

105TH CONGRESS
1ST SESSION

H. R. 356

To improve health status in medically disadvantaged communities through comprehensive community-based managed care programs.

IN THE HOUSE OF REPRESENTATIVES

JANUARY 7, 1997

Mr. TOWNS introduced the following bill; which was referred to the Committee on Commerce

A BILL

To improve health status in medically disadvantaged communities through comprehensive community-based managed care programs.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Comprehensive Health
5 Access District Act”.

6 **SEC. 2. DEFINITIONS.**

7 (a) COMPREHENSIVE HEALTH ACCESS DISTRICT.—
8 The term “comprehensive health access district” means
9 a community in which unemployment and the percentage

1 of residents with incomes below the poverty line are great-
2 er than the national average, and in which a majority of
3 the following conditions occur at rates greater than the
4 national average:

5 (1) Infant mortality and low birth-weight ba-
6 bies.

7 (2) Proportion of children below the age of 5
8 who have not received age-appropriate routine child-
9 hood immunizations.

10 (3) Hospitalization for preventable illnesses and
11 conditions that may be managed successfully on an
12 outpatient basis, such as otitis media, diabetes, and
13 hypertension.

14 (4) Emergency room visits for nonemergency
15 conditions.

16 (5) Accidental injury.

17 (6) Incidence of tuberculosis, acquired immune
18 deficiency syndrome, Black Lung disease, or cancer.

19 (7) Incidence of violent crimes.

20 (b) COMPREHENSIVE COMMUNITY-BASED HEALTH
21 ACCESS PLAN.—The term “comprehensive community-
22 based health access plan” (hereafter in this Act referred
23 to as a “health access plan”) means an entity that pro-
24 vides health care services on a prepaid, capitated basis or

1 any other risk basis and that the Secretary has certified
2 meets the requirements contained in section 5 of this Act.

3 (c) SECRETARY.—The term “Secretary” means the
4 Secretary of Health and Human Services.

5 **SEC. 3. MEDICAID STATE PLAN REQUIREMENTS FOR COM-**
6 **PREHENSIVE HEALTH ACCESS DISTRICTS.**

7 Section 1902(a) of the Social Security Act (42 U.S.C.
8 1396a(a)) is amended by adding after paragraph (62) the
9 following new paragraph:

10 “(63) provide that each comprehensive health
11 access district located within the State is served by
12 a comprehensive community-based health access dis-
13 trict plan.”

14 **SEC. 4. HEALTH ALLIANCE OBLIGATIONS WITH RESPECT**
15 **TO COMPREHENSIVE HEALTH ACCESS DIS-**
16 **TRICTS.**

17 Each Health Alliance or other health insurance pur-
18 chasing cooperative created as a result of the enactment
19 of comprehensive health care reform legislation that re-
20 ceives premiums on behalf of persons formerly insured
21 under title XIX of the Social Security Act and whose
22 boundaries encompass a comprehensive health access dis-
23 trict shall insure that a least one comprehensive commu-
24 nity-based health access plan is available to persons living
25 in such district.

1 **SEC 5. COMPREHENSIVE COMMUNITY-BASED HEALTH AC-**
2 **CESS PLANS.**

3 To be certified as a comprehensive community-based
4 health access plan, an entity must meet all of the following
5 requirements:

6 (a) ORGANIZATIONAL REQUIREMENTS.—A
7 health access plan must—

8 (1) be a public or private organization, or-
9 ganized under the laws of any State;

10 (2) locate its primary place of business in
11 the comprehensive health access district it
12 serves;

13 (3) give preference in hiring to otherwise
14 qualified individuals who live within the com-
15 prehensive health access district; and

16 (4) have made adequate provision against
17 the risk of insolvency, which provision is satis-
18 factory to the State and which assures that in-
19 dividuals enrolled in a plan are in no case liable
20 for debt of the plan in case of the plan's insol-
21 vency. Provisions against the risk of insolvency
22 may include—

23 (A) escrow or similar arrangements to
24 ensure that funds for the payment of pro-
25 viders are available only for such payments
26 and cannot be otherwise used by the plan;

1 (B) reinsurance purchased by the plan
2 of an amount which is reasonably adequate
3 to insure against unexpected costs;

4 (C) a demonstration of financial via-
5 bility, as evidenced by the plan's obtaining
6 a significant amount of reinsurance, line of
7 credit, or performance bond; or

8 (D) such other mechanisms and re-
9 quirements as the State finds appropriate.

10 (b) SERVICE REQUIREMENTS.—

11 (1) BASIC BENEFITS.—A health access
12 plan shall provide, either directly or through ar-
13 rangements with providers, the following basic
14 benefits:

15 (A) Hospital services, including inpa-
16 tient, outpatient and 24-hour emergency
17 services.

18 (B) Emergency and ambulatory medi-
19 cal and surgical services.

20 (C) Physicians' services.

21 (D) Medical care other than physi-
22 cians' services recognized under State law
23 and furnished by licensed practitioners
24 within the scope of their practice as de-
25 fined by State law.

1 (E) Dental services.

2 (F) Vision services.

3 (G) Preventive health care services
4 (including children's eye and ear examina-
5 tions to determine the need for vision and
6 hearing correction, well child services, im-
7 munizations against vaccine-preventable
8 diseases, and screening for elevated blood
9 lead levels).

10 (H) Outpatient laboratory, radiology,
11 and diagnostic services.

12 (I) Ambulance services.

13 (J) Mental health and substance
14 abuse services.

15 (K) Family planning services and
16 services for pregnant women.

17 (L) Outpatient prescription drugs and
18 biologicals.

19 (2) COMMUNITY-BASED HEALTH SERV-
20 ICES.—In addition to providing the services de-
21 scribed in paragraph (b)(1), a health access
22 plan shall—

23 (A) identify the most frequent causes
24 of morbidity and mortality in the com-
25 prehensive health access district (such as

1 acquired immune deficiency syndrome, tu-
2 berculosis, mental illness, substance abuse
3 and addiction, childhood developmental dis-
4 orders (particularly those caused by chil-
5 dren's exposure to violence), asthma, teen
6 pregnancy, unhealthy behaviors (such as
7 smoking and high-fat diets), and lead poi-
8 soning); and

9 (B) design and implement programs
10 of prevention, early intervention, or treat-
11 ment intended to ameliorate or eliminate
12 the factors identified in subparagraph
13 (b)(2)(A).

14 (3) COORDINATION OF SERVICES.—In ad-
15 dition to providing the services described in
16 paragraphs (b)(1) and (b)(2), a health access
17 plan must promote its enrollees' access to so-
18 cial, educational or economic services (such as
19 child day care, nutritional services, vocational
20 training, and adult literacy programs).

21 (c) SERVICE NETWORK REQUIREMENTS.—

22 (1) BASIC SERVICE NETWORK.—A health
23 access plan shall enter into arrangements with
24 a sufficient number and variety of providers to
25 guarantee that—

1 (A) the plan’s enrollees have access to
2 the services described in subsection 4(b);
3 and

4 (B) the provider network takes into
5 account and is representative of the cul-
6 tural identity and diversity of the commu-
7 nity being served.

8 (2) TRADITIONAL COMMUNITY PROVID-
9 ERS.—A health access plan shall, to the extent
10 feasible, draw upon health care providers cur-
11 rently serving the community, including com-
12 munity health centers (as defined in section
13 330(a) of the Public Health Service Act) and
14 hospitals operated by units of local government,
15 in developing its service network.

16 (3) DEVELOPMENT OF NEW HEALTH RE-
17 SOURCES.—A health access plan shall develop
18 new health resources in the community (such as
19 schoolbased clinics, mobile screening programs,
20 and clinics based in public housing) to meet
21 needs that are not met by existing community
22 resources.

23 (d) ACCESS STANDARDS.—A health access plan
24 shall insure that each individual enrolled in it—

1 (1) is linked with the primary care physi-
2 cian within the health access plan's provider
3 network of the individual's choice and has ac-
4 cess to that doctor on a 24-hour a day, 7-day
5 a week basis;

6 (2) has round-the-clock telephone access to
7 a central program office for information pur-
8 poses as well as to voice grievances; and

9 (3) has access to interpreter services as
10 necessary (where a significant proportion of the
11 population in the community health access dis-
12 trict is non-English speaking, the health access
13 plan shall insure that a corresponding propor-
14 tion of its health care providers have multi-
15 lingual capability).

16 (e) **QUALITY ASSURANCE STANDARDS.**—A
17 health access plan shall establish and maintain a
18 quality assurance program that includes at least the
19 following activities:

20 (1) **TREATMENT STANDARDS.**—A health
21 access plan shall establish—

22 (A) minimum standards for treating
23 patients that participating providers must
24 satisfy;

1 (B) a program of ongoing medical
2 record reviews and other provider audits to
3 insure compliance with the plan's treat-
4 ment standards; and

5 (C) a system of sanctions to insure
6 that providers who do not comply with the
7 plan's treatment standards will be penal-
8 ized and, if found to be repeatedly out of
9 compliance, terminated from participation
10 in the health access plan service network.

11 (2) DATA COLLECTION.—A health access
12 plan shall monitor morbidity and mortality
13 within the comprehensive health access district
14 and identify the leading causes of death and
15 disease.

16 (3) MEMBER SURVEYS.—A health access
17 plan shall survey its enrollees on a regular basis
18 to determine their satisfaction with the quality
19 of services received.

20 (4) INDEPENDENT QUALITY AUDITS.—A
21 health access plan shall be evaluated on a regu-
22 lar basis by an independent health care accred-
23 iting organization.

1 (f) EFFECTIVE GRIEVANCE PROCEDURES.—A
 2 health access plan must provide for effective proce-
 3 dures for hearing and resolving grievances between
 4 the plan and individuals enrolled in the plan.

5 (g) CONFIDENTIALITY OF ENROLLEE
 6 RECORDS.—

7 (1) A health access plan shall ensure that
 8 information concerning its enrollees is protected
 9 from unauthorized disclosure by the plan, its
 10 employees or its providers.

11 (2) To promote the coordination of benefits
 12 to health plan enrollees, a health access plan
 13 may disclose information about its enrollees to
 14 the extent necessary to facilitate the enrollee's
 15 receipt of services and assistance from other en-
 16 tities.

17 **SEC. 6. DESIGNATION OF COMPREHENSIVE HEALTH AC-**
 18 **CESS DISTRICTS AND CERTIFICATION OF**
 19 **COMPREHENSIVE COMMUNITY-BASED**
 20 **HEALTH ACCESS PLANS.**

21 The Secretary shall designate a community that
 22 meets the criteria set forth in section 2(a) of this Act a
 23 comprehensive health access district and shall certify an
 24 entity that meets the criteria set forth in section 5 of this

1 Act as a comprehensive health access plan. Each such cer-
2 tification and designation shall be reviewed every five
3 years. The Secretary may delegate all or part of the cer-
4 tification function to the State in which the health access
5 plan operates.

6 **SEC. 7. NATIONAL HEALTH OUTCOMES RESEARCH AND**
7 **EVALUATION.**

8 (a) PROVISION OF INFORMATION.—In order to evalu-
9 ate the performance of health access plans in improving
10 the health status of persons living in comprehensive health
11 access districts, each health access plan shall provide the
12 Secretary, at a time and in a manner specified by the Sec-
13 retary, at least the following information:

14 (1) Information on the characteristics of enroll-
15 ees that may affect their need for or use of health
16 services.

17 (2) Information on the types of treatments and
18 services and outcomes of treatments with respect to
19 the clinical health, functional status and well-being
20 of enrollees.

21 (3) Information on enrollee satisfaction.

22 (4) Information on health care expenditures,
23 volume and prices of procedures, and use of special-
24 ized services.

1 (b) ANALYSIS OF INFORMATION.—The Secretary
2 shall analyze the information reported by health access
3 plans in order to report to Congress, the plans and the
4 public, no less than annually, on the following:

5 (1) The health status of persons living in com-
6 prehensive health access district (particularly those
7 indicators listed in section 2(a) of this Act).

8 (2) The level and rate of expenditures by health
9 access plans on medical services and other programs
10 to improve health status.

11 (3) The effectiveness of health access plans in
12 improving health outcomes (particularly outcomes
13 related to health indicators listed in section 2(a) of
14 this Act).

15 (c) RESEARCH.—

16 (1) The Secretary shall examine the relation-
17 ship between socioeconomic factors and health status
18 and, based on his findings, suggest interventions ap-
19 propriate to comprehensive health access districts.

20 (2) The Secretary may contract with non-gov-
21 ernmental entities to perform this research. Persons
22 undertaking this work shall have access to the infor-
23 mation provided by the health access plans to the
24 Secretary.

1 **SEC. 8. CHANGES TO THE MEDICAID STATUTE TO FACILI-**
2 **TATE STATE CONTRACTS WITH COMPREHEN-**
3 **SIVE COMMUNITY-BASED HEALTH ACCESS**
4 **PLANS.**

5 (a) Section 1903(m)(2) of the Social Security Act (42
6 U.S.C. 1396b(m)(2)) is amended by adding after subpara-
7 graph (H) the following new subparagraph:

8 “(I) Clause (ii) of subparagraph (A) does not
9 apply to any entity certified as a comprehensive
10 health access plan pursuant to section 6 of the Com-
11 prehensive Health Access District Act.”

12 (b) This amendment shall apply to payments for med-
13 ical assistance for calendar quarters beginning on or after
14 July 1, 1996.

15 **SEC. 9. REGULATIONS AND EFFECTIVE DATE.**

16 (a) The Secretary shall promulgate regulations nec-
17 essary to implement this Act.

18 (b) This Act shall take effect on July 1, 1998, with-
19 out regard to whether or not final regulations to carry out
20 this Act have been promulgated by such date.

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