended would also amend the Controlled Substances Act to permit the Attorney General to deny, revoke, or suspend the registration to manufacture, distribute or dispense a controlled substance for any individual or entity excluded from the Medicare or Medicaid programs for a conviction relating to a program-related crime or abuse or neglect of patients.

Title II of the Committee bill as amended would add a number of provisions to amend Medicare and Medicaid authority, and other health authority in a number of areas.

Several provisions would modify Medicare's prospective payment system (PPS). Calculation of payment rates would be modified to include an annual requirement for recalibration of the diagnostic related group (DRG) categories; require rebasing of the DRGs and modification of the method to determine outlier payments to better reflect urban and rural costs; require reclassification of certain DRGs; and modify on a temporary basis outlier payments for burn patients. The PPS system would be expanded to include Puerto Rican hospitals. Other modifications would be made including the extension of special payments to sole community hospitals.

Several provisions are designed to improve quality of care under the Medicare and Medicaid programs. A number of reports would be mandated and the Secretary of HHS would be required to coordinate studies of quality of care under PPS. The conditions of

participation and the survey process for skilled nursing homes and intermediate care facilities that participate in Medicare and Medicaid would be improved to increase quality of care in nursing homes.

Other provisions change Medicare's part A program requirements including clarification that payment may be made for the services of psychologists.

Provisions impacting Medicare's part B program include authorization of direct payment for certified registered nurse anesthetists; coverage of psychologist service in rural health clinics; coverage of physician assistants; and delay of the mandatory assignment requirement for clinical laboratory services provided in a physician's office.

Several provisions address research, demonstration, or data requirements. New studies include a clinical trial of personal emergency response systems and waivers to test comprehensive services to the frail elderly.

Provisions change the requirements of Medicare's End Stage Renal Disease (ESRD) program. Facilities would now be required to provide information to patients on their rights; a national registry would be established, and ESRD Network functions would be maintained and consolidated. In addition, protocols would be required for organ procurements.

A number of provisions make modifications and clarifications in the Medicaid program. Eligibility for the homeless, hospice coverage for the dually eligible, and hospital payment limits are clarified. Medicaid payments are authorized for certain hospitals in South Carolina and for administratively necessary days in New York.

Additional minor and technical Medicare and Medicaid provisions are included.

The bill as amended also includes provisions to increase the authorization level for the Maternal and Child Health block grant subject to certain stipulations, and to require that the Secretary of HHS conduct regular surveys of medical expenditures.

SHORT TITLE

This bill as amended may be cited as the "Medicare and Medicaid Patient and Program Protection Act of 1986."

IV. EXPLANATION OF PROVISIONS

TITLE I. FRAUD AND ABUSE PROVISIONS

Current Law (Sections 101–107)

Under current law, the Department of Health and Human Services (HHS) can exclude practitioners from participation in Medicare for a number of reasons:

Conviction of a criminal act against Medicare (title XVIII), Medicaid (title XIX) or title XX of the Social Security Act;

Imposition of a civil monetary penalty for acts against Medicare or Medicaid;

Submitting false claims to Medicare;

Repeatedly providing more services than necessary to Medicare beneficiaries;

Submitting Medicare claims with charges that substantially exceed the practitioner's customary charges;

Providing services to Medicare beneficiaries that are of a quality which fails to meet professionally recognized standards of care;

Failing to keep adequate records to demonstrate the need for services rendered.

HHS has the authority to require all States to exclude practitioners from participating in Medicaid only when the practitioner is convicted of a criminal act against Medicare, Medicaid or title XX, or where HHS has imposed a civil monetary penalty on the practitioner for acts against Medicare or Medicaid. HHS also has the authority to exclude entities from participation in Medicare and Medicaid if they are owned or controlled by individuals who have been convicted of program related crimes.

Under current law, the Secretary is authorized to impose a civil monetary penalty (of up to $2,000 per item or service) plus and assessment of twice the amount claimed, on any person who files a claim for a medical or other item or service that the person knew or had reason to know was not provided as claimed. Under current law, a person may be subject to imprisonment or fine under sections 1877 or 1909 if they commit certain acts relating to kickbacks, bribes, or false statements.

If HHS excludes a practitioner, HHS is required to notify the State and local agencies responsible for health care licensing or certification of the suspension, and request that they invoke sanctions in accordance with applicable State law or policy.

On May 1, 1984, the U.S. General Accounting Office (GAO) issued a report to the Secretary of HHS which concluded that there was a need to expand Federal authority to protect Medicare and Medicaid patients from health practitioners who lose their licenses. The GAO report found that Medicare and Medicaid patients are being treated in some States by health care practitioners whose licenses were revoked or suspended by another State's licensing board because they did not meet minimum professional standards. This occurred because practitioners can move to another State where they have a license and continue to practice. Such practitioners are able to treat Medicare and Medicaid patients because HHS does not have the authority to exclude them from these programs in all States based on licensing board findings and sanctions in one State. Currently, HHS is only empowered to exclude the practitioner in the State in which he or she has lost a license.

In addition, HHS is unable to bar individuals or entities from participation that have been convicted of defrauding private health insurers or defrauding other Federal. State or local government programs

In summary, HHS currently does not have authority to exclude individuals or entities from Medicare, Medicaid, the maternal and child health program and title XX social services program who have been convicted of non-program related crimes such as fraud, financial abuse, neglect or patients or unlawful distribution of a controlled substance. It does not have the authority in all cases to

exclude those who have been sanctioned for defrauding or abusing the Medicaid program from participation in Medicare or vice versa. Further, HHS does not have the authority to exclude nationwide those individuals or entities that have lost their licenses to provide health care or have otherwise been sanctioned by a State licensing authority.

Explanation of Provisions (Sections 101–107)

SECTION 101. EXCLUSION FROM MEDICARE AND STATE HEALTH CARE PROGRAMS

A. Mandatory exclusions

Subsections 1128(a) (1) and (2) would require the Secretary to exclude individuals and entities for specified reasons. Minimum periods of exclusion would be established.

1. Mandatory exclusion for program-related crimes

The Secretary would be required to exclude from participation in Medicare any individual or entity convicted of a criminal offense related to their participation in Medicare, or the Medicaid, maternal and child health, or title XX social service programs. The exclusion would be for a period of not less than five years, except that the Secretary may waive the exclusion for an individual or entity that is the sole community physician or sole source of essential services in a community if requested by a State.

If the Secretary excludes an individual or entity from Medicare under this provision, the State would be required to exclude such individual or entity from participation in Medicaid, the maternal and child health program under title V, and the title XX social services program for a similar period. (Hereafter, Medicaid, the maternal and child health program, and the title XX social services programs are referred to as the State health care programs.)

While there is currently a mandatory exclusion from Medicare and Medicaid for crimes related to Medicare, Medicaid or title XX, there is no minimum period of exclusion specified in the law. This provision would amend current law to require a minimum exclusion.

This provision would also extend current law to require mandatory exclusion from the maternal and child health and title XX Social Security programs of individual or entities convicted of program-related crimes.

2. Mandatory exclusion for crimes related to patient neglect or abuse

The Secretary would be required to exclude from participation in Medicare any individual or entity that has been convicted of a criminal offense relating to neglect or abuse of patients in connection with the delivery of health care.

If the Secretary excludes any individual or entity under this provision, the State would be required to exclude such individual or entity from participation in State health care programs for the same period.

Under current law, the Secretary does not have the authority to exclude persons who have been convicted of criminal offenses that

are not related to Medicare or other State health care programs. This provision would give the Secretary the authority to protect Medicare and the State health care program beneficiaries from individuals or entities that have already been tried and convicted of offenses which the Secretary concludes entailed or resulted in neglect or abuse of other patients and whose continued participation in Medicare and the State health care programs would, therefore, constitute a risk to the health and safety of patients in those programs.

This provision is subject to the mandatory five-year minimum exclusion period with the exception that upon a request from a State, the Secretary may waive the exclusion for an individual or entity that is the sole community provider or sole source of essential services.

B. Permissive exclusions

Subsections 1128(b)(1) through (14) would establish discretionary authority for the Secretary to exclude individuals and entities from Medicare for specified reasons. Although the Secretary would have discretion as to whether to initiate an exclusion proceeding in any particular case, the amendment makes it clear that, if the Secretary concluded that an exclusion was warranted, these authorities would have to be exercised in a manner that resulted in the exclusion of the individual or entity from all of the Medicare and State health care programs for which the individual or entity was otherwise eligible to participate. The Committee has included fraud convictions (b)(1) and felony convictions related to controlled substances (b)(3) as permissive exclusions because it recognizes that there may be extenuating circumstances that require a flexible authority. The Committee expects that most of these situations will result in exclusion, however, it wishes to give the Secretary the option to not require the exclusion if there are extenuating circumstances, such as when, in the judgment of the Secretary, the exclusion would jeopardize another investigation.

1. Authority to exclude for conviction relating to fraud

The Secretary would be authorized to exclude any individual or entity convicted of a criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility or other financial misconduct in connection with the delivery of health care or with respect to a program that is financed, at least partially, by any Federal, State or local government.

This provision would permit the Secretary to exclude individuals or entities convicted of criminal offenses that are not related to Medicare or the State health care programs, who have already been tried and convicted of offenses relating to their financial integrity, if the offenses occurred in delivering health care to other patients or if they occurred during participation in any other governmental programs.

2. Authority to exclude for conviction relating to obstruction of an investigation

The Secretary would be authorized to exclude any individual or entity convicted of interference or obstruction of any investigation

into any criminal offense for crimes that would require mandatory exclusion under section 1128(a) or permit exclusion under section 1128(b)(1).

3. Authority to exclude for conviction relating to controlled substance

The Secretary would be authorized to exclude any individual or entity convicted of a felony offense relating to unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

4. Authority to exclude for license revocation or suspension

The Secretary would be authorized to exclude any individual or entity whose license to provide health care has been suspended or revoked by a State licensing authority or whose license has otherwise been lost for reasons bearing on the individual's professional competence, professional conduct or financial integrity. This provision would permit the Secretary to exclude practitioners from Medicare in all States who lose their license in one State, and move to another State and to require the States to exclude them from participation in any State health care program.

This provision would also permit the exclusion of individuals or entities who surrender their licenses while disciplinary proceedings involving professional performance, professional conduct or financial integrity are pending. This provision will prevent unfit practitioners from avoiding exclusion through the expedient surrendering their license before the State can conclude proceedings against them.

It is the Committee's expectation that the Secretary will use the discretion intended in this permissive authority not to exclude individuals whose licenses have been suspended for minor infractions, such as failure to pay licensing fees, failure to maintain required continuing education credits, or violation of strict advertising requirements. The Committee feels that the exclusion penalty, which would preclude participation in Medicare and State health programs nationwide, would be too harsh. However, the Committee would expect the Secretary to review the circumstances of the exclusion to assure that the minor infraction stated in the final determination was the full reason for the exclusion.

5. Authority to exclude for exclusion from Federal health care programs

The Secretary would be authorized to exclude any individual or entity suspended or excluded for reasons bearing on professional competence, professional performance, or financial integrity, from any Federal program involving the provision of health care. Programs included would be those administered by the Department of Defense or the Veterans Administration, as well as Medicaid and the other State health care programs.

This provision is designed to correct the current anomaly whereby individuals or entities who have been found unfit to participate in one Federal health program or Federally-funded State health care program may continue to participate in Medicare and the State health care programs. The Committee recommends that the

Committees with jurisdiction over health programs authorized by the Department of Defense and Veterans legislation enact a reciprocal authority to permit exclusion under their programs for individuals and entities excluded or otherwise sanctioned under this provision.

6. Authority to exclude for excessive charges, unnecessary services, or failure of certain organizations to furnish medically necessary services

(a) The Secretary would be authorized to exclude any individual or entity the Secretary determines submitted requests for payment which contain charges (or costs) substantially in excess of usual charges (or costs). The Committee intends that the standard is to be measured against the person's or entity's usual or normal charge, which may in fact be higher than the Medicare recognized "customary charge." This provision does not in any way alter the amount of the charge which will be recognized as "reasonable" under title XVIII. The provision does not apply where payment is neither made on a cost or charge basis such as a prospective payment rate.

(b) The Secretary would be authorized to exclude any individual or entity that the Secretary determines causes to be furnished items or services substantially in excess of the patient's needs or a quality that fails to meet professionally recognized standards of health care. The Committee expects that Peer Review Organizations (PROs) will be responsible for assessing quality of services under their review responsibility by determining whether professionally recognized standards of health care are met. The Committee is aware that currently PROs are responsible under their contracts only for review of Medicare inpatient hospital services. Even for these Medicare inpatient services, there may be situations when the PRO does not make the final quality decision, such as in cases where a PRO contract is not in effect. The Secretary (and the appropriate State health agency) is responsible for assuring that all other services meet professionally recognized standards of care.

(c) The Secretary would be authorized to exclude a risk-sharing health maintenance organization (HMO) or competitive medical plan (CMP), approved under Medicare or Medicaid, or an entity with a waiver under the Medicaid freedom-of choice requirements to provide primary care case management which has failed substantially to provide medically necessary items or services as required by law or contract if the failure has adversely affected or has the likelihood of adversely affecting Medicare or Medicaid beneficiaries.

The first two items of this provision essentially recodify current law under section 1862(d) which requires denial of Medicare payment to persons committing any of these acts. The provision expands current law to include the State health care programs.

The new provisions affecting HMOs, competitive medical plans, and case management waivers are intended to deal with serious failures to abide by acceptable standards of medical practice, rather than isolated cases of inadvertant omissions. The Committee intends for the Secretary to examine whether there was a deliberate omission or a pattern of failing to provide necessary items and

services, the seriousness of the effect on or risk to patients, and the reasons or circumstances involved. It is also expected that the practice standards used to determine that items or services were medically necessary would be based on generally accepted HMO practice standards. The Committee expects that these standards could be developed by physicians involved with prepaid group practices, other HMOs and CMPs, State agencies that have contracts with HMOs, Peer Review Organizations (PROs) or other organizations engaged in quality assurance assessment.

7. Authority to exclude for fraud, kickbacks, and other prohibited activities

The Secretary would be authorized to exclude any individual or entity which has committed an act described in section 1128A and the new section 1128B relating to kickbacks and bribes.

This provision recodifies current law and permits sanctions and exclusions not only for Medicare but also for the other State health care programs. The Secretary could exercise this authority to exclude an individual or entity without the necessity of imposing a civil monetary penalty or obtaining a criminal penalty or conviction. It is the Committee's intent that the burden of proof requirements under this authority would be those customarily applicable to administrative proceedings.

8. Authority to exclude entities controlled by a sanctioned individual

The Secretary would be authorized to exclude any entity that has a person with an ownership or controlling interest, or that has an officer, director, agent or managing employee that has been convicted of certain program-related offenses (described in section 1128(a) or section 1128(b)(1)(2) or (3)), or against whom a civil monetary penalty has been assessed, or who has been excluded from participation in Medicare or a State health care program.

This section recodifies section 1128(b) of current law with respect to excluding entities from Medicare which have a close relationship to individuals who have been excluded or sanctioned by the program on the basis of a program-related conviction. It also recodifies section 1128(c) of current law with respect to exclusion of entities that have a person against whom a civil monetary penalty has been assessed. This provision expands the exclusion authority to include entities which have a close relationship with individuals who have been excluded from Medicare or the other State health care programs or who have had a civil monetary penalty imposed against them.

9. Authority to exclude for failure to make certain disclosures

The Secretary would be authorized to exclude any individual or entity which fails fully and accurately to make any disclosure required regarding persons with ownership or control, or persons convicted of program-related crimes, or which fails to supply the Secretary as requested information pertaining to the ownership of a subcontractor or to significant business transactions. In addition, the Secretary would be permitted to exclude any individual or entity that fails to provide information that the Secretary or the

State Medicaid agency determines is necessary to determine amounts payable or refuses to permit examination of its fiscal or other records as may be necessary to verify such information.

These provisions are essentially a recodification of current law under section 1866(b)(2)(C) and (6), with an expansion in the entities covered and an extension to include exclusions from the State health care programs.

10. Authority to exclude for failure to grant immediate access

The Secretary would be authorized to exclude an individual or entity that fails to grant, upon reasonable request, immediate access to the Secretary, State agency, Inspector General, or a State Medicaid fraud control unit for the purpose of performing their statutory functions. The Secretary would be required to define by regulation what constitutes immediate access and reasonable request. The Committee intends that the guidelines on reasonable request will specify that the provision will only apply to situations where there is information to suggest that the individual or entity has violated statutory requirements under Titles V, XI, XVIII, XIX or XX. The Committee further intends that allowances be made for failure to provide immediate access if there are circumstances beyond the control of the individual or entity under review, for example, if the hospital record is under review at the PRO. The period of exclusion for individuals would be equal to the period during which access was denied and an additional period not to exceed 90 days as set by the Secretary.

11. Authority to exclude for failure to take corrective action

The Secretary would be authorized to exclude any hospital which fails to comply substantially with a corrective action necessary to prevent or correct inappropriate admissions or practice patterns under the prospective payment system if required to do so under the provisions of section 1886(f)(2) pertaining to the review and recommendations of a peer review organization. This provision clarifies the sanctions available under current law and extends them to include exclusions from the State health care programs.

12. Authority to Exclude for Default on Health Education Loan or Scholarship Obligations

The Secretary would be authorized to exclude any individual who is in default on repayment of scholarship obligations or loans for health education that have been made or secured in whole or in part by the Secretary. The Secretary may not exclude individuals who are the sole source of essential services in the community or whose services are necessary to assure Medicare and Medicaid beneficiary access to services if requested by the State.

The Secretary shall explore the feasibility of using administrative alternatives to exclusion whenever feasible to collect outstanding loan obligations. For example, the Secretary should consider the feasibility of deducting overdue loan obligations made available through Section 338D of the Public Health Service Act (National Health Service Corps Scholarship program) from amounts that Medicare or Medicaid would otherwise pay for services rendered by the defaulting physicians. Civil authority in the tax code adminis-

tered by the Attorney General could be used to deduct loan obligations from tax refunds.

C. Due process

All mandatory and permissible exclusions under section 1128 and 1128A would be effective at such time and upon such reasonable notice to the public and to the individual or entity as may be specified in regulation. An exclusion would be effective on or after the effective date specified by the notice of exclusion.

In order to avoid disruptions in care that would be harmful to patients and to permit an orderly transfer to another provider, payment to an excluded provider would be permitted under Medicare, Medicaid, and a State health care program for up to 30 days for inpatient institutional services furnished to an individual admitted prior to the exclusion, and for home health services or hospice care furnished pursuant to a plan established before the date of the exclusion. The Secretary could stop payments for such patients sooner than 30 days after exclusion if the Secretary concluded that the risk to the health and safety of the patients was sufficiently serious to warrant a more immediate transfer to a different provider.

Under the amendment, the notice of the exclusion under section 1128 or 1128A would be required to state the earliest date on which the individual or entity could be reinstated in Medicare, Medicaid and the other State health care programs. The period could not be less than five years for an exclusion under the mandatory provisions in section 1128(a), except that the Secretary may waive the exclusion in the case of an individual or entity that is the sole community physician or sole source of essential specialized services upon request of a State. Individuals excluded under section 1128(b)(12) have a special period of exclusion equal to the period during which access was denied and an additional period not to exceed 90 days set by the Secretary.

The individual or entity excluded under section 1128 would be entitled to reasonable notice and opportunity for a hearing by the Secretary after the notice of exclusion and to judicial review of the Secretary's final decision. These are the same hearing and notice requirements provided under present law in sections 1862(d), 1128 and 1156.

The amendment consolidates several different authorities governing the various provisions available to the Secretary to sanction individuals and entities. The Committee intends that the Secretary will promulgate a uniform set of procedures to the extent possible.

The provisions of section 205(h) of the Social Security Act have been expressly incorporated in the bill to make clear that the review process provided for in the bill shall be the exclusive means of review for questions arising under this section (and under sections 1128A and 1156).

The Secretary would be required to notify promptly the appropriate State agencies of the exclusion from Medicare under section 1128 and 1128A. This is essentially a restatement of current law with respect to notice. With respect to required State sanctions, the bill restates current law under section 1128(a) requiring States to exclude individuals and entities convicted of a program-related

crime. With respect to section 1128A civil monetary penalties, States would be required to exclude the individual or entity, rather than the Secretary being permitted to decide whether to direct the States to exclude such individual or entity. For all other current and new offenses, the State would be required to exclude from State health care programs for the same period as the Medicare exclusion. In addition, as under current Medicare law, the Secretary would be permitted to waive the exclusion from the State health care program upon the request of the State.

The Secretary, State health agencies, and Peer Review Organizations would also be required a report the facts and circumstances of cases of possible physician misrepresentation or fraud to the State or local agency or authority having responsibility for the licensing or certification of an individual or entity.

An individual or entity excluded from participation under section 1128 or the section 1128A civil monetary penalty provisions would be permitted to apply to the Secretary for reinstatement under Medicare, and the State health care programs. The Secretary could reinstate such individual or entity if the Secretary determined that there was no basis for a continuation of the exclusion. The Secretary would consider the conduct of the applicant which occurred after the date of the notice of the exclusion or which was unknown to the Secretary at the time of the exclusion. The Secretary would have to be satisfied that there were reasonable assurances that the actions which were the basis for the original exclusion have not recurred or would not recur. The Committee also intends for the Secretary to set forth in regulations the frequency with which applications for reinstatement can be made in order to prevent unduly repetitious submission of such applications. The provision does not allow judicial review of a reinstatement that is denied.

SECTION 102. CIVIL MONETARY PENALTIES

The Committee amendment consolidates and clarifies these authorities, along with some expansion of the grounds for penalties and exclusion.

The amendment clarifies the civil monetary penalty statute. First, the statute would be amended to make actionable those claims a person knew or had reason to know were "false or fraudulent." This provision is intended to clarify that the scope of the statute includes such conduct as double billing, but is not intended to change the current standard of proof regarding the requirement that a person knew or had reason to know the claim was wrongful.

The amendment further clarifies the statute by expressly providing that the submission of claims for physician's services or items or services incident to a physician's service which are furnished or supervised by a non-licensed physician are actionable under the statute. This language is a restatement of the requirement in section 1861(r) that a physician must be legally authorized to practice medicine or surgery by the State in which he performs such service.

The amendment makes subject to civil monetary penalty the submitting, or causing to be submitted, of claims for payment during a

period when the person furnishing the services is excluded from participation. This provision will make clear the Committee's intent that civil monetary penalties apply to cases where claims are filed by beneficiaries because an excluded party failed to inform them of the exclusion.

The Committee notes a clarification of intent with respect to the definition of "item or service" in section 1128A(h)(3) of the current statute. Since the enactment of the civil monetary penalty statute, the Congress has enacted the prospective payment system (PPS) for inpatient hospital services furnished under Medicare (section 1886 of the Social Security Act). Consequently, hospitals now bill Medicare for a hospital inpatient stay and receive a payment that encompasses all the hospital inpatient services furnished during that stay. This change in the mechanism and documentation by which hospitals make claims for services under PPS does not affect their status as claims for items or services within the meaning of section 1128A. Other examples of information that hospitals provide under PPS that may constitute a claim include diagnostic and procedural information, cost reports, reports on the numbers and time allocation of interns and residents, and length of stay information.

Under the amendment, the Secretary's authority to exclude a person against whom a civil monetary penalty or assessment is imposed would be relocated from section 1128 to section 1128A. The intent of this change is to make explicit the policy that the Secretary may use a single administrative procedure both for imposition of penalties and assessments and for exclusions.

The amendment, in the new section 1128(b)(7), would also authorize the Secretary to exclude an individual or entity who commits an act that would be a basis for a civil monetary penalty under section 1128A. Thus, the amendment would give the Secretary two alternative procedures for exclusion. The Secretary could use section 1128, which does not involve civil monetary penalties and for which the opportunity for hearing follows the notice of exclusion, or could use section 1128A, which combines actions for exclusion and civil monetary penalties and which offers an opportunity for hearing prior to the exclusion and penalty. It is the Committee's intent, however, that the Secretary choose one or the other alternative in each instance and that the Secretary not subject an individual or entity to both procedures on the same set of facts.

By consolidating the exclusion and penalty provisions in section 1128A, the amendment would also provide a single forum for judicial review of such penalties, assessments and exclusions. Under current law, civil monetary penalties and assessments are subject to review by the Courts of Appeal; whereas, exclusions based on them under section 1128 are subject to review under Section 205(g) in the district courts.

Under the amendment, the Secretary would not be permitted to initiate an action under the civil monetary provisions later than six years after a claim had been presented. This is the same period provided in the False Claims Act (31 U.S.C. 3731). In addition, the section clarifies that actions may be initiated by serving notices of the action by any means authorized by Rule 4, Federal Rules of Civil Procedure.

A State's share of funds collected under the civil monetary penalty statute in cases involving Medicaid claims would be increased under the bill. Under current law, the State recovers only its share of the Medicaid funds actually paid as a result of false claims. Under the amendment, the State would be paid a portion of the total amount collected under the civil monetary penalty statute, in proportion to its share of the amount it paid for the claims on which the amount collected is based. The intent of this provision is to encourage States to develop and refer civil monetary penalty cases to the Secretary, and to recompense them for their investigative and support services in civil monetary penalty cases.

The amendment would authorize the Secretary to issue and enforce subpoenas with respect to civil monetary penalty proceedings to the same extent the Secretary has such authority in other Medicare and Medicaid matters. The Secretary may delegate this authority to the Inspector General for use in an investigation.

If the Secretary has evidence that any person has engaged, or is engaging in any activity which makes the person subject to a civil monetary penalty, the Secretary would be permitted to bring an action in district court to enjoin such activity or to enjoin such persons from concealing, removing, encumbering, or disposing of assets which may be required in order to pay a civil monetary penalty, or to seek other appropriate relief, including receivership. This provision is modeled on the injunctive authorities of other government agencies with anti-fraud responsibilities, namely the Securities and Exchange Commission (See 15 U.S.C. 77t) and the Federal Trade Commission (*See* 15 U.S.C. 53(b)). It is intended that district courts will grant the Secretary appropriate relief based on evidentiary showings which are no more burdensome than evidentiary showings required of those agencies.

Authority would be added to permit the Secretary to assess civil monetary penalties against inpatient hospitals that improperly charge Medicare beneficiaries for care covered by Medicare and included in the prospective payment rate or that knowingly give false or misleading information that could influence the decision on when to discharge a Medicare patient.

SECTION 103. CRIMINAL PENALTIES FOR CERTAIN FRAUD AND ABUSE RELATED TO MEDICARE AND STATE HEALTH CARE PROGRAMS

The amendment would relocate the kickback, bribe, and false statements provisions of Medicare (currently section 1877) and Medicaid (currently section 1909) into a new section 1128B. The scope of these offenses would be broadened to encompass the maternal and child health program and the Title XX social services program. This amendment also would provide criminal penalties for persons presenting claims for physician's services when the person was not a licensed physician.

SECTION 104. INFORMATION CONCERNING SANCTIONS TAKEN BY STATE LICENSING AUTHORITIES AGAINST HEALTH CARE PRACTITIONERS AND PROVIDERS

A State would be required to have in effect a system of reporting information with respect to formal proceedings concluded against an individual or entity by the State licensing authority.

The State would be required to maintain a reporting system on any adverse actions taken by such licensing authority, including any revocation or suspension of a license, reprimand, cessation of the proceedings by reason of the practitioner or entity surrendering the license or leaving the State, and any other loss of license whether by operation of law, voluntary surrender, or otherwise.

The State would be required to provide the Secretary, or an entity designated by the Secretary, access to such information for the purpose of carrying out this Act. The information must be supplied to the Secretary or, under other suitable arrangements by the Secretary, to another entity in such a manner as determined by the Secretary. Information would be required to be provided to State licensing authorities, to other State health care programs, Federal agencies administering Federal health care programs such as the Department of Defense, Veterans Administration, the Attorney General, or other law enforcement officials as the Secretary deems appropriate.

The amendment would leave to the Secretary the discretion to determine who might appropriately collect the information. If the Secretary decides to use another organization for the collection and dissemination of information, it is incumbent upon the Secretary to ensure that any organization chosen can provide the information in a timely manner and in such a way as to be useful to the Secretary.

The Secretary would be required to provide suitable safeguards to ensure the confidentiality of the information furnished by State licensing authorities. It is the Committee's expectation that safeguards will include restricting the use of information reported by State licensing authorities for purposes directly connected with the performance of the legal duties of the Secretary, State agencies and other entities receiving information under this section.

As required under current law, the Committee expects the Secretary to establish safeguards to protect the confidentiality of psychiatric or psychological treatment notes included in medical or other records.

SECTION 105. OBLIGATIONS OF HEALTH CARE PRACTITIONERS AND PROVIDERS

The provision would amend section 1156 of the Social Security Act which currently sets forth the obligations of physicians and other practitioners treating Medicare patients to provide quality of care which is medically necessary and appropriately documented, and provides for the exclusion from Medicare of providers who, upon review and recommendation of a utilization and quality control peer review organization, are found to have violated those obligations to encompass all health care services for which payment may be made under the Social Security Act, not just Medicare.

Further, the exclusion authority would extend to encompass violations occurring in, and exclusions from, any health care program for which payment may be made under the Social Security Act.

SECTION 106. EXCLUSION UNDER THE MEDICAID PROGRAM

The provision would give the States the express authority to exclude or otherwise bar individuals or entities from participation in State title XIX programs for any of the reasons that constitute a basis for an exclusion from title XVIII under Sections 1128, 1128A or 1866(b)(2). This provision clarifies that the State must exclude HMOs and entities with section 1915(b) case management waivers if they could be excluded under the Secretary's authority to exclude entities controlled by a sanctioned individual (section 1128(b)(8).

SECTION 107. MISCELLANEOUS AND CONFORMING AMENDMENTS

Denial, revocation or suspension of registration to manufacture, distribute or dispense a controlled substance

Titles V (maternal and child program), XIX (Medicaid) and XX (social services program) would be amended to clarify that no payment could be made for any item or service other than an emergency item or service furnished by an individual or entity excluded from participation in those programs. Medicare and Medicaid payments would also be denied for items and services (except for emergencies) furnished at the medical direction or on the prescription of an excluded physician.

The provision would also amend title XVIII (Medicare) to provide that an institution or agency would not be entitled to separate notice and an opportunity for a hearing under both section 1128 and section 1866(b)(2) (termination of provider agreements) with respect to a detemination or determinations based on the same underlying facts and issues.

The provision would amend the Controlled Substances Act to add as a basis for the denial, revocation or suspension of registration to manfacture, distribute or dispense a controlled substance by the Attorney General, any individual or entity that has been excluded, (or directed to be excluded) from participation in a program pursuant to section 1128(a).

In addition, it makes other technical and conforming amendments to the Social Security Act.

Effective date (Sections 101–107)

The provisions in sections 101–107 are effective fifteen days after enactment. Administrative proceedings that are commenced before the effective date would continue under current law requirements. Mandatory exclusions based on convictions occurring before enactment would not be subject to the five year minimum exclusion period. The provision giving the Secretary authority to enjoin persons from disposing of assets takes effect on enactment. Provisions impacting Medicaid payments apply to calendar quarters beginning more than thirty days after enactment.

SECTION 108. CLARIFICATION OF MEDICAID MORATORIUM PROVISIONS OF DEFICIT REDUCTION ACT OF 1984

Section 108 of the amendment would clarify the Medicaid moratorium provision in section 2373(c) of the Deficit Reduction Act of 1984 (P.L. 98-369).

Current law.—Under the "Omnibus Budget Reconciliation Act of 1981" (OBRA), States were given certain flexibility in structuring their medically needy programs. They were allowed to limit coverage to certain categories of persons and to vary the scope of services offered. However, regulations implementing the OBRA provision also permitted States to change financial eligibility rules by allowing the States to impose narrower or "more restrictive" standards and methodologies to evaluate income and resources for Medicaid eligibility.

The "Tax Equity and Fiscal Responsibility Act of 1982" (TEFRA) amended the Medicaid statute to clarify that Congress did not intend to change the policies governing income and resource standards and methodologies for determining eligibility of the medically needy from those in effect prior to OBRA. The TEFRA provision specified that the methodology to be used in determining income and resource eligibility for the medically needy must be the same methodology used under the relevant cash assistance program. However, the regulations implementing this provision led to unintended, and in certain cases, undesirable consequences because of the strict enforcement of the requirement that the noncash eligibility rules follow the eligibility rules for the cash assistance program.

The "Deficit Reduction Act of 1984" (DEFRA) intended to establish a moratorium period during which the Secretary was directed not to take any compliance, disallowance penalty or other regulatory action against a State because a State, in determining eligibility for noncash Medicaid recipients, used an income or resource standard or methodology that was less restrictive than the applicable cash assistance standard or methodology. The Secretary was directed to report to Congress within 12 months of enactment on the impact on States and recipients of applying income and resource standards and methodologies under the cash assistance programs to noncash eligibles. DEFRA further specified that no provision of law could repeal or suspend the moratorium unless such provision specifically amended or repealed that provision.

In January 1985, the Health Care Financing Administration (HCFA) issued a Medicaid Action Transmittal (85-1) to all State Medicaid agencies setting forth HCFA's interpretation for the implementation of the moratorium provision of the Deficit Reduction Act. The Transmittal limits the moratorium by concluding that the moratorium applies only where the "existing approved State plan" is, or would be, in violation of the requirement that permits the States to apply the cash assistance methodology or standards to their noncash assistance recipients. The Transmittal also limits the application of the moratorium by concluding, "Since the moratorium applies only where the existing approved state plan is or would be in violation of the provisions of section 1902(a)(10)(C)(i)(III) and since Medicaid eligibility quality control (MEQC) reviews are conducted against the approved State plan, the moratorium will have

no effect on MEQC reviews or error rates for past or future periods."

This interpretation is inconsistent with the intent of Congress (H. Rept. No. 861, 98th Cong. 2nd Sess. (1984) which intended to protect states whose noncash income and resources policies were not consistent with cash rules during the moratorium period. HFCA's refusal to approve State plan amendments to permit medically needy and other noncash eligibility policies that were less restrictive than applicable cash assistance methodologies or standards is directly contrary to the intent of the DEFRA moratorium.

More recently, a related problem has come to the Committee's attention. When a Medicaid applicant or recipient who owns his own home is admitted to a hospital or nursing home, the value of the residence continues to be disregarded in determining whether he is eligible for Medicaid provided he intends to return home. However, if it is established that the individual no longer intends to return home, the value of his residence becomes a resource that can increase his resources beyond the permitted level. In the past, under Federal Medicaid policy such an individual would not lose Medicaid eligibility if he was making a bona fide effort to dispose of the property. Proceeds from the eventual sale of the house could then be used to repay the benefits paid during this period of eligibility and to finance the patient's institutional costs until he had reduced his resources to the allowable level and could again be eligible to receive Medicaid payments.

This policy had provided a reasonable period to determine whether it was realistic to expect a patient to return home. It avoided requiring a patient to give up his home while there was still a chance that his stay would be temporary. If it was determined that an individual no longer intended to return home, he would be assured of the continuity of his care while he was given enough time to sell his residence at its reasonable market value rather than being forced to dispose of it quickly at what may be below-market value.

Recent interpretation by the Administration could change these policies and would tend to force premature sale of the homes of institutionalized Medicaid applicants and recipients. For example, one interpretation would require the value of an unsold house to be counted as an available resource even though the applicant or recipient is making a bona fide effort to dispose of it. Another new policy would force premature sale of homes by some patients who still have reasonable expectations of returning home.

Explanation of provision.—The provision would clarify that the moratorium on the Secretary's sanction activities applies to State Medicaid plans, as well as the operation or administration of a Medicaid program by a State agency pursuant to that State plan. The moratorium applies to State policies and procedures reflected in the State plans, amendments to State plans, as well as State operating or procedure manuals that are submitted to the Secretary; regardless of whether the Secretary has approved, disapproved, acted upon, or not acted upon the State plan, the amendment, or operating or procedures manual. It applies to all States, including those States operating plans pursuant to section 1902(f) of the Social Security Act (relating to special eligibility rules for aged,

blind, and disabled individuals receiving Supplemental Security Income) and it applies both to the "medically needy" as defined in section 1902(a)(10)(C) of the Act and to the "optional categorically needy" as defined in clauses (IV), (V) and (VI) of section 1902(a)(10)(A)(ii).

It applies to Medicaid eligibility and quality control reviews and error rates from October 1, 1982 until the end of the moratorium period which is 18 months after the Secretary submits the report required by the original DEFRA provision.

Thus, for example, State plans or operating manuals could provide that medically needy or optional categorically needy aged, blind or disabled applicants in nursing homes, who have marginally excess resources on the first day of the month, can still attain Medicaid eligibility during that month if they deplete their excess resources during the month, SSI rules notwithstanding. Similarly, SSI does not count resources worth up to $6,000 if they produce income. In Medicaid, a State plan could permit people in institutions to keep higher value income producing property, especially real estate (including contracts for deed), and use the income produced to offset the monthly cost of their care. State plans could also permit non-cash recipients to exclude from resources one car, regardless of its value or whether the car is necessary for employment or regular medical care as required under current SSI rules. Similarly, burial plots could be excluded as a resource even though the plots are not intended solely for the use by non-cash recipients or their immediate family members. Household goods and personal effects also could be excluded whether or not their equity value exceeds $2,000. Under this clarification to the moritorium, a State plan could permit exclusion of the equity in nonhomestead property, although current SSI rules prohibit this exclusion. Also, under the moratorium, state plans could permit use of community property laws or other divisions of income and property specified under the State Medicaid plan or operating manuals in determinations of eligibility for medically needy aged, blind and disabled, as long as such laws did not render ineligible for Medicaid, individuals or couples in the case of married individuals living together who otherwise would be eligible.

The provision only intends to permit States to broaden Medicaid eligibility by changing the rules under section 1902(a) (10) and (17) that govern income and resource eligibility of individuals not receiving cash assistance. Medicaid eligibility cannot be broadened by changing other Medicaid requirements. For example, the moratorium does not eliminate the limits on income and resources of eligible individuals and families under section 1903(f) (including the requirements that the applicable medically needy income level not exceed the amount determined in accordance with standards prescribed by the Secretary to be equivalent to 133⅓% of the most generous AFDC eligibility standard, and that income of individuals receiving a State supplementary payment in a medical institution or receiving home and community-based services under a special income standard not exceed 300% of the SSI standard). The moratorium also does not permit States to provide Medicaid benefits to those who are not "categorically related" individuals (that is, indi-

viduals who would not be eligible for Medicaid, regardless of the amount of their income or resources).

Finally, the provision would also restore for the duration of the moratorium the previous Medicaid policy in effect on October, 1982 governing the period when homeownership by an institutionalized individual is permitted and the period of time given for the sale of a home. The homeownership moratorium would apply for purposes of determining the eligibility of recipients and applicants who seek to qualify for Medicaid under the medically needy provisions, the special income standard (300 percent of the SSI payment standard) for individuals in medical care institutions, and other institutionalized individuals who could be covered as optional categorically needy persons.

Effective date.—The provision would take effect on October 1, 1982.

SECTION 109. LIMITATION OF LIABILITY OF MEDICARE BENEFICIARIES WITH RESPECT TO SERVICES FURNISHED BY EXCLUDED INDIVIDUALS AND ENTITIES

Current law.—Under current law, the Secretary can assess a civil monetary penalty against an individual or entity that has been excluded from Medicare and submits claims for medical items or services if the Secretary has initiated a termination proceeding. In addition, payment may not be made where the individual or entity knowingly and willfully made any false statement or misrepresentation in requesting payment. The Secretary may, after appropriate notice, also terminate a provider agreement if the Secretary determines that the provider has made a misrepresentation of material fact in requesting payment.

Explanation of provision.—The amendment would require that Medicare payment be made for claims submitted by a beneficiary for services rendered by an individual or entity that had been excluded from Medicare participation if the beneficiary had no knowledge of the exclusion. The Secretary would be required to notify the beneficiary of the exclusion of the individual or entity, and to specify in regulations a reasonable period of time that the Medicare payments would continue.

The provision provides specific authority for the Secretary to terminate the provider agreement after the provider has been excluded under the exclusion or civil monetary penalty provisions.

The Committee intends this provision to protect Medicare beneficiaries from harm and to provide financial protection when the excluded party fails to inform them of their exclusion. The Committee wishes to stress that an excluded party has a positive obligation to notify all patients eligible for Medicare benefits of the exclusion.

Effective date.—Fifteen days after enactment.

SECTION 110. DEFINITION OF PERSON WITH OWNERSHIP OR CONTROL INTEREST

Current law.—Under current law, a person with an "ownership or control interest" in an entity is defined as a person who: (A) (i) has directly or indirectly an ownership interest of 5 percent or more in an entity, or (ii) is the owner of a whole or part interest in

any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by the entity or any property or assets thereof, which interest is equal to or exceeds $25,000 or 5 percent of total property and assets of the entity; or (B) is an officer or director of the entity, if the entity is organized as a corporation; or (C) is a partner in the entity, if the entity is organized as a partnership.

Explanation of provision.—The bill would amend the definition of ownership or control interest. The new definition would limit reporting to interest in obligations which amount to 5 percent or more of the assets of the entity.

Effective date.—Fifteen days after enactment.

SECTIONS 111–114. INTERMEDIATE SANCTIONS FOR MEDICARE AND MEDICAID PROVIDERS AND SUPPLIERS

Current law.—Under current law, the Secretary may terminate provider agreements where the entity fails to meet the terms and conditions of the agreement or conditions of participation. An alternative to termination is provided for skilled nursing facilities (SNFs) under Medicare and Medicaid, and intermediate care facilities (ICFs) under Medicaid if deficiencies do not immediately jeopardize the health or safety of the patients. Under the intermediate sanction alternative, the Secretary and/or State may, instead of terminating the facility's participation in the program, refuse to make payment on behalf of eligible individuals admitted to a SNF or ICF after a notice and until the deficiencies are corrected to the Secretary's satisfaction.

"Look-behind" surveys are on-site surveys conducted by Federal staff on a sample of SNFs and ICFs to evaluate whether the State survey agency has correctly determined compliance of the facility with Medicare and Medicaid requirements. If the Federal review finds a problem, the Secretary may terminate the facility from participation in Medicare and Medicaid until the problem is corrected and there is reasonable assurance that it will not recur.

Explanation of provision.—This provision would expand the intermediate sanction authority in current law to all Medicare and Medicaid agreements with providers and suppliers. The provider or supplier would not be entitled to a hearing before the intermediate sanction was imposed.

In the case of inpatient services, payment could be made only for services to individuals admitted before the notice of the intermediate sanction. For all other services, payment could be made only for services scheduled (as determined by the Secretary in regulations) before the date of the notice. If the Secretary (or State) determines that the deficiencies have not been corrected, the agreement shall be terminated. It is the Committee's intent that the Secretary use the intermediate sanction authority to penalize hospitals paid under Medicare's prospective payment system that fail to properly distribute the notice of beneficiary rights.

Clarifying and conforming changes would be made to the Secretary's "look-behind" authority. First, the effective date of termination of a skilled nursing facility that participates in both Medicare and Medicaid would be the same for both programs. Second, the provision conforms the "look-behind" authority to the intermediate

sanction authority. The Secretary would be given the authority to apply an intermediate sanction in lieu of termination if he finds a problem as part of the "look-behind" review. Finally, the facility would not be entitled to a hearing before the intermediate sanction is imposed.

Effective date.—Fifteen days after enactment.

SECTION 115. HEALTH MAINTENANCE ORGANIZATION AND COMPETITIVE MEDICAL PLAN SANCTIONS

Current law.—Section 1876 provides for Medicare payments to Health Maintenance Organizations (HMOs) and Competitive Medical Plans (CMPs) on either a risk or cost contracting basis. Each Medicare contracting HMO and CMP must have at least half of their membership composed of enrollees that are not entitled to benefits under either Medicare or Medicaid. The Secretary may waive this requirement only if special circumstances warrant such a waiver and if the organization is making reasonable efforts to enroll individuals not entitled to Medicare or Medicaid. Each contract is for the term of at least a year; however, the Secretary may terminate a contract at any time (after reasonable notice) if the HMO or CMP substantially violates the terms of its contract. The Secretary does not have specific authority to terminate a contract at any time if the plan has more than half of its membership composed of individuals entitled to Medicare or Medicaid.

Section 1903(a) provides for contracts between HMOs with State Medicaid programs. HMOs contracting to provide services to Medicaid beneficiaries may not have more than 75 percent of their membership composed of individuals entitled to Medicare of Medicaid.

Explanation of provision.—The provision would permit the Secretary (with respect to contracts under Medicare) and State Medicaid directors (with respect to contracts under Medicaid) to suspend new enrollments for HMOs and CMPs that violate their contracts if such violation does not jeopardize the health and safety of their enrollees. That is, payments to these organizations would only be made for individuals enrolled in the HMOs and CMPs prior to the date that these plans are notified that they are not in compliance with their contracts. The provision would also permit the Secretary (with respect to contracts under Medicare) and State Medicaid directors (with respect to contracts under Medicaid) to terminate at any time contracts with HMOs and CMPs that do not comply with the contract requirements relating to composition of the membership.

The provision would create new authority to permit the Secretary to assess civil money penalties against HMOs and CMPs. The provision would permit the Secretary to assess these penalties for five types of violations—1) If an HMO or CMP charged its Medicare enrollees more than permitted under the plan's contract, the Secretary could assess a civil money penalty equal to twice the excess charge plus $2,000 per instance. 2) If an HMO or CMP failed to provide a Medicare beneficiary medically indicated treatment that is covered under the contract, the Secretary could assess a civil money penalty up to $25,000 per patient. 3) If an HMO or

CMP disenrolled Medicare beneficiaries in a manner not permitted by law, the civil money penalty would be up to $15,000 per instance. 4) If the HMO or CMP engaged in any practice which would reasonably be expected to have the effect of excluding from enrollment under the contract any individuals eligible for Medicare whose present medical condition or past medical history indicates a need for substantial future medical services, the Secretary could assess a civil money penalty up to $100,000 and up to $15,000 per individual excluded. 5) If the HMO or CMP misrepresented or falsified enrollment information, the civil money penalty would be up to $100,000 for each time the Department of Health and Human Services is misinformed.

Effective date.—Fifteen days after enactment.

SECTION 116. AMENDMENT RELATING TO FRAUD INVOLVING MEDICARE SUPPLEMENTAL HEALTH INSURANCE

Current law.—Under current law, criminal sanctions are established for fraud and abuse relating to the sale of supplemental health insurance.

Explanation of provision.—The bill would amend the provisions establishing criminal penalties for fraud and abuse relating to the sale of "Medigap" supplemental health insurance policies to provide that whoever "knowingly and willfully" misrepresents a material fact is guilty of a felony. Current law reads "knowingly or willfully". This is a technical change and conforms the legislative language in section 1882(d) to language generally used in similar statutes.

Effective date.—Fifteen days after enactment.

SECTION 117. DENIAL OF MEDICAID PAYMENT TO STATES WHERE INFORMATION SUPPORTING CLAIMS IS NOT FURNISHED TO THE SECRETARY

Current law.—Medicaid requires persons or institutions providing services under the State plan to furnish the State agency or the Secretary with information regarding any payments claimed for providing services as the State agency or Secretary may request.

Explanation of provision.—Authority would be added to permit the Secretary to deny Federal payments for Medicaid services furnished by an individual or entity that failed to furnish information required under Medicare or Medicaid.

Effective date.—Fifteen days after enactment.

SECTION 118. AMENDMENTS TO THE UTILIZATION CONTROL REQUIREMENTS

Current law.—Under Medicaid, a state must have an effective program of medical review, including onsite inspections and recertification of the need for continued care, of patients who have long stays in a hospital (over 60 days), a skilled nursing facility or intermediate care facility (over 30 days), or a mental hospital (over 90 days). If the state does not provide the necessary assurances to the Secretary, the Federal medical assistance percentage will be reduced.

Explanation of provision.—The bill would amend the utilization control provisions to provide that the patient stays on which the penalty is calculated include all consecutive stays, whether or not during the same fiscal year. This change would eliminate the need to recalulate stays annually for long term care patients who are essentially permanently institutionalized.

Effective date.—Fifteen days after enactment.

SECTION 119. PROHIBITION OF CERTAIN PHYSICIAN INCENTIVE PLANS

Current law.—Utilization and Quality Control Peer Review Organizations (PROs) are responsible for reviewing quality of hospital services and may recommend sanctions against persons or providers who have failed in a substantial number of cases to meet their obligations to provide services meeting professionally recognized standards of health care. The Secretary of Health and Human Services may bar persons from participation in the program if they furnish services which fail to meet professionally recognized standards. Provider agreements may be terminated for the same reason. In addition, program payment may be denied if the service is not deemed medically necessary.

Some hospitals have developed physician incentive plans under which physicians may be rewarded if they achieve reductions in hospital costs associated with their Medicare patients. The General Accounting Office has reviewed such plans and concluded that in some cases they can provide physicians with too strong an incentive to underserve patients.

Explanation of provision.—The amendment permits the Secretary to assess civil monetary penalties against a physician who fails to furnish medically necessary services or supplies, or fails to admit a beneficiary based on the amount of services or length of stay required if 1) the failure adversely affects the health and safety of the individual and 2) the PPS hospital pays directly or indirectly a bonus (in cash or kind) based in whole or in part on the amount of services or length of stay. The Secretary would also be permitted to assess civil monetary penalties against the PPS hospital participating in these bonus arrangements. The penalty would not be more than $25,000 for each patient. The penalty would be limited to cases where the Medicare patient or the physician could be individually identified.

As a condition of participation, hospitals must provide a copy of the incentive plan to the Secretary, and make it available for inspection in accordance with the requirements of the Secretary. The Secretary would have the authority to assess a civil monetary penalty of $15,000 against a hospital that failed to disclose a physician incentive plan.

The amendment does not apply to incentive compensation arrangements covering physicians serving health maintenance organizations or competitive medical plans. Incentive arrangements of this type, under which a physician's compensation is at risk, based upon the overall operation in relation to forecast, have been found to provide appropriate incentives for the delivery of cost-effective health care services. Incentive plans that have been approved by

the Secretary of HHS as part of a demonstration project are excluded from penalties under this provision.

The amendment has adopted a narrow definition of the types of physician incentive plans that would be subject to the civil monetary penalty because the Committee believes that while some physician incentive plans are a threat to patient care, other incentive plans represent appropriate mechanisms to control unnecessary costs intended in the prospective payment system. The provision would require the Secretary to study and report by January 1988 on the need to expand the scope of the provision to encompass other types of physician incentive plans (including plans operated by PPS hospitals, HMOs, CMPs, or other entities or organizations) that have the effect of pressuring physicians to improperly discharge patients from hospitals before their discharge is medically appropriate, or to reduce medically appropriate services.

Effective date.—Fifteen days after enactment.

SECTION 120. AMENDMENTS TO ANTI-KICKBACK PROVISIONS

Current law.—Medicare and Medicaid prohibit individuals or entities from soliciting, receiving, offering, or paying any remuneration in return for referring for or arranging for the furnishing of any item or service, or in return for purchasing, leasing, or ordering or arranging for any good, facility or service for which payment may be made. Remuneration may include a kickback, bribe or rebate that is paid directly or indirectly, either in cash or in kind. The penalty upon conviction is a felony conviction subject to a fine of not more than $25,000 or imprisonment of not more than 5 years.

Explanation of provision.—Subject to certain conditions, this provision would exempt two practices from criminal prosecution under the kickback provision. First, the exemption would apply to certain PPS hospitals who waive the Part A deductible or coinsurance requirements. The second exemption would apply to certain PPS hospitals or other providers paid on a risk basis who participate in group purchasing arrangements. The Secretary would be required to publish regulations identifying other competitive practices involving the referral or acceptance of services covered by Medicare or Medicaid which would not be considered a kickback for the purpose of imposition of criminal penalties. Criminal penalties would be maintained for individuals or entities who do not meet the conditions established in this provision or who are not exempted by regulations.

The Secretary would be required to establish a new condition of participation requiring hospitals to develop a written policy on collection of Part A deductible and coinsurance. The Secretary would have the authority to exclude the hospital from participation in the Medicare program or impose intermediate sanctions if it fails to comply with the written policy. PPS hospitals would be permitted to waive (or reduce) the Part A deductible or coinsurance if the reduction applies uniformly to all Medicare patients in the same diagnostic category (DRG) at the same hospital. In addition, the hospital would be required to offset the amount waived against Medicare bad debt. Finally, the Peer Review Organization (PRO) would

be required to conduct a preadmission review on a substantial number of procedures which could also be performed on an outpatient basis where the cost-sharing is waived to assure that the inpatient setting is appropriate. The provision would permit all PPS hospitals who currently waive cost-sharing for veterans to continue their programs for two years.

The Committee believes that waiver of cost-sharing requirements may be an appropriate activity in certain competitive environments. However, there is also concern that the waiver may reduce necessary revenues with a potential impact on quality of care or Medicare payment levels. Thus, this provision also requires the General Accounting Office to conduct a study of the impact of these waiver requirements on beneficiary access and competition in the health care industry. The GAO study would be required to recommend restrictions or expansions of the waiver authority. The Committee intends that this provision will not apply to HMOs or CMPs that offer reduced premiums, permitted under current law, as an incentive for beneficiaries to enroll.

The amendment would exempt PPS hospitals and other providers paid on a risk basis who participate in group purchasing organizations (GPOs) from criminal penalties. Instead, this provision would require that the GPO have a written agreement with each provider or hospital, and the supplier or vendor. The GPO would also be required to provide full disclosure on all fees and payment. The bill retains the criminal penalty for payments made by a vendor to the GPO for providers paid on a cost basis.

Effective date.—Fifteen days after enactment.

TITLE II. MEDICARE, MEDICAID, AND OTHER AMENDMENTS

A. MEDICARE

1. Annual recalibration of PPS (Section 201)

Current law.—Under Medicare's prospective payment system (PPS), the Secretary of Health and Human Services is required to adjust, at least every 4 years, the categories and weighting factors used to classify patients in specific diagnosis related groups (DRGs). These periodic adjustments are intended to assure that the categories and weighting factors continue to reflect the types of patients treated and the relative use of hospital resources among them.

Explanation of provision.—The provision would require that the Secretary recalibrate the prospective payment system by adjusting all the DRG categories and weighting factors at least every year beginning with fiscal year 1988. In addition, the Secretary would be allowed to reweight specific DRGs without reweighting all DRGs on an across-the-board basis.

Effective date.—Enactment.

2. Rebasing PPS rates for Fiscal Year 1988 (Section 202)

Current law.—The prospective payment system (PPS) rates for 1983 were based on unaudited cost data from hospital cost reporting periods ending in calendar year 1981 updated to reflect the effect of inflation between 1981 and fiscal year 1984.

Explanation of provision.—The provision would require the Secretary to rebase the PPS rates for fiscal year 1988 to reflect the reasonable costs reported by urban and rural hospitals in hospital cost reporting periods beginning in fiscal year 1984 under the reasonable cost methodology applied to non-PPS hospitals. The cost impact of the provision would be budget neutral. That is, if aggregate payments in 1988 are expected to be lower or higher as a result of rebasing, the Secretary would be required to apply an additional factor to increase or decrease all rates to a level which prevents a change in overall spending. With respect to setting the urban and rural average standardized payment amounts, the rebasing would be done on a weighted discharge basis.

Effective date.—Enactment.

3. Reporting of hospital costs (Section 203)

Current law.—The Secretary of Health and Human Services is required to maintain a hospital cost reporting system for hospitals paid under the prospective payment system (PPS), at least until September 30, 1988.

Explanation of provision.—The provision would require cost reports to be maintained through hospital cost reporting periods ending in fiscal year 1993. It requires the Secretary, after consultation with the Prospective Payment Assessment Commission, General Accounting Office, the Office of Technology Assessment; and representatives of research, accounting, and health care organizations to recommend to Congress an improved cost reporting system within one year. The Secretary would be restricted from changing the general scope and content of the cost report requirements other than to reflect changes in law until the report to Congress is submitted.

Effective date.—Enactment.

4. Coverage of hospitals in Puerto Rico under a DRG prospective payment system (Section 204)

Current law.—When the prospective payment system (PPS) was enacted, hospitals in Puerto Rico were excluded from the system because the data were insufficient to determine if the payment method was appropriate for these hospitals. The Secretary of Health and Human Services was required to prepare a report to Congress recommending a method for including Puerto Rico hospitals under the prospective payment system.

Explanation of provision.—The provision would include Puerto Rico hospitals in Medicare's prospective payment system. Under the provision:

a. Puerto Rico would be designated as a separate region for payment purposes;

b. The payment rate would be based on a blend—75 percent of the Puerto Rico standardized rate and 25 percent of the national standardized payment rate;

c. The Puerto Rico standardized rate would distinguish rates for urban hospitals and rural hospitals while the national rate would combine urban and rural hospital rates using a discharge weighted average;

d. The base-year would be the latest year for which reasonable cost data is available; and

e. Puerto Rico hospitals would be exempt from restrictions regarding direct medical education payments for foreign medical graduates.

As under the national system, Puerto Rico hospitals that qualify would receive additional payments or exceptions for such factors as: (1) indirect costs of teaching; (2) serving a disproportionate share of low-income patients; (3) outliers; (4) costs of non-physician anesthetists; (5) capital-related costs; and (6) sole community provider status.

National payment rates would be restandardized to include Puerto Rico hospitals, making the cost impact of this provision budget netural.

The Secretary of Health and Human Services would be required to conduct a study to determine whether special adjustments are needed for non-labor costs, such as supplies and equipment.

Effective date.—Discharges occuring on or after October 1, 1987.

5. Reclassification of certain DRGs (Section 205)

Current law.—The Prospective Payment Assessment Commission (ProPAC) is an independent commission designated by Congress to review Medicare's prospective payment system (PPS). One of ProPAC's responsibilities is to evaluate scientific evidence and make annual recommendations to the Secretary of Health and Human Services regarding changes in the diagnosis related groups (DRG) classification system used to establish payment rates under PPS.

Explanation of provision.—The provision would require the Secretary to implement ProPAC recommendations to reclassify two diagnosis related groups. The PPS would be adjusted to assure that these changes are budget neutral.

The first change would be to reclassify the implantation of penile prostheses (a surgical procedure and device used to treat impotence) into a unique DRG because the resource use associated with this procedure is significantly greater and different from the resources required by other surgical procedures in the current DRG classification.

The second change would be to adjust the heart pacemaker DRGs to distinguish between dual chamber or functionally similar pacemakers, and single chamber pacemakers.

Effective date.—For discharges occurring on or after October 1, 1987, and before October 1, 1989.

6. Modification of PPS outliers (Section 206)

Current law.—Five to 6 percent of the Federal portion of the estimated prospective payments is set aside each year to pay for "outliers"—complex cases that require substantially longer lengths of stay or higher costs compared to the average case in the same diagnosis group. Thus under current regulations, the Federal rates are reduced by 5 percent for all hospitals. However, on average, urban hospitals receive a greater share of total outlier payments compared to rural hospitals. That is, aggregate outlier payments to urban hospitals amount to more than 5 percent of their total Fed-

eral DRG payments, while outlier payments to rural hospitals amount to less than 5 percent of their total payments.

Explanation of provision.—This provision would replace the current overall national outlier percentage set-aside factor with separate urban and rural set aside factors for each region. The factor corresponding to the hospital's location (by urban or rural area and geographic region) would be applied to the hospital's Federal payment amount per discharge. As a result, the amounts set aside for outlier payments to urban and rural hospitals within each region would be approximately equal to the amounts of outlier payments they are expected to receive.

Effective date.—For discharges occurring on or after October 1, 1987.

7. Burn outlier study; payment adjustment (Section 207)

Current law.—Five to 6 percent of the Federal portion of the estimated prospective payments is set aside each year to pay for "outliers"—complex cases that require substantially longer lengths of stay or higher costs compared to the average case in the same diagnosis related group (DRG). Currently, outlier payments are intended to cover the marginal cost of an extra day of care which is assumed to be equal to 60 percent of the average cost of a day care in the DRG.

Preliminary information suggests that the marginal cost of an extra day of care for burn patients may be higher than for other categories of patients.

Explanation of provision.—The provision would require the Prospective Payment Assessment Commission (ProPAC) to recommend by April 1987 a modification of the prospective payment system to better accommodate outliers for burn cases, including a recommendation as to whether there should be separate payment rates for burn center hospitals.

The provision would also require a temporary adjustment to the payment rates for all burn outliers until new rates are established based on the required ProPAC study. The temporary payment adjustment would increase the outlier payment from 60 percent to 80 percent of the cost of an extra day of care for all burn outlier cases.

Effective date.—Discharges occurring on or after October 1, 1986, and before the Secretary implements a payment modification based on the ProPAC study.

8. Sole community provider extension (Section 208)

Current law.—The Secretary is required to apply a special payment for sole community provider hospitals. These are hospitals that (by reason of factors such as isolated location, weather conditions, travel conditions, or absence of other hospitals) are the sole source of inpatient services reasonably available in a geographic area. Under the prospective payment system, sole community providers are paid under a separate formula—25 percent of the payment is based on regional DRG rates and 75 percent on each hospital's historical cost base. These amounts are adjusted each year by the PPS update factor.

There is an additional payment provision for any sole community provider that experiences an annual decrease of more than 5 per-

cent in patient volume due to circumstances beyond its control. The fixed costs of a hospital in this situation, including the reasonable cost of maintaining necessary core staff and services, are spread over fewer cases. Therefore, the hospital's total cost per discharge increases. The Secretary is required to adjust the payment per discharge to fully compensate these hospitals for the increased costs. The additional payment provision only applies to hospital cost reporting periods beginning prior to October 1, 1986.

Explanation of provision.—The provision would extend indefinitely the additional payment provision for a 5 percent decrease in volume. The Secretary of Health and Human Services would be required to conduct a study of new payment methodologies which might be more appropriate for sole community providers and other low-volume rural hospitals.

Effective date.—Cost reporting periods beginning on or after October 1, 1986.

9. Impact analyses of Medicare and Medicaid regulations on small rural hospitals (Section 209)

Current law.—The Regulatory Flexibility Act requires that all executive agencies perform a regulatory flexibility analysis whenever they propose regulations that would have a significant economic impact on a substantial number of small entities.

The Department of Health and Human Services defines all hospitals as being small entities. Therefore, regulatory flexibility analysis of the impact of proposed Medicare or Medicaid regulations often fail to isolate the effects on subgroups of hospitals which may be especially vulnerable, such as small rural hospitals.

Explanation of provision.—The provision would require regulatory flexibility analysis to include a specific analysis of the impact of all proposed Medicare and Medicaid regulations on small rural hospitals. A small hospital would be defined as any sole community provider hospital or any rural hospital of 50 beds or less. This requirement would be in addition to any analysis otherwise required by the Regulatory Flexibility Act.

Effective date.—Applies to regulations proposed after enactment.

10. Regional referral centers for States previously under waiver (Section 210)

Current law.—Under the prospective payment system (PPS), regional referral centers located in rural areas may qualify for the urban payment rate if they meet certain criteria relating to bed size, or criteria relating to case mix, volume, or patient referrals in the preceding fiscal year based on 12 months of data.

New York and Massachusetts were originally exempt from PPS under waivers for State payment systems, but came under PPS on January 1, 1986. Consequently hospitals in those States do not have PPS case mix data for the full fiscal year 1986.

Explanation of provision.—The provision would allow, in the case of a hospital in a State which was previously under a waiver, regional referral center status for fiscal year 1987 to be established on the basis of data for the 9 months of fiscal year 1986 during which the State was under PPS.

Effective date.—October 1, 1986.

11. Psychologists' services (Section 211)

Current law.—The Social Security Act includes within the definition of covered inpatient hospital services "such other diagnostic or therapeutic items or services, furnished by the hospital or by others under arrangements with them made by the hospital, as are ordinarily furnished to inpatients either by such hospital or by others under such arrangements." The services of psychologists employed by or providing services under arrangements with hospitals have been included under this authority.

Explanation of provision.—The provision would clarify in statute that inpatient hospital services for which payment may be made under Part A may include services provided by a clinical psychologist as defined by the Secretary.

Effective date.—Enactment.

12. Correction of effective date of provisions affecting hospital participation in CHAMPUS and CHAMPVA (Section 212)

Current law.—The Consolidated Omnibus Reconciliation Act of 1985 (COBRA) requires a Medicare-participating hospital to participate in CHAMPUS (Civilian health and Medical Program of the Uniformed Services) and CHAMPVA (Civilian Health and Medical Program of the Veteran's Administration) in accordance with admissions practices, payment methodologies and amounts prescribed in regulations. The provision is effective for participation agreements entered into or renewed on or after the date of enactment but only applies to inpatient hospital services provided for hospital admissions occurring on or after January 1, 1987.

Explanation of provision.—The provision would delete the requirement that the COBRA provision apply to agreements "entered into or renewed after the date of enactment". Medicare does not periodically renew hospital agreements.

Effective date.—As if included in COBRA when enacted.

13. Coordination of and oversight of quality evaluations (Section 213)

Current law.—A number of studies to assess the impact of the prospective payment system (PPS) on the quality of patient care are required by law. Currently, no agency or office is establishing research priorities and coordinating studies, data, and reports on the quality of care under PPS.

Explanation of provision.—The provision would require the Secretary of Health and Human Services (HHS) to designate an office to coordinate the development of studies on the quality of care under PPS. A task force consisting of interested congressional agencies, beneficiary groups, and health care organizations would be convened to develop an agenda and establish priorities for quality studies.

The Secretary would be required to submit the initial agenda to Congress within 1 year of enactment. Specific gaps in studies and data should be identified. An annual review of the agenda would be required to assess accomplishments and changes in priorities. The Secretary also would be responsible for establishing a plan to coordinate access to data necessary to conduct the studies and for

maintaning a clearinghouse on PPS quality studies conducted by HHS and other entities.

Effective date.—Enactment.

14. Quality studies and reports (Sections 214–218)

Current law.—Medicare law authorizes the Secretary of Health and Human Services to conduct research and demonstration projects designed to improve the operation and effectiveness of the Medicare program.

Explanation of provision.—The provision would require the Secretary to conduct five studies:

a. Refinement of the Prospective Payment System.—The Secretary would be required to submit a legislative proposal to improve the prospective payment system by January 1988. The proposal should account for variations in severity of illness and case complexity which are not adequately accounted for by either the prospective payment rates or payment for outliers.

b. Review of Medicare Hospital Conditions of Participation.—The Secretary would be required to determine if the current standards used to certify hospitals for Medicare participation are adequate to maintain quality services given incentives under the prospective payment system to lower levels of patient care.

c. Payment of Administratively Necessary Days.—The Secretary would be required to assess whether additional payment should be made for administratively necessary days. An administratively necessary day is an additional day of inpatient hospital care made necessary because no skilled nursing facility is available for the patient.

d. Development of Uniform Needs Assessment Instrument.—The Secretary would be required to develop a uniform needs assessment instrument to be used by discharge planners, providers, and fiscal intermediaries in evaluating an individual's need after discharge for skilled nursing facility services, home health services, and other long term care services of a health-related or supportive nature. An advisory panel would be established for consultation with the Secretary.

e. Including Information in PPS Annual Reports.—The annual reports to Congress concerning the prospective payment system would be expanded to include:

i. an evaluation of the adequacy of procedures for assuring the quality of post-hospital services provided under Medicare;

ii. an assessment of barriers to receiving appropriate post-hospital services; and

iii. information concerning reconsiderations and appeals for post-hospital services covered under Medicare.

Effective date.—Enactment.

15. Connecticut hospice waiver (Section 219)

Current law.—Medicare certified hospices are required to maintain no more than 20 percent of total days of care provided as inpatient days. The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), which authorized Medicare's hospice benefit, required

the Secretary of HHS to grant waivers of this inpatient care limitation to hospices which began operation before January 1, 1975 (essentially Connecticut Hospice Inc.). TEFRA also required the Secretary to grant waivers to early hospices for limitations on reimbursements (relating to the cap amount) and on the frequency and number of respite care days (defined as a period of relief for the family or friend who provides care to a dying patient). The requirement for the Secretary to grant waivers of these limitations expires October 1, 1986.

Explanation of provision.—The provision would permanently waive Connecticut Hospice Inc. from the limitation which requires that not more than 20 percent of patient care days be inpatient care days and would establish for this hospice a new limitation that the proportion of inpatient days not exceed 50 percent. The new limitation would only apply to those inpatient beds licensed and in service as of July 1, 1986. Waivers would no longer be available to Connecticut Hospice for the reimbursement cap or the limitation on respite care days.

Effective date.—October 1, 1986.

16. Disproportionate share technical (Section 220)

Current law.—The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) provided for additional Medicare payments to hospitals that serve a disproportionate share of low income patients. One method by which a hospital can qualify for the adjustment is to be located in an urban area, have 100 or more beds, and receive more than 30 percent of its net inpatient revenues (excluding Medicare and Medicaid) from State and local Government sources for indigent care.

The Health Care Financing Administration issued interim final regulations on May 6, 1986, implementing the disproportionate share adjustment. The preamble to the regulation noted that it would be incumbent upon a hospital to demonstrate that more than 30 percent of its net patient revenues were received from State and local government sources and were specifically earmarked for indigent care. In addition, the hospital would not be permitted to include funds furnished to the hospital to cover general operating deficits in order to meet this criterion.

Many State and local governments do not specifically earmark funds provided to hospitals for indigent care. Instead, much of the funding for indigent care is made in the form of general payments to cover hospital operating deficits.

Explanation of provision.—The provision would allow hospitals the flexibility to demonstrate that State and local government funding is actually used for indigent care, regardless of how it is characterized in State and local government budgets.

Effective date.—Effective as if included in COBRA as originally enacted.

17. Physician Payment Review Commission membership (Section 221)

Current law.—The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) provided for the establishment of a Physician Payment Review Commission appointed by the Director of the

Office of Technology Assessment (OTA). The Commission is to make recommendations to the Congress regarding Medicare payment for physicians' services. The Commission consists of eleven members with expertise in the provision and financing of physicians' services. Members of the Commission are to be appointed for three years except that the Director may provide initially for shorter terms as necessary to ensure that (on a continuing basis) the terms of no more than four members expire in any one year.

Explanation of provision.—The provision would increase the number of members on the Commission to thirteen. The terms of members would be adjusted to ensure that the terms of no more than five members expire in any one year. The provision would require the appointment of the two additional members within 60 days of enactment. It is the Committee's intent that at least one of the new members would be from a rural area.

Effective date.—Enactment.

18. Delay mandatory assignment for clinical laboratory services performed in a physician's office (Section 222)

Current law.—The Deficit Reduction Act of 1984 (DEFRA) established two fee schedules for the payment of clinical laboratory services under Medicare. One fee schedule was established for laboratory tests performed by a physician or by an independent laboratory. A second schedule was established for hospital-based laboratory services provided to a hospital's outpatients. A national fee schedule for services performed by either a physician or independent laboratory was slated to go into effect July 1, 1987. Under the DEFRA provision, a physician was permitted to bill for clinical laboratory services only if he personally performed or supervised the performance of the test. Independent laboratories were required to accept assignment on claims (i.e., they were required to accept Medicare's fee as payment in full and not charge beneficiaries additional amounts). Under the mandatory assignment provision, laboratories receive 100% of the fee schedule amount and beneficiary cost-sharing is waived.

The Consolidated Omnibus Reconciliation Act of 1985 (COBRA) provided that beginning January 1, 1987, payments for laboratory tests performed by physicians would conform to the requirements for independent laboratories, namely payments must be made on the basis of assignment and beneficiary cost-sharing is waived. The provision also placed limits on fee schedule amounts and provided that the national fee schedule would go into effect on January 1, 1988.

Explanation of provision.—The provision would delay until January 1, 1988 the effective date of the requirement that laboratory services provided in physician's offices must be paid on the basis of assignment. The waiver of beneficiary cost-sharing would likewise be delayed.

Effective date.—Enactment.

19. Coverage of services of registered nurse anesthetists (Section 223)

Current law.—Payments for services of certified registered nurse anesthetists (CRNAs) employed by hospitals are made to the hospi-

tal on a cost basis and are temporarily excluded from the definition of operating costs under the prospective payment system. For services of CRNAs employed by physicians, the physician is paid on a reasonable charge basis as if he or she had performed the service, and the physician makes payment to the CRNA according to the terms of employment. Physicians who provide medical direction for CRNAs employed by a hospital receive an adjusted reasonable charge payment.

Provisions relating to payment for services of hospital-employed CRNAs provided to hospital inpatients are effective for cost reporting periods beginning on or after October 1, 1984 and before October 1, 1987.

Explanation of provision.—The provision would authorize direct reimbursement for anesthesia and related care furnished by a certified registered nurse anesthetist who is legally authorized to perform those services in the State. The term certified registered nurse anesthetist is defined as a registered nurse licensed by the State which meets such education, training and other requirements relating to anesthesia services and related care as the Secretary may prescribe. The Secretary may use the same requirements as those used by a national organization for the certification of nurse anesthetists.

The provision would authorize payments to be made in an amount equal to 80% of a fee schedule established by the Secretary. The Secretary could vary the fee schedule by geographic area.

Initially, the fee schedule would be established at a level based on the costs of anesthesia services provided by CRNAs in the preceding year. The initial fee schedule amount would be adjusted to the extent necessary to ensure that the total amount paid by Medicare in any year for anesthesia services (including services provided by CRNAs and the medical direction provided by physicians) plus applicable coinsurance could not exceed the amount which would be paid plus applicable coinsurance in the absence of this provision. In order to meet this requirement, the Secretary would be permitted to adjust payment levels either for CRNA services only, or for both medical direction and CRNA services. The initial fee schedule would be adjusted to reflect audited cost data for FY 85 when it becomes available. The provision would require the fee schedule to be updated annually by the percentage increase in the Medicare economic index.

In establishing the initial fee schedule the Secretary shall to the extent practicable ensure that the economic incentives for employing CRNAs are not significantly altered.

The provision would require CRNAs to accept assignment for all Medicare services. Payments would be made directly to the CRNA, or the hospital or physician could bill for and receive payment for CRNA services where an employment relationship or contract so stipulates. The hospital or physician could not bill more for CRNA services than the amount the CRNA could bill directly. Unpaid deductible and coinsurance amounts on CRNA services billed by a hospital could not be counted as bad debt for the hospital.

Effective date.—Applies to services provided on or after October 1, 1987.

20. Coverage of services of a physician assistant (Section 224)

Current law.—Payments are made to a physician for services and supplies furnished incident to a physician's professional services. The services of nonphysicians are covered as incident to physicians services and must be rendered under the direct supervision of the physician by employees of the physician.

Explanation of provision.—The provision would authorize Medicare coverage of the services of physicians' assistants furnished under the supervision of a physician in a hospital or skilled nursing facility, or as an assistant-at-surgery. The physician assistant must be legally authorized to perform such services in the State in which the services are performed. Payment would be authorized only for services for which payment would be made if furnished by a physician.

The provision would specify that the prevailing charge for a service furnished by a physician's assistant may not exceed 90% of the prevailing charge for the same service when furnished by a physician in the same locale. Payment could only be made to the employer of the physician assistant when services are provided on the basis of assignment.

Effective date.—Applies to services furnished on or after January 1, 1987.

21. Coverage of psychologists' services furnished at rural health clinics (Section 225)

Current law.—Medicare does not make direct payments for psychological services delivered by a non-physician provider except in the case of diagnostic testing services. The services of psychologists employed by or providing services under arrangements with hospitals may be included within the definition of inpatient hospital services. Psychologists services may also be covered as "incident to" physicians services provided there is direct personal supervision by a physician; program payment is made directly to the physician.

Payment may be made under Medicare Part B for rural health clinic services. Included in the definition of rural health clinic services are nurse practitioner and physician assistant services and services and supplies incident to such services. The services of such individuals are covered, whether or not the clinic is under the full-time direction of a physician, if the individual is legally permitted under State law to perform such services and meets training, education, and experience requirements prescribed by the Secretary. Medicare payments may not exceed 80% of the reasonable costs for such services.

Explanation of provision.—The provision would include psychologists services within the definition of covered rural health clinic services even when such services are not provided under the supervision of a physician.

Effective date.—Services provided on or after enactment.

22. Extension of moratorium on laboratory payment demonstration (Section 226)

Current law.—The Secretary, pursuant to existing demonstration authority, proposed to experiment with competitive bidding for

purchase of clinical laboratory services. The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) prohibited the Secretary from conducting such demonstration projects prior to January 1, 1987. However, the Secretary could contract for the design of and site selection for such demonstration projects.

Explanation of provision.—The provision would extend the moratorium for one year from the date of enactment. The Department of Health and Human Services would be required to publish in the *Federal Register* a description of the experiment 90 days prior to its implementation.

Effective date.—Enactment.

23. Home emergency response clinical trial (Section 227)

Current law.—A personal home emergency response system consists generally of equipment in a person's home which transmits a signal for medical assistance to an emergency response center. Such systems are considered emergency communications systems which do not serve a diagnostic or therapeutic purpose and are therefore not covered by Medicare.

Explanation of provision.—The provision would require the Secretary to conduct a 48 month clinical trial to determine the efficacy and economic feasibility of providing Medicare coverage for personal emergency response systems. The Secretary would be required to report to the Congress on the results of the trial 12 months after the trial is completed.

Effective date.—Enactment.

24. Prevention health services demonstration program (Section 228)

Current law.—The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) required the Secretary to establish a 4-year preventive health services demonstration program designed to reduce disability and dependency for Medicare program beneficiaries. The program is to be conducted under the direction of accredited public or private nonprofit schools of public health or preventive medicine departments accredited by the Council on Education for Public Health. The program is to be conducted in at least five sites which are geographically diverse and readily accessible to a significant number of Medicare beneficiaries. COBRA specified that total funding for the demonstration program could not exceed $4 million.

The total cost of operating and evaluating the five demonstration projects is estimated to be $5.9 million.

Explanation of provision.—The provision would clarify that the $4 million funding limitation applies only to the administrative cost of designing and conducting the demonstration and the accompanying evaluation. The funding limitation would be increased by $1.9 million.

The provision would also specify that at least one of the five sites chosen for the demonstration must serve a rural area. The Secretary may adjust, if necessary and appropriate, the adjusted average per capita cost (AAPCC) for any area served by one of the projects.

Effective date.—Enactment.

25. Requiring consumer representative on PRO boards (Section 229)

Current law.—Utilization and Quality Control Peer Review Organizations (PROs) are physician-sponsored or physician-assisted organizations which have responsibility under the Medicare program or reviewing the medical necessity and reasonableness of care, the quality of care, and the appropriateness of the setting where the services are provided. Physician-sponsored organizations are composed of a substantial number of the licensed doctors of medicine and osteopathy engaged in the practice of medicine in the area. Physician-assisted organizations have available to them the services of a sufficient number of such physicians to assure the adequate peer review of the services provided. The law does not contain specific requirements pertaining to the composition of a governing body or board.

Explanation of provision.—The bill would require each PRO to name at least one consumer representative to its governing board.

Effective date.—The provision would apply to contracts entered into or renewed on or after January 1, 1987.

26. Improvements in administration of end-stage renal disease networks and program (Section 230)

Current law.—The Social Security Amendments of 1972 extended Medicare coverage to individuals who require renal dialysis or kidney transplantation because they suffer from end-stage renal disease (ESRD), i.e., chronic and irreversible kidney failure. In 1978, Congress authorized the establishment of the ESRD network organizations. These organizations, which include a coordinating council and a medical review board, are responsible for assuring the effective and efficient administration of the ESRD program within defined geographic areas. The Secretary defined 32 geographic areas and established network organizations within each area. Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the Secretary is permitted to reduce the number of network areas and network organizations to no less than 14 for the purpose of achieving efficiencies in the administration of the ESRD program. On August 26, 1986, the Secretary published final regulations that reduced the number of networks to 14, redesignated the geographic areas of the networks, and modified the current functions and responsibilities of the network organizations.

Explanation of the provision.—The provision would require the Secretary to revise the final regulations published in the Federal Register on August 26, 1986. While the Secretary would still be permitted to reduce the number of network areas and network organizations to no fewer than 14, the current functions and responsibilities of the network organizations would have to be maintained. The provision would require that the responsibilities of the network organizations include: (1) collection and validation of ESRD facility data, (2) development of quality assurance standards for evaluating the quality of patient care rendered by ESRD providers and facilities, (3) patient advocacy, and (4) implementation of patient grievance procedures.

The Secretary would be required to develop standards, criteria and procedures for evaluating the performance of network organizations. The provision would require that these same standards and criteria be used in the establishment of the reorganized networks. After consultation with appropriate professional and patient organizations, the Secretary would be required to publish criteria for determining new geographic areas for each network. The provision would allow the use of competitive bidding during the process of reducing the number of network organizations from 32 to 14. However, the Secretary would be required to retain the old organizations for 30 days after the designation of the new organizations to ensure a smooth transition and to ensure that records and data are transferred to the appropriate new entity.

The Secretary would be required to establish a national end-stage renal disease registry by January 1988, from data supplied by the ESRD network organizations, transplant centers and other sources. The registry would permit the collection, validation, analysis and dissemination of data on all ESRD patients in order to identify the economic impact, cost effectiveness, and medical efficiency of alternative modes of treatment of ESRD patients.

Effective date.—Enactment.

27. End-stage renal disease patients rights (Section 231)

Current law.—The Social Security Amendments of 1972 extended Medicare coverage to individuals who require renal dialysis or kidney transplantation because they suffer from end-stage renal disease (ESRD), i.e., chronic and irreversible kidney failure. Dialysis facilities and providers treating ESRD patients are required to receive the patient's written consent prior to administering treatment.

Explanation of the provision.—The provision would require facilities that reuse renal dialysis equipment and supplies to inform patients in writing of the known risks and benefits of reuse as a condition of participation in the Medicare ESRD program. The provision also would require patients to be given the freedom to decide whether or not to accept treatment at the facility.

Effective date.—Ninety days after date of enactment.

28. Requirements for transplant hospitals and organ procurement agencies (Section 232)

Current law.—Medicare covers kidney transplants and certain other medically appropriate transplants that are deemed by the Department to be non-experimental. Medicaid coverage of organ transplants varies among the States. Current law does not include certification standards for organ procurement agencies as a condition of Medicare or Medicaid reimbursement for organ procurement services.

The Task Force on Organ Transplantation, created by the National Organ Transplant Act (P.L. 98-507), found that opportunities for obtaining organs were lost due to shortcomings in the present organ procurement process. The Task Force recommended legislation requiring certification standards for organ procurement agencies.

Explanation of the provision.—The provision would require as a condition for payment under Medicare or Medicaid for organ transplants that hospitals in which such organ transplants are performed be members of and abide by the rules and requirements of the Organ Procurement and Transplantation Network (OPTN) established under section 372 of the Public Health Service Act. The provision would further require that to receive reimbursement under Medicare and Medicaid for organ procurement, organs must be obtained from organ procurement agencies which are members of the OPTN and are either operating under a grant as a qualified organ procurement organization under section 371 of the Public Health Service Act or certified by the Secretary as meeting certain standards. In addition to the standards required of qualified organ procurement agencies under section 371 of the Public Health Service Act, agencies certified by the Secretary will be required to meet additional standards. These include performance-related standards prescribed by the Secretary. Organ procurement agencies will also be required to allocate organs locally by the same rules that the network uses for national sharing.

By requiring that hospitals performing transplants and organ procurement agencies abide by the rules of the OPTN, the Committee is aware that the policy of the OPTN is to utilize all transplantable organs for U.S. citizens and resident aliens before turning to a separate list of foreign nationals.

Effective date.—For discharges occurring on or after October 1, 1986.

29. Medicare Automated Data Retrieval System (MADRS) database expansion (Section 233)

Current law.—The Secretary of Health and Human Services currently keeps separate data systems on Part A Medicare claims and part B Medicare claims.

Explanation of provision.—The provision would require the Secretary to integrate information on beneficiary claims under parts A and B beginning with fiscal year 1980. This combined data base (known as the Medicare Automated Data Retrieval System or MADRS) will provide the Secretary with data that are important in comparing Medicare costs, utilization, and quality before and after the implementation of the hospital prospective payment system.

It is the Committee's intent that the Secretary assess the cost-effectiveness of integrating data beginning with fiscal year 1980. If beneficiary claims for parts A and B are not complete, or the cost of reconstructing the data base is prohibitive, it is the Committee's intent that the MADRS data base begin with fiscal year 1982. However, the Committee encourages the Secretary to include 1980 and 1981 data if at all possible because this data will facilitate analysis of PPS effects as compared to pre-PPS behavior.

Effective date.—Enactment.

B. MEDICAID

1. Clarification of eligibility of homeless individuals (Section 241)

Current law.—States are prohibited from imposing residency requirements that exclude any otherwise qualified individual who resides in the State from applying for Medicaid. There is no Federal requirement that an individual have a fixed or permanent residence in order to qualify for Medicaid. However, according to the Department of Health and Human Services and the General Accounting Office, some States and localities require applicants for Medicaid to supply a fixed address in order to qualify.

Explanation of provision.—The provision would clarify current law so that States and localities are prohibited from imposing any residency requirement which excludes from Medicaid any otherwise qualified individual who resides in the State, regardless of whether or not the residence is maintained permanently or at a fixed address. Qualified homeless individuals would be able to establish residency through the use of a mailing address at a shelter or similar facility, or by affidavit, or through other means consistent with the circumstances under which the homeless live.

Effective date.—Enactment.

2. Hospice benefits for dual eligibles (Section 242)

Current law.—The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) gave States the option of covering hospice care for their Medicaid beneficiaries. In the situation where the beneficiary is a resident in a Medicaid nursing home and the State has a hospice benefit, Medicaid can coordinate payments to the providers. The hospice receives a separate State payment which covers only the cost of the room and board provided by the nursing home since the normal hospice payment already includes payment for nursing services. The hospice then pays the nursing home so that there are no duplicate payments.

However, this system can not be replicated for people who are eligible for both Medicaid and Medicare (the so-called "dual eligibles") and are residents in nursing homes in a State that does not elect to cover hospice services under Medicaid. While hospice coverage is available to all Medicare beneficiaries, the State's Medicaid program cannot make the "room and board only" payment because the hospice is not a qualified Medicaid provider. Thus, the nursing home would receive a full payment from Medicaid, the hospice would receive full payment from Medicare, and the Medicare/Medicaid programs would have "overpaid" the provider.

Explanation of provision.—This proposal would clarify the intent of the Medicaid hospice benefit and allow the "room and board only" payment to be made to a Medicare certified hospice in a State where there is no Medicaid hospice benefit for beneficiaries dually eligible for Medicare and Medicaid.

Effective date.—Ninety days after enactment.

3. Clarification of institutional payment rate limitation (Section 243)

Current law.—The Social Security Act requires that Medicaid payments to hospitals, skilled nursing facilities, and intermediate

care facilities must be on the basis of rates "which the State finds, and makes 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 to assure that individuals eligible for medical assistance have reasonable access . . . to inpatient services of adequate quality. . . ." Hospital payment rates must also take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs. In addition, State payments for all services must be consistent with efficiency, economy and quality of care.

Implementing regulations require that the Medicaid agency's estimated average proposed payment rate must reasonably be expected to pay no more in the aggregate for institutional services than the amount the agency reasonably estimates would be paid for the services under Medicare principles of reimbursement. As a result, these regulations have the effect of limiting the year-to-year increases that States allow institutions to the increases allowed under Medicare, unless the State's Medicaid hospital reimbursement level in the previous year was below Medicare's payment level.

Explanation of provision.—The proposal would clarify current law. Under the provision, the amount the State agency reasonably estimates would be paid using Medicare principles of reimbursement could generally serve as an upper limit for the purpose of assessing the reasonableness of State rates. However, an exception would be required for hospital payment rates which include disproportionate share adjustments required by a State. Under this authority, a State would be permitted to pay for a reasonable share of charity care and bad debts even if aggregate payments exceeded the upper payment limit otherwise applicable. Further, the Secretary would be permitted to make other reasonable exceptions to the upper limits of rates for hospitals, and skilled nursing and intermediate care facilities. Such other exceptions could include, for example, an adjustment to account for State prospective payment systems which might have different methodologies than the Medicare prospective payment system. Some prospective systems may have methodologies which take into account upcoding or "DRG creep" in formulating the appropriate rate of increase; whereas the Medicare system builds those factors into the calculation of the rate of increase and does not explicitly reflect these factors in the final rate of increase percentage.

Effective date.—Apply as though included in the Omnibus Budget Reconcilation Act of 1981 as originally enacted.

4. Waiver of certain Medicaid requirements (Section 244)

Current law.—Medicaid law authorizes coverage, for up to three months prior to application, for an individual if such individual: (1) received services during that time period of a type that would be covered under the plan; and (2) would have been eligible for Medicaid at the time the services were received if he or she had applied for Medicaid.

South Carolina expanded its Medicaid program in October 1984 to cover pregnant women with high medical bills. From October 1984 to July 1985, the Medical University of South Carolina had served 1,300 patients under the expanded program, but no Medicaid application had been submitted for the women it served and no Medicaid payment to the University had been made.

Explanation of provision.—The provision would extend the normal retroactive coverage period for the Medical University of South Carolina. Medicaid would be allowed to pay for claims for services provided during the period October 1, 1984 to July 1, 1985, to persons who are determined no later than 6 months after the date of enactment to have been eligible when the services were rendered.

Effective date.—Enactment.

5. Alternative standard of determining payment for administratively necessary days (Section 245)

Current law.—Medicaid hospital reimbursement policy requires that States pay a lower rate for those hospital days that are spent by a patient waiting for placement in a nursing home. These days are called "administratively necessary days" because the patient has been determined to be no longer in need of "acute" level of care which is normally provided by a hospital, but a nursing home bed is not yet available. Since the patient is receiving less intensive care from the hospital, the hospital does not need the same level of reimbursement.

The only exception to the above policy for a lower reimbursement rate for these administrative days is when no excess hospital bed capacity exists. The excess bed standard is defined as having an occupancy rate of less than 80 percent in the specific hospital and the region around the hospital.

Explanation of proposal.—The proposal would allow New York to have an alternative payment standard which would allow the excess hospital bed standard to be applied when either the 80 percent occupancy standard is exceeded in the hospital or the region. In addition, the Secretary of HHS must determine that a sufficient number of "excess" hospital beds had been decertified to offset the additional costs of a higher rate.

Effective date.—January 1, 1986.

6. ICF/MR technical correction (Section 246)

Current law.—The Consolidated Omnibus Reconciliation Act of 1985 (COBRA) amended Medicaid law to allow a State the option to reduce gradually the population of an intermediate care facility for the mentally retarded (ICF/MR) that is found to have deficiencies of a non-life threatening nature.

Prior to this amendment, the State had to make large expenditures for capital improvements and/or staff increases to bring the facility into compliance with Federal standards or close the facility immediately.

Regulations implementing the COBRA change have not yet been published as a final rule. HCFA contends that the option to phase down gradually is not available to the States because the regulations are not final.

Explanation of provision.—The provision would clarify Congressional intent that the bed reduction option for ICFs/MR should be available to States from the time of enactment of COBRA and not from the time that regulations are made final.

Effective date.—As if included in COBRA when enacted.

C. MEDICARE AND MEDICAID

1. Frail elderly demonstration project waivers (Section 251)

Current law.—In San Francisco, the "On Lok" Community Care Organization for Dependent Adults has provided health care services to frail elderly patients at risk of institutionalization under Medicare and Medicaid waivers as a demonstration project. The organization is paid on a capitated basis under the waiver, which will remain in effect for so long as the organization meets the conditions of the waiver.

The Robert Wood Johnson Foundation, a private, non-profit entity which funds research in alternative means of health care delivery, provided a grant to "On Lok" for the purpose of identifying and assisting other existing community-based organizations which will provide comprehensive services to frail elderly patients at risk of institutionalization.

Explanation of provision.—The Secretary would be authorized to grant up to ten Medicare waivers to community-based organizations that provide comprehensive services to the frail elderly. Similar Medicaid waivers would also be authorized. The waivers would provide for capitated payments for Medicare beneficiaries in the same manner as the "On Lok" waiver. It is the intent of the Committee that these waivers be granted to organizations which directly provide a substantial number of non-institutional Medicare benefits to the patients. Conditional waivers would be for a 3-year period, and permanent waivers could be authorized thereafter.

Effective date.—Enactment.

2. Conditions of participation for skilled nursing facilities (SNFs) and intermediate care facilities (ICFs) (Section 252)

Current law.—In order to be certified to participate in Medicare and Medicaid, skilled nursing facilities (SNFs) must meet certain requirements contained in section 1861(j) of Medicare and in regulations at 42 CFR Part 405, Subpart K, often referred to as conditions of participation. These requirements detail standards of staffing, organization, and health and safety which SNFs must comply with in order to receive Medicare and/or Medicaid reimbursement.

At their option, States may also cover in their Medicaid plans intermediate care facility (ICF) services. Medicaid law defines an ICF as an institution which is licensed under State law to provide on a regular basis health-related care and services to individuals who do not require the degree of care and treatment provided by hospitals or SNFs but who because of their mental or physical condition require care above the level of room and board that can be made available to them only through institutional facilities. ICFs must also meet (1) standards prescribed by the Secretary for the proper provision of care, (2) standards of safety and sanitation established by the Secretary in addition to those applicable to nursing homes

under State law, and (3) requirements for protecting patients' personal funds. Standards for ICFs have been published by the Secretary in regulations at 42 CFR Part 442, Subpart F.

Explanation of provision.—The provision would revise some existing and establish some new conditions of participation for both Medicare and Medicaid SNFs, and apply these same conditions to Medicaid ICFs. The new and revised conditions are described below.

(1) Each State would be required to establish training and competency testing programs for nurse aides. The Secretary must establish criteria on which to evaluate whether or not the State's training and testing programs meet minimum acceptable standards. The Committee intends that such criteria should include, for initial training purposes, safety precautions, infection control, hygiene, basic nursing procedures, preventive care, residents' rights, observation and reporting. For continuing training purposes, criteria should include instruction in rehabilitation, nutrition, communication, and supportive behavior. The training may be conducted in long-term care facilities or other settings, at the option of the State. Nurse aides would be required to pass a State-approved and administered competency test before they assume their duties. In addition, after a two-year break in employment as a nurse aide, an individual must pass the test again before reassuming patient care duties.

(2) Criminal background checks would have to be conducted by the nursing homes on all employees providing direct patient care. The Committee expects the Secretary, through regulations, to specify how these background checks would be conducted in order that they (a) be the least burdensome to the facilities, and (b) focus attention on convictions of offenses related to the employee's responsibilities and functioning in the nursing home.

(3) The State long-term care ombudsman would be given access to the facilities and its residents, as well as to the resident's medical and social records with the resident's, or their legal guardian's, permission. It is not the Committee's intent to limit State laws which could provide the ombudsman more extensive access rights, rather the provision is viewed as a minimum standard for ombudsman access.

(4) Clinical records would have to be maintained for all residents by all nursing homes.

(5) Nursing homes would be required to perform, upon admission and periodically thereafter, accurate assessments of patients. Assessments would include (but not be limited to) the identification of medical problems, and the measurement of physical, mental and psychosocial functioning. The assessments would be performed by a registered nurse, or under the supervision of a registered nurse, by a practical nurse trained in performing assessments. Other health care professionals, such as nutritionists and physical therapists, can contribute information that the nurse would use in performing the assessment. The Secretary would be required to develop within two years of enactment minimum factors which must be included in the assessment instrument, criteria for the frequency of administering the assessments, and guidelines for the training of assessment nurses. The Committee intends that these criteria and guide-

lines should be designed to allow the States and the nursing homes flexibility in carrying out these functions.

(6) SNFs and ICFs would be required to provide a supportive, comfortable, homelike environment in which patients have a reasonable choice over their surroundings, schedules, health care, and activities. The Secretary would define "reasonable" in regulations as it applies to this situation.

(7) The patient rights for SNFs that are cited in the regulation published as of October 1, 1985 in the Code of Federal Regulations (42 CFR 405.1121(k)) would be elevated to a condition of participation and would apply to both SNFs and ICFs.

(8) No retaliation or reprisal could be made against any patient or employee because they filed a complaint about the facility.

(9) SNFs and ICFs would not be allowed to discriminate against recipients of either Medicare or Medicaid by (a) requiring private pay duration of stay contracts in which the patient or others would agree to not apply for Medicaid benefits for a given length of time while continuing to pay the full private nursing home rate; (b) by requiring "responsible-party" signatories, so that relatives or friends would pay the private rate instead of the Medicaid program paying the facility; (c) by requiring nonrefundable deposits; or (d) by providing fewer services or lower quality services to Medicaid or Medicare beneficiaries than those that would be provided to other residents, because the Medicaid payment rate is lower than the private payment rate.

(10) The Committee expects the Secretary, as he revises these conditions of participation that this provision requires, also will review and revise, as appropriate, the other conditions of participation that were not changed to better focus these regulations on the quality of patient care.

Effective date.—October 1, 1987.

3. Changes in the certification program and process (Sections 253 and 254)

Current law.—Section 1864 of Medicare law requires the Secretary to enter into agreements with States to survey nursing homes and certify their compliance or noncompliance with Medicare participation requirements. Section 1902(a)(33)(B) of Medicaid law requires the State Medicaid agency to contract with the State survey agency used by Medicare (if that agency is the agency responsible for licensing health facilities) to determine whether facilities meet the requirements for participation in the Medicaid program. The survey agency may certify a facility that fully meets requirements and standards for up to 12 months. Survey agencies may also certify a facility for participation if it is found to be deficient in one or more standards if the deficiencies, individually or in combination, do not jeopardize the health and safety of patients and if the facility submits an acceptable plan for correction for achieving compliance within a reasonable period of time. The Secretary is required to make public, in readily available form and place, the results of surveys of nursing homes. Medicare law also allows State survey agencies to furnish specialized consultative services to facilities which may need to meet one or more conditions of participation.

HCFA regional offices also conduct on-site surveys of a sample of facilities to evaluate whether the survey agency has correctly determined continued compliance of the facility with program requirements. When HCFA reviews certifications of facilities that participate only in Medicaid, it is referred to as "look behind." If HCFA finds that such a facility fails to meet program requirements and standards, it is authorized to terminate the facility's participation until the reason for the termination has been removed and there is a reasonable assurance that it will not recur. The Secretary is required to make the results of its validation surveys available to State Medicaid agencies and subject to certain limitations, available for public inspection.

Medicare law also requires the Secretary to pay States the reasonable cost of performing surveys and certifications. Payments are made according to an annual agreement which HCFA negotiates with each State for performing survey activities. The Medicaid program authorizes a 75 percent Federal matching rate to the States for costs attributable to compensation or training of skilled professional medical personnel and staff supporting such personnel. A portion of Medicaid nursing home survey costs fall into this category. Other survey-related expenditures under Medicaid are reimbursed at the 50 percent Federal matching rate for general administrative costs.

Explanation of provision.—The provision would make the following changes in the survey and certification process for SNFs and ICFs participating in the Medicare and/or Medicaid programs:

(a) Consultative services provided by State survey agencies for nursing homes seeking compliance with certification requirements would be required to be separate from the survey process and furnished by individuals not conducting the survey.

(b) The Secretary could release a report of HCFA's inspections of nursing homes to the State long-term care ombudsman before the end of a 30 day period when the facility would have an opportunity to review and comment on the findings.

(c) Certification surveys could not be announced in advance.

(d) Surveys would be required to be conducted by a multidisciplinary team of professionals licensed by the State (including at least a registered nurse, a registered dietician, and a registered sanitarian). The Secretary can waive the regular survey team composition if the State can demonstrate that they have a better idea for survey team composition, or if the State cannot hire a member of the multidisciplinary team despite a good-faith effort.

(e) Surveys would be required to focus on the quality of care provided to patients and include a private meeting between patients and survey personnel to discuss patients' experience.

(f) Surveys would be conducted on a random time basis, between 9 and 15 months after the previous survey of the facility, with surveys being conducted, on a Statewide average, 12 months apart.

(g) Surveys may be conducted less often than annually for facilities that meet all minimum standards in two consecutive in-

spections (excluding complaint inspections), but in no case less often than every 18 months.

(h) States would be required to provide comprehensive initial and continuing training for for surveyors, as approved by the Secretary. The training would be required to relate to the procedures and techniques of certification surveys, both for newly hired surveyors and for current employees.

(i) Within 45 days after a change in ownership of a facility, a change in a facility's administrator, or a change in a facility's director of nursing, a State could, at their discretion, provide an abbreviated or full survey of the facility. The State also has the option not to survey the facility if the Secretary agrees with the State's written request that the facility does not need to be surveyed immediately.

(j) The State survey agency would be required to maintain and utilize a specialized survey team for chronically substandard facilities. A chronically substandard facility is any facility that has exhibited (a) a pattern of repeated violation of the same condition, standard, or element, or (b) a pattern of substandard care even if not in violation of the same conditions, standards, or elements at each inspection.

(k) States would be required to investigate certain complaints against nursing homes. Complaints determined by the States to be frivolous or beyond the jurisdiction of the State agency need not be fully investigated.

(l) The Secretary would be required to develop and implement critieria and procedures for the evaluation of plans of correction submitted by facilities seeking compliance with certification requirements.

(m) The Secretary would be required to provide for 5 years full reimbursement for any reasonable State incremental expenditures incurred in surveys of nursing homes that result from the requirements of this provision.

In addition, the provision would require the Secretary to submit a proposal eliminating separate categories of facilities providing long-term care under Medicare and Medicaid, and replacing these categories with a single designation of long-term care facility which would provide and be reimbursed for various levels of long-term care. The proposal would be due on January 1, 1988.

Effective date.—October 1, 1986.

D. OTHER

1. Maternal and child health services block grant (Section 261)

Current law.—Title V of the Social Security Act provides a program of block grants to States for maternal and child health (MCH) services. The current level of authorization is $478 million for each fiscal year. Beginning with 1987. A Federal set-aside of not more than 15 percent nor less than 10 percent is required for special projects, genetic disease programs, and hemophilia programs.

Explanation of provision.—The provisions would increase the authorization level from $478 million to $553 million for each fiscal year beginning with 1987.

Of the additional $75 million in new spending authority, two-thirds would be allocated as under current law. The remaining one-third would be allocated to the States and the Secretary as under current law, but must be used as follows:

(a) In the case of the amounts allocated to the Secretary, for special projects of regional or national significance, training, and research that promote access to primary health services for children, and community-based service networks and case management for children with special health care needs; and

(b) In the case of the amounts allocated to the States, for developing primary health services demonstration programs and projects that promote the development of community-based service networks and case management for children with special health care needs.

Effective date.—Fiscal years beginning October 1, 1986.

2. National medical expenditure survey (Section 262)

Current law.—The Public Health Service Act authorizes the Secretary of Health and Human Services to use one percent of the total appropriations for the Public Health Service (PHS) to conduct research and evaluation studies or surveys. The last PHS survey of national medical expenditures was completed in 1977. This survey considered the costs, financing and utilization of health care services in the United States.

Explanation of the provision.—The provision would require the National Survey of Medical Expenditures to be conducted at least once a decade beginning in fiscal year 1987.

Effective date.—Enactment.

3. Collection of data relating to adoption and foster care (Section 263)

Current law.—The Social Security Act requires the Secretary of Health and Human Services periodically to collect and publish data pertaining to the incidence and characteristics of foster care and adoptions in this country. At the present time, the major source of such data is a voluntary system operated by a non-governmental entity. This entity lacks authority to establish or enforce reporting standards which would assure completeness and uniformity of data.

Explanation of the provision.—The provision would require the Secretary of Health and Human Services to create an advisory committee to identify the national needs for data relating to adoption and foster care and to evaluate alternative ways of collecting such data on a comprehensive basis. By January, 1988, the Secretary would be required to report to Congress on a proposed data collection system. Final regulations providing for the implementation of such a system would have to be promulgated by July 1, 1988 with full implementation to take place no later than October 1, 1991.

Effective date.—Enactment.

V. COSTS OF CARRYING OUT THE BILL AND VOTE OF THE COMMITTEE

A. BUDGET EFFECTS

In compliance with paragraph 11(a) of Rule XXVI of the Standing Rules of the Senate, the following statement is made relative to the estimated budget effect of H.R. 1868, as amended by the committee.

Outlay effects

The table below summarizes the estimates of the net changes in outlays for fiscal years 1987–1989.

SUMMARY OUTLAY EFFECTS OF H.R. 1868, AS AMENDED

[Fiscal years; in millions of dollars]

	1987	1988	1989	Total
Title I, Fraud and Abuse	0	0	0	0
Title II:				
Medicare	−40	−10	−1	−51
Medicaid	0	0	0	0
Other	0	0	0	0
Total outlays	−40	−10	−1	−51

The estimate from the Congressional Budget Office follows:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, October 1, 1986.

Hon. BOB PACKWOOD,
Chairman, Committee on Finance,
U.S. Senate, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the attached cost estimate for H.R. 1868, the Medicare and Medicaid Patient Protection Act of 1986, as reported by the Senate Committee on Finance on September 10, 1986.

If you wish further details on this estimate, we will be pleased to provide them.

With best wishes,

Sincerely,

RUDOLPH G. PENNER, *Director.*

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

1. Bill number: H.R. 1868.

2. Bill title: Medicare and Medicaid Patient Protection Act of 1986.

3. Bill status: As ordered reported by the Senate Committee on Finance on September 10, 1986.

4. Bill purpose: The primary purpose of this bill is to strengthen fraud and abuse protections in the medicare and medicaid programs. The bill also makes a number of administrative and programmatic changes in the Medicare, Medicaid and Maternal and Child Health programs.

5. Estimated cost to the Federal Government:

[By fiscal years, in millions of dollars]

	1987	1988	1989	1987–89
Direct spending provisions:				
Budget authority	−40	−10	−1	−51
Outlays	−40	−10	−1	−51
Amounts subject to appropriations action:				
Authorization levels	39	45	39	123
Outlays	39	45	39	123
Total:				
Budget authority/authorization level	−1	35	38	72
Outlays	−1	35	38	72

Note: The costs of this bill fall within functions 550 and 570.

Basis of Estimate.—The estimates for the individual sections are shown in the attached Table A. Sections 101, 227, 233, 252, and 261 are authorizations. Other spending sections would result in direct spending. All authorizations are assumed to be fully appropriated at the beginning of each fiscal year. In addition, Section 262, the National Medical Expenditure Survey will require $45 million in Public Health Service Act Section 2113 evaluation program funds.

6. Estimated cost to State and local government: The budgets of state and local governments will not be significantly affected by the bill.

7. Estimate comparison: None.

8. Previous CBO estimate: None.

9. Estimate prepared by: Don Muse.

10. Estimate approved by: C.G. Nuckolz (for James L. Blum, Assistant Director for Budget Analysis).

TABLE A.—MEDICARE AND MEDICAID PROTECTION ACT OF 1986 (CBO ESTIMATES OF PROVISIONS)

	1987	1988	1989	1987–89
TITLE I				
101—Exclusion from Medicare and State Programs	7	5	4	16
TITLE II—MEDICARE, MEDICAID, AND OTHER				
Subtitle A—Medicare				
201—Annual Recalibration of DRG's	0	0	0	0
202—Rebase PPS Rates	0	0	0	0
203—Extend Hospital Cost Reporting	0	0	0	0
204—PPS for Puerto Rico	0	0	0	0
205—Reclassification of Certain DRG's	0	0	0	0
206—Modify PPS Outliers	0	0	0	0
207—Burn Outliers Study	0	0	0	0
208—Sole Community Provider Extension	0	0	0	0
209—Rural Hospital Regulation Analysis	(1)	(1)	(1)	(1)
210—Regional Referral Centers in Waiver States	(1)	(1)	(1)	(1)
211—Coverage of Psychologists' Services	0	0	0	0
212—CHAMPUS/CHAMPVA Technical	0	0	0	0
213—Coordination of Quality Studies	0	0	0	0
214—Refinement of PPS	(1)	(1)	(1)	(1)
215—Review of Medicare Participation Standards to Assure Quality	(1)	(1)	(1)	(1)
216—Administratively Unnecessary Days	0	0	0	0
217—Develop Uniform Needs Assessment	(1)	(1)	(1)	(1)
218—Post-Hospital Care Quality in ProPAC Reports	(1)	(1)	(1)	(1)

TABLE A.—MEDICARE AND MEDICAID PROTECTION ACT OF 1986 (CBO ESTIMATES OF PROVISIONS)—Continued

	1987	1988	1989	1987-89
219—Connecticut Hospice Waiver	(1)	(1)	(1)	(1)
220—Disproportionate Share Technical	0	0	0	0
221—Additions to MD Payment Board	0	0	0	0
222—Delay Clin Lab Mand. Assignment	−45	−15	−5	−65
223—CRNA Reimbursement	0	0	0	0
224—Physicians' Assistants	0	0	0	0
225—Rural Clinical Psychologists	1	1	1	3
226—Clinical Lab Demonstration	0	0	0	0
227—Home Emergency Response Study	2	2	2	6
228—Prevention Demonstration Technical	1	1	0	2
229—Consumer Representative on PRO Board	0	0	0	0
230—ESRD Networks	(1)	(1)	(1)	(1)
231—ESRD Patients' Rights	0	0	0	0
232—Organ Transplant Standards	0	0	0	0
233—MADRS Database Expansion	2	0	0	2
Subtitle B—Medicaid				
241—Eligibility of the Homeless	0	0	0	0
242—Hospice Benefits for Dual Eligibles	(1)	(1)	(1)	(1)
243—Hospital Payment Rate Limitation	0	0	0	0
244—Waiver of Certain Medicaid Requirements	0	0	0	0
245—Administratively Unnecessary Days	0	0	0	0
246—ICF/MR Technical	0	0	0	0
Subtitle C—Medicare and Medicaid				
251—Waivers for Frail Elderly Projects	(1)	(1)	(1)	(1)
252—SNF Participation Conditions	8	8	8	24
253—Propose Long-Term Care Leg	0	0	0	0
254—Certification Program Technical	0	0	0	0
Subtitle D—Other Provisions				
261—MCH Block Grant	20	30	25	75
262—National Medical Expenditure Survey	0	0	0	0
Cumulative effect of studies [2]	3	3	3	9
DIRECT SPENDING				
Budget authority	−40	−10	−1	−51
Outlays	−40	−10	−1	−51
AUTHORIZATIONS				
Authorization levels	39	45	39	123
Outlays	39	45	39	123

[1] Less than $500,000 in additional outlays.
[2] The total bill has a number of provisions that are less than $500,000. The bill also calls for more than twenty-two studies and/or reports by the Secretary. The cumulative cost of these studies is an additional cost of $3 million per year.

B. COMMITTEE VOTE

On September 10, 1986, the Senate Finance Committee considered the provisions of H.R. 1868 with amendments and reported the bill without objection.

VI. REGULATORY IMPACT AND OTHER MATTERS TO BE DISCUSSED UNDER SENATE RULES

A. REGULATORY IMPACT

Pursuant to paragraph 11(b) of Rule XXVI of the Standing Rules of the Senate, the committee makes the following statement con-

cerning the regulatory impact that might be incurred in carrying out H.R. 1868 as amended by the committee.

Numbers of individuals and businesses who would be regulated

The bill modifies existing health provisions of the Social Security Act related to fraud and abuse and makes other program changes in the Medicare and Medicaid and other health program authorities. No change is made in the number of beneficiaries served. Several new practitioners are added under the Medicare program—physician assistants who work in hospitals, skilled nursing facilities or who assist at surgery; and psychologists who work in rural health clinics. The bill would require a specific analysis of the impact of all proposed Medicare and Medicaid regulations on small rural hospitals in addition to the requirements of the Regulatory Flexibility Act.

Economic impact of regulation on individuals, consumers and business

The provisions are not intended to have a regulatory impact on substantive economic activities of individuals, consumers or businesses.

Impact on personal privacy

The provisions generally do not relate to the personal privacy of individuals.

Determination of the amount of paperwork

The provisions do not change the amount of paperwork burden.

VII. CHANGES IN EXISTING LAW MADE BY THE BILL

In the opinion of the committee, it is necessary in order to expedite the business of the Senate, to dispense with the requirements of paragraph 12 of Rule XXVI of the Standing Rules of the Senate (relating to the showing of changes in existing law made by the provisions of H.R. 1868, as reported by the committee).

○