

## Specifications for Universal Health Insurance Coverage

**III. Essential Health Facilities**

## PART ONE: ESSENTIAL COMMUNITY PROVIDERS

- I. Medicare's Essential Access Community Hospital (EACH) program for rural health networks would be expanded from seven States to all States
  - A. Authorization would be increased from \$15 million to \$40 million per year
  - B. Funds available for State planning activities for the creation of rural provider networks would be increased from the current level of \$10 million per year to \$50 million per year
- II. An Essential Community Provider (ECP) program would be created to facilitate the organization and delivery of, and access to, primary, preventive and acute care services for medically underserved populations in urban areas by fostering networks of essential community providers
  - A. The Secretary would make grants to States, local governments and eligible health care facilities
  - B. Grants could be used for the expansion of primary care sites, development of information, billing and reporting systems, or health promotion and outreach to underserved populations
  - C. Grants to States and local governments would be used for activities related to planning and implementing community health networks
  - D. To be eligible for a grant, a State or local government must prepare a community health plan designed to create community health networks, promote integration of health services, and improve access to hospital and other services for urban residents
    1. State or unit local government must designate non-profit or public hospitals and facilities as essential community providers within community health networks

2. A State must consider local input in developing a State plan, and the State plan must address the needs of all underserved communities in the State
  3. In the case of a State that develops a community health plan after a unit of local government has been awarded a Federal grant, the State must take into account the local government plan in developing the State plan
- E. When a State and a unit of local government within the State both seek a Federal grant, the local government community health plan must be approved by the State
1. This requirement would not apply in the case of a local government in a State that is not seeking a Federal grant, or in a State that develops a community health plan after a unit of local government has been awarded a Federal grant
- F. Facilities eligible for designation as essential community providers include
1. Facilities that are members of community health networks (defined below)
  2. Hospitals that would qualify for a Medicare disproportionate share adjustment under section 1886(d)(5)(F)(i)(II) or 1886(d)(5)(F)(vii)(I) of the Social Security Act
  3. Federally Qualified Health Centers, except that the governance requirements need not be met with respect to membership of the Board of Directors if the facility provides assurances of significant consumer input
- G. A community health network would be defined as a public or nonprofit entity which would provide primary care and acute care services to medically underserved populations in the entity's service area
1. The network would have to substantially provide these services directly or through limited contracting with non-network providers
  2. The network would consist of at least one hospital and at least three non-hospital essential

community providers that are located in an urban area

3. At the election of the network members, any other entity that provides primary care or other health care services to the medically underserved populations served by the network could be a member of the network
  4. To be considered a community health network, each member hospital must provide staff privileges to physicians providing care at non-hospital sites, and each member must agree to
    - a) provide appropriate emergency and medical support services to other members,
    - b) accept referrals from other members, and
    - c) share in the same communications system, including, where appropriate, the electronic sharing of patient data, medical records, and billing services
- H. A hospital or facility would be eligible to receive a grant if the hospital or facility is located in a State or locality with an approved community health plan, is designated as an essential community provider by the State in which it is located and is a member of a community health network
1. Hospitals and facilities must also be certified by the State in which the facility is located that the receiving of such grant by the hospital or facility is consistent with the State's or locality's community health plan, and that the State has approved the application
- I. A consortium of hospitals and facilities, each of which is part of the same community health network, is eligible to receive a grant if each of its members would be individually eligible to receive a grant.
- J. Grants to hospitals, facilities, and consortia would be used to finance the costs incurred in planning, implementing and joining community health networks, including costs related to
1. development of primary care service sites

2. development of information, billing and reporting systems
  3. planning and needs assessment
  4. recruitment and training of health professionals and administrative staff, and
  5. health promotion outreach to underserved populations in the service area
- K. A grant made to a hospital or facility could not exceed \$200,000 and the total amount of a grant paid to a consortia of hospitals and facilities could not exceed \$1 million.
- L. Funding of \$160 million per year for each of the fiscal years 1995 through 1999 would be available for the Essential Community Provider program
1. \$80 million from the Federal Hospital Insurance Trust Fund would be authorized for grants to hospitals for the purpose of becoming a part of a community health network
  2. \$80 million would be authorized for grants to non-hospital facilities for the purpose of becoming a part of a community health network

PART TWO: FINANCIAL ASSISTANCE FOR CAPITAL NEEDS

- I. The Secretary of HHS would provide capital financing assistance to eligible facilities in the form of loan guarantees, interest rate subsidies, direct matching loans, and (in cases of urgent life and safety needs) direct grants
- A. Eligible hospitals include Essential Access Community Hospitals, Rural Primary Care Hospitals, and hospitals that would qualify for Medicare disproportionate share payments under section 1886(D)(5)(F)(vii)(I) with a disproportionate share patient percentage of 40 percent or more, except that investor-owned facilities would not be eligible
  - B. Non-hospital facilities that are designated as essential community providers (see above) would be generally eligible for capital financing assistance

- C. Applications filed with the Secretary would be required to have been determined by the State in which the project is located to be consistent with any relevant community health plan developed as part of the Essential Community Provider grant program or rural health care plan under the Essential Access Community Hospital program
    - 1. In the case of a State determined by the Secretary to have a plan and process for review and approval of capital expenditures, the application must be determined by the State to be consistent with the State capital expenditure plan
  - D. The Secretary would give preference to assistance needed to bring a facility into compliance with Federal, State or local regulatory standards, improve the provision of essential services, or provide access to otherwise unavailable essential health services
  - E. Preference would also be given to projects that include non-Federal assurances of financial support, would be unlikely to be financed without assistance, and to projects involving essential community providers (see above)
  - F. Any health care facility accepting capital financing under this section would agree to provide a significant volume of services to persons unable to pay
- II. A Capital Financing Trust Fund would be created to finance capital assistance, and administered by the Secretary of HHS
- A. A Capital Financing Trust Fund Board would be created to advise the Secretary on the program and would meet quarterly
    - 1. Board would be composed of the Secretary, the Secretary of the Treasury, the Assistant Secretary for Health, the Administrator of the Health Care Financing Administration, and 5 public members appointed by the President to serve 4 year terms
    - 2. Board would be responsible for approving regulations, establishing program criteria, and recommending and approving expenditures by the Secretary under the Program

III. Loan guarantees would be available to qualified health care facilities for repayment of loans to non-Federal lenders making loans for health care facility replacement, modernization and renovation projects, and capital acquisitions

- A. Facilities would be required to demonstrate that a Federal loan guarantee is essential to obtaining bond financing from non-Federal lenders at a reasonably affordable rate of interest
- B. Facilities must also demonstrate an ability to meet debt service, assume the public service responsibilities, operate the facility in accordance with a Trust Fund Board-approved management-improvement-and-operating plan, continue any State or local support
- C. Up to \$150,000,000 would be annually allocated within the Trust Fund to finance loan guarantees
  - 1. At least ten percent of the dollar value of the loan guarantees would be allocated for eligible rural health care facilities, to the extent a sufficient number of applications are made
  - 2. No more than twenty percent of the amount allocated each year to the loan guarantee program would be available to guarantee refinancing of loans during that year
- D. The principal amount of any guaranteed loan could not exceed 95 percent of the total cost of the project, including land, and the Trust Fund Board would be able to institute additional terms and conditions
- E. The Trust Fund Board would determine a reasonable loan insurance premium to be charged for loan guarantees and would be authorized to collect sufficient amounts to cover the costs of appraisals and inspections of the property
  - 1. The Board could waive premium for financially distressed facilities
- F. The Board would be authorized to pursue to final collection all claims assigned and transferred to the Trust Fund as a result of any property secured by any defaulted loans

- G. Loans guaranteed through this legislation would be included in Section 149(b)(3)(A) of the Internal Revenue Code in order to maintain, where applicable, the tax exempt status of the loans guaranteed
- IV. Interest subsidies would be available to reduce the cost of financing qualifying projects by providing partial Federal subsidy of debt service payments where state and local entities have issued bonds
- A. Up to \$220,000,000 in interest rate subsidies would be made available annually
    - 1. At least ten percent of the total value of the all interest subsidies awarded in any given year would be awarded to rural health care facilities, provided that a sufficient number of applications are approved, with any one State limited to receive no more than 25 percent of the total value of all interest subsidies made during that year
  - B. Interest subsidies would be made in the amount of three percentage points for qualifying non-Federal loans and, interest subsidy grants in an amount of up to five percentage points would be made for qualifying Federal loans made under the program if the project would not be otherwise financially viable
  - C. Subsidies could be provided to assist in refinancing if the health care facility were unable to secure permanent financing at an affordable current market rate
  - D. Eligible health care facilities would have had to issue bonds for capital projects, or would have to be obligated to pay debt service on bonds, after December 31, 1992
  - E. No federal subsidy would be provided unless State or local participation was in an amount at least equal to the amount of the federal subsidy to be provided
- V. Direct matching loans would be made available to eligible facilities otherwise unable to obtain financing
- A. Financing would be for the purpose of essential facility replacement (either construction or acquisition), modernization, and renovation

- B. Direct matching loans would be provided primarily for smaller projects where the transaction costs of securing financing from other sources may be disproportionately onerous in relationship to the amount financed
- C. Up to \$200,000,000 in direct matching loans would be made available annually, with priority given to projects designed to achieve compliance with governmental regulatory standards
  - 1. Eligible applicants could receive a project loan of up to \$50,000,000
  - 2. Not more than 75 percent of the cost of the project could come from Federal sources, except in instances the Trust Fund Board waives the requirement for financially distressed health care facilities
  - 3. Not less than ten percent of the total value of the loans made under the program would be made to rural health care facilities, provided that a sufficient number of applications are approved
  - 4. Loans would be made for a period equal to the construction period plus up to 39 years
  - 5. The interest rate will be a market rate determined by the Trust Fund Board to be no higher than the most recent applicable index for revenue bonds
  - 6. Loans for refinancing may be granted, although the total amount of assistance provided for refinancing could not exceed twenty percent of the total amount made available for direct matching loans in the year
  - 7. All loan repayments made would be held in a revolving loan fund in the Trust Fund and could be used for additional loans
  - 8. Prior to beginning collection proceedings in the case of a default of a loan, the Trust Fund Board could attempt to negotiate a revised repayment schedule to avoid foreclosing on property services by such loan.
- VI. Direct grants would be made available to eligible facilities for urgent capital needs

- A. Direct grants would be available for three types of projects
  - 1. Health care facilities threatened with closure or loss of accreditation or certification of a facility or of essential services as a result of life or safety code violations or similar facility or equipment failures
  - 2. Health care facilities requiring renovation, expansion, or replacement necessary to the maintenance or expansion of essential safety and health services such as obstetrics, perinatal, emergency and trauma, primary care and preventive health services
  - 3. Health care facilities requiring pre-approval assistance to meet regulatory requirements, in the form of planning grants to be used to apply for other assistance under the Program
- B. Priority would be given to financially distressed health care facilities as defined by the Secretary
- C. Up to \$400,000,000 in grants for capital expenditures would be made available annually
  - 1. Assistance would be limited to \$25,000,000 per eligible health care facility
  - 2. At least half of the projects funded in a year must receive fifty percent of their funding from state or local sources, with the remaining projects eligible for a combination of Federal grants and loans equal to 90 percent of total funding
  - 3. Not less than ten percent of the grant funds would be reserved for rural health care facilities, provided that a sufficient number of applications are approved

VII. Applicants who can demonstrate general qualifications for the direct matching loan, loan guarantee would be eligible for a grant of up to \$200,000 to assist in implementation of key budgetary and financial systems as well as management and governance restructuring

VIII. Adjustments would be made to the level of reimbursement under the Medicare program where appropriate to take into account the extent to which capital-related costs incurred by a hospital are costs with respect to which the hospital received financial assistance under this legislation

IX. For purposes of determining the costs of indirect medical education, the Secretary would count services of residents under a medical residency training program that are conducted at a facility other than the teaching hospital designated as an essential community provider if:

- A. The hospital is designated as an essential community provider,
- B. The hospital incurs all or substantially all the costs of the training program, and
- C. The facility is a member of the same community health network

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## Specifications for Universal Health Insurance Coverage

## IV. Capital Allocation

- I. Each State would be required to develop a capital allocation plan for the review of health-care related capital expenditures in accordance with standards developed by the Secretary of Health and Human Services (HHS)
  - A. The State would be required to identify a single agency of the State government to develop and enforce the capital allocation plan
  - B. Any capital expenditures in a State exceeding \$1 million would be subject to review
    1. States may set a lower threshold
    2. Capital expenditures for a project which, in the aggregate, exceed \$1,000,000 would be subject to review, even if individual component expenditures did not exceed the threshold
- II. A State's capital allocation plan would be designed to assure that the needs of the State's residents for health care services are met
  - A. Plan must be consistent with criteria developed by the Secretary, include occupancy targets for hospital facilities and utilization targets for inpatient and outpatient health care services and equipment
  - B. Plan must provide an opportunity for formal review and comment before becoming final
  - C. Plan would provide for regionalization of services where appropriate
  - D. Plan would identify which facilities (or parts of facilities) would be closed in order to reach occupancy and utilization targets for health facilities and services
  - E. Plan would address the special needs and circumstances of public and other disproportionate share hospitals and the provision of trauma care

III. The plan would provide, in a manner satisfactory to the Secretary, for such controls as are necessary to ensure that the capital expenditures approved under the capital allocation plan would not result in facility and service capacities in excess of the needs of the population to be served

IV. A review of capital expenditures would be required to include consideration of a number of factors

A. The relationship of a proposed activity to the State's capital allocation plan

B. The extent to which quality of care would be impacted at the facility under review and at other existing facilities

C. The availability of alternative, less costly, or more effective means of providing the services

D. The impact of the project on the utilization of the applicant's capital resources

E. The need to eliminate unnecessary duplication of services

F. The impact on the price of health care services to the population to be served

G. The extent to which the proposed facilities and services will be available to all residents of the area

V. Review of capital expenditure applications must be made in public in accordance with procedures and criteria established by the Secretary

A. If a determination is made by the review agency that there is a need for a proposed activity, other health care providers (in addition to the original applicant) would be allowed to file an application to address the identified need, and the review agency would select the applicant that was determined to best meet the needs of the community

B. States would create a regularized schedule for the review of applications. To the extent possible, applications affecting substantially the same service area would be considered at the same time

- C. Projects approved and monitored by a State under the plan could be provided a waiver from Federal antitrust enforcement
- VI. The capital allocation plan would provide for on-going review of approved activities and provide for the ability of the State to rescind the approval of the terms of the agreement if they are not upheld
- VII. Enforcement through the Medicare program
- A. Effective October 1, 1996 no Medicare payments would be made for capital-related costs in a State unless the State had an approved capital allocation plan
  - B. No Medicare payment for capital-related costs would be made to a facility if a State notifies the Secretary that the facility undertook a capital expenditure in violation of the State's capital allocation plan
- VIII. A State could designate regional review agencies to conduct the review of capital expenditures under the capital allocation plan
- A. Each regional review agency would be a not-for-profit public benefit corporation, a public regional body, or a single unit of local government that is governed by a board, a majority of the members of which are consumers or purchasers of health services in the region
  - B. The State could designate regional health alliances as the review agencies for this purpose
  - C. One or more contiguous States could provide for the establishment of an interstate regional review agency
  - D. A regional review area could not subdivide an MSA
- IX. A capital allocation plan need not provide for review of health facilities and services provided in rural areas if the State has developed a rural health plan according to criteria established by the Secretary under the EACH program.
- A. The rural health plan would have as its major focus the assurance of access to facilities and services by low density rural populations in the State

- B. The rural health plan would, where appropriate include regionalization of services, alternatives to traditional inpatient hospital facilities, the development of new organizations for delivering health services, and consideration of the need for special emergency and other health-services-related transportation services
  - C. In the case of a State with an approved rural health plan, the State may modify the review criteria for facilities and services primarily serving rural areas
- X. The Secretary would make a grant to each State, in each fiscal year beginning in fiscal year 1994, in an amount equal to 75 percent of the operating costs of carrying out the capital allocation plan
- A. The amount paid to each State could not be in excess of the total allotment which is equal to the product of \$0.70 and the population of the State
  - B. The amount of the allotment to States with regional review agencies would be equal to the product of \$1.00 and the population of the State
  - C. Grants would be made from the Federal Hospital Insurance Trust Fund

Specifications for Universal Health Insurance Coverage

**TITLE IV. MEDICARE AND MEDICAID**

**I. Additional Medicare Savings**

(to be added)

**II. Medicare Part C**

**I. Establishment of Medicare Part C**

- A. The Social Security Act would be amended to add Title XXII to establish a new health insurance program

**II. Eligibility and Enrollment**

- A. Unless an individual is covered under a private health plan that meets defined Federal standards, enrollment in Medicare Part C would be automatic
- B. An eligible individual would be defined to include any individual who is residing in the United States, and who is:
  - a. a citizen or national of the United States;
  - b. an alien permanently residing in the United States under color of law; or
  - c. a long-term nonimmigrant
- C. An initial special enrollment period would be established
  - 1. Unless covered by a family member enrolled in a private health plan that meets defined Federal standards individuals would be enrolled automatically at birth

2. During the first six months prior to implementation of Medicare Part C, continuing for 6 months after implementation of Medicare Part C, for all individuals eligible to enroll in Medicare Part C
3. A continuous special enrollment period would be provided for individuals whose coverage under such a private health plan is terminated

D. Employment-based enrollment

1. Employers with 100 or fewer employees would be required to make contributions, on behalf of employees, to Medicare Part C, unless the employer provided health insurance coverage to employees under a private plan that meets defined Federal standards
  - a. An employer with fewer than 100 employees that did not provide private health insurance would provide for payments of premiums imposed under Medicare Part C, and would be prohibited from collecting more than twenty percent of the Medicare premium from a full-time worker
2. If an employer with fewer than 100 employees elects to offer employees coverage under a private health plan, employees of the employer would enroll in a plan offered by the employer, and would not be permitted to enroll in Medicare Part C
3. Any employer with fewer than 100 employees that elects to offer employees the opportunity to enroll in a private health plan, would be required to give employees notification two years prior to the termination of the private health plan
4. Penalties would be imposed on any employer that fails to comply with the mandate to provide health insurance
  - a. The employer would be assessed an excise tax equal to \$250 per day for each employee for every day the employer was not in compliance
  - b. Employees of non-compliant employers would be permitted to enroll in Medicare Part C, and the employer would be obligated to pay 100 percent of the Medicare Part C premium

- E. Low income employees would be permitted to elect coverage under an employer plan or Medicare Part C

### III. Coverage Period

- A. In general, coverage under Medicare Part C would be continued until the individual is covered under a private health plan
  - 1. Individuals enrolled at birth would be covered under Medicare Part C as of the date of birth, unless otherwise covered under a private health plan
- B. Individuals terminated from another health plan who enroll during a special enrollment period would be covered under Medicare Part C as of the date of termination to avoid gaps in coverage

### IV. Benefits under Medicare Part C (see benefits outline)

- A. Medicare Part C benefits would be consistent with benefits provided under the guaranteed national benefit package

### V. Additional benefits would be provided under Medicare Part C for low income individuals up to 200 percent of the Federal poverty level (see low income outline)

### VI. Determination of Medicare Part C Premium Amounts

- A. The Secretary would compute a premium for Medicare Part C on a state-by-state basis
  - 1. The premium would be set to cover the full actuarial cost of benefits covered under the national guaranteed benefit package, plus all administrative costs
    - (a) The Secretary would exclude from such calculations the cost of services provided to the SSI disabled population
    - (b) Additional general revenues would be used to fund additional costs incurred by the SSI disabled population, that are not otherwise covered by premium payments and low income subsidies under Medicare Part C

- (c) Premium obligations for SSI disabled individuals would not differ from premium obligations required of the non-SSI disabled population
- 2. Premiums would be established for families with one adult, and families with more than one adult, with the cost of children averaged into each premium
- B. The Secretary would publish applicable premiums by September 30th of each year (beginning in 1995) for the succeeding year
- C. Premiums would be paid to the IRS, in a manner specified by the Secretary of the Treasury
- D. All individuals would be required to make premium payments to the IRS, unless the individual files proof of coverage with tax form
- E. The Secretary of the Treasury would transfer payments to the Secretary of HHS, for deposit in the Medicare Part C Trust Fund

VII. Establishment of Medicare Part C Trust Fund

- A. A new Medicare Part C Trust Fund would be established
- B. Premiums collected by the IRS from individuals and employers would be deposited in the Trust Fund
- C. Additional funds would be appropriated from general revenues to assure that funds are sufficient to cover low income subsidies -- net of State-maintenance-of-effort payments

VIII. Payments for services covered under Medicare Part C would be consistent with the payment rates and methodologies specified under Medicare Parts A and B, with appropriate adjustment in payment amounts to reflect the population served by Medicare Part C

- A. The Secretary would establish standardized amounts for inpatient hospital services under Part C by adjusting the Part A standardized amount to reflect differences in the average cost of treating enrollees under the two programs

1. The Secretary would be authorized to develop separate DRG categories and weights to reflect resource needs of the Medicare Part C population
  - B. Payment amounts for services (other than prescription drugs) not currently covered under either Part A or Part B would be established by the Secretary of HHS, in consultation with ProPAC and PhysPRC
    1. Payments for prescription drugs would be determined as described in the Prescription Drug Coverage outline
  - C. The Secretary would make necessary changes to the AAPCC for payments on behalf of non-aged Medicare Part C beneficiaries who elect to enroll in HMOs with risk contracts under section 1876
- IX. In general, the following current Medicare program provisions would be applied to the operations of Medicare Part C in the same manner as they apply to Parts A and B
- A. Use of carriers and intermediaries
  - B. Definitions of services and providers
  - C. Certification of facilities and provider qualifications
  - D. Health Maintenance Organizations
  - E. Peer Review and Fraud and Abuse

## Specifications for Universal Health Insurance Coverage

## III. Low-Income Coverage

- I. All low-income individuals would be enrolled in Medicare Part C, unless such an individual elects coverage under a private health plan that meets Federal standards
  - A. Low-income individuals would include those with family income up to 200 percent of the Federal poverty level
- II. Premium obligations for low-income individuals would be based upon family income, as determined by the Internal Revenue Service
  - A. The Medicare Part C premium obligation would be set to zero for individuals with income up to 100 percent of poverty
  - B. The Medicare Part C premium obligation would increase from zero at 100 percent of poverty to the full actuarial value of the Medicare Part C premium at 200 percent of poverty -- on a sliding-scale basis
    1. The premium for low-income workers between 100 and 200 percent of poverty, would be reduced by the amount contributed on behalf of such individual by an employer
  - C. Low-income individuals with ties to the workforce would be permitted to adjust their withholding to subsidize the share of premiums paid by low-income workers
    1. The amount of FICA tax withheld could be reduced for individuals expecting nominal or no income tax liability
      - (a) The IRS would transfer funds to SSA at end of year to reconcile for reduced FICA withholding

2. To the extent that low-income workers withheld more than the premium amount required, such individual would receive an adjustment, as appropriate, through an EITC-type mechanism
3. The value of the public subsidy amount be capped at the lower of (1) the subsidy amount for enrollment under Medicare Part C, or (2) the employee obligation under the plan offered by the employer
4. Low-income workers that elect coverage under a plan offered by an employer would be liable for the excess premium amount, if the employee share of the employer-plan premium exceeds the value of the maximum public subsidy amount

III. A wrap-around benefit package would be provided under Medicare Part C for low-income individuals with family income up to 100 percent of the Federal poverty level

- A. Deductibles and copayments would be waived
- B. All EPSDT services for children to age 18, not otherwise included in the guaranteed benefit package, would be covered
- C. Vision and hearing care, including eyeglasses and hearing aids would be covered

IV. The wrap-around benefit package would also be provided under Medicare Part C for low-income individuals with family income between 100 and 200 percent of the Federal poverty level

- A. However, individuals with income between 100 and 200 percent of poverty would be required to contribute toward the cost of wrap-around benefits, on a sliding-scale basis
- B. The combined premium contributions incurred by individuals between 100 and 200 percent of the poverty level (for the guaranteed benefit package, and the wrap-around benefit package) could not equal or exceed the Medicare premium for Medicare Part C

V. Wrap-around benefits would be provided under Medicare Part C for low-income individuals that elect coverage under private plans offered by employers

A. Low-income employees covered under an employer plan would be able to receive Medicare Part C subsidies and benefits, that would otherwise be covered under Medicare Part C, if such benefits were not otherwise covered by the employer

1. Non-discrimination rules would require employers to offer the same benefits to low income employees, as all other employees

B. Medicare Part C would become the secondary payer to the plan offered by the employer

1. Medicare would cover **wrap-around** benefits provided under Medicare Part C to low income individuals, that are in excess of the guaranteed national benefit package

2. Medicare would be the secondary payer for cost-sharing required under the employer plan for benefits covered under the guaranteed benefit package

VI. Providers would be compensated by Medicare Part C for the deductibles, copayments or coinsurance not paid by low income Medicare Part C beneficiaries

VII. Medicaid would continue to provide benefits not covered under the nationally guaranteed benefit package, or covered under the Medicare Part C wrap-around benefit package.

A. State Medicaid payments for such services would continue to be subject to the current Federal match

B. Benefits covered under Medicaid would include:

1. All long-term care services

2. Enabling services, including transportation and translation services

VIII. Eligibility Defined

A. Eligibility would be based upon annualized income

1. Uniform, national eligibility criteria
  2. No asset test would be applied
  3. In general, eligibility for low-income benefits would be for a one-year period
- IX. Method for determining low-income eligibility for premium subsidy for the guaranteed national benefit package
- A. Eligibility for low-income premium subsidies would be determined through the income tax system
  - B. Eligibility for low-income benefits would be verified as part of annual tax filing
  - C. Individuals could voluntarily terminate subsidy eligibility, due to an increase in income
    1. Individual could notify the Secretary of HHS
    2. The Secretary would terminate subsidies, upon notification from an individual, within 60 days after such a notice was filed
    3. Individuals could elect to increase the withholding, to adjust for a mid-year increase in income, and an expected increase in premium liability
  - D. The premium obligation for AFDC and SSI cash recipients would be deemed to be zero
  - E. The premium obligation for non-filers would be deemed to be zero
  - F. The individual would have a right to appeal denial of low-income benefits, and a right to an explanation for the denial
  - G. The Secretary of HHS would provide information needed to IRS for the purpose of verifying subsidy eligibility
  - H. The Secretary of the Treasury would provide information needed, if requested by the Secretary of HHS
- X. Low-income benefits and subsidies would be funded by the new Medicare Part C Trust Fund (see Medicare Part C outline)



## Specifications for Universal Health Insurance Coverage

**IV. State Medicaid Maintenance of Effort**

- I. Continuation of Current Medicaid Coverage for Long-term Care and other Services not Covered Under Federal Plan
  - A. Medicaid would continue to function as under current law
    1. The Secretary would be prohibited from approving any change in a State's Medicaid program that would take effect prior to the implementation of Medicare Part C and that would substantially reduce a State's obligations under the maintenance of effort provisions that follow
  - B. Payments made under Medicaid would be secondary to payments made under any Federal program, including Medicare Parts A, B and C, and to any Federal supplemental coverage provided to low-income beneficiaries (see Low-Income outline)
    1. States would continue to provide Medicaid coverage for services, and to individuals, not covered under Medicare Part C, including long term care services for beneficiaries that would qualify under current law
- II. State Maintenance of Effort Payments to Medicare Part C
  - A. States would make "maintenance-of-effort" payments to Medicare Part C to partially offset need for Federal subsidies of low-income, non-cash recipients enrolled in Medicare Part C
    1. Payments would be made in the same manner, and using the same process, as current State "buy-in" payments to Medicare Part B

- B. Computation of State Maintenance-of-Effort Amount for Non-cash Recipients
1. For each State, a 1993 baseline level of Medicaid expenditures for non-cash recipients (less Federal financial participation), not eligible for Medicare Part A, for covered Medicare Part C services, including deductibles and co-insurance
  2. State maintenance of effort payments in the initial year would be XX percent of the 1993 baseline updated to 1996
  3. In subsequent years, the amount is updated by the allowable growth in per capita spending in Medicare, and growth in the general population under age 65
- C. Computation of State Maintenance of Effort Amount for Cash Recipients
1. States would make per capita payments to Medicare Part C for cash recipients (AFDC and SSI)
    - a. Payments are based on baseline per capita Medicaid spending for services covered under Medicare Part C made on behalf of AFDC and SSI individuals and families under current law
    - b. The State share of the per capita spending amount for cash recipients would be based on the State's share of Medicaid financing as determined under current law
  2. The State payments for cash recipients would be equal to XX percent of the sum of the AFDC/SSI "per capita amounts" times the number of each such type of recipient
  3. The per capita payments for each State would be based on a 1993 baseline level of Medicaid expenditures for AFDC and SSI beneficiaries not entitled to Part A, for services and cost sharing covered under Part C
    - a. The per capita payments would be computed separately for AFDC and SSI

- b. The per capita payments would reflect current Medicaid coverage of services that will be covered under the Federal low-income plan
  4. The 1993 baseline AFDC or SSI per capita payments would be updated to 1996
  5. In subsequent years, the per capita AFDC and SSI payments would be updated by the allowable increase in Medicare Part C spending
  6. The Secretary would be given broad authority to alter these computations and requirements (and the non-cash maintenance of effort amounts) in applying these rules to Puerto Rico and other commonwealths and territories
- D. Effective date
1. The maintenance of effort requirement would be effective in each State no later than on the first day of the first year following the close of the first regular session of the State's legislature that begins on or after enactment of this Act
  2. In the case of States for which this date would be after January 1, 1996, such States would be required to make payments to Medicare Part C of 100 percent of the Part C premium on behalf of each individual entitled to Medicaid under the State plan

### III. Enforcement of State Maintenance of Effort Payments

- A. States would be required to make payments to Medicare Part C on a timely basis
- B. In the case of a State that fails to make required payments, the Secretary of HHS would withhold the required amount from Federal matching payments that would otherwise be paid to the State
- C. In the case of a State for which the Federal matching payments are not equal to or greater than the State's maintenance of effort obligation, the Secretary of HHS would not make any other payments to the State for any program within the HHS

1. Federal payments made directly to individuals would continue to be made

## Specifications for Universal Health Insurance Coverage

**TITLE V. QUALITY AND CONSUMER PROTECTION****I. Quality Management and Improvement**

- I. Federal standards would be established for a national quality management program that would enhance the quality, appropriateness and effectiveness of health care services
  - A. The States would enforce the standards for the National Quality Management Program
    1. States would be required to adopt the Federal standards within one year after they were issued by the Secretary
      - (a) States in which the legislature was not scheduled to meet during the year prior to the date by which the State must adopt the Federal standards would be required to adopt the standards by the first quarter after the close of the next scheduled meeting of the legislature
    2. The Secretary of HHS would certify State compliance and would assume responsibility for enforcing the standards in a State that did not comply
    3. Funding of \$300 million per year for each of the fiscal years 1996 through 2000 would be available to States for consumer protection and quality oversight efforts
  - B. The Secretary would develop and update a set of national quality and performance measures which would apply to health plans, institutions and health care professionals

1. In developing and selecting national measures of quality of performance, the Secretary would consult with appropriate interested parties, including States, health plans, health care providers, and consumers
  2. National measures of quality performance would be selected in a manner that provides information on the following subjects:
    - (a) Access to health care services by enrollees
    - (b) Appropriateness of health care services provided to consumers
    - (c) Outcomes of health care services and procedures
    - (d) Consumer satisfaction
- D. The Secretary would adopt methodologies for profiling the patterns of practice of health care professionals and for identifying outliers
1. An outlier would mean any health care provider whose pattern of practice suggests deficiencies in the quality of health care services
    - (a) The Secretary would disseminate said methodologies to States
  2. The Secretary would develop standards for education and sanctions with respect to outliers so as to assure the quality of health care services
- E. The Secretary would develop and approve a standard design for consumer surveys
1. The Secretary would specify sampling strategies that would have to be used to ensure that survey samples adequately measure populations that are considered to be at risk of receiving inadequate health care

2. Health plans, institutions and health care professionals would be required to conduct periodic surveys to gather information concerning access to care, use of health services, health outcomes and patient satisfaction

- (a) Summaries of survey results would be submitted to the States

- F. All health plans, institutions and providers would be required to submit information, as provided by the Secretary, to the State in order to enable quality review and outcome analysis

1. The required information would be transmitted using a uniform electronic format

- (a) The data required to be submitted would be developed by the Secretary

- (b) The data required to be submitted would conform to the requirements under administrative simplification

2. The Secretary would establish rules by which the data in the data base would be made available

3. The Secretary would establish standards to protect the privacy and otherwise shield the identity of the patient

## II. Outcomes research and guideline development

- A. The Secretary would establish a procedure by which individuals and entities would be able to submit guidelines to the Agency for Health Care Policy and Research (AHCPR) for evaluation and certification

1. The Secretary would direct AHCPR to establish and oversee a clearinghouse for dissemination of approved practice guidelines

2. On the basis of data, including data from outcomes research AHCPR would develop practice guidelines

- (a) AHCPR would be required to update on an annual basis such guidelines

- (b) The guidelines would be required to be based on monitoring of outcomes research and on existing clinical knowledge
  - (c) The guidelines would be required to be based on the degree to which a process of care increases the probability of desired patient outcomes
3. AHCPR would develop guidelines for certain medical procedures performed only in facilities that meet certain criteria
- (a) Guidelines would be developed based on standards for frequency of procedure performance and intensity of support mechanisms that are consistent with the high probability of desired patient outcome
  - (b) No payment would be required to be made for designated procedures provided in violation of the guidelines
  - (c) The Secretary may exclude any person or entity from participation in Medicare if any person or entity provides such designated service that such person or entity knows or should know is in violation of this section

C. AHCPR would disseminate guidelines to the States

III. Evaluating and reporting of quality performance

- A. The State would be required to monitor compliance of health plans, institutions and providers with standards established by the national quality management program
1. An annual, independent, external review of the quality of the services provided under a health plan would be required
- (a) The review could be conducted by the State or an independent entity under contract with the State

2. If the State finds, after affording reasonable opportunities for improvement, that a provider, institution or plan fails to engage in quality improvement activities or continues to furnish services of poor technical quality, the State would be required to notify the appropriate federal and State board or boards responsible for the licensing and disciplining of providers and plans

B. The State would be required to update annually and make available to consumers, in a standard format the performance of each health plan, institution and provider within the State, including results of consumer surveys

1. Performance of health plans, institutions and providers would be based on measures established by the Secretary

2. States would be required to provide to the Secretary an annual report that outlines the performance of health plans, institutions and providers

V. Research on health care quality

A. The Secretary would direct the Agency for Health Care Policy and Research (AHCPR) to support research, including research with respect to:

1. Outcomes of health care services and procedures

2. Effective and efficient dissemination of information, standards and guidelines

3. Methods of measuring quality and shared decision making

4. Design and organization of quality of care components of automated health information systems

- VI. Health plans would be required to meet standards established by the Secretary
- A. Establish an internal quality assurance program
  - B. Make available to enrollees information about their rights and responsibilities
  - C. Provide a grievance process that provides for effective and timely responses to complaints
  - D. Establish procedures for taking appropriate remedial action whenever inappropriate or substandard services are provided
  - E. Verify providers' credentials
  - F. Establish a policy to identify and investigate sources of dissatisfaction, outline action steps to follow-up on the findings and inform practitioners and providers of assessment results
  - G. Ensure that the confidentiality of specified patient information and records is protected
    - 1. Establish in writing policies and procedures on confidentiality, including confidentiality of medical records
    - 2. Assure that patient care offices/sites have implemented mechanisms that guard against the unauthorized or inadvertent disclosure of confidential information to persons outside of the medical care organization
- B. Health plans may not operate a physician incentive plan as defined in section 1876(i)(8)(B) of the Social Security Act unless the following requirements are met:
- 1. No specific payment is made directly or indirectly under the plan to a physician or a physician group as an inducement to reduce or limit medically necessary services provided with respect to a specific individual enrolled with the entity
  - 2. In the case of a plan that places a physician or a physician group at substantial financial risk as determined by the Secretary pursuant to section 1876(i)(8)(A)(ii), for services not provided by the physician or physician group, the entity

complies with the provisions of subclauses (I) and (II) of section 1876(i)(8)(A)(ii)

3. Upon request by the Secretary, the entity provides the Secretary with access to descriptive information regarding the plan, in order to permit the Secretary to determine whether the plan is in compliance with the requirements of this clause

#### VII. Grievance and appeals process

- A. Health plans would be required to notify an enrollee of denial of payment or provision of benefits
  1. The health plan would be required to provide such notice within 10 days
  2. If the health plan fails to notify an enrollee within 10 days such failure would be treated as a plan approval
  3. An enrollee would have 60 days, after receipt of notice of the denial, to request in writing a reconsideration of the claim
    - (a) The health plan would be required to complete any review and provide the enrollee notice of the plan's decision, within 30 days after receipt of the request for reconsideration
- B. Health plans would be required to provide an expedited appeals process for denials or terminations relating to services that are urgently needed
  1. A health plan would be required to make a determination within 24 hours
- C. Health plans would be required to establish a grievance process for patients dissatisfied with the type or extent of services being provided by the plan

- D. Each State would be required to establish a review office pursuant to standards established by the Secretary
  - 1. A complaint may be made about a denial or delay of payment or provision of benefits under the health plan
  - 2. Such complaints may only be filed after the claimant has exhausted the remedies under the plan
  - 3. Each review office would be required to review a complaint relating to services that are urgently needed within 3-days
- E. Any person aggrieved by a review office decision may seek a review of the decision in the court of competent jurisdiction

VIII. Additional remedies and enforcement provisions

- A. Any person who is discriminated against by a health plan on the basis of race, national origin or sex may commence on action pursuant to the provisions of the Civil Rights Act of 1866

IX. Privacy of information standards would apply to the disclosure of protected health information

- A. Standards would apply to any individual or entity who receives, collects, uses or maintains protected health information
- B. Protected health information means any information in any form, that identifies an individual and relates to the physical or mental health of the individual, provision of health care to the individual, or payment for the provision of health care to the individual

- C. Any individual or entity may disclose protected health information if such use or disclosure is:
1. For the purpose of providing health care to an individual
  2. For the purpose of providing for the payment for health care services
  3. For use by a health oversight agency for a purpose authorized by law
  4. For use in disease reporting, public health surveillance, or public health investigations as authorized as by State law
  5. To alleviate an emergency affecting the health or safety of an individual
  6. Pursuant to the Federal Rules of Civil Procedure, the Federal Rules of Criminal Procedure, or comparable rules
  7. Pursuant to a law requiring the reporting of specific medical information or child abuse or neglect information to law enforcement authorities
  8. To a law enforcement agency for the use in an investigation or prosecution of health care fraud, as authorized by law
  9. Pursuant to a subpoena, summons or warrant
  10. For use in utilization, quality assurance and health research projects as required under the national quality and assurance program
  11. For use in licensing, accrediting or certifying health facilities or health professional
- D. Information may only be used for the purpose for which the information was collected or was obtained, or a related purpose
1. The use or disclosure of health information would be limited to the minimum amount of information necessary to accomplish the purpose for which the information is used or disclosed

- E. Health information may be disclosed if a patient has signed a patient authorization form
1. The authorization form must specify the individual authorized to disclose such information, the person to whom the information is to be disclosed and the information to be disclosed
  2. The Secretary would develop standards with respect to patient authorizations for disclosures that are in electronic form
- F. The privacy of information standards would not apply to individuals who are casual recipients of health information
- G. Any individual aggrieved by any act of an individual or entity in violation of this section may bring a civil action in the district court of the United States
1. The court may award actual damages and grant equitable relief
    - \* In an action where a complainant has prevailed because of a knowing violation, the court may award punitive damages and reasonable attorneys' fees and costs
  2. No action may be brought unless such action is begun within two years from the date of the act complained of or the discovery of such act

## Specifications for Universal Health Coverage

## II. Information Systems and Administrative Simplification

## I. Uniform health claims card

- A. Each beneficiary of a health benefit plan, including the public plans, would be issued a uniform health claims card
  - 1. A health benefit plan that fails to issue a health claims card would be subject to civil monetary penalties
- B. Each card would include a uniform health claims identification number which would be the Social Security number of the beneficiary
- C. The Secretary would establish standards respecting the form and information to be contained on the cards
  - 1. Information relating to organ donation would be included on the cards
- D. The card would be in a form similar to that of a credit card and would have information encoded in electronic form

## II. Requirement for entitlement verification systems

- A. The Secretary would provide for an electronic system for the verification of an individual's enrollment in a health plan, including a public plan and entitlement to benefits
  - 1. The Secretary would establish standards respecting the type of information that employers and health plans, including public plans would be required to submit. Information reported would include:
    - a. Name and address of health plan elected
    - b. Name, address and social security number of the individuals enrolled

- c. The type of coverage elected, and
  - d. The period during which such coverage is elected
  - e. Status of individuals with respect to deductibles, copayments and out-of-pocket limits
2. Information would have to be submitted periodically whenever eligibility for coverage changed
  3. Health benefit plans that fail to provide enrollment information on a timely basis would be subject to civil monetary penalties
- B. The Secretary would establish standards respecting the requirements for certification of entitlement verification systems
1. The system would be required to be able to coordinate benefit information among health plans
  2. The system would also be required to accept inquiries from health care providers and health benefit plans electronically through the use of electronic card readers, touch-tone telephones, or computer modems
    - (a) Each system would be required to respond to such inquiries electronically
  3. Health benefit plans that fail to provide for an electronic verification system would be subject to civil monetary penalties
- C. In developing a system the Secretary would take into account the recommendations of private sector task forces, including the Workgoup on Electronic Data Interchange, National Uniform Billing Committee, the Uniform Claim Task Force and national organizations representing healthcare financial managers

## III. Uniform claims and electronic claims data set

- A. All claims submitted by providers would be transmitted using a uniform electronic format to be developed by the Secretary
  - 1. The standards would relate to the form and manner of submission of claims and would define the data elements to be contained in a uniform electronic claims data set
  - 2. The electronic transmission standards would be consistent with the format developed by the American National Standards Institute (ANSI)
  - 3. In adopting standards the Secretary would take into account the recommendations of private sector task forces, including the Workgroup on Electronic Data Interchange, National Uniform Billing Committee, the Uniform Claim Task Force and the Computer-based Patient Record Institute
- B. The Secretary would develop a single, uniform coding system for procedures and diagnoses
- C. The Secretary would provide for a unique identifier code for each health service provider and health plan
- D. Health service providers that fail to submit a claims for payment in a form and manner consistent with the standards would be subject to civil monetary penalties
- E. All claims for clinical laboratory tests would be submitted directly by the person or entity that performed the tests

## IV. Electronic medical records and reporting

- A. The Secretary would promulgate standards for hospitals concerning electronic medical records
  - 1. The standards would include a definition of a uniform hospital clinical data set for claims adjudication and for quality review
    - (a) The development of these standards would be in consultation with the American National Standards Institute, hospitals, and health benefit plans

B. As a condition of Medicare participation each hospital would be required to maintain hospital clinical data in electronic form in accordance with these standards

1. Each hospital, upon request of the Secretary, a utilization and quality control peer review organization or fiscal intermediary or carrier, would be required to transmit electronically data requested

2. A health plan may not require that a hospital provide any data not in the uniform hospital clinical data set

C. The Secretary would promulgate standards, by January 1, 2000, for other providers concerning electronic patient care information

D. State quill pen laws that require medical or health information to be maintained in written form would be pre-empted

V. Uniform hospital cost reporting

A. Each hospital would be required to report information on costs to the Secretary in a uniform manner consistent with standards established by the Secretary

Specifications for Universal Health Coverage

**III. Medical Malpractice**

I. General

- A. The following reforms would apply with respect to any medical malpractice claim brought in Federal or State court, unless State law is more stringent
- B. Any issue that is not governed by any provision of law established by or under this part would be governed by otherwise applicable State or Federal law

II. Tort reforms

A. Collateral source offset

- 1. The total amount of damages recovered by a plaintiff in a medical malpractice liability action would be reduced by the amount of "collateral source benefits" received in the past, or to be received in the future

B. Periodic payment of future damages

- 1. At the request of any party to a medical malpractice liability action, the defendant would be permitted to make such payments periodically based on a schedule established by the court

C. Frivolous suit penalty

- 1. The court could award reasonable attorney fees and costs where a meritless claim or defense is asserted

D. Limitation on contingency fees

- 1. An attorney who represents, on a contingency basis, a plaintiff in a medical malpractice liability action may not collect more than 33-1/3% of the total amount covered by a judgment or settlement

- E. Affidavit and medical report must be attached to the complaint
1. An affidavit of the attorney filing suit must be attached to the complaint attesting to a reasonable and meritorious cause of action
  2. A written report, by a medical professional who practices in the same specialty as the defendant, stating the reasons for the determination that a meritorious cause of action exists, must be attached to the affidavit accompanying the complaint
  3. Two exceptions would exist that would allow for a 90-day delay in filing of the affidavit and medical report with the complaint
    - (a) When the statute of limitations prevents obtaining a consultation
    - (b) When the claimant has made a request for medical records and the parties to which the request was made failed to produce such records within 60 days of receipt of the request

III. Alternative dispute resolution demonstration projects

- A. The Secretary would establish a demonstration project under which the Secretary would provide funds, to no more than 10 States, to determine the effect of various alternative dispute resolution systems
1. Demonstration projects would be conducted for a four year period
  2. The Secretary would promulgate regulations that establish the criteria and procedures by which the Secretary would determine whether or not to certify a State's alternative dispute resolution system

3. In order to participate a State must submit an application to the Secretary assuring that the State has established an alternative dispute resolution system that meets specific requirements promulgated by the Secretary
4. Not later than four years after the date of certification the State would be required to prepare and submit to the Secretary appropriate information to enable the Secretary to report on the matters to Congress

IV. Pilot program applying practice guidelines to medical malpractice litigation

- A. The Secretary would establish a demonstration project under which the Secretary would provide funds, to no more than 10 States, to determine the effects of applying practice guidelines in the resolution of medical malpractice liability actions

V. Physician recertification

- A. Standards for the physician qualification evaluation program would be established by the Secretary of HHS
  1. As a condition of payment under Medicare Part A, B, & C, a physician-
    - (a) Must have taken and passed, during the year or during any of the previous seven years, an approved examination offered by the Secretary or a qualified organization, or
    - (b) Must be licensed as a physician in a State with an approved physician licensure program
- B. The Secretary would establish and periodically update standards for physician examinations
  1. The standards would be established in consultation with the American Board of Medical Specialties, the National Board of Medical Examiners, the Federation of State Medical Boards, the American Osteopathic Association, and other organizations representative of physicians

2. Upon application and approval by the Secretary, a physician specialty certifying board which is a member board of the American Board of Medical Specialties, or the National Board of Medical Examiners, the American Osteopathic Association or a State medical board may offer the examination
- C. The Secretary would develop and provide for the offering of an approved examination in the general practice of medicine and osteopathy
  - D. The Secretary would review and approve the physician licensure program of any State
    1. Any program must provide for time-limited licenses for physicians and periodic relicensure of all physicians in the State
    2. Any program must include an objective evaluation of the qualifications of physicians to practice medicine or osteopathy

VI. Miscellaneous provision

- A. A enrollee aggrieved by an insurance contractor's failure to provide a benefit would be able to recover damages as specified under State law

## Specifications for Universal Health Insurance Coverage

## IV. Fraud and Abuse

- I. All-payer Fraud and Abuse Program
  - A. The Secretary of Health and Human Services and the Attorney General would establish and coordinate an all-payer national health care fraud control program
  - B. The Secretary, Attorney General and Inspector General would be authorized to conduct investigations, audits, evaluations and inspections relating to the delivery of and payment for health care
  - C. The administration of the national program would include the coordination of the Medicare and Medicaid fraud and abuse program
- II. Coordination With Law Enforcement Agencies and Third Party Insurers
  - A. The Secretary and the Attorney General would be required to consult with, and arrange for the sharing of data with, State law enforcement agencies, State Medicaid fraud and abuse units, State agencies responsible for the licensing and certification of health care providers, health plans, and third party insurers
- III. Regulations Regarding All-payer Fraud and Abuse Program
  - A. All health plans, providers, and others would be required to cooperate with the national fraud control program and to provide such information necessary for the investigation of fraud and abuse
    - (1) Procedures would be established to assure the confidentiality of the information required by the national fraud and abuse program and the privacy of individuals receiving health care services
  - B. Health plans and providers would be required to disclose information that the Secretary deems appropriate, including information relating to the ownership of a health care entity

C. The Inspector General of the Department of Health and Human Services would be authorized access to documentation in accordance with the Inspector General Act of 1978

(1) Any individual or entity who fails to comply with a request of the Office of the Inspector General of the Department of Health and Human Services for records, documents and other information necessary to carry out activities under the all-payer fraud and abuse control program may be excluded from participating in Medicare and State health care programs

D. A qualified immunity would be provided to persons providing information to the Secretary or Attorney General under the health care fraud and abuse program

#### IV. Authorization of Appropriations

A. Additional amounts of money would be authorized to be appropriated to the Office of the Inspector General of the Department of Health and Human Services and the Attorney General

#### V. Establishment of Fraud and Abuse Account

A. Civil money penalties, fines, gifts, bequests, and damages assessed would be deposited in a "All-Payer Health Care Fraud and Abuse Control Account"

B. The assets in the Account would be used, in addition to such appropriated amounts, to meet the operating costs of the national health care fraud control program

#### VI. Amendments to Anti-kickback provisions in Medicare fraud and abuse program

A. An intermediate civil monetary penalty of \$50,000 would be established for anti-kickback violations

B. The current criminal monetary penalty would be increased to no more than \$50,000

C. An assessment of three times the total amount of remuneration would be established as an additional penalty for both civil and criminal violations

D. The elements of a kickback offense would be clarified:

- (1) "In return for referring" would be stricken and "to refer" would be inserted
- (2) A violation would exist if one or more purposes of the remuneration were unlawful

VII. Amendments to exceptions to anti-kickback provisions in Medicare fraud and abuse program

- A. Current exception for discounts would be modified to prevent providers from:
  - (1) Giving discounts in exchange for an agreement to buy a different item or service
  - (2) Giving discounts in the form of a cash payment
- B. Current exception for bona fide employment relationships would be modified to require that the remuneration be consistent with fair market value, and not be determined in a manner that takes into account the volume or value of any referral
  - (1) The exception would also be modified to allow employees to be paid remuneration in the form of a productivity bonus based on services personally performed by the employee
- C. Current exception for waiver of coinsurance would be modified to allow for such arrangements if-
  1. A waiver or reduction of coinsurance is made pursuant to a public schedule of discounts which the person is obligated as a matter of law to apply
  2. After a determination in good faith that the individual is indigent, or
  3. After reasonable efforts to collect coinsurance or deductible amounts
- D. An exception would be provided for certain arrangements were providers are paid wholly on a capitated basis
- E. The Secretary would be authorized to impose by regulation such other requirements as needed to protect against program or patient abuse

VIII. Amendments to Civil Monetary Penalties in the Medicare Fraud and Abuse Program

- A. A civil monetary penalty would be established for the following new violations:
- (1) Offering inducements to individuals to receive from a particular provider an item or service
  - (2) Retention by an excluded individual of an ownership or control interest of in an entity
  - (3) Engaging in a practice which has the effect of limiting or discouraging the utilization of health care services
  - (4) Substantially fails to cooperate with a quality assurance program or a utilization review activity
  - (5) Substantially fails to provide or authorize medically necessary items or services that are required to be provided under the health plan, if the failure has adversely affected (or had a substantial likelihood of adversely affecting) the individuals
  - (6) Employing or contracting with any individual or entity who is excluded under Medicare or Medicaid for the provision of health care services
- B. Civil monetary penalties would be increased to no more than \$10,000 for each item or service
- C. The assessment would be increased to three times the amount claimed and interest shall accrue on the penalties and assessments
- D. If within one year the Attorney General does not initiate an action the Secretary could initiate a proceeding

IX. Application of Civil Penalties to all payers

- A. The provisions under the Medicare and Medicaid programs which provide for civil monetary penalties for specified fraud and abuse violations would apply to similar violations for all payers in the national health care system.

- (1) This provision would apply to all amendments to civil monetary penalties in the Medicare Fraud and Abuse program
- B. Violations specifically tailored to the Medicare and Medicaid programs would not, however, constitute violations under the all-payer fraud and abuse control program
- (1) Such violations include overcharging under an assignment agreement and physician or supplier participation agreement, charging more than limiting charge or actual charge concerning hospital services which could reasonably be expected to influence a decision concerning when to discharge a patient
- C. The following activity would be prohibited and subject to a civil monetary penalty not to exceed \$10,000:
- (1) Expelling or refusing to re-enroll an individual in violation of federal standards for health plans or State law
  - (2) Engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment a health plan on the basis of a medical condition
  - (3) Engaging in any practice to induce enrollment in a health plan through representations which the person knows or should know are false
  - (4) Offering or paying remuneration to any individual that such person knows or should know is likely to influence enrollment in a particular plan
- D. An individual who has suffered damages as a result of the civil monetary penalty section would be permitted to bring an action, if after the expiration of a sixty-day period, neither the Attorney General, or the Secretary, notifies the individual that they intend to pursue a civil monetary penalty
- (1) If after one year, the Secretary has not proceeded with reasonable due diligence in investigating the matter, the individual may proceed with an action

- (2) If the Secretary proceeds with the action, the individual may receive an amount the Secretary decides is appropriate restitution.
- (3) If the Secretary does not proceed with an action, 10 percent of the proceeds of the action or settlement of a claim would be deposited in the anti-fraud and abuse account

X. Amendments to exclusionary provisions in Fraud and Abuse Program

- A. The Secretary would have the authority to exclude individuals and entities based on felony convictions relating to fraud, theft, embezzlement, breach of fiduciary responsibility or other financial misconduct
- B. The current permissive exclusion authority would be extended to permit the Secretary to exclude individuals who retain an ownership or control interest in a sanctioned entity
- C. Minimum periods of exclusion for certain violations already specified in statute would be established
  - (1) In the case of an exclusion of an individual or entity for a misdemeanor conviction relating to fraud, the period of the exclusion would be three years unless the Secretary determines that a shorter or longer period is more appropriate
  - (2) In the case of an exclusion of an individual or entity relating to obstruction of an investigation or the unlawful manufacture, distribution, prescription or dispensing of a controlled substance, the period of the exclusion would be three years unless the Secretary determines that a shorter or longer period is more appropriate
  - (3) In the case of license revocation or suspension under Federal or State Health care programs, the exclusion would be no less than the period during which the individual's license to provide health care is revoked or the individual is excluded from a program
  - (4) In the case of an exclusion for filing claims for excessive charges or unnecessary services and failure to furnish medically necessary services the minimum period of exclusion would be one year

- (5) The minimum period of exclusion for practitioners failing to meet quality of care obligations would be one year

XI. Amendments to quality of care sanctions

- A. Practitioners or persons who fail to substantially comply with the corrective action plan of the Peer Review Organization would be subject to a civil monetary penalty or not more than \$10,000
- B. The requirement that the provider be shown to be "unwilling or unable" to meet obligations agreed to by the provider before the Secretary may exclude the individual from participating in Medicare would be deleted

XII. HMO intermediate sanctions under Medicare

- A. The Secretary would also be able to impose civil monetary penalties on Medicare-qualified HMOs for violation of Medicare contracting requirements

XIII. Application of criminal penalties to all payers

- A. The provisions under the Medicare and Medicaid program which provide for criminal penalties for specified fraud and abuse violations would apply to similar violations for all payers in the national health care system
- B. Violation specifically tailored to the Medicare and Medicaid program would not, however, constitute violations under the all-payer fraud and abuse control program
- C. For providers who violate specified fraud and abuse provisions, penalties would include fines, treble damages, and imprisonment
  - (1) The Secretary would also identify opportunities for the satisfaction of community service obligations that a court may impose upon the conviction of an offense under this section

XIV. Amendments to criminal law

- A. A criminal violation for health care fraud would be created for the following crimes
  - (1) Whoever knowingly executes a scheme to defraud any health plan or person, in connection with the delivery of health care services
  - (2) Penalties would include a fine and a prison term of not more than 5 years
  
- B. Forfeitures for violations of fraud statutes
  - (1) If the court determines that a Federal health care offense is of a type that poses serious threat to a person's health, or has significant detrimental impact on the health care system, the court could order the person to forfeit property used in or derived from proceeds from the offense and is of value proportionate to the offense
  
- C. Injunctive relief relating to health care offenses
  - (1) Injunctive relief would be available against any individual who was committing or was about to commit a Federal health care offense
  
- D. The civil false claims act would be amended to cover false claims submitted to health plans

## Specifications for Universal Health Insurance Coverage

## V. Physician Ownership and Referral

- I. Application of ban on self-referral to all payers
  - A. The physician ownership and referral ban would be extended beyond Medicare and Medicaid to all payers
- II. Extension of ban to additional services
  - A. The physician ownership and referral ban would be extended to cover the following additional services:
    - (1) Diagnostic services
    - (2) Home infusion
    - (3) Any other item or service not rendered by the physician personally or by a person under the physician's direct supervision
- III. Continuation of current exceptions to the general rule
  - A. The exceptions in current law to the general ban on referrals would be continued with a series of modifications
- IV. Exceptions related to both ownership and compensation arrangements
  - A. The exception for physicians' services would be repealed
  - B. The in-office ancillary service exception would be modified to provide an exception in the case of clinical laboratory services, x-ray services, ultrasound services, and other low cost services as determined by the Secretary, that are-
    - \* Wholly owned by the referring physician,
    - \* Furnished personally by the referring physician, or personally by individuals who are directly supervised by the physician, and

- \* In an office location in which the referring physician furnishes physician services unrelated to the furnishing of designated health services

C. The in-office ancillary service exception would be further modified to provide an exception in the case of-

1. Clinical laboratory services, x-ray services, and ultrasound services and other low cost services as the Secretary may determine, that are furnished-

- \* Personally by a physician in the same group practice or personally by individuals who are directly supervised by a physician in the group practice, and

- \* In a building used by the group practice

2. All other designated health services, that are furnished-

- \* Personally by a physician in the same group practice or personally by individuals who are directly supervised by a physician in the group practice, and

- \* In a building which is used by the group practice for the centralized provision of the group's designated health services within any given MSA, or

-- For purposes of the standard the term "centralized location" would include any building which is located adjacent to another building

- \* In a building used by the group practice in a rural area (outside MSAs)

D. The exception for prepaid plans would be modified in the following way:

- \* The exception for Federally Qualified Health Maintenance Organizations would be modified to require that payment be made on a prepaid and capitated basis

- \* An exception would be provided for prepaid capitated plans

V. Exceptions related only to ownership or investment

- A. The current standard under the publicly traded securities exception would require that at the time acquired by the physician that ownership of investment securities, at the time acquired by the physician, purchased on terms generally available to the public
- B. The current exception for rural providers would be clarified to exempt entities providing 85% of their services to rural residents

VI. Exceptions related only to compensation arrangements

- A. The exception for remuneration unrelated to the provision of designated health services would be repealed
- B. The exception for isolated transactions would be modified to prohibit the financing of the sale between the parties

VII. Referring physician

- A. An exception would be provided for requests by nephrologists for any item or service administered in a renal dialysis facility

VIII. Miscellaneous and technical provisions

- A. The current limitations would be clarified to prohibit a physician from submitting a claim pursuant to a prohibited referral
- B. The definition of financial relationship would be clarified to provide that an interest held in a trust that holds an investment or ownership interest is a financial relationship
- C. The exception for payments by physician for items and services would be modified to require that the items and services be furnished at a price that is consistent with fair market value
- D. Reporting requirements would be expanded to require physicians to report investment and compensation arrangements in addition to ownership information

- E. The current standards used to define a group practice would be expanded to allow the Secretary to impose by regulation requirements for the physical grouping of physician practices as may be reasonably required to prevent against program abuse
- F. The applications of effective dates with respect to exceptions in current law would be clarified

**TITLE VI. PREMIUM-BASED FINANCING**

**I. Premiums for Medicare Part C**

(to be added)

**TITLE VII. REVENUE PROVISIONS**

**I. Financing**

(to be added)

**II. Health Insurance Deduction for the Self-Employed**

(to be added)