EXECUTIVE SESSION

WEDNESDAY, SEPTEMBER 10, 1986

U.S. Senate

Committee on Finance

Washington, D.C.

The committee met, pursuant to notice, at 10:12 a.m. in Room SD-215, Dirksen Senate Office Building, the Honorable Bob Packwood (chairman) presiding.

Present: Senators Packwood, Dole, Chafee, Heinz, Wallop, Durenberger, Armstrong, Grassley, Long, Bentsen, Matsunaga, and Baucus.

Also present: Glenn Hackbarth, Deputy Administrator, Health Care Finance Administration; Craig Holden, Esquire, Inspector General's Office, Health and Human Services.

Also present: Ed Mihalski, Deputy Chief of Staff; Shannon Salmon, Health Counsel; Jean Lemasurier, Health Counsel; Karen Worth, Social Security Counsel; Bruce Kelly, Minority Health Counsel; Joe Humphreys, Professional Staff Member; and Susan Taylor, Administrative Director.

The Chairman. The committee will come to order.

Senator Long and I have noted that a quorum is present.

I am going to try to take members from time to time as they come. Chuck has got to go to a budget hearing where they have the unpleasant task this morning, the House and the Senate jointly are recommending where the sequester should come, and I know that he has got a couple amendments.

Senator Dole will come and have a couple amendments. But if, Ed, you could start down the bill. I would like to accommodate at least Senator Grassley being able to present his amendments before he has to go. Obviously we are not going to vote on very much right now until a few more people show up. We need at least six for amendments unless there is no objection.

So why don't you start, Ed, and then, Chuck, why don't you bring up the amendments you have and at least explain them and let the staff comment.

I told the Administration--Mr. Hackbarth and Mr. Holden--just to feel free to interject when they choose to.

Go ahead, Ed.

Mr. Mihalski. Yes, sir.

Basically, there's a number of materials that was handed out which describe and summarize the two bills that are before the committee this morning. Let me just talk about what those say a little bit.

First off, the H.R. 1868, which is a House-passed bill, which is the so-called Fraud and Abuse bill, is a bill which recodifies the existing law with respect to some and abuse provisions, but more importantly, it adds certain new provisions to prohibit, for example, doctors who may lose their license in one state for moving to another state and the new state does not know he lost his license. And it would prohibit him then from practicing in that state for Medicare.

It also closes a number of other loopholes that have been identified.

In addition to the fraud and abuse bill, which there have been several staff modifications to the basic bill, there are a number of other outstanding amendments that the staff has put together which is a document which is some 50-some pages long. That particular document--and I can go through those--these are changes to the Medicare or Medicaid program.

The Chairman. These are amendments that are pretty much agreed upon?

Mr. Mihalski. Yes, sir.

The Chairman. Unless there is some insistence upon the committee to go through them, if you have cleared them on both sides and they are reasonably acceptable, I am not there is any point in going through them.

If any members comes and wants to go over any of them,

I will be happy to do so, but I don't think there is any point in just use seriatim going through one through fifty and saying this has been agreed upon, this has sort of been agreed upon, this has been agreed upon.

Let me ask Mr. Humphrey, is that all right with you? Do you know the ones that he is talking about?

Mr. Kelly. Senator, at the staff level we have gone over all these amendments, and they are agreeable at the staff level. There are a few members that may have some very technical concerns that we would then have to consider.

The Chairman. That's fine.

So unless the member comes and says, can I talk about item 37, as far as you are concerned, the ones that he is talking about are all right.

Senator Long. Well, Mr. Chairman, it may be that at some point between now and the time the bill -- the measure comes up in the Senate, we might want to hold a Democratic caucus with the Democrats on the committee, let the staff run through them, and notify you that anything there that you may want to reconsider. But with that understanding that it could be reconsidered, if that is what the Senators want to do --

The Chairman. Actually, Russell, yes. That's fine. The Republican members, in terms of members, have not run through them either. These are amendments that have been run by all

of our staff. But I think you are absolutely right. If any member, whether or not you have a caucus, wants to bring them up --

Senator Long. Well, you know, I agree with everything you have said with the understanding that,you know, now and then we, the members of the Congress, have to at least protrect the image of us being necessary around here too. It looks as though the staff does all the work. We don't know what it is that some folks might wonder why we have all those Senators on that staff.

The Chairman. That's fine.

Senator Long. So with that understanding, Mr. Chairman, I will go along.

The Chairman. All right.

Go ahead, Ed.

Mr. Mihalski. Well, in addition to the materials that were handed out in that 50-some page package there was agreement last night on a number of other proposals of which there are about six or seven. That is a small package that each member has before him.

First, there is an errata sheet which corrects a couple of mistakes that were in the original materials, and then there are about six or seven new proposals. It is dated September 10th at the top.

That includes, I believe, one of the amendments that

Senator Grassley was interested in, and that is, to do with how we pay for outlier cases. These are cases which are extraordinarily expensive, or individuals who stay in the hospital for an extraordinarily length of time -- I mean, in burn centers.

The initial staff proposal just had a study of how that particular problem was because apparently there is not enough reimbursement in the PPS rates for those kind of patients since they are very intensive care patients.

Instead of the study, we have modified the provision now to allow for a higher rate of payment for those outlier cases until a study can be done and until the Congress can consider then how it might best change those rates.

The Chairman. Chuck, do you want to comment on that?

Senator Grassley. Thank you, Mr. Chairman.

I feel that he has said it as best as he said. I would just simply comment that by the time it is all said and done, the reimbursement for outlier is about 47 percent. And if it was attached to this amendment for favorable provisions, it would be about 65 percent.

I see that the information we have here that the cost to process this is either negligible or none, whatever the case might be. But I don't know if that means that if it is under $10 million, we might pass that.

Mr. Mihalski. Yes.

Senator Grassley. In relationship to the money that is set aside for contingencies in this matter, the Congressional set aside, we will use a small percent of that amount of money anyway.

Mr. Mihalski. Yes. The Secretary estimates how much money would be spent for the so-called outlier cases over a year, and sets aside a certain pool of money for that. So there will be now additional money coming out of this pool for these cases, but it would not normally increase overall what we pay under Medicare.

Senator Grassley. Now I suppose another point that should be addressed is where there's a lot of outliers related to hospital care procedures, you know, in every instance of time where this stands up as one where just the largest percentage of them turn into outlier instances, and that there's hardly a hospital where that's not the case. So I think that every member to a considerable extent would be affected by this provision, and would find that this is, you know, a very clear case of where there's an inequity in the way it is now, and that we ought to do something in the short-term while we are waiting for the study.

The Chairman. Further comments on the burn outlier provision.

(No response)

The Chairman. All right. Ed, go ahead.

Mr. Mihalski. I might, for everybody's benefit, go through these additional ones that came up very recently.

The second one is on page 4 of 12 of that small handout dated September 10th. And this basically is a proposal that Senator Durenberger had which would delay for one year the imposition of mandatory assignments on clinical lab services provided in a doctor's office. This was a provision that was put in last year.

When we established a lab fee schedule for laboratory services for independent laboratories and laboratories in hospitals, at that time we required that those services be provided on a mandatory assignment basis, that is, the laboratory had to accept whatever Medicare determined was reasonable as their payment in full. They could not then "balance bill", as it is called, the patient for additional money.

Last year then that was extended to also include physicians' laboratory services, that is, laboratory services are not done in these independent labs or in hospitals but actually done in the physician's office.

Senator Durenberger had asked, and it would seem reasonable, to delay for one year the imposition of mandatory assignment for those services in doctors' offices until some of the studies involved in this issue are available, and would give us a better chance then next year to decide what to do

with this particular provision.

The next one is item C on page 6 of 12. It is a modification of a proposal that is already in the staff package. The staff package provides an increase of $75 million a year in the maternal and child health block grant. It was only the last couple of days that we have been able to work out a so-called set aside so that some of that money would be set aside for specific purposes.

There is already a set aside for the current block grant program. The question was, how to apply the set aside to this additional $75 million? And basically the decision was to take one-third of that amount, set it aside, and allow the states to use that for primary health services and community base services basically for children with special health care needs.

The next item deal with organ transplants. It is item D, page 7 of 12. And this basically requires that any hospital that participates in Medicare or Medicaid, when they obtain their organs--that is, kidneys, hearts, whatever--that they have to obtain them through a certified organ procurement agency; and that also, in order to receive payment in Medicare, they have to participate in the organ procurement and transplantation network, both of which are established under the Public Health Service Act.

This is just another way of getting those hospitals to

comply with those two very good public policy conditions in the Public Health Service Act.

The next one is item E, on page 8 of 12.

We now have a process under the prospective payment system where certain hospitals--and this is particularly rural hospitals, large rural hospitals--can apply for special payment levels as regional referral centers. However, in two states--and that is New York and Massachusetts--were exempt from prospective payment system up until recently. The hospitals then that would qualify for this do not have a full year's worth of data to show the Secretary to make their case. And the rules say that it has to be a full 12-months worth of data.

Since they only have nine months worth of data--and it looks like, based on that nine months, and it is unlikely that it would change with an additional three months added to it; that they would qualify--we would simply say for those hospitals in those two states, they could initially qualify this first year based on that nine months worth of data.

The Chairman. Ed, all of these amendments were amendments that were added last night. They are not new. I realize you have been talking about them having been worked out last night.

Mr. Mihalski. Had been worked out last night, yes, sir.

The next one, on page 9 of 12, is on physician

assistance. And this would simply allow Medicare payments for physician assistance. These are people who have gone through a program--it is a well recognized program--to do many things doctors do, but certainly not as comprehensive, cannot provide the comprehensive level of service that doctors provide.

In any case, we would allow their payments to be made if they perform those services in a hospital or in a skilled nursing facility, or if they act as an assistant at surgery.

In Virginia, for example, there is a very good program where doctors, instead of using another doctor as thier assistant, are actually using these physician assistants. It is a much lower cost and it is advantageous to do it that way. And this then would allow those people to be paid under Medicare.

One more that was worked out with Senator Heinz is item G under nursing home quality reforms, page 10 of 12.

This is basically a modification of some of the items in Senator Heinz' quality of care bill dealing with nursing homes. And the gist of it is that what we do is require that hospitals have to provide patients with certain rights--the right to a clean and safe environment; the right to grievances; the right to meeting with an ombudsman, things like that. And we would have those rights become a condition of participation. So in other words, each nursing home, in

order to participate in the program would have to grant those rights.

In addition, they would also have to provide a training program for their nurses' aides, and they would also be included in this package a prohibition against anything that discriminates from certain discriminations from bringing Medicaid patients into a nursing home.

In some cases, the nursing home may say, well, if you are a Medicaid patient you cannot come in here unless you agree first to pay us a full year as a private pay patient, or similar devices like that. And those would be prohibited, so that the poor people under Medicaid would have better access to these nursing homes.

The last one deals with the surveys that are conducted of the nursing homes to see that they are in general compliance with rules and regulations.

A lot of that compliance in the past has been focused on whether they meet life safety codes, and sort of a brick and mortar type review.

This particular amendment would refocus that review to looking more at quality of care, patient outcomes, how patients are being treated, whether any abuse problems, those kinds of issues, rather than sort of just a brick and mortar type of thing.

And because there are some significant requirements in

this, the new requirements would be financed entirely by the federal government for the first five years. After that, it would drop back to the standard Medicaid participation rates for those activities.

Mr. Hackbarth. Mr. Chairman, could I interject a point on the nursing home issue?

The Chairman. Mr. Hackbarth. Yes.

Mr. Hackbarth. As I think the committee is aware, the Health Care Financing Administration contracted with the Institute of Medicine to conduct a study of the conditions of participation and survey and certification requirements for nursing homes. That report was filed earlier this year, and HCFA has been over the course of this summer reviewing the recommendations of the Institute of Medicine.

Just within the past week or so, we have sent out recommendations to Secretary Bowen. And I would like to make the committee aware that HCFA believes very strongly that, in fact, we need to redirect our review of the nursing homes that participate in the Medicare and Medicaid programs. And we concur in the Institute of Medicine's recommendation that the process should be more outcome oriented as opposed to emphasizing organizational requirements and paper requirements, so to speak.

And we intend to redirect through regulation our requirements so that the process is much more directed to

assuring the quality of care on an outcome basis.

We are concerned about some of the legislative provisions that are being considered in the sense that they might unduly restrict our flexibility in dealing with some of these issues in the coming months.

In addition to that, we are concerned about some of the provisions, in that they would add substantially to costs.

Let me just cite a couple of items that are on this list. For example, requiring nurses aide training is one of the recommendations in the Institute of Medicine report that we were, in fact, concerned about. It seems to us that that is an example of a process or/and requirement as opposed for a requirement that is directed toward assuring the quality of service going to Medicare and Medicaid beneficiaries.

So we would prefer to avoid mandating through legislation things that are of a process nature so that we can, in fact, focus on outcomes.

The Chairman. Thank you.

Mr. Mihalski. Mr. Hackbarth has a point. There is a lot yet to be done. There is a lot in the Institute of Medicine study. There is certainly a lot more in Senator Heinz's bill that we ought to look at real hard next year.

This is sort of just a minimum type of thing that Senator Heinz thought was very important to at least get this stuff in and going this year. And that is what this is

geared toward.

The Chairman. Further comments?

Mr. Kelly. Mr. Chairman?

The Chairman. Go right ahead.

Mr. Kelly. This provision is also one that some of our members have expressed reservations in that they have not seen the exact specifications of this provision as yet. And I do know that some of them are concerned about the requirements it would place on the states to comply. And I would just add that they have expressed a concern, particularly over this provision.

The Chairman. Thank you.

Mr. Mihalski. That basically is a summary of the health provisions. The major other item of business, of course, is Senator Dole's bill, which we can start a brief description on if you so like, Mr. Chairman.

The Chairman. Go right ahead.

Mr. Mihalski. Karen?

Ms. Worth. S. 2209 will make permanent Section 1619 a provision in the Social Security amendments of 1980. This provision otherwise expires June 30th, 1987.

The provision extends cash benefits and Medicaid coverage to certain recipients of supplemental security income who work for amounts that would ordinarily end their eligibility, because it is considered to constitute substantial

gainful activity.

Specifically, Section 1619 --

The Chairman. Can you restate that in English?

Ms. Worth. Yes, sir.

(Laughter)

Ms. Worth. Under current law, under Section 1619, a special benefit, cash benefit, can be paid, or Medicaid ban be paid to former SSI disability recipients who work and whose earnings ordinarily would have terminated their eligibility under the supplemental security income program because those earnings are, under current law, in excess of $300.00 a month. And that is the earnings level at which ordinarily earnings are considered substantial gainful activity.

The Chairman. And the bill would make an exception to that limitation.

Ms. Worth. That is right. It would continue an exception that was implemented in the 1980 disability amendments.

The Chairman. Thank you.

Ms. Worth. Section 1619(A) deals specifically with a cash benefit that is payable for the group whose earnings are, current law, less than about $757.00 a month. The Section 1619(B), the second part of that provision, deals with workers who have earnings in excess of the cutoff point but

are still eligible under those circumstances to Medicaid while they work.

The Chairman. And that is all there is to the bill?

Ms. Worth. No. There are other sections.

Senator Long. Well, I am a little concerned about this, Mr. Chairman. Is this the portion that has got the 13 sponsors on it?

Ms. Worth. There were 38 sponsors as of September 3rd.

Senator Long. Thirty-eight sponsors in the House or Senate? The 38 sponsors were Senators or what?

Ms. Worth. Thirty-eight Senators on S. 2209.

Senator Long. Well, is this the part that has to do with the so-called disabled people who --

Mr. Humphreys. Yes, Senator. It is 13 Finance Committee co-sponsors.

Senator Long. I see.

Well, I am very concerned about this. Now, I don't know any better way for any of us to try to judge this than just people we know. Frankly, Senators ought to know more of these people, because my impression of the way this thing is working out in the real world is that people have a severe health setback, the doctor gives them a certificate that you could read more ways than one. So that under the strict standards that were set in this legislation from the beginning, if they can make any substantial amount of income they are not

qualified to be on the eligibility rolls. And we have been through that. At one time this thing was liberalized to the extent that they projected eight times as many people on the rolls that we anticipated. I think we have got it down now, Mr. Humphreys, to about four times what we anticipated when we initially passed the program. I think it is about 4 percent of the work force. We anticipated about 1 percent, didn't we?

Mr. Humphreys. Well, yes. The cost to the program now is running about four times what was originally projected, and the number of recipients is up in that area, two and a half, three times the original projections.

Senator Long. Let me tell you what I am finding, just individual human beings out there. They have a setback, a heart attack, angina, any one of several things in the past would not cause that person to drop out of the labor force. More and more there is a tendency to think, don't go back to work. The smart thing to do is to apply for the disability. And then after you get the disability, go ahead and find ways to make as much as you can and still get the disability benefit.

I have had honorable, decent people tell me, well, now, they asked my advice as a friend: Do you think I ought to go far with this thing? For example, the Department turns them down. The advice they are getting and the advice I am getting

here is if they appeal it, the chances are that they can get reinstated or maybe be put on the rolls in the first instance if they had been turned down by the trial examiner.

Now, I have had honorable people tell me, well, now, look, I know I could get on them--I've been advised that the chances are good I could get on there and do this--but I don't know if I ought to. I'll be a liar for the rest of my life, pretending that I can't work when for a fact I know I can. And I just think that we had better be careful with this program, lest we do what we have done with welfare, and encourage all the wrong kinds of citizenship.

Now it sounds easy enough to say, well, now we're going to let them earn more money. I regret to say that I don't think this program can stand an investigation. I think that you have got large numbers of cases out there right now where people are making money and not reporting it to us. Just like they are doing on welfare.

Does anybody have any answers and any information on that?

The Chairman. Does the Administration have any answers on that?

Ms. Worth. Mr. Chairman, HHS did conduct a study of those in the 1619(A) and (B) program. This study was based on 1985 data. And what they did tell us was that -- compared to

the rest of the SSI population, we are dealing here with fairly young people. About 80 percent of them are under the age of 40. And the primary impairments were mental retardation, mental impairments, and deafness.

So, Senator Long, many of these people really never did work in the work force prior to entering on to SSI eligibility.

Senator Long. Well then I will not object to this, Mr. Chairman. I do think that in this area--and I won't be around after this year--but I certainly hope that the committee will watch this thing carefully though, because here is an area where we have got four times as many people on the rolls as we had when we first sold this idea to the Congress. Incidentally, you know, we put this into law over Presidential objection. The Republicans on the committee did not want it. And we, Democrats, back under Eisenhower, we--I was a co-sponsor--probably claimed that, look, what we are going to do. We are going to take care of these disabled people.

And so we voted through and put it in the law and probably claimed credit for it. But when this program started getting out of hand, Jimmy Carter decided it was necessary to recommend to us that we tighten up on the program. And this committee--Democrats and Republicans alike--must have the courage to tighten up on the program, and take

all the calimy and storm that went with it. I don't know whether anybody else suffered the abuse I have had because I had been a sponsor of this thing. You have got to go before these groups and tell them, I don't think you people are qualified to be on the rolls.

And so having been through that, this program could easily be in short order with eight times the number of people on there that are supposed to be on, and half of them making money on the side that they are not supposed to be making.

And this sounds all right. I just hope that we ease up on these things and don't wind up in the trap we found ourselves in before.

So I predict the next time it will be a lot tougher to get this thing under control.

But it sounds to me like what you are talking about would be all right. What percentage of these people you said have never been in the work force at all?

Ms. Worth. I am sorry. I do not have that particular statistic from the study.

Senator Long. You say it is most of them?

Ms. Worth. I said that the majority of these were suffering from impairments from childhood, either mental retardation or mental impairment or a loss of hearing. And that is well over half of those in the study.

The Chairman. Over the years I have come to trust Senator Long's intuitive judgment on these things. I remember when we got into that social service program that you finally put a cap on of $2.5 billion. I don't know how many billions it would be at now if we had not capped it.

Senator Long. Well, the thing that really sort of turned me off on this program was that some old fellow down the road from where I had a place and I went to help him get some work done, which he had done many times before. It was a large job type thing. And so he said, I'm sorry, I can't help you. I said, why is that? He said, well, I'm on disability. And so I found out how he got on disability. He went down there to get on the rolls because he thought he was entitled to social security. He had reached 65, and he was eligible, entitled to be on the rolls and all that. They didn't have the records, didn't have the records of this man of his employer having paid the tax and done what the employer should have done.

So as they were struggling around with that paperwork for a while, they said, well, maybe we could just put you on the rolls as being disabled.

Now that wasn't his idea that he was disabled; it was their idea that he was disabled. So they sold him the idea that he was disabled; put the old fellow on therolls. So any time he did something he had to sneak around and pretend

he couldn't do anything. He would say, now all we have to do is solder this pipe. Now if you just hand me your torch, and you tell me what to do, I will saw the fool pipe myself.

So he said, wait a minute. Hand me the torch. So he takes the torch and solders the pipe. And he said, now don't tell anybody about this. So that is the kind of thing we have got going on in the country with this program. Now the taxpayers are paying for this. And when they find out that they are being taken for a ride, they complain, and they have a right to complain.

And this committee is going to have a problem of taking on the welfare program next year. Good luck, gentlemen. All I can say is good luck. But this is the area where the taxpayers expect you to get them a fair return for their money.

Thank you, Mr. Chairman.

The Chairman. Thank you.

Further comments?

Senator Durenberger. Mr. Chairman?

The Chairman. David.

Senator Durenberger. Thank you very much, Mr. Chairman.

I just briefly want to compliment Henson Moore who provided us with the vehicle to bring us together today, and I want to compliment you, Mr. Chairman, and Senator Long and their staffs for providing I think in this piece of

this legislation we are considering some very important, although they may be incremental, improvements in Medicare and Medicaid policy, and in a couple of cases in preventing things that I don't think we are ready for from happening. Two of those happen to be in the area of clinical laboratory services.

I for a while was prepared to suggest that HCFA's notion of doing this demonstration bidding process ought to be just killed off. But I think your judgment is probably better to put it in a moratorium for a year, and the same thing with regard to mandatory assignment under Part B for clinical labs or lab services in a doctor's office.

I don't know yet whether that is not the right way to go. I suspect it is not the right way to go. Lab services in a doctor's office are different from other places. There are implications here for rural health care. There are other implications. And since we have already decided twice in DEFRA and once in COBRA to try to get some information from GAO and HCFA by early next year on how to do a better payment system overall for lab services, I think your judgment in postponing the effective date for that COBRA provision on mandatory assignment to put that off for a year is very good judgment. That way, I guess in neither case are we deciding the issue, but we are giving ourselves an opportunity next year to do it better than I think that

quickie COBRA process gave us.

So I really congratulate you. And I don't know how, it must be just excellent staff work, or something that is putting all this together while you are busy performing other miracles. But I certainly recommend this to my colleagues.

The Chairman. Further comments?

(No response)

The Chairman. Ed, go ahead.

Are we done with Senator Dole's bill?

Ms. Worth. No.

The Chairman. Oh, pardon me.

Ms. Worth. Mr. Chairman, we probably should go through it this section that the staff has made staff proposals on. But did you want to wait for Senator Dole? I think he had some concerns about some of those changes.

The Chairman. That is fine.

Ed, go ahead.

Mr. Mihalski. I have basically gone through the staff package, the modifications of the staff package, on health. There are two things I did not mention that I should mention. And that is that on the errata sheet. One is on a proposal that deals with a waiver of Medicare cost sharing under Part A of Medicare, which is an amendment to the basic fraud and abuse bill; that we would grandfather in those hospitals which are currently granting that waiver for veterans. There

are a number of programs, a number of hospitals that have designed programs for veterans to come to their hospital and receive the same care they would have received in the veteran's hospital at basically the same price, and that is no price to them because they have waivered the deductible, so, therefore, the veteran doesn't have to waive the deductible.

And we would grandfather those particular hospitals for two years until we can take a look at that entire issue. Because ordinarily the way the proposal reads is that if a hospital waives it within any one diagnosis related group, it has to waive it for everybody in that group. It cannot pick and choose amongst people.

The other one I wanted to mention is that there was a modification of Senator Durenberger's suggested proposal on reclassifying some of these diagnosis related groups.

It was originally that we did not have cost estimates that was in the package. CBO then gave us a pretty significant cost. So we have now modified it to do it on a budget neutral basis.

But other than that, that is, unless there are questions, all I have in the health area.

The Chairman. I know some members have some amendments. Senator Grassley, do you have any others?

Senator Grassley. No.

The Chairman. All right.

Senator Grassley. Am I right that as a result of this discussion then my position persists then as a part of the package? And also now my third amendment is part of the package.

Mr. Mihalski. Yes, sir.

Senator Grassley. So it will not have to be discussed separately.

Mr. Mihalski. That is correct.

The Chairman. That is correct.

Senator Grassley. I had one more, but I am not going to bring that up.

The Chairman. All right.

Senator Heinz?

Senator Heinz. Mr. Chairman, first I would like to express my appreciation to you, Mr. Chairman, as well as the member of the committee, for having adopted two sets of amendments in which this Senator has had a great interest, namely, the nursing home reform provision, and the organ transplant provision, both of which I think are going to be extremely helpful. And given the fact that I know that the committee and staff had a rather limited amount of time to review, really both, I want to express my appreciation.

I do think that what we have done with the organ transplant amendment is going to assure that U.S. citizens

have a preferred opportunity, or perhaps not as strongly preferred as I would wish and as I will suggest in legislation I will introduce later this week, but that they will now have a substantially more preferred position so that they receive organs donated by Americans on the basis of need.

In terms of the nursing home provisions, I think that the tightening up of conditions of participation or residents' rights, nurse aide training, the prohibition on a vareity of Medicaid discrimination, and some improvements in surveying certification, I understand those have all been adopted as well. And I think those are a major step forward, Mr. Chairman, in safeguarding the promises that we made; that people who are admitted to nursing homes, irrespective of whether it is Medicaid, Medicare, private pay, that they will all receive equal treatment as the law has always intended.

This does not plow any new ground, but it makes sure that the field doesn't crop up with a whole bunch of weeds between the rows of corn.

And I want to commend you, Mr. Chairman, and thank you and all who participated in that.

The Chairman. Well, let me thank you for the yeoman work you have done, not just on this but on the pension stuff and the tax bill. You have been an absolute, not just a supporter but a leader in this area. And it has been very

helpful. And most of what you have suggested we have adopted.

Senator Chafee?

Senator Chafee. Mr. Chairman, I want to also thank you for what you have done in connection with this, and I especially want to thank the staff for including in one of the amendments that Senator Bentsen and I have been working on, namely, the $75 million increase in the authorization level for the maternal and child health block care grant. And that is of a particular concern to me.

As you know, Mr. Chairman, my interest is in doing more about preventative health care services for children. And I just think this is an area that deserves every bit of attention we can.

And as a side advantage to all this, I don't think there is a more cost effective program that we can deal with than these preventive efforts.

So not only have we done that, but we have set aside one-third of that to increase the amounts that the states have to develop primary care services, such as check ups for children and preventive measures, innoculations and the like.

So I want to thank the staff very much for having accomplished that, and you, Mr. Chairman. And this, as I mentioned, is something that Senator Bentsen and I have been working on for the past several months.

The Chairman. Further comments?

Senator Heinz. Mr. Chairman, there is just one other point I want to bring up for clarification. And if the committee, and in particular, Senator Durenberger, has raised this, I apologize by going over ground.

I want to ask Senator Durenberger, Dave, you introduced, together with Senator Kennedy and myself, a very important bill on risk pools. And I wanted to inquire, Mr. Chairman, whether that subject has been brought up and discussed this morning, and if it has I would like to know if we have been able to achieve anything in that area.

Senator Durenberger. Mr. Chairman, if I may respond. I did not bring the subject up this morning. I brought it up in discussions in preparation for this hearing, and related to the chairman and staff the fact that we think we have got a great idea, a more efficient way to get more people, particularly the high risk, uninsurable people in this country, covered for health care. But that we have not had an opportunity since we introduced the bill to have a hearing in this committee on that subject. I did hold a hearing on state pool over in the Intergovernmental Relations because of the federal-state-local implications. And at that hearing, we got some support and some concerns from state government, and got almost no support and a whole lot of concern from small employers.

The Chairman. Who might have to pay into the pool.

Senator Durenberger. Yes. Exactly. And also some good suggestions at that hearing. And I felt, John, that the input was generally encouraging, but that we had some work that we could do between now an appropriate time next year, at which time I feel, as you do, very strongly that we ought to ask this committee to endorse the risk pool notion.

Senator Heinz. Mr. Chairman, I would like to strongly encourage the committee, as Senator Durenberger suggested, to do that. Just last month, Secretary Bowen's public-private sector advisory committee, a catastrophic illness, recommended that existing barriers to the development of state risk pools be removed.

And I think the committee is at least on record as having identified state risk pools as an appropriate way of expanding health care coverage to medically and underinsured. There are about two to three million disabled persons right now who just do not have access to health insurance. So it is an important issue, and it is one I hope we will revisit. And I think we can do it, as I think Dave has suggested, in a way that is not disruptive. It does not impose heavy cost on the unaffordable, to small employers, and which--and this is equally important--it does not cost the federal government anything.

Senator Wallop. Well in one respect it may, because it

may just drive out those who have health plans from maintaining them. And having killed a flea, you may have loosed an eagle. I mean, it's not without some consequences and people are going to react. And I think while we may satisfy ourselves that it looks great, I think the consequences may not be so neat.

The Chairman. Senator Grassley.

Senator Grassley. Mr. Chairman, just a word of caution in taking off from where Senator Wallop just left off. Maybe things can be worked out in this area, but let me assure you that from the work that we have done on the Labor-Human Resources Committee, this is a very,very difficult area. We have been working on it for months. We have not reached a concensus. We have come up with an awful lot of problems that I think that we need to be cognizance of in this committee, and at least three or four of us serve on both committees; that this is an area that cannot be brought up, you know, on some package piece of legislation at the last minute and passed. So I am happy that two members of the committee who think that this is a godd idea and that maybe the problems can be worked out are willing to give it a month to be done.

The Chairman. Further comments?

Senator Matsunaga. Mr. Chairman?

The Chairman. Senator Matsunaga.

Senator Matsunaga. Mr. Chairman, I would like to commend you and the committee, the Finance Committee majority and minority staff, for recognizing in the package the necessity and urgency of including a certified nurse anesthetist.

As the chairman is aware and so are other members of the committee, the pass through provision in which Medicare pays hospitals outside the prospective payment system for the cost of services performed for hospital patients by a CRNA--that is, the certified registerned nurse anesthetist--which we enacted as part of the Deficit Reduction Act of 1984, will expire on October 1, 1987.

Now this CRNA provision before us today replaces the expiring pass through.I understand that the termination of the pass through has been leading to confusion for hospitals, not knowing what will replace it, and in some locations the pass through has not achieved as desired results of not discouraging the use of CRNA.

I respectfully request that the report language of H.R. 1868, as reported by this committee, clarify and reflect the committee's legislative intent that the CRNA payment system, which will be developed via the Health Care Financing Administration, provide roughly the same payments to CRNAs as is now being received by hospital-employed and physician-employed CRNAs. In other words, no disincentives be created for the use of CRNAs.

Now this is the provision, Mr. Chairman and members of the committee, which is a rate one. It will save the government money.

The Chairman. Further comments?

(No response)

The Chairman. If not, why don't we move on to 2209 while Senator Dole is here.

Senator Dole. Mr. Chairman, I thank you very much.

I introduced 2209 with a number of my colleagues, and with Congressman Steve Bartlett on the House side. He had been working with Democrats and Republicans on the House side. We believe it is a long needed change. I know there is some opposition to it. I know Senator Long is feeling the other direction. But I think working with the committee staff and the Ways and Means staff and others, that we have made a number of corrections that have actually improved the bill.

The only question I would have would be the one referenced where the staff made a suggestion to delete the provision which would permit that individuals eligible for 1619(A) or (B) that a prior month be allow for up to two months of SSI benefits in any 24-month period.

Now my view is that that is a good provision. It ought to be retained. But I think we could modify it to take away some of the objection, that this provision will apply where

the state has agreed not to use the SSI monies to finance the institutional cost of care. I would hope we might keep that provision with that addition so that we are not just turning over the money to the institution.

As I understand those who support this provision--I think with justification--indicate that it provides for the needs of mentally disabled persons who may have episodic institutionalization but need their SSI benefits to pay for their group home residency even while they are institutionalized. That seems to make a certain amount of sense to me, being somewhat familiar with some persons in this category. And I would hope with that provision, where we wouldn't just permit somebody to take the benefits for the care itself, we could keep that provision in the bill. Otherwise, I think that the staff made some very sound recommendations and they have improved the bill.

The Chairman. Comments?

(No response)

The Chairman. Any comments at all?

(No response)

The Chairman. You sold everybody.

Ms. Worth. Mr. Chairman, a point of clarification when we are drafting.

We are concerned here with people who are confined to medical institutions. The term "public institution" would

include such things as prisons if we don't narrow it down.

Senator Dole. Right. Well, let's narrow it down. Yes.

Ms. Worth. All right.

The Chairman. Is there objection to reporting the bill?

Senator Long. Mr. Chairman, would you report it as an amendment to this bill?

Senator Dole. This is a second bill.

The Chairman. This is a second bill. This is not the big one we were just discussing.

Senator Long. A free standing bill?

The Chairman. Yes.

Senator Long. I will not object to it, sir.

The Chairman. Is there objection to reporting it?

(No response)

The Chairman. Without objection.

Now let's go back to --

Senator Dole. That will include that one change.

The Chairman. Yes.

Senator Long. Mr. Chairman, if I might just interrupt for a moment. I would like to consider offering an amendment to this bill that would be a significant amendment. And I would hope it would have the support of the Administration. I have talked to certain important persons in the Administration who seem to be symphathetic to the amendment, but I am not ready to offer it at this time. And

I would hope that if we agree to report the bill in which we have been working here that we would have an understanding that the bill would not be called up until the members have a chance to study what is in it and to even have an opportunity to suggest further amendments to members of the committee, and hoping that the chairman could modify the bill on the floor.

The Chairman. That would be my intention. I would like to get this out of committee today so we have it out of our way. And then if other membes have amendments, I think I would call the committee together, adopt them as committee amendments, and just attach them to the bill.

Senator Long. Well my interest in that is because this might be the last train through the station if one wants to send something in social welfare down to the President, it doesn't have a good prospect of becoming law. And I don't want to be closed out on that. And I would like to have it submitted before the committee rather than just offer it on the floor. And I would hope that other members of the committee would have the same consideration.

The Chairman. That would be my intention.

Senator Bentsen?

Senator Bentsen. Mr. Chairman, on the previous bill, 1868, I would like to offer an amendment calling for data collection on adoption and foster care. We have very

inadequate information. It is from voluntary organizations. And you have no standard of reporting to develop information on which to exercise our judgment on federal legislation affecting adoption and foster care.

I understand it has been cleared on both sides of the aisle. The Administration had some question concerning additional cost. And I would be quite pleased to alter the amendment and have the language taken care of, where it is done at no additional cost, with staff that is currently available, and that being enough to suffice accomplishment to accomplish it.

Actual implementation of the data collection system would take place over three years, so it would be fully operational by 1991.

The Secretary would be required to set up an advisory committee. I would say that instrumental in the development of the language that I am offering today was the National Committee For Adoption. I find myself a little bias in this regard, being co-chairman of the Coalition on Adoption, the Child Welfare League, the Childrens' Defense Fund, and the American Public Welfare Association.

The Chairman. Comments?

Ms. Worth. Staff has no objection, Mr. Chairman.

The Chairman. Does the Administration have any comments?

Mr. Hackbarth. That is outside my domain.

The Chairman. All right.

That often does not stop other Administration witnesses.

(Laughter)

The Chairman. Any further comments?

(No response)

The Chairman. Without objection.

Senator Bentsen. Mr. Chairman, thank you.

The other one that I would like to bring up is on the -- I think that we ought to have a preventive health care demonstration with rural participation. We have five of them mandated. But I would like to see one of them that was dedicated to the rural effort to better understand it. You see great variances in cost that take place.

The Congressional Research Service has shown that in 1984, for example, that the prevailing charge for follow up hospital visits--and that is one of the more frequently billed services--are performed by a physician in general practice, ranged from just over $10.00 in rural Mississippi to nearly $31.00 in New York City.

We have five of these demonstration projects, as I understand it, that are being mandated, and I would like to see that one of them have a rural orientation.

The Chairman. You are not suggesting a new one, just one of the five.

Senator Bentsen. No. I am talking about one of the five,

and wherever it is awarded, that we have an institution or an entity that has demonstrated its experience in delivering health care to rural residents.

The Chairman. Comments?

Mr. Mihalski. I understand the Administration is about ready to let those contracts, but they feel they can modify them so that one of them looks at rural areas.

The Chairman. Without objection.

Any other further amendments?

Senator Bentsen. I would be delighted to fill in the institution's name.

(Laughter)

The Chairman. If there are no other amendments, is there objection to reporting the bill with the understanding that, as other members may have amendments, I will try to call the committee together, assuming they are acceptable to the entire committee and add them as committee amendments?

Without objection, the bill is reported.

We stand adjourned.

(Whereupon, at 11:08 a.m., the hearing was concluded.)

C E R T I F I C A T E

This is to certify that the foregoing proceedings of an Executive Session before the Committee on Finance, held on September 10, 1986, were held as herein appears, and that this is the original transcript thereof.

WILLIAM J. MOFFITT
Official Court Reporter

My Commission expires April 14, 1987.

EXECUTIVE SESSION
99th Congress, 2nd Session
September 10, 1986

SENATE COMMITTEE ON FINANCE

EXECUTIVE SESSION

Wednesday, September 10, 10:00 A.M.; Room SD-215

1. Mark-up of H.R. 1868, Medicare and Medicaid Patient and Program Protection Act of 1986, and proposed amendments related to H.R. 1868. (Attachment A).

2. Other proposed amendments to Medicare and Medicaid. (To be provided separately.)

3. Mark-up of S.2209, Employment Opportunities for Disabled Americans Act. (Attachment B).

United States Senate

COMMITTEE ON FINANCE
WASHINGTON, DC 20510

September 8, 1986

MEMORANDUM

FROM: COMMITTEE STAFF

TO: MEMBERS, COMMITTEE ON FINANCE

SUBJECT: SEPTEMBER 10, 1986 MARK-UP

Attached are briefing materials for the September 10 mark-up of H.R. 1868, the Medicare and Medicaid Patient and Program Protection Act, and S. 2209, the Employment Opportunities for Disabled Americans Act. These materials include:

- a copy of H.R. 1868 as passed by the House of Representatives;
- a summary of H.R. 1868 which reflects proposed amendments;
- a side-by-side which describes H.R. 1868 and proposed amendments;

- descriptions of other proposed Medicare and Medicaid amendments which will be provided separately; and

- a copy of S. 2209 as introduced;

- a summary of S. 2209 and proposed amendments; and

- a side-by-side which describes the provisions of S. 2209 and proposed amendments.

The mark-up is scheduled for 10:00 a.m. on Wednesday, September 10, in Room SD-215.

(C0875)

United States Senate

COMMITTEE ON FINANCE
WASHINGTON, DC 20510

September 8, 1986

MEMORANDUM

FROM: COMMITTEE STAFF

TO: MEMBERS, COMMITTEE ON FINANCE

SUBJECT: SEPTEMBER 10, 1986 - EXECUTIVE SESSION, FOLLOW-UP INFORMATION

Attached are the materials that we indicated would be provided separately for the September 10 Executive Session. These materials are descriptions of the proposed Medicare and Medicaid amendments to H.R. 1868, the Medicare and Medicaid Patient Protection Act of 1986.

(C0876)

September 8, 1986

SENATE FINANCE COMMITTEE
CBO ESTIMATES
(Dollars in millions)

	FY 87	FY 88	FY 89	3-Yr total
H.R. 1868 - Fraud and Abuse Bill	5	4	3	12
Related Amendments	2	1	1	4
Subtotal	7	5	4	16
Other Amendments:				
MEDICARE				
A. Disproportionate Share Technical	0	0	0	0
B. Rural Hospital Regulation Analysis	0	0	0	0
C. Sole Community Provider Extension	N/A	N/A	N/A	N/A
D. Connecticut Hospice Waiver	*	*	*	*
E. Burn Outliers Study	0	0	0	0
F. Consumer Representative on PRO Board	0	0	0	0
G. PPS for Puerto Rico	0	0	0	0
H. Coordination of Quality Studies	*	*	*	*
I. Hospital Cost Report Extension	0	0	0	0
J. Annual Recalibration of DRGs	0	0	0	0
K. Reclassification of Certain DRGs	N/A	N/A	N/A	N/A
L. Rural Clinic Psychologist	1	1	1	3
M. Rebase PPS Rates	0	0	0	0
N. Modify PPS Outliers	0	0	0	0

September 8, 1986

SENATE FINANCE COMMITTEE
CBO ESTIMATES
(Dollars in millions)

		FY 87	FY 88	FY 89	3-Yr total
O.	CRNA Reimbursement	0	0	0	0
P.	Quality Studies and Reports	4	1	0	5
Q.	ESRD Networks	*	*	*	*
R.	Home Emergency Response Study	2	2	2	6
S.	ESRD Patient's Rights	0	0	0	0
T.	Additions to MD Payment Board	0	0	0	0
U.	Coverage of Psychologists' Services	0	0	0	0
V.	Prevention Demostration Technical	1	1	0	2
W.	MADRS Database Expansion	2	0	0	2
X.	Clinical Lab Demonstration	0	0	0	0
Y.	Waivers for Frail Elderly Projects	*	*	*	*
MEDICAID					
A.	Eligibility of the Homeless	0	0	0	0
B.	Hospice Benefits for Dual Eligibles	*	*	*	*
C.	Hospital Payment Rate Limitation	0	0	0	0
D.	South Carolina Hospital Adjustment	1	1	0	2
E.	Administratively Necessary Days	0	0	0	0
F.	ICF/MR Technical	0	0	0	0

September 8, 1986

SENATE FINANCE COMMITTEE
CBO ESTIMATES
(Dollars in millions)

	FY 87	FY 88	FY 89	3-Yr total
OTHER HEALTH				
A. MCH Block Grant (See Footnote)	0	0	0	0
B. CHAMPUS/CHAMPVA Technical	0	0	0	0
C. Nat'l Medical Expenditure Survey	0	0	0	0
Subtotal	11	6	3	20
Total	18	11	7	36
S. 2209 - Disabled Employment Bill	-1	-8	-7	-16

NOTE: * -- Less than $500,000 in additional outlays.

N/A -- CBO estimate not yet available.

MCH -- The Congressional Budget Office (CBO) will show an annual increase in authorizations of $75 million, but the $75 million will not be scored against the Finance Committee for Maternal and Child Health (MCH).

I. MEDICARE

A. Disproportionate Share Technical

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.

On May 6, 1986, the Health Care Financing Administration issued interim regulations implementing the disproportionate share adjustment. The preamble to the regulation noted that it would be incumbent upon a hospital to demonstrate that the 30 percent of revenues must be specifically earmarked for indigent care, and could not include funds furnished to the hospital to cover general operating deficits.

Many State and local governments do not earmark funds provided to hospitals for indigent care with the specificity which the regulation may require, and much of the funding for indigent care is made in the form of general payments to cover operating deficits.

Explanation of Proposal: Congressional intent would be clarified to specify that funding to cover indigent care

need not be formally characterized as such by specific budget items. Hospitals would have flexibility to demonstrate that State and local government funding is actually used for indigent care, regardless of how it is characterized in the budget.

Outlay Effect: (In millions of dollars)

	Fiscal Year--			
	1987	1988	1889	3-Year Total
	0	0	0	0

B. Rural Hospitals Regulation Analysis

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, so when a regulatory flexibility analysis is done with respect to a proposed Medicare or Medicaid regulation, the analysis relates to the effect of the regulation on hospitals in general, not on urban and rural hospitals as different entities.

Explanation of Proposal: A specific analysis of the impact of all proposed Medicare and Medicaid regulations on small rural hospitals would be required. A "small" rural hospital would mean 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.

Outlay Effect: (In millions of dollars)

Fiscal Year--			
1987	1988	1889	3-Year Total
0	0	0	0

C. Sole Community Provider Extension

Current Law: Under the prospective payment system (PPS), a sole community provider hospital may be paid under a separate formula which consists of 75 percent of its own hospital-specific costs per discharge, and 25 percent of the PPS rate per discharge. 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 five percent in patient volume due to circumstances beyond its control. Medicare will adjust the payment per discharge to fully compensate these hospitals. Their fixed costs, including the reasonable cost of maintaining necessary core staff and services, are spread over fewer cases so that the total cost per discharge increases. The additional payment provision only applies to cost reporting periods beginning prior to October 1, 1986.

Explanation of Proposal: The additional payment provision for five percent decrease in volume would be extended indefinitely, and the Secretary 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.

Outlay Effect: (In millions of dollars)

Fiscal Year--			
1987	1988	1889	3-Year Total
N/A	N/A	N/A	N/A

N/A Not available

D. Connecticut Hospice Waiver

Current Law: Medicare certified hospices are required to have a ratio of at least 80 home-care days to every 20 inpatient days. The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) provided a temporary exception from the 20 day limit on inpatient days for hospices which commenced operation before January 1, 1975 (essentially the Connecticut Hospice). TEFRA also permitted this early hospice to receive exceptions from the reimbursement cap and the limitation on the number of respite care days (defined as a period of relief for the family or friend who provides care to a dying patient.) TEFRA exceptions expire October 1, 1986.

Explanation of Proposal. This proposal would make Connecticut Hospice Inc. eligible for a permanent waiver of the 20 day limit on inpatient days and a new 50 day limit would be imposed. No waiver would be permitted for the reimbursement cap or the limitation on respite care days.

Outlay Effect: (In million of dollars)

	Fiscal Year--			
	1987	1988	1889	3-Year Total
	*	*	*	*

* Less than $500,000

(C0837)

E. Burn Outliers Study

Current Law: Five to six percent of the estimated prospective payments are set aside each year to pay for complex cases that require substantially longer lengths of stay or higher costs compared to the average case in the same diagnostic category, the so-called, "diagnosis related group" or DRG. These cases are known as "outliers". Preliminary information suggests that burn patients became outlier cases at higher rates than other categories of patients.

Explanation of Proposal: This proposal would require the Prospective Payment Assessment Commission (ProPAC) to recommend, by April 1987, a modification of the prospective payment system to better accommodate outlier for burn cases, including the need for separate payment rates for burn center hospitals. The new rates would apply in fiscal year 1988.

Outlay Effect: (In millions of dollars)

	Fiscal Year--			
	1987	1988	1889	3-Year Total
	0	0	0	0

F. Consumer Representative on PRO Board

Current Law: Peer Review Organizations (PROs) are independent organizations that assess the appropriateness, necessity, or quality of services paid by Medicare. These organizations are composed of licensed physicians, nurses, and other health care practitioners who are qualified to conduct "peer" review of health care services delivered by physicians, practitioners or institutions. Currently, PRO contracts are limited to review of inpatient hospital services.

Explanation of Proposal: Each peer review organization (PRO) would be required to name at least one consumer representative to its board of directors.

Outlay Effect: (In millions of dollars)

Fiscal Year--			
1987	1988	1889	3-Year Total
0	0	0	0

(C0617)

G. PPS for Puerto Rico

Current Law: When the prospective payment system (PPS) was enacted, hospitals in Puerto Rico were excluded from the system because there was insufficient data to assess whether the payment method was appropriate for those hospitals. The Secretary of Health and Human Services was required to prepare a report to Congress recommending a method to include Puerto Rico hospitals under the prospective payment system.

Explanation of Proposal: This proposal would include Puerto Rico hospitals in Medicare's prospective payment system. Under the proposal:

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

(2) The payment rate would be based on a blend -- 75 percent of the Puerto Rico standardized rate and 25 percent of the national payment rate;

(3) The 75 percent Puerto Rico rate would include separate rates for urban hospitals and rural hospitals while the 25 percent national rate would average urban and rural hospital rates.

(4) The base-year would be the latest year for which cost data is available; and

(5) Puerto Rico hospitals would be exempt from restrictions on foreign medical graduates.

For Puerto Rico hospitals that qualify, the payment rates would be adjusted for five factors currently used in the national system:

(1) teaching costs;

(2) low income population;

(3) exceptionally high cost cases;

(4) anesthesia; and

(5) sole community provider.

The proposal would be budget neutral because national payment rates would be restandardized to include Puerto Rico hospitals.

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

Outlay Effect: (In millions of dollars)

	Fiscal Year--			
	1987	1988	1889	3-Year Total
	0	0	0	0

(C0834)

H. Coordination of Quality Studies

Current Law: Congress has required a number of studies to assess the impact of the prospective payment system (PPS) for hospitals on the quality of patient care. Currently, there is no central office responsible for assuring that research priorities are established and that studies, data and reports are coordinated.

Explanation of Proposal: The Secretary for Health and Human Services would be required 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 agencies would be convened to develop an agenda and establish priorities for quality studies. The agenda should be submitted to Congress within one 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 would also be responsible for establishing a plan to coordinate access to data necessary to conduct the studies and for maintaining a clearinghouse on PPS quality studies conducted by the Department and other entities.

Outlay Effect: (In millions of dollars)

	Fiscal Year--			
	1987	1988	1889	3-Year Total
	*	*	*	*

* Less than $500,000 in outlay increase.

(C0826)

I. Hospital Cost Report Extension

Current Law: Hospitals under PPS are required to report their costs to the Secretary through September 30, 1988.

Explanation of Proposal: This proposal would require cost reports to be maintained through 1993. It requires the Secretary, after consultation with appropriate health care representatives, to recommend to Congress an improved cost reporting system within one year. The Secretary would be restricted from changing the cost report requirements until the report to Congress is submitted.

Outlay Effect: (In millions of dollars)

	Fiscal Year--			
	1987	1988	1889	3-Year Total
	0	0	0	0

(C0824)

J. Annual Recalibration of DRGs

Current Law: Under Medicare's prospective payment system (PPS), the Secretary is required to adjust every four years, the categories and weighting factors used to classify patients in specific diagnosis-related groups (DRGs). These categories and weighting factors reflect the relative use of hospital resources.

Explanation of Proposal: This proposal would require that the Secretary adjust the DRG categories and weighting factors every year beginning with fiscal year 1988.

Outlay Effect: (In millions of dollars)

	Fiscal Year--			
	1987	1988	1889	3-Year Total
	0	0	0	0

(C0823)

K. Reclassification of Certain DRGs

Current Law: The Prospective Payment Assessment Commission (ProPAC) is an independent commission designated by Congress to review Medicare's hospital inpatient prospective payment system. One of ProPac's responsibilities is to evaluate scientific evidence and recommend changes in the classification system used to establish payment rates.

Explanation of Proposal: This proposal would implement Propac recommendations to reclassify two diagnosis related groups (DRGs), the categories into which patients are grouped for payment under PPS. The first change would be to reclassify the implantation of penile protheses (i.e., a surgical procedure and device used to treat impotence) into a unique DRG because the resource use is significantly greater and different from other surgical procedures in the current DRG classification. The second change would be to adjust the heart pacemaker DRGs to distinguish between dual-chamber and single-chamber models.

Outlay Effect: (In millions of dollars)

	Fiscal Year--			
	1987	1988	1889	3-Year Total
	N/A	N/A	N/A	N/A

N/A not available.

(c0097)-2

L. Rural Clinic Psychologist

Current Law: Psychological services delivered by a non-physician provider cannot be directly reimbursed by Medicare. Medicare part A or part B reimbursement for psychological services is authorized only when delivered under the supervision of a psychiatrist.

Explanation of Proposal: This proposal would allow reimbursement for psychologist services provided in a rural health care clinic only. It would permit psychologist sevices to be included in a facility's Medicare part A charges, even if not provided under the supervision of a psychiatrist. This would be consistent with administrative procedures which allow the inclusion in part A charges of services provided by non-supervised physician assistants and nurse practitioners.

Outlay Effect: (In millions of dollars)

	Fiscal Year--			
	1987	1988	1889	3-Year Total
	1	1	1	3

(B)-2

M. Rebase PPS Rates

Current Law: For 1983, the prospective payment system (PPS) rates were based on unaudited cost data from 1981 that was updated to reflect inflation.

Explanation of Proposal: This proposal would require the Secretary to rebase the PPS rates for fiscal year 1988 to reflect the actual costs reported by urban and rural hospitals in 1985. The proposal would be budget neutral. That is, if aggregate payments in 1988 are expected to be lower as a result of rebasing, an additional factor would be used to increase each rate to a level which prevents a reduction in overall spending.

Outlay Effect: (In millions of dollars)

	Fiscal Year--			
	1987	1988	1889	3-Year Total
	0	0	0	0

N. Modify PPS Outliers

Current Law: Between 5 and 6 percent of projected prospective payment system (PPS) expenditures for all hospital discharges are set aside for additional payments for "outliers" (i.e,, those cases that exceed specified length of stay or cost thresholds). Under current practice, the outlier set-aside is distributed as claims are submitted. Due to their high volume of patients, urban hospitals receive a disproportionately larger share of the outlier set-aside relative to their contribution. Rural hospitals receive less of a share.

Explanation of Proposal: This proposal would require that the outlier set-aside be allocated so that rural hospitals and urban hospitals within geographic regions receive payments that are equal to their contribution.

Outlay Effect: (In millions of dollars)

	Fiscal Year--			
	1987	1988	1889	3-Year Total
	0	0	0	0

(D)-2

O. CRNA Reimbursement

Current Law: Medicare pays hospitals for the costs of services performed for hospital patients by a certified registered nurse anesthetist (CRNA) who is employed by, or under contract with, the hospital. This payment is in addition to the prospective payment system (PPS) payment to the hospital. This provision is due to expire on October 1, 1987.

The services of a CRNA are also recognized, for purposes of Medicare reimbursement, when the CRNA is employed by a physician. In this situation, the physician can bill, on a reasonable charge basis under part B, as if he had actually performed the service. The CRNA's compensation in this instance is a matter between the CRNA and the physician employer.

Physicians are also able to receive payment, on a reasonable charge basis, when they provide medical direction to a CRNA employed by or under contract with a hospital. In this instance, the reasonable charge of the physician is reduced, from what it would have been had he performed the anesthesia service himself, to reflect the reduced level of his involvement and the fact that reimbursement for the CRNA is being made through the hospital.

Explanation of Proposal: Direct reimbursement under part B of Medicare would be established for CRNA services. Payment would be equal to 80 percent of a fee schedule established by the Secretary. The Secretary could vary the fee schedule by geographic area.

The fee schedule would be established initially at a level based on the costs of anesthesia services provided by CRNA's, but subject to a requirement that total Medicare payments for anesthesia services (both services provided by CRNA's and medical direction provided by physicians) could not increase by reason of the change in reimbursement methodology for CRNA services. In order to meet this requirement, the Secretary could adjust payment levels for CRNA services or both anesthesiologist services and CRNA services, if necessary. The fee schedule would be updated annually by the Medicare economic index.

CRNA's would be required to take assignment for all Medicare services. Payments would be made directly to the CRNA, or the CRNA could allow a hospital or physician to bill for the CRNA services where an employment relationship or contract so stipulates, but the hospital or physician could not bill more for CRNA services than the amount the CRNA could bill independently.

The provision would become effective on October 1, 1987.

Outlay Effect: (In millions of dollars)

Fiscal Year--			
1987	1988	1889	3-Year Total
0	0	0	0

P. Quality Studies and Reports

Current Law: Medicare law includes authority to conduct pilot, research, and demonstration projects designed to improve the operation and effectiveness of the Medicare program.

Explanation of Proposal: The Secretary of Health and Human Services would be required to conduct five studies:

1) 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.

2) Review of Medicare Hospital Conditions of Participation -- The Secretary would be required to determine whether the current standards used to qualify hospitals for participation in Medicare are adequate to maintain quality of services under a prospective payment system which includes financial incentives to underserve.

3) Study of Payment of Administratively Necessary Days -- A study would be required to assess whether additional payment should be made for administratively necessary days (ANDs). (An AND is a day of continued inpatient hospital stay necessitated by delays in obtaining placement in a skilled nursing facility.)

4) Development of Uniform Needs Assessment Instrument -- A study 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.

5) Including Information in PPS Annual Reports -- The annual reports to Congress concerning the prospective payment system would be expanded to include:

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

b) an assessment of problems that have prevented beneficiaries from receiving appropriate post-hospital services; and

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

Outlay Effect: (In millions of dollars)

	Fiscal Year--			
	1987	1988	1889	3-Year Total
	4	1	0	5

(C0617)

Q. ESRD Networks

Current Law: The Social Security Amendments of 1972 extended Medicare coverage to individuals who require renal dialysis or transplantation because they suffer from end-stage renal disease (ESRD) i.e., kidney failure. In 1978 Congress authorized the establishment of ESRD networks. These organizations were to develop a system to coordinate the professionals and facilities involved in the treatment of persons with ESRD. There are currently 32 networks. The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) required the Secretary to maintain networks as authorized and prohibited merging them with other organizations. Networks could be consolidated to no fewer than 14 entities. On August 26, 1986, HCFA published final regulations to redesignate and reorganize networks.

Explanation of Proposal: This proposal would require the Secretary to revise the final regulations published in the Federal Register on August 26, 1986. It would require the Secretary to maintain the current functions and responsibilities of the Networks and to consolidate to no fewer than 14 entities. These responsibilities are to include:

a. the collection and validation of ESRD facility and patient data;

b. the development of quality assurance standards;

c. patient advocacy; and

d. implementation of patient's grievance mechanism.

Competitive bidding is not precluded, but, in order to ensure a smooth transition from 32 networks to no fewer than 14, the Secretary must designate the new organizations and retain the old organizations for 30 days so that records and data may be transmitted to the appropriate new entity during the transition period. The Secretary must publish, after consultation with appropriate professional and patient organizations, the criteria for determining the geographic area for each Network.

In order to better evaluate the performance of Networks, and in order to establish the reorganized Networks, the Secretary is directed to establish standards, criteria, and procedures for evaluating Networks.

The Secretary would be required to establish a national end stage renal disease registry from data reported by ESRD network organizations, transplant centers, and other resources. The purpose of this registry is to

collect, validate, analyze, and disseminate data on all ESRD patients in order to identify the economic impact, cost effectiveness, and medical efficiency of alternative modes of treatment.

Outlay Effect: (In millions of dollars)

	Fiscal Year--			
	1987	1988	1889	3-Year Total
	*	*	*	*

* Less than $500,000 in increased outlays.

(c0107)

R. Home Emergency Response Study

Current Law: Medicare does not cover the cost of a personal home emergency response system. These systems consist generally of equipment in a person's home which transmits a signal for emergency medical assistance to an emergency response center.

Explanation of Proposal: The Secretary would be required to conduct a clinical trial to determine the efficiency and economic feasibility of providing Medicare coverage for personal emergency response systems.

Outlay Effect: (In millions of dollars)

	Fiscal Year--			
	1987	1988	1889	3-Year Total
	2	2	2	6

S. ESRD Patient's Rights

Current Law: Facilities are required to receive the patient's written consent prior to administering treatment in the ESRD program.

Explanation of Proposal: This proposal would require that, as a condition of participation in the Medicare End-Stage Renal Disease Program,

1) facilities that reuse renal dialysis equipment must inform patients in writing of the potential risks and benefits of reuse; and

2) the patient be given the freedom to decide whether or not to accept treatment at the facility.

Outlay Effect: (In millions of dollars)

	Fiscal Year--			
	1987	1988	1889	3-Year Total
	0	0	0	0

(c0114)(a)

T. Additions to MD Payment Board

Current Law: The Physician Payment Review Commission was created by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) to advise the Congress with respect to Medicare payment for physician services. The Commission consists of 11 members, appointed by the Director of the Congressional Office of Technology Assessment (OTA). Members are appointed for three-year terms, except that some initial terms are shorter to insure that the terms of no more than four members expire in any one year.

Explanation of Proposal: The number of members of the Commission would be expanded to 13. The terms of members would be adjusted to insure that the terms of no more than five members expire in any one year. The two additional members would be appointed within 60 days after enactment.

Outlay Effect: (In millions of dollars)

Fiscal Year--			
1987	1988	1889	3-Year Total
0	0	0	0

U. Coverage of Psychologists' Services

Current Law: The Social Security Act defines inpatient hospital services paid by Medicare as "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."

Explanation of Proposal: The provision would clarify that inpatient hospital services for which payments may be made under Medicare part A would include diagnostic or therapeutic services provided by a psychologist. The provision would be effective upon enactment.

Outlay Effect: (In millions of dollars)

	Fiscal Year--			
	1987	1988	1889	3-Year Total
	0	0	0	0

V. Prevention Demonstration Technical

Current Law: COBRA required the Secretary of Health and Human Services to establish a four-year demonstration of preventive health services. Funding for the demonstration program was not to exceed $4 million over the duration of the program.

Explanation of Proposal: This proposal would clarify that the $4 million limitation on funding applies only to the administrative cost of designing and conducting the demonstration and the accompanying evaluation. Because the cost of operating and evaluating the five demonstrations is estimated to be $5.9 million, $1.9 million additional funding is allowed. These funds do not apply to the cost of the services provided.

Outlay Effect: (In millions of dollars)

	Fiscal Year--			
	1987	1988	1889	3-Year Total
	1	1	0	2

(C0852)

W. MADRS Database Expansion

Current Law: No provision. The Secretary currently keeps separate data systems on part A claims and part B claims.

Explanation of Proposal: This proposal would require the Secretary of Health and Human Services to integrate information on beneficiary claims under parts A and B of Medicare beginning with fiscal year 1980. This combined data base (known as MADRS) will provide the Secretary with sufficient data to compare Medicare costs, utilization, and quality before and after the implementation of the hospital prospective payment system.

Outlay Effect: (In millions of dollars)

	Fiscal Year--			
	1987	1988	1889	3-Year Total
	2	0	0	2

(c0102)-2

X. Clinical Lab Demonstration

Current Law: Pursuant to his demonstration authority, the Secretary has proposed to experiment with competitive bidding as a method of purchasing clinical laboratory services under the Medicare program. COBRA placed a moratorium on the demonstration until December 31, 1986, except that the design and site selection for such demonstrations was permitted to proceed.

Explanation of Proposal: This proposal would extend the moratorium for one year from enactment and require the Department to describe the experiment prior to implementation.

Outlay Effect: (In millions of dollars)

	Fiscal Year--			
	1987	1988	1889	3-Year Total
	0	0	0	0

(c0112)-2

Y. Waivers for Frail Elderly Projects

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 a Medicare waiver as a demonstration project. The organization is paid on a capitated basis under the Medicare 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 Proposal: The Secretary would be authorized to grant up to ten waivers to organizations that provide comprehensive services to the frail elderly. The waivers would provide for capitated payments for Medicare beneficiaries in the same maner as the "On Lok" waiver. Conditional waivers would be for a three-year period, and permanent waivers could be authorized thereafter.

Outlay Effect: (In millions of dollars)

Fiscal Year--			
1987	1988	1889	3-Year Total
*	*	*	*

* Less than $500,000 in increased outlays.

II. MEDICAID

A. Eligibility of the Homeless

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 Proposal: Current law would be clarified 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 any other means consistent with the circumstances under which the homeless live.

Outlay Effect: (In millions of dollars)

Fiscal Year--			
1987	1988	1889	3-Year Total
0	0	0	0

B. Hospice Benefits for Dual Eligibles

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

However, there is a problem for people who are eligible for both Medicaid and Medicare (the so-called "dual eligibiles") 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 a full payment from Medicare; and the Medicare/Medicaid programs would have "overpaid" the provider.

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

Outlay Effect: (In millions of dollars)

	Fiscal Year--			
	1987	1988	1889	3-Year Total
	*	*	*	*

*Less than $500,000.

(C0821)

C. Hospital Payment Rate Limitation

Current Law: The Social Security Act requires that State Medicaid payments to hospitals be "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities". In addition, the State payments must be "consistent with efficiency, economy, and quality of care". The regulations which implement these provisions establish an upper limit on State hospitals' reimbursement. The upper limit is defined by Medicare's cost-based principles of reimbursement. Therefore, a State cannot reimburse its hospitals under Medicaid more than Medicare would have under cost-based reimbursement.

The regulations also limit the year-to-year increases that States allow hospitals to the increases allowed under Medicare's prospective payment system, unless the State's Medicaid hospital reimbursement level was below Medicare's payment level.

Thus, a State could be prohibited from providing what it believes is a "reasonable and adequate" rate of increase to Medicaid hospitals because Medicare rates of increase have been lower. New York and Georgia are already having this problem.

(Note: These upper limits for hospitals also apply to other instituitional providers such as nursing homes and intermediate care facilities for the mentally retarded (ICF/MR). New upper limit regulations were recently proposed which would apply to every different type of State reimbursement rates, such as the ICF/MR facility rates.)

Explanation of Proposal: The proposal would clarify current law to specify that the Medicare cost-based reimbursement principles are not an absolute test of "reasonableness". Although the Medicare cost-based principles would act as an "upper limit" of testing the reasonableness of State rates, reasonable exceptions would also be allowed. One such exception, would be to allow for payment rates to exceed Medicare payment rates for "disproportionate share adjustments" which would allow the State to pay for a reasonable share of charity care and bad debt. (This item is not included under Medicare cost-based reimbursement principles.) The Secretary would be allowed to permit other reasonable exceptions.

Outlay Effect: (In millions of dollars)

Fiscal Year--			
1987	1988	1889	3-Year Total
0	0	0	0

(C0819)

D. South Carolina Hospital Adjustment

Current Law: South Carolina expanded its Medicaid program in October 1984 to cover pregnant women who had 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. The Medical University wants retroactive payment for these services. Although Medicaid allows a 90-day retroactive eligibility period, the retroactive period begins only from the date of application. Since no application had ever been submitted, there is no method to assist South Carolina without some statutory change.

Explanation of Proposal: This amendment would extend the normal retroactive period to cover the eligibility period from October 1, 1984 to July 1, 1985 for the Medical University of South Carolina. Thus until March 31, 1987, Medicaid would be allowed to pay for claims for services provided during that period to those determined eligible for Medicaid.

Outlay Effect: (In millions of dollars)

Fiscal Year--			
1987	1988	1889	3-Year Total
1	1	0	2

(C0820)

E. Administratively Necessary Days

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 in the situation that there is no excess hospital bed capacity. The excess bed standard is defined as having a 80 percent occupancy level in the specific hospital or 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 would be closed to offset the additional costs of a higher rate.

Outlay Effect: (In millions of dollars)

	Fiscal Year--			
	1987	1988	1889	3-Year Total
	0	0	0	0

(C0838)

F. ICF/MR Technical

Current Law: The Consolidated Omnibus Reconciliation Act of 1985 (COBRA) allows 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 change, 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. HCFA contends that the option to phase down gradually is not available to the States because the regulations are not final.

Explanation of Proposal: Clarify that the intent of Congress was to make the option available to States from the time of enactment and not from the time that the regulations are made final.

Outlay Effect: (In millions of dollars)

Fiscal Year--			
1987	1988	1889	3-Year Total
0	0	0	0

(C0827)

III. OTHER HEALTH

A. MCH Block Grant

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. 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 Proposal: The authorization level would be increased from $478 million to $553 million for each fiscal year.

Outlay Effect: (In millions of dollars)

	Fiscal Year--			
	1987	1988	1889	3-Year Total
	0	0	0	0

Note: The Congressional Budget Office (CBO) will show an annual increase in authorizations of $75 million, but the increase will not be scored against the Finance Committee.

B. CHAMPUS/CHAMPVA Technical

Current Law: The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) required that hospitals that participate in Medicare also participate in the Department of Defense health programs (CHAMPUS) and the Veterans Administration health programs (CHAMPVA) for admissions occurring after 1986.

Explanation of Proposal: This technical change would delete the requirement that the provision apply to agreements "entered into or renewed after the date of enactment". Medicare does not periodically renew hospital agreements.

Outlay Effect: (In millions of dollars)

	Fiscal Year--			
	1987	1988	1889	3-Year Total
	0	0	0	0

(C0822)

C. National Medical Expenditure Survey

Current Law: The Public Health Services Act authorizes the Secretary of HHS to use one percent of the total appropriations for the Public Health Services (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 Proposal: This proposal would require that the National Survey of Medical Expenditures be conducted at least once a decade beginning in fiscal year 1987.

Outlay Effect: (In millions of dollars)

	Fiscal Year--			
	1987	1988	1889	3-Year Total
	0	0	0	0

(C0825)

Attachment A

Summary of H.R. 1868, the Medicare and Medicaid Patient Protection Act of 1986, Including Proposed Amendments

This bill has two purposes:

1) to recodify existing Medicare and Medicaid fraud provisions; and

2) to add new fraud provisions that close loopholes in current law.

H.R. 1868 passed the House on June 4, 1985, and was sent to the Senate. Two related bills, were introduced in the Senate; S. 1323, sponsored by Senator Roth, and S. 837, sponsored by Senator Heinz. Selected provisions from the Senate bills are proposed as amendments to H.R. 1868. The Congressional Budget Office (CBO) estimates that H.R. 1868 and the proposed amendments would increase Medicare and Medicaid administrative costs by $16 million over a three year period.

Following is a brief section by section summary of the fraud and abuse provisions enacted by the House with proposed amendments:

Section 1: Describes the purpose of the bill.

Section 2: Exclusion from Medicare and State Health Programs -- Broadens the conditions under which the Secretary of the Department of

Health and Human Services (HHS) and the State Medicaid directors would be required to exclude, or would have the option to exclude, individuals or entities from participating in the Medicare and Medicaid programs. The bill would:

First, establish a minimum five year period of exclusion for mandatory exclusions. In addition to a mandatory exclusion for program-related crimes, the bill would add a new mandatory exclusion for individuals and entities convicted of neglect or abuse of patients.

Second, specify fourteen specific reasons that may justify an exclusion. New reasons for discretionary exclusion include:

1) convictions related to obstruction of an investigation;
2) controlled substance violations;
3) loss of license;
4) failure of an HMO to provide medically necessary services;
5) failure to grant immediate access to Federal or State investigators;
6) exclusion from the Veterans Administration or Defense Department health programs; and

7) default on health loans or scholarships.

Finally, the bill would extend Medicare and Medicaid exclusions to the, Maternal and Child Health Block Grant program and the Social Services program under Titles V and XX of the Social Security Act.

Section 3: Civil Monetary Penalties -- Broadens the Secretary's authority to impose civil monetary penalties and clarify procedures for imposing civil monetary penalties. New language would close loopholes that permit payment of improper claims, such as double billing, and clarify penalties for claims submitted by non-licensed physicians. New authority would be added to permit the Secretary to assess penalties against hospitals that improperly charge Medicare beneficiaries for care already paid under the prospective payment system or against hospitals that provide improper information that may influence a discharge decision.

Section 4: Criminal Penalties -- Extends current criminal penalties for kickbacks, bribes or false statements to the Title V and Title XX programs and clarifies criminal penalties for physicians who are not licensed.

Section 5: Information Concerning Sanctions Taken by State Licensing Authorities Against Health Care Practitioners -- Requires States to maintain a system and report to the Secretary all adverse actions, such as revocation of a license, taken by a State licensing authority against an individual or entity. The reports would be provided to State licensing authorities, State and Federal health care programs, and appropriate law enforcement officials nationwide.

Section 6: Obligations of Health Care Practitioners and Providers -- Clarifies that the Medicare requirement that all physicians and practitioners provide health care which is medically necessary and appropriately documented applies to Medicaid.

Section 7: Exclusion Under the Medicaid Program -- Gives States clear authority to exclude individuals or entities from Medicaid for the reasons included in the bill.

Section 8: Miscellaneous and Conforming Amendments -- Precludes payment for services furnished by an excluded individual or entity. Medicare and Medicaid payment would also be denied for services provided under the medical direction

or prescription of an excluded physician. Under the bill, an individual mandatorily excluded under Medicare or a State health program would also be subject to loss of their registration to dispense a controlled substance.

Section 9: Medicaid Moratorium -- Clarifies Congressional intent that no sanctions be imposed against States whose Medicaid eligibility requirements for recipients who do not receive cash are less restrictive than for cash recipients. A proposed amendment would clarify that the moratorium applies to services delivered after October 1982 and that the moratorium extends to all non-cash recipients (not only the medically needy.) In order to receive protection, States must submit a State plan amendment or manuals describing the eligibility variations which would be considered approved by the Secretary.

Section 10: Reporting Requirements for Financial Interest -- Eliminates Medicare and Medicaid reporting of financial interest for owners or individuals who control less than five percent of the assets of an entity. Entities would be required to disclose owners or managers who have been assessed penalties or excluded from

participation in Medicare or other State health programs.

Section 11: Intermediate Sanctions -- Permits the Secretary and the State Medicaid agency, in cases where there is no jeopardy to the health and safety of the patient, to impose intermediate sanctions, including a probationary period where payment would be restricted, on a provider or supplier who violates specific terms of a Medicare or Medicaid agreement. It also would permit the Secretary to apply an intermediate sanction in lieu of termination to a long term care facility for a problem found as part of a "look-behind" review, i.e., Secretary's review of a State's certification decision.

Section 12: HMO and CMP Sanctions -- Permits the Secretary to suspend new enrollments in Health Maintenance Organizations (HMO's) and Competitive Medical Plans (CMP's) that violate their contract without jeopardizing the health and safety of patients and to impose civil monetary penalties for specified reasons.

Section 13: Medigap Policies -- Makes a technical clarification in the Medicare law relating to

fraud and abuse involving the sale of "Medigap" insurance.

Section 14: Denial of Medicaid Payments -- Permits the Secretary of Health and Human Services to require information to support a claim from an entity participating in Medicaid that may exceed the requirements of the state Medicaid program.

Section 15: Medicaid Utilization Control -- Amends the time period for calculation of the utilization control penalty under Medicaid. The change would eliminate the need to recalculate stays in long term care institutions for patients that are essentially, permanently institutionalized.

Section 16: Prohibition of Certian Physician Incentive Plans -- Permits civil monetary penalties to be assessed against prospective payment system hospitals and physicians who participate in financial arrangements that provide financial bonuses for inappropriate under-utilization.

Section 17: Anti-Kickback Provisions -- Exempts from criminal prosecution as kickbacks, PPS hospitals that:

(a) waive the Part A deductible or coinsurance requirements, or

(b) participate in group purchasing arrangements.

Civil and administrative penalties would be used to enforce new conditions that would be required as safeguards for both of these arrangements.

In addition, the Secretary would be required to publish regulations to define other competitive practices that would be exempt from criminal penalties as kickbacks.

(C0818)

MEDICARE AND MEDICAID PATIENT AND PROGRAM PROTECTION ACT

Description of H.R. 1868 and Proposed Finance Committee Amendments

September 5, 1986

ITEM	H.R. 1868	PROPOSED AMENDMENT
I. General Concept	The bill is designed to protect Medicare and Medicaid beneficiaries from unfit health care practitioners and to recodify and strengthen the anti-fraud provisions of the Social Security Act.	Similar intent.
II. Exclusion from Medicare and State Health Care Programs		
A. Mandatory Exclusions	The Secretary of Health and Human Services is required to exclude from participation in Medicare and required to direct States to exclude from State health care programs (i.e. Medicaid, Title V and Title XX of the Social Security Act) any individual or entity:	
	-- convicted of a criminal offense relating to the delivery of services under Medicare or a State health care program;	Similar provision.
	-- convicted under Federal or State law, of a criminal offense related to neglect or abuse of patients in connection with the delivery of a health care item or service.	Similar provision.

ITEM	H.R. 1868	PROPOSED AMENDMENT
B. Permissive Exclusions	The Secretary of HHS may exclude from participation in Medicare and may direct States to exclude from participation in a State health care program (i.e. Medicaid, Title V and Title XX of the Social Security Act) any individual or entity:	
	-- convicted of fraud with respect to any Federal, State, or locally financed health care program;	Similar provision.
	-- convicted of interfering with the investigation of health care fraud;	Similar provision.
	-- convicted of unlawfully manufacturing, distributing, prescribing, or dispensing a controlled substance;	Similar provision except limited to felony convictions.
	-- whose health care license has been suspended or revoked by any State licensing authority, or who otherwise lost such a license for reasons bearing on the individual's professional competence, professional conduct or financial integrity or whose licensing authority was pending;	Similar provision. Report language encourages discretion for minor infractions.
	-- suspended or excluded from participation in a Federal or State health care program;	Similar provision except limited to reasons related to professional competence, professional performance, or financial integrity.

ITEM	H.R. 1868	PROPOSED AMENDMENT
B. Permissive Exclusions (continued)	-- claiming excessive charges; furnishing items or services substantially in excess of the patients' needs or of a quality that fails to meet professionally recognized standards; or is a HMO or an entity operating under a waiver of Medicaid's freedom-of-choice requirement under Section 1915(b)(1) of the Act, which has failed to furnish medically necessary services as required by law or the contract with the Medicaid program if the failure has adversely affected (or has a substantial likelihood of adversely affecting) the patients;	Similar provision except that excessive charges are clarified to be higher than "usual" charges for physicians. Providers that are paid on "other than a cost or charge" basis, such as PPS hospitals, are not included. The excess charge provision is limited to only Medicare and State health program patients. Report language clarifies that PROs will be responsible for assessing quality of Medicare services included under their contracts.
	-- committing fraud, kickbacks or other prohibited acts;	Similar provision.
	-- owned or controlled by an individual convicted of certain program-related offenses, 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;	Similar provision.
	-- failing to disclose required ownership information;	Similar provision.
	-- failing to supply requested information on subcontractors and suppliers;	Similar provision except adds State Medicaid agency request.

ITEM	H.R. 1868	PROPOSED AMENDMENT
B. Permissive Exclusions (continued)	-- failing to supply certain payment information;	Similar provision except adds State Medicaid agency request.
	-- failing to grant immediate access to the Secretary, State agency, Inspector General, or State Medicaid fraud control unit for the purpose of performing their statutory functions;	Similar provision. Report language expresses Committee intent that provisions apply only to situations where legal violations are suspected.
	-- failing (in the case of a hospital) to take corrective action required by the Secretary (based on information supplied by a peer review organization) to prevent or correct inappropriate admissions or practice patterns;	Similar provision.
	No comparable provision.	-- defaulting on repayment of scholarship obligations or loans in connection with health professions education, except that the Secretary may not exclude a sole community physician or sole source of essential specialized services, and must take into account access of beneficiaries to services. Report language directs the Secretary to explore feasibility of administrative alternatives.

ITEM	H.R. 1868	PROPOSED AMENDMENT
C. Notice and Effective Date	Mandatory and permissive exclusions 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 in the notice, except that an exclusion cannot apply until 30 days after the effective date of the exclusion to payments made under the Medicare program or under a state health care program for: -- inpatient institutional services furnished to an individual who was admitted to such institution before the date of the exclusion, or -- home health services and hospice care furnished under a plan of care established before the date of the exclusion.	Similar provision.

ITEM	H.R. 1868	PROPOSED AMENDMENT
D. Period of Exclusion	The Secretary is required to specify in the notice of exclusion the minimum period of exclusion. The minimum period of the exclusion for persons convicted of program-related crimes may not be less than 5 years. The minimum period of the exclusion for failure to grant immediate access to the Secretary and other agencies is the sum of the length of the period in which the individual or entity failed to grant the immediate access and an additional period not to exceed 90 days.	Similar provision except that minimum period of exclusion is five years for all mandatory exclusions. The Secretary has the authority to waive the exclusion where the individual or entity is the sole community provider or where the exclusion would adversely affect Medicare or Medicaid. The Secretary's decision to waive the exclusion would not be reviewable. The special exclusion period for failure to grant immediate access is limited to individuals only.
E. Notice to State Agencies and Exclusion Under State Health Care Programs	The Secretary is required to promptly notify each appropriate State agency administering or supervising the administration of each State health care program of the fact and circumstances of each exclusion effected against an individual or entity and the period for which the State agency is directed to exclude the individual or entity from participation in the State health care program.	Similar provision.
	The period of exclusion under a State health care program must be the same as any period of exclusion under Medicare unless the Secretary received and approved a waiver request from the State agency.	Similar provision.

ITEM	H.R. 1868	PROPOSED AMENDMENT
E. Notice to State Agencies and Exclusion Under State Health Care Programs (continued)	The Secretary is also required to promptly notify State licensing authorities concerning exclusions, request that appropriate investigations be made and sanctions invoked in accordance with State law and policy and request that the agency keep the Secretary and Inspector General informed of actions taken.	Similar provision except that State agencies are also required to report and reporting is broadened to include possible cases of physician misrepresentation or fraud.
F. Hearing, Judicial Review and Application for Termination of Exclusion	Current Medicare law provisions relating to opportunity for a hearing and judicial review of the Secretary's final decision would apply. Any individual or entity excluded from participation may apply to the Secretary (as specified in regulations) at the end of the initial period of exclusion and at such other times as the Secretary may provide, for reinstatement as a participant in these programs. The Secretary could reinstate the individual or entity if the Secretary determines there is no basis for continuation of the exclusion and there are reasonable assurances that the actions which led to the exclusion would not recur. The Secretary must notify State agencies of termination of exclusion.	Similar provision, except that review is not provided for denial of an application for reinstatement.

ITEM	H.R. 1868	PROPOSED AMENDMENT
III. Civil Monetary Penalties	The bill clarifies and consolidates authorities related to civil monetary penalties. It clarifies that the Secretary would be permitted to subject a person to civil monetary penalties for any claim the person knows is false or fraudulent.	
	The Secretary would be permitted to impose civil monetary penalties if the person submits a claim for a physician's service and is not licensed as a physician, had obtained a license by misrepresenting a material fact or falsely claimed to the patient to be board certified in a medical specialty.	Similar provision except it is limited to unlicensed physicians. Report language directs the Secretary and State health agencies to report possible cases of physician misrepresentation or fraud to the State licensing agency.
	The Secretary would be permitted to exclude the person from participation in Medicare and to direct the State agency to exclude the person from any health care program.	Similar provision.
	The Secretary would be permitted to use a single administrative and unified judicial review procedure for both the civil monetary penalty and the exclusion based on such penalty.	Similar provision.

ITEM	H.R. 1868	PROPOSED AMENDMENT
III. Civil Monetary Penalties (continued)	The Secretary would not be permitted to initiate an action under this section with respect to a claim later than 6 years after the claim was presented.	Similar provision.
	The Secretary would be permitted to issue and enforce subpoenas with respect to civil monetary penalties to the same extent the Secretary has such authority in other areas of Medicare.	Similar provision.
	The State's share of funds collected under the civil monetary penalty would be increased. The State would receive a portion of the total amount collected under the penalty in proportion to the State's share in the original claim.	Similar provision.
	If it appears to the Secretary that any person has engaged, is engaging or is about to engage in any activity which would constitute a violation subject to civil monetary penalties, the Secretary would be permitted to enjoin such person from concealing or removing assets that could be required in order to pay a civil monetary penalty.	Similar provision, except does not apply to cases where it appears the individual is about to engage in such activities.

ITEM	H.R. 1868	PROPOSED AMENDMENT
III. Civil Monetary Penalties (continued)	No comparable provision.	The Secretary would be permitted to assess civil monetary penalties against inpatient hospitals that improperly charge Medicare beneficiaries for care covered in the prospective rate or that knowingly give false or misleading information that could influence a decision on when to discharge a Medicare patient.
IV. Criminal Penalties	The measure consolidates the existing criminal penalty provisions for Medicare and Medicaid and broadens the scope to include Titles V and XX.	Similar provision.
	The measure provides criminal penalties for persons presenting a claim for a physician's service when the person was not a licensed physician or the license has been obtained through misrepresentation of material fact.	Similar provision except it does not include physicians whose licenses have been obtained through misrepresentation of material fact. Reporting would be required for cases of suspected misrepresentation.
V. Information Concerning Sanctions Taken by State Licensing Authorities Against Health Care Practitioners	As a condition of approval of a Medicaid plan, each State is required to have a system of reporting information with respect to formal proceedings concluded against a health care practitioner or entity by a State licensing authority.	Similar provision.

ITEM	H.R. 1868	PROPOSED AMENDMENT
V. Information Concerning Sanctions Taken by State Licensing Authorities Against Health Care Practitioners (continued)	A State is required to maintain a reporting system on any adverse actions taken by a licensing authority, including any revocation or suspension of a license, reprimand, reason of the practitioner or entity surrendering the license or leaving the State, also any other loss of license whether by operation of law, voluntary surrender, or otherwise.	Similar provision.
	The State is required to provide the Secretary, or an entity designated by the Secretary, access to documents as may be necessary to determine the facts and circumstances of such actions. The information must be supplied to the Secretary or, under other suitable arrangements made by the Secretary, to another entity in such a manner as determined by the Secretary.	Similar provision.

ITEM	H.R. 1868	PROPOSED AMENDMENT
V. Information Concerning Sanctions Taken by State Licensing Authorities Against Health Care Practitioners (continued)	Information would be required to be provided to State licensing authorities, State health care programs, peer review organizations and State fraud control units in order for such authorities to determine the fitness of individuals to provide health care services, to protect the health and safety of beneficiaries and to protect the fiscal integrity of such programs.	Similar provision, except that it also requires reporting to other Federal health agencies and law enforcement officials.
	The Secretary is required to provide suitable safeguards in order to ensure the confidentiality of such information as is not otherwise available to the public.	Similar provision. Report language restricts the use of information to legal duties and protects confidentiality of psychiatric or psychological treatment notes.

ITEM	H.R. 1868	PROPOSED AMENDMENT
VI. Obligations of Health Care Practitioners and Providers	The bill extends the provisions relating to obligations of health care practitioners to provide medically necessary services of a quality meeting professionally recognized standards to all health care services paid for under the Social Security Act. It extends the exclusion authority to encompass violations occurring in and exclusions from any health care program for which payment could be made under the Act.	Similar provision.
VII. Exclusion Under the Medicaid Program	The bill permits a State to exclude any individual or entity from participation in a State Medicaid plan for any reason which the Secretary could have excluded an individual from participation in Medicare. It requires a State, in order to receive Federal payments with respect to a health maintenance organization (HMO) or an entity operating under a waiver of Medicaid's freedom-of-choice requirement under Section 1915(b)(1), to exclude any such entity that: (1) could be excluded because of the conviction of the owners or managers of certain crimes; or (2) has a substantial contractual relationship with any individual or entity convicted of such crimes.	Similar provision.

ITEM	H.R. 1868	PROPOSED AMENDMENT
VIII. Miscellaneous and Conforming Amendments	The bill clarifies that no payment could be made under Medicare or a State health program for any item or service furnished by an individual or entity excluded from participation in those programs.	Similar provision except payments may be made for an emergency item or service. Medicare would assume responsibility for the first claim from an individual or entity to protect the beneficiary if the beneficiary did not know that the claim would not be paid. Medicare and Medicaid payment would also be denied for items or services furnished at the medical direction or on the prescription of an excluded physician.
	The bill provides that an institution or agency would not be entitled to separate notice and an opportunity for a hearing under both the provision relating to exclusions and that relating to termination of provider agreements with respect to a determination or determination based on the same underlying facts and issues.	Similar provision.
	The bill amends the Controlled Substances Act to add as a basis for the denial, revocation, or suspension of registration to manufacture, distribute, or dispense a controlled substance by the Attorney General, any individual or entity that has been excluded (or directed to be excluded) from Medicare.	Similar provision.

ITEM	H.R. 1868	PROPOSED AMENDMENT
VIII. Miscellaneous and Conforming Amendments (continued)	The bill makes other technical and conforming changes.	The provision makes other technical and conforming changes.
IX. Medicaid Moratorium	The measure amends the provision added by DEFRA which established a moratorium on sanctions against States whose standards or methods of determining eligibility for non-cash Medicaid recipients are less restrictive than the standards or methods of the comparable cash assistance program. The measure specifies that the moratorium applies to any State Medicaid plan change submitted to the Secretary either before or after enactment of DEFRA whether or not approved, disapproved, acted on or not acted on.	Similar provision except: clarifies that the moratorium applies only to services delivered after 10/1/82; clarifies that non-cash recipients are not limited to the medically needy; provides a grace period for an institutionalized person to sell his home; and provides that states will submit state plan amendments or manuals that describe all services provided to non-cash Medicaid recipients who do not meet cash assistance eligibility rules. Such information will be considered approved when submitted.
X. Reporting Requirement for Financial Interests	No comparable provision.	The amendment changes the definition of ownership or controlling interests to eliminate reporting requirements with respect to interests in obligations which amount to less than 5 percent of the assets of the entity.

ITEM	H.R. 1868	PROPOSED AMENDMENT
XI. Intermediate Sanctions	No comparable provision.	The amendment permits the Secretary to impose penalties (other than termination of all provider or supplier agreements) in cases where deficiencies would justify termination of the agreement but where the health and safety of patients would not be jeopardized. Intermediate sanctions would include a probationary period where payment would be restricted to patients admitted or services scheduled before the date of the notice. The provider would not be entitled to a hearing before the sanction was imposed. Report language would clarify committee intent that hospitals that fail to properly distribute the notice of beneficiary rights will be subject to intermediate sanctions. Similar amendments are included for Medicaid. The amendment gives the Secretary the authority to impose intermediate sanctions under Medicaid's "look-behind" authority. (This authority permits the Secretary to reassess a State's survey of a SNF or ICF and make an independent and binding decision with respect to a facility's participation.)

ITEM	H.R. 1868	PROPOSED AMENDMENT
XII. HMO and CMP Santions	No comparable provision.	The amendment permits the Secretary (or the State Medicaid Director) to suspend new enrollments for HMOs and CMPs that violate their contract without jeopardizing the health and safety of patients. The Secretary could impose civil monetary penalties in five specified circumstances. In addition, the Secretary (or State Director) could terminate a contract if the HMO or CMP does not comply with requirements concerning the ratio of Medicare and Medicaid patients to private patients.
XIII. Medigap Policies	No comparable provision.	The amendment establishes criminal sanctions for fraud and abuse relating to the sale of "Medigap" insurance to provide that whoever "knowingly and willfully" misrepresents a material fact is guilty of a felony. Current law is "knowingly or willfully".
XIV. Denial of Medicaid Payments When Information Supporting Claims Is Not Furnished to the Secretary	No comparable provision.	The amendment authorizes the Secretary to deny Federal Medicaid payments for services furnished by an individual or entity which failed to furnish required information.

ITEM	H.R. 1868	PROPOSED AMENDMENT
XV. Medicaid Utilization Control	No comparable provision.	The amendment provides that the length of patient stay on which the utilization control penalty is calculated include all consecutive stays, whether or not during the same fiscal year.
XVI. Prohibition of Certain Physician Incentive Plans	No comparable provision.	This amendment would permit civil monetary penalties to be assessed against hospitals and physicians who are involved in payment arrangements under PPS that inappropriately reward reduction of costs related to Medicare patients, or who fail to disclose physician incentive plans. HMOs and CMPs are exempt.

ITEM	H.R. 1868	PROPOSED AMENDMENT
XVII. Anti-Kickback Provisions		
A. Group Purchasing Organizations	No comparable provision.	The amendment eliminates criminal penalties for PPS hospitals and other providers paid on a risk basis that participate in group purchasing arrangements. Through written agreements, group purchasing organizations (GPOs) must provide full disclosure of all fees paid by participating hospitals and vendors.
B. Waiver of Deductible	No comparable provision.	The amendment eliminates criminal penalties for PPS hospitals that waive the part A deductible or coinsurance. The Secretary would be required to establish a new condition of participation that requires each PPS hospital to develop a written cost-sharing policy which includes, but is not limited to, the following requirements: (1) if any portion of Part A's deductible or coinsurance is waived, the waived amount must be offset against bad debt, (2) the cost-sharing policy must apply uniformly to all beneficiaries in the same DRG at the same hospital, and

ITEM	H.R. 1868	PROPOSED AMENDMENT
B. Waiver of Deductible (continued)		(3) the PRO must conduct preadmission review to determine the appropriateness of the setting and whether the procedure could be done on an outpatient basis. The General Accounting Office would be required to conduct a study of the impact of these requirements on beneficiary access and competitive effects, and recommend restrictions or expansions of the waiver authority in two years. Report language would clarify that HMOs and CMPs that offer reduced premiums are not subject to these requirements.
C. Competitive Practice Guidelines	No comparable provision.	The Secretary would be required by regulation to identify other competitive practices involving the referral or acceptance of services covered by Medicare or Medicaid that would be exempt from criminal penalties as kickbacks.

99TH CONGRESS
1ST SESSION

H. R. 1868

IN THE SENATE OF THE UNITED STATES

JUNE 6 (legislative day, JUNE 3), 1985

Received; read twice and referred to the Committee on Finance

AN ACT

To amend the Social Security Act to protect beneficiaries under the health care programs of that Act from unfit health care practitioners, and otherwise to improve the antifraud provisions of that Act.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; REFERENCES IN ACT.

(a) SHORT TITLE.—This Act may be cited as the "Medicare and Medicaid Patient and Program Protection Act of 1985".

(b) AMENDMENTS TO THE SOCIAL SECURITY ACT.—Except as otherwise specifically provided, whenever in this Act an amendment is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Social Security Act.

TABLE OF CONTENTS

SEC. 2. EXCLUSION FROM MEDICARE AND STATE HEALTH CARE PROGRAMS.

Section 1128 (42 U.S.C. 1320a–7) is amended to read as follows:

"EXCLUSION OF CERTAIN INDIVIDUALS AND ENTITIES FROM PARTICIPATION IN MEDICARE AND STATE HEALTH CARE PROGRAMS

"SEC. 1128. (a) MANDATORY EXCLUSION.—The Secretary shall exclude the following individuals and entities from participation in any program under title XVIII and shall direct that the following individuals and entities be excluded from participation in any State health care program:

"(1) CONVICTION OF PROGRAM-RELATED CRIMES.—Any individual or entity that has been convicted of a criminal offense related to the delivery of an item or service under title XVIII or under any State health care program (as defined in subsection (h)).

"(2) CONVICTION RELATING TO PATIENT ABUSE.—Any individual or entity that has been convicted, under Federal or State law, of a criminal offense relating to neglect or abuse of patients in connection with the delivery of a health care item or service.

"(b) PERMISSIVE EXCLUSION.—The Secretary may exclude the following individuals and entities from participation in any program under title XVIII and may direct that the following individuals and entities be excluded from participation in any State health care program:

"(1) CONVICTION RELATING TO FRAUD.—Any individual or entity that has been convicted, under Federal or State law, in connection with the delivery of a health care item or service or with respect to any act or omission in a program operated by or financed in whole or in part by any Federal, State, or local government agency, of a criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or financial abuse.

"(2) CONVICTION RELATING TO OBSTRUCTION OF AN INVESTIGATION.—Any individual or entity that has been convicted, under Federal or State law, in connection with the interference or obstruction of any investigation into any criminal offense described in paragraph (1) or in subsection (a).

"(3) CONVICTION RELATING TO CONTROLLED SUBSTANCE.—Any individual or entity that has been convicted, under Federal or State law, of unlawful manufacture, distribution, prescription, or dispensing of a controlled substance or other criminal offense relating to a controlled substance.

"(4) LICENSE REVOCATION OR SUSPENSION.—Any individual or entity—

"(A) whose license to provide health care has been revoked or suspended by any State licensing authority, or who otherwise lost such a license, for reasons bearing on the individual's or entity's professional competence, professional conduct, or financial integrity, or

"(B) who surrendered such a license while a formal disciplinary proceeding was pending before such an authority and the proceeding concerned the individual's or entity's professional competence, professional conduct, or financial integrity.

"(5) EXCLUSION FROM FEDERAL HEALTH CARE PROGRAM.—Any individual or entity which has been suspended or excluded from participation, or otherwise sanctioned, under any Federal program, including programs of the Department of Defense or the Veterans' Administration, involving the provision of health care, or under a State health care program (as defined in subsection (h)).

"(6) CLAIMS FOR EXCESSIVE CHARGES OR UNNECESSARY SERVICES AND FAILURE OF CERTAIN ORGANIZATIONS TO FURNISH MEDICALLY NECESSARY SERVICES.—Any individual or entity that the Secretary determines—

"(A) has submitted or caused to be submitted bills or requests for payment under title XVIII or a State health care program containing charges (or, in applicable cases, requests for payment of costs) for items or services furnished substantially in excess of such individual's or entity's customary charges (or, in applicable cases, substantially in excess of such individual's or entity's costs) for such items or services, unless the Secretary finds there is good cause for such bills or requests containing such charges or costs;

"(B) has furnished items or services to patients (whether or not eligible for benefits under title XVIII or a State health care program) substantially in excess of the needs of such patients or of a quality which fails to meet professionally recognized standards of health care;

"(C) is—

"(i) a health maintenance organization (as defined in section 1903(m)) providing items and services under a State plan approved under title XIX, or

"(ii) an entity furnishing services under a waiver approved under section 1915(b)(1),

and has failed substantially to provide medically necessary items and services that are required (under law or the contract with the State under title XIX) to be provided to individuals covered under that plan or waiver, if the failure has adversely affected (or has a substantial likelihood of adversely affecting) these individuals; or

"(D) is an entity providing items and services as an eligible organization under a risk-sharing contract under section 1876 and has failed substantially to provide medically necessary items and services that are required (under law or such

contract) to be provided to individuals covered under the risk-sharing contract, if the failure has adversely affected (or has a substantial likelihood of adversely affecting) these individuals.

"(7) FRAUD, KICKBACKS, AND OTHER PROHIBITED ACTIVITIES.—Any individual or entity that the Secretary determines has committed an act which is described in section 1128A or section 1128B.

"(8) ENTITIES CONTROLLED BY A SANCTIONED INDIVIDUAL.—Any entity with respect to which the Secretary determines that a person—

"(A)(i) with an ownership or control interest (as defined in section 1124(a)(3)) in that entity, or

"(ii) who is an officer, director, agent, or managing employee (as defined in section 1126(b)) of that entity—

is a person—

"(B)(i) who has been convicted of any offense described in subsection (a) or in paragraph (1), (2), or (3) of this subsection;

"(ii) against whom a civil monetary penalty has been assessed under section 1128A; or

"(iii) who has been excluded from participation under a program under title XVIII or under a State health care program.

"(9) FAILURE TO DISCLOSE REQUIRED INFORMATION.—Any entity that did not fully and accurately make any disclosure required of it by section 1124 or section 1126.

"(10) FAILURE TO SUPPLY REQUESTED INFORMATION ON SUBCONTRACTORS AND SUPPLIERS.—Any disclosing entity (as defined in section 1124(a)(2)) that fails to supply (within such period as may be specified by the Secretary in regulations) upon request specifically addressed to the entity by the Secretary—

"(A) full and complete information as to the ownership of a subcontractor (as defined by the Secretary in regulations) with whom the entity has had, during the previous 12 months, business transactions in an aggregate amount in excess of $25,000, or

"(B) full and complete information as to any significant business transactions (as defined by the Secretary in regulations), occurring during the five-year period ending on the date of such request, between the entity and any wholly owned supplier or between the entity and any subcontractor.

"(11) FAILURE TO SUPPLY PAYMENT INFORMATION.—Any individual or entity furnishing items or

services for which payment may be made under title XVIII or a State health care program that fails to provide such information as the Secretary or the appropriate State agency finds necessary to determine whether such payments are or were due and the amounts thereof, or has refused to permit such examination of its records by or on behalf of the Secretary or that agency as may be necessary to verify such information.

"(12) FAILURE TO GRANT IMMEDIATE ACCESS.—Any individual or entity that fails to grant immediate access, upon reasonable request (as defined by the Secretary in regulations) to any of the following:

"(A) To the Secretary, or to the agency used by the Secretary, for the purpose specified in the first sentence of section 1864(a) (relating to compliance with conditions of participation or payment).

"(B) To the Secretary or the State agency, to perform the reviews and surveys required under State plans under paragraphs (26), (31), and (33) of section 1902(a) and under section 1903(g).

"(C) To the Inspector General of the Department of Health and Human Services, for the

purpose of reviewing records, documents, and other data necessary to the performance of the statutory functions of the Inspector General.

"(D) To a State medicaid fraud control unit (as defined in section 1903(q)), for the purpose of conducting activities described in that section.

"(13) FAILURE TO TAKE CORRECTIVE ACTION.—Any hospital that fails to comply substantially with a corrective action required under section 1886(f)(2)(B).

Subject to subsection (d)(2), the Secretary shall exercise the authority under this subsection in a manner that results in an individual's or entity's exclusion from all the programs under title XVIII and all the State health care programs in which the individual or entity may otherwise participate.

"(c) NOTICE, EFFECTIVE DATE, AND PERIOD OF EXCLUSION.—(1) An exclusion under this section or under section 1128A shall be effective at such time and upon such reasonable notice to the public and to the individual or entity excluded as may be specified in regulations consistent with paragraph (2).

"(2)(A) Except as provided in subparagraph (B), such an exclusion shall be effective with respect to services furnished to an individual on or after the effective date of the exclusion.

"(B) Unless the Secretary determines that the health and safety of individuals receiving services warrants the exclusion taking effect earlier, an exclusion shall not apply to payments made under title XVIII or under a State health care program for—

"(i) inpatient institutional services furnished to an individual who was admitted to such institution before the date of the exclusion, or

"(ii) home health services and hospice care furnished to an individual under a plan of care established before the date of the exclusion,

until the passage of 30 days after the effective date of the exclusion.

"(3)(A) The Secretary shall specify, in the notice of exclusion under paragraph (1) and the written notice under section 1128A, the minimum period (or, in the case of an exclusion under subsection (b)(12), the period) of the exclusion.

"(B) In the case of an exclusion under subsection (a)(1), the minimum period of the exclusion may not be less than five years.

"(C) In the case of an exclusion under subsection (b)(12), the period of the exclusion shall be equal to the sum of—

"(i) the length of the period in which the individual or entity failed to grant the immediate access described in that subsection, and

"(ii) an additional period, not to exceed 90 days, set by the Secretary.

"(d) NOTICE TO STATE AGENCIES AND EXCLUSION UNDER STATE HEALTH CARE PROGRAMS.—(1) The Secretary shall promptly notify each appropriate State agency administering or supervising the administration of each State health care program (and, in the case of an exclusion effected pursuant to subsection (a) and to which section 304(a)(5) of the Controlled Substances Act may apply, the Attorney General)—

"(A) of the fact and circumstances of each exclusion effected against an individual or entity under this section or section 1128A, and

"(B) the period (described in paragraph (2)) for which the State agency is directed to exclude the individual or entity from participation in the State health care program.

"(2)(A) Except as provided in subparagraph (B), the period of the exclusion under a State health care program under paragraph (1) shall be the same as any period of exclusion under a program under title XVIII.

"(B) The Secretary may waive an individual's or entity's exclusion under a State health care program under paragraph (1) if the Secretary receives and approves a request for the waiver with respect to the individual or entity from the State agency administering or supervising the administration of the program.

"(e) NOTICE TO STATE LICENSING AGENCIES.—The Secretary shall—

"(1) promptly notify the appropriate State or local agency or authority, having responsibility for the licensing or certification of an individual or entity excluded (or directed to be excluded) from participation under this section or section 1128A, of the fact and circumstances of the exclusion,

"(2) request that appropriate investigations be made and sanctions invoked in accordance with applicable State law and policy, and

"(3) request that the State or local agency or authority keep the Secretary and the Inspector General in the Department of Health and Human Services fully and currently informed with respect to any actions taken in response to the request.

"(f) NOTICE, HEARING, AND JUDICIAL REVIEW.—(1) Any individual or entity that is excluded (or directed to be excluded) from participation under this section (or is denied

termination of the exclusion under subsection (g)) is entitled to reasonable notice and opportunity for a hearing thereon by the Secretary to the same extent as is provided in section 205(b), and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g).

"(2) The provisions of section 205(h) shall apply with respect to this section and sections 1128A and 1156 to the same extent as it is applicable with respect to title II.

"(g) APPLICATION FOR TERMINATION OF EXCLUSION.—(1) An individual or entity excluded (or directed to be excluded) from participation under this section (other than under subsection (b)(12)) or section 1128A may apply to the Secretary, in the manner specified by the Secretary in regulations and at the end of the minimum period of exclusion provided under subsection (c)(3) and at such other times as the Secretary may provide, for termination of the exclusion effected under this section or section 1128A.

"(2) The Secretary may terminate the exclusion if the Secretary determines, on the basis of the conduct of the applicant which occurred after the date of the notice of exclusion or which was unknown to the Secretary at the time of the exclusion, that—

"(A) there is no basis under subsection (a) or (b) or section 1128A(a) for a continuation of the exclusion, and

"(B) there are reasonable assurances that the types of actions which formed the basis for the original exclusion have not recurred and will not recur.

"(3) The Secretary shall promptly notify each appropriate State agency administering or supervising the administration of each State health care program (and, in the case of an exclusion effected pursuant to subsection (a) and to which section 304(a)(5) of the Controlled Substances Act may apply, the Attorney General) of the fact and circumstances of each termination of exclusion made under this subsection.

"(h) DEFINITION OF STATE HEALTH CARE PROGRAM.—For purposes of this section and sections 1128A and 1128B, the term 'State health care program' means—

"(1) a State plan approved under title XIX,

"(2) any program receiving funds under title V or from an allotment to a State under such title, or

"(3) any program receiving funds under title XX or from an allotment to a State under such title.".

SEC. 3. CIVIL MONETARY PENALTIES.

(a) GROUNDS FOR IMPOSITION.—(1) Subsection (a)(1) of section 1128A (42 U.S.C. 1320a–7a) is amended by striking out "the Secretary determines" and all that follows through "; or" and inserting in lieu thereof "the Secretary determines—

"(A) is for a medical or other item or service that the person knows or has reason to know was not provided as claimed,

"(B) is for a medical or other item or service and the person knows or has reason to know the claim is false or fraudulent,

"(C) is presented for a physician's service (or an item or service incident to a physician's service) by a person who knows or has reason to know that the individual who furnished (or supervised the furnishing of) the service—

"(i) was not licensed as a physician,

"(ii) was licensed as a physician, but such license had been obtained through a misrepresentation of material fact (including cheating on an examination required for licensing), or

"(iii) represented to the patient at the time the service was furnished that the physician was certified in a medical specialty by a medical specialty board when the individual was not so certified, or

"(D) is for a medical or other item or service furnished during a period in which the person was excluded under the program under which the claim was made pursuant to a determination by the Secretary

under this section or under section 1128, 1156, 1160(b) (as in effect on September 2, 1982), 1862(d) (as in effect on the date of the enactment of the Medicare and Medicaid Patient and Program Protection Act of 1985), or 1866(b); or".

(2) Subsection (a)(2)(B) of such section is amended by inserting "(or other requirement of a State plan under title XIX)" after "State agency".

(3) Subsection (a) of such section is further amended by adding at the end thereof the following new sentence: "In addition the Secretary may make a determination in the same proceeding to exclude the person from participation in the programs under title XVIII and to direct the appropriate State agency to exclude the person from participation in any State health care program.".

(4) No civil penalty or assessment may be imposed under section 1128A(a) of the Social Security Act in the case of a claim filed before August 13, 1981, if liability for the amount of the penalty or assessment could not have been imposed with respect to the claim under section 3729 of title 31, United States Code (relating to false claims).

(b) STATUTE OF LIMITATION ON ACTIONS.—Subsection (b)(1) of such section is amended by adding at the end the following new sentences: "The Secretary may not initiate an action under this section with respect to any claim later

than six years after the date the claim was presented. The Secretary may initiate an action under this section by personal service or by mailing, by registered or certified mail, the notice required by paragraph (2).".

(c) CONFORMING AMENDMENT.—Subsections (b), (c), (f), and (g) of such section are each amended by striking out "penalty or assessment" and inserting in lieu thereof "penalty, assessment, or exclusion" each place it appears.

(d) PRO-RATED PAYMENT OF RECOVERIES TO STATE AGENCIES.—Subsection (e)(1)(A) of such section is amended by striking out "equal to the State's share of the amount paid by the State agency" and inserting in lieu thereof "bearing the same proportion to the total amount recovered as the State's share of the amount paid by the State agency for such claim bears to the total amount paid".

(e) NOTICE TO STATE AGENCIES.—Subsection (g) of such section is further amended by inserting "the appropriate State agency or agencies administering or supervising the administration of State health care programs (as defined in section 1128(h))," after "professional organization,".

(f) APPLICATION OF SUBPOENA POWER AND INJUNCTIVE POWERS.—Such section is further amended by adding at the end the following new subsections:

"(i) The provisions of subsections (d) and (e) of section 205 shall apply with respect to this section to the same extent as they are applicable with respect to title II.

"(j) Whenever the Secretary has reason to believe that any person has engaged, is engaging, or is about to engage in any activity which makes the person subject to a civil monetary penalty under this section, the Secretary may bring an action in an appropriate district court of the United States (or, if applicable, a United States court of any territory) to enjoin such activity, or to enjoin the person from concealing, removing, or encumbering assets which may be required in order to pay a civil monetary penalty if any such penalty were to be imposed or to seek other appropriate relief.".

SEC. 4. CRIMINAL PENALTIES FOR ACTS INVOLVING MEDICARE AND STATE HEALTH CARE PROGRAMS.

(a) TECHNICAL AMENDMENTS.—Section 1909 (42 U.S.C. 1396h) is amended—

(1) by amending the heading to read as follows:

"CRIMINAL PENALTIES FOR ACTS INVOLVING MEDICARE OR STATE HEALTH CARE PROGRAMS";

(2) in subsection (a)(1), by striking out "a State plan approved under this title" and inserting in lieu thereof "a program under title XVIII or a State health care program (as defined in section 1128(h))";

(3) in the matter in subsection (a) following paragraph (4), by striking out "this title" the first place it appears and inserting in lieu thereof "the program";

(4) in the last sentence of subsection (a), by striking out "this title" the first place it appears and inserting in lieu thereof "title XIX", and by striking out "this title" the second place it appears and inserting in lieu thereof "that title";

(5) in paragraphs (1)(A), (1)(B), (2)(A), (2)(B), and (3)(A) of subsection (b), by striking out "this title" and inserting in lieu thereof "title XVIII or a State health care program" each place it appears;

(6) in subsection (c), by striking out "or home health agency (as those terms are employed in this title)" and inserting in lieu thereof "home health agency, or other entity for which certification is required under title XVIII or a State health care program"; and

(7) in subsection (d), by striking out "this title" and inserting in lieu thereof "title XIX" each place it appears.

(b) CRIMINAL PENALTIES FOR PHYSICIAN MISREPRESENTATIONS.—Subsection (a) of such section is further amended—

(1) by striking out "or" at the end of paragraph (3),

(2) by inserting "or" at the end of paragraph (4), and

(3) by inserting after paragraph (4) the following new paragraph:

"(5) presents or causes to be presented a claim for a physician's service for which payment may be made under a program under title XVIII or a State health care program and knows that the individual who furnished the service either—

"(A) was not licensed as a physician, or

"(B) was licensed as a physician, but such license had been obtained through a misrepresentation of material fact (including cheating on an examination required for licensing),".

(c) REDESIGNATION OF SECTION 1877(d) AS SECTION 1128B(e).—Subsection (d)" of section 1877 (42 U.S.C. 1395nn) is redesignated as subsection (e) and is transferred and inserted in section 1909 at the end thereof.

(d) REDESIGNATION OF SECTION 1909 AS SECTION 1128B.—Section 1909, as amended by subsections (a), (b), and (c) of this section, is redesignated as section 1128B and is transferred to title XI and inserted immediately after section 1128A.

(e) REPEAL.—Section 1877 (other than subsection (d) thereof which was transferred under subsection (c) of this section) is repealed.

SEC. 5. INFORMATION CONCERNING SANCTIONS TAKEN BY STATE LICENSING AUTHORITIES AGAINST HEALTH CARE PRACTITIONERS AND PROVIDERS.

(a) MEDICAID PLAN REQUIREMENT.—Section 1902(a) (42 U.S.C. 1396a(a)) is amended—

(1) by striking out "and" at the end of paragraph (45),

(2) by striking out the period at the end of paragraph (46) and inserting in lieu thereof "; and", and

(3) by inserting after paragraph (46) the following new paragraph:

"(47) provide that the State will provide information and access to certain information respecting sanctions taken against health care practitioners and providers by State licensing authorities in accordance with section 1919.".

(b) INFORMATION REQUIRED.—Title XIX is amended by adding at the end the following new section:

"INFORMATION CONCERNING SANCTIONS TAKEN BY STATE LICENSING AUTHORITIES AGAINST HEALTH CARE PRACTITIONERS AND PROVIDERS

"SEC. 1919. (a) INFORMATION REPORTING REQUIREMENT.—The requirement referred to in section 1902(a)(47) is that the State must provide for the following:

"(1) INFORMATION REPORTING SYSTEM.—The State must have in effect a system of reporting the following information with respect to formal proceedings (as defined by the Secretary in regulations) concluded against a health care practitioner or entity by any authority of the State (or of a political subdivision thereof) responsible for the licensing of health care practitioners or entities:

"(A) Any adverse action taken by such licensing authority as a result of the proceeding, including any revocation or suspension of a license (and the length of any such suspension), reprimand, censure, or probation.

"(B) Any dismissal or closure of the proceedings by reason of the practitioner or entity surrendering the license or leaving the State or jurisdiction.

"(C) Any other loss of the license of the practitioner or entity, whether by operation of law, voluntary surrender, or otherwise.

"(2) ACCESS TO DOCUMENTS.—The State must provide the Secretary (or an entity designated by the Secretary) with access to such documents of the authority described in paragraph (1) as may be necessary for the Secretary to determine the facts and circumstances concerning the actions and determinations described in such paragraph for the purpose of carrying out this Act.

"(b) FORM OF INFORMATION.—The information described in subsection (a)(1) shall be provided to the Secretary (or, under suitable arrangements made by the Secretary, to another entity) in such a form and manner as the Secretary determines to be appropriate in order to provide for activities of the Secretary under this Act and in order to provide, directly or through suitable arrangements made by the Secretary, information—

"(1) to licensing authorities described in subsection (a)(1),

"(2) to State agencies administering or supervising the administration of State health care programs (as defined in section 1128(h)),

"(3) to utilization and quality control peer review organizations described in part B of title XI, and

"(4) to State medicaid fraud control units (as defined in section 1903(q)),

in order for such authorities to determine the fitness of individuals to provide health care services, to protect the health and safety of individuals receiving health care through such programs, and to protect the fiscal integrity of such programs.

"(c) CONFIDENTIALITY OF INFORMATION PROVIDED.—The Secretary shall provide for suitable safeguards for the confidentiality of such of the information furnished under subsection (a) as is not otherwise available to the public.".

SEC. 6. OBLIGATION OF HEALTH CARE PRACTITIONERS AND PROVIDERS.

Section 1156 (42 U.S.C. 1320c–5) is amended—

(1) by striking out "title XVIII" and "such title" in subsection (a) and inserting in lieu thereof "this Act" in each instance, and

(2) by striking out "title XVIII" in subsection (b) and inserting in lieu thereof "this Act" each place it appears.

SEC. 7. EXCLUSION UNDER THE MEDICAID PROGRAM.

Section 1902 (42 U.S.C. 1396b) is amended by inserting after subsection (f) the following new subsection:

"(g)(1) In addition to any other authority, a State may exclude any individual or entity for purposes of participating under the State plan under this title for any reason for which the Secretary could exclude the individual or entity from participation in a program under title XVIII under section 1128, 1128A, or 1866(b)(2).

"(2) In order for a State to receive payments for medical assistance under section 1903(a), with respect to payments the State makes to a health maintenance organization (as defined in section 1903(m)) or to an entity furnishing services under a waiver approved under section 1915(b)(1), the State must provide that it will exclude from participation, as such an organization or entity, any organization or entity that—

"(A) could be excluded under section 1128(b)(8) (relating to owners and managing employees who have been convicted of certain crimes or received other sanctions), or

"(B) has, directly or indirectly, a substantial contractual relationship (as defined by the Secretary) with an individual or entity that is described in section 1128(b)(8)(B).

"(3) As used in this subsection, the term 'exclude' includes the refusal to enter into or renew a participation agreement or the termination of such an agreement.".

SEC. 8. MISCELLANEOUS AND CONFORMING AMENDMENTS.

(a) MATERNAL AND CHILD HEALTH PROGRAM.—Section 504(b) (42 U.S.C. 704(b)) is amended—

(1) by striking out "or" at the end of paragraph (4),

(2) by striking out the period at the end of paragraph (5) and inserting in lieu thereof "; or", and

(3) by adding at the end thereof the following new paragraph:

"(6) payment for any item or service furnished by an individual or entity excluded from participation in the program under this title pursuant to section 1128 or section 1128A.".

(b) DISCLOSURE REQUIREMENTS.—(1) Subsection (a) of section 1126 (42 U.S.C. 1320a–5) is amended—

(A) in the first sentence, by striking out "or other institution" and all that follows through the period at the end and inserting in lieu thereof "or other entity (other than an individual practitioner or group of practitioners) shall be required to disclose to the Secretary or to the appropriate State agency the name of any person that is a person described in subparagraphs (A) and (B) of section 1128(b)(8).". and

(B) in the second sentence, by striking out "institution, organization, or agency" and inserting in lieu thereof "entity".

(2) Subsection (b) of such section is amended by striking out "institution, organization, or agency" and inserting in lieu thereof "entity" each place it appears.

(c) MEDICARE PAYMENTS.—(1) Section 1862 (42 U.S.C. 1395y) is amended—

(A) by striking out subsection (d), and

(B) by amending subsection (e) to read as follows:

"(e) No payment may be made under this title with respect to any item or service furnished by an individual or entity during any period when the individual or entity is excluded from participation in a program under this title pursuant to section 1128 or section 1128A.".

(2) Section 1842(j) (42 U.S.C. 1395u(j)) is amended—

(A) in paragraph (2)—

(i) by amending subparagraph (A) to read as follows:

"(A) excluding a physician from participation in the programs under this title for a period not to exceed 5 years, in accordance with the procedures of subsections (c), (f), and (g) of section 1128, or", and

(ii) by striking out "barred from participation in the program" in the second sentence and inserting in lieu thereof "excluded from participation in the programs"; and

(B) by striking out "bar" in paragraph (3)(A) and inserting in lieu thereof "exclude".

(3) Section 1862(h)(4) (42 U.S.C. 1395y(h)(4)) is amended by striking out "paragraphs (2) and (3) of subsection 1862(d)" and inserting in lieu thereof "subsections (c), (f), and (g) of section 1128".

(4) Paragraph (3) of section 1886(f) (42 U.S.C. 1395ww(f)) is amended to read as follows:

"(3) The provisions of subsections (c) through (g) of section 1128 shall apply to determinations made under paragraph (2) in the same manner as they apply to exclusions effected under section 1128(b)(13).".

(d) TERMINATION OF PROVIDER AGREEMENTS UNDER MEDICARE.—Section 1866 (42 U.S.C. 1395cc) is amended—

(1) by striking out paragraph (3) of subsection (a);

(2) by amending subsection (b) to read as follows:

"(b)(1) A provider of services may terminate an agreement with the Secretary under this section at such time and upon such notice to the Secretary and the public as may be provided in regulations, except that notice of more than six months shall not be required.

"(2) The Secretary may refuse to enter into an agreement under this section or, upon such reasonable notice to the provider and the public as may be specified in regula-

tions, may refuse to renew or may terminate such an agreement after the Secretary—

"(A) has determined that the provider fails to comply substantially with the provisions of the agreement, with the provisions of this title and regulations thereunder, or with a corrective action required under section 1886(f)(2)(B),

"(B) has determined that the provider fails substantially to meet the applicable provisions of section 1861, or

"(C) has excluded the provider from participation in a program under this title pursuant to section 1128 or section 1128A.

"(3) A termination of an agreement or a refusal to renew an agreement under this subsection shall be effective on the same date, and with respect to the same items and services, as an exclusion from participation under the programs under this title would become effective under section 1128(c).";

(3) in paragraphs (1) and (3) of subsection (c), by striking out "an agreement filed under this title by a provider of services has been terminated by the Secretary" and inserting in lieu thereof "the Secretary has terminated or has refused to renew an agreement under this title with a provider of services";

(4) by inserting "or nonrenewal" in subsection (c) after "termination" each place it appears; and

(5) by adding at the end the following new subsection:

"(g)(1) Except as provided in paragraph (2), an institution or agency dissatisfied with a determination by the Secretary that it is not a provider of services or with a determination described in subsection (b)(2) shall be entitled to a hearing thereon by the Secretary (after reasonable notice) to the same extent as is provided in section 205(b), and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g).

"(2) An institution or agency is not entitled to separate notice and opportunity for a hearing under both section 1128 and this section with respect to a determination or determinations based on the same underlying facts and issues.".

(e) CONFORMING AMENDMENT.—Section 1869 (42 U.S.C. 1395ff) is amended by striking out subsection (c).

(f) MEDICAID PLAN REVISIONS.—Section 1902(a) (42 U.S.C. 1396b(a)) is amended—

(1) in paragraph (23), by inserting "subsection (g) and in" after "except as provided in",

(2) in paragraph (38), by striking out "respectively, (A)" and all that follows up to the semicolon at the

end and inserting in lieu thereof "the information described in section 1128(b)(9)", and

(3) in paragraph (39)—

(A) by striking out "bar" and inserting in lieu thereof "exclude",

(B) by striking out "person" and inserting in lieu thereof "individual or entity" each place it appears, and

(C) by inserting "or section 1128A" after "section 1128".

(g) DENIAL OF FEDERAL FINANCIAL PARTICIPATION UNDER MEDICAID.—Paragraph (2) of section 1903(i) (42 U.S.C. 1396b(i)) is amended to read as follows:

"(2) with respect to any amount expended for items or services furnished under the plan by any individual or entity during any period when the individual or entity is excluded from participation in the State plan under this title pursuant to section 1128 or section 1128A; or".

(h) OTHER MEDICAID CONFORMING AMENDMENTS.—(1) Subsection (n) of section 1903 (42 U.S.C. 1396b) is repealed.

(2) Paragraph (2) of section 1915(a) (42 U.S.C. 1396n(a)) is amended to read as follows:

"(2) restricts for a reasonable period of time the provider or providers from which an individual (eligible for medical assistance for items or services under the State plan) can receive such items or services, if—

"(A) the State has found, after notice and opportunity for a hearing (in accordance with procedures established by the State), that the individual has utilized such items or services at a frequency or amount not medically necessary (as determined in accordance with utilization guidelines established by the State), and

"(B) under such restriction, individuals eligible for medical assistance for such services have reasonable access (taking into account geographic location and reasonable travel time) to such services of adequate quality.".

(i) TITLE XX.—Section 2005(a) (42 U.S.C. 1397d(a)) is amended—

(1) by striking out "or" at the end of paragraph (7),

(2) by striking out the period at the end of paragraph (8) and inserting in lieu thereof "; or", and

(3) by adding at the end thereof the following new paragraph:

"(9) for payment for any item or service furnished by a person excluded from participation in the program under this title pursuant to section 1128 or section 1128A.".

(j) DENIAL, REVOCATION, OR SUSPENSION OF REGISTRATION TO MANUFACTURE, DISTRIBUTE, OR DISPENSE A CONTROLLED SUBSTANCE FOR ENTITIES EXCLUDED FROM THE MEDICARE PROGRAM.—Section 304(a) of the Controlled Substances Act (21 U.S.C. 824(a)) is amended—

(1) by striking out "or" at the end of paragraph (3),

(2) by striking out the period at the end of paragraph (4) and inserting in lieu thereof "; or", and

(3) by inserting after paragraph (4) the following new paragraph:

"(5) has been excluded (or directed to be excluded) from participation in a program pursuant to section 1128(a) of the Social Security Act.".

SEC. 9. CLARIFICATION OF MEDICAID MORATORIUM PROVISIONS OF DEFICIT REDUCTION ACT OF 1984.

Section 2373(c) of the Deficit Reduction Act of 1984 (Public Law 98-369; 98 Stat. 1112) is amended—

(1) in paragraph (1)—

(A) by inserting "(whether or not approved)" after "such State's plan",

(B) by inserting "(including any part of the plan operating pursuant to section 1902(f) of that Act), or the operation thereunder," after "Social Security Act", and

(C) by inserting "(or its operation's)" after "such plan's"; and

(2) by adding at the end the following new paragraph:

"(5) In this subsection, a State plan is considered to include any amendment or other change in the plan which is submitted by a State, or for which the Secretary otherwise has notice, whether before or after the date of enactment of the Deficit Reduction Act of 1984 and whether or not the amendment or change was approved, disapproved, acted upon, or not acted upon by the Secretary.".

SEC. 10. EFFECTIVE DATES.

(a) IN GENERAL.—Except as provided in subsections (b), (c), (d), and (e), the amendments made by this Act shall become effective at the end of the fourteen-day period beginning on the date of the enactment of this Act and shall not apply to administrative proceedings commenced before the end of such period.

(b) MANDATORY MINIMUM EXCLUSIONS APPLY PROSPECTIVELY.—Section 1128(c)(3)(B) of the Social Security Act (as amended by this Act), which requires an exclusion of

not less than five years in the case of certain exclusions, shall not apply to exclusions based on convictions occurring before the date of the enactment of this Act.

(c) EFFECTIVE DATE FOR CHANGES IN MEDICAID LAW.—(1) The amendments made by sections 5 and 8(f) apply (except as provided under paragraph (2)) to payments under title XIX of the Social Security Act for calendar quarters beginning more than thirty days after the date of the enactment of this Act.

(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by this Act, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act.

(3) Subsection (j) of section 1128A of the Social Security Act (as added by section 3(f) of this Act) takes effect on the date of the enactment of this Act.

(d) PHYSICIAN MISREPRESENTATIONS.—Clauses (ii) and (iii) of section 1128A(a)(1)(C) of the Social Security Act,

as amended by section 3(a)(1)(F) of this Act, and subparagraph (B) of section 1128B(a)(5) of the Social Security Act, as amended by section 4(b)(3) of this Act, apply to claims presented for services performed on or after the effective date specified in subsection (a), without regard to the date the misrepresentation of fact was made.

(e) CLARIFICATION OF MEDICAID MORATORIUM.—The amendments made by section 9 apply as though they were originally included in the enactment of section 2373(c) of the Deficit Reduction Act of 1984.

(f) TREATMENT OF CERTAIN DENIALS OF PAYMENT.—For purposes of section 1128(b)(8)(B)(iii) of the Social Security Act (as amended by section 2 of this Act), a person shall be considered to have been excluded from participation under a program under title XVIII if payment to the person has been denied under section 1862(d) of the Social Security Act, as in effect before the effective date specified in subsection (a).

Passed the House of Representatives June 4, 1985.

Attest: BENJAMIN J. GUTHRIE,

Clerk.