TITLE VII—MEDICAID REFORM

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Subtitle A—Per Capita Spending Limit

SEC. 7001. LIMITATION ON EXPENDITURES RECOGNIZED FOR PURPOSES OF FEDERAL FINANCIAL PARTICIPATION.

(a) IN GENERAL.—Title XIX of the Social Security Act is amended—

(1) in section 1903(a), by striking "From" and inserting "Subject to section 1931, from";

(2) by redesignating section 1931 as section 1932; and

(3) by inserting after section 1930 the following new section:

"LIMITATION ON FEDERAL FINANCIAL PARTICIPATION BASED ON PER BENEFICIARY SPENDING

"SEC. 1931. (a) IN GENERAL.—Subject to subsection (e), the total amount of State expenditures for medical assistance for which Federal financial participation may be made under section 1903(a) for quarters in a fiscal year (beginning with fiscal year 1997) may not exceed the sum of the following:

"(1) NONDISABLED MEDICAID CHILDREN.—The product of—

"(A) the number of full-year equivalent nondisabled medicaid children (described in subsection (b)(1)) in the State in the fiscal year, and

"(B) the per capita medical assistance limit established under subsection (c)(1) for such category of individuals for the fiscal year.

"(2) NONDISABLED MEDICAID ADULTS.—The product of—

"(A) the number of full-year equivalent nondisabled medicaid adults (described in subsection (b)(2)) in the State in the fiscal year, and

"(B) the per capita medical assistance limit established under subsection (c)(1) for such category individuals for the fiscal year.

"(3) NONDISABLED ELDERLY MEDICAID BENEFICIARIES.—The product of—

"(A) the number of full-year equivalent nondisabled elderly medicaid beneficiaries (described in subsection (b)(3)) in the State in the fiscal year, and

"(B) the per capita medical assistance limit established under subsection (c)(1) for such category of individuals for the fiscal year.

"(4) DISABLED MEDICAID BENEFICIARIES.—The product of—

"(A) the number of full-year equivalent disabled medicaid beneficiaries (described in subsection (b)(4)) in the State in the fiscal year, and

"(B) the per capita medical assistance limit established under subsection (c)(1) for such category individuals for the fiscal year.

"(5) ADMINISTRATIVE EXPENDITURES.—The product of—

"(A) the number of full-year equivalent medicaid beneficiaries who are in any category of beneficiaries in the State in the fiscal year, and

"(B) the per capita limit established under subsection (c)(1) for administrative expenditures for the fiscal year.

This section shall not apply to expenditures for which no Federal financial participation is available under this title.

"(b) DEFINITIONS RELATING TO CATEGORIES OF INDIVIDUALS.—In this section:

"(1) NONDISABLED MEDICAID CHILDREN.—The term 'nondisabled medicaid child' means an individual entitled to medical assistance under the State plan under this title who is not disabled (as such term is used under paragraph (4)) and is under 21 years of age.

"(2) NONDISABLED MEDICAID ADULTS.—The term 'nondisabled medicaid adult' means an individual entitled to medical assistance under the State plan under this title who is not disabled (as such term is used under paragraph (4)) and is at least 21 years of age but under 65 years of age.

"(3) NONDISABLED ELDERLY MEDICAID BENEFICIARY.—The term 'nondisabled medicaid adult' means an individual entitled to medical assistance under the State plan under this title who is not disabled (as such term is used under paragraph (4)) and is at least 65 years of age.

"(4) DISABLED MEDICAID BENEFICIARIES.—The term 'disabled medicaid beneficiary' means an individual entitled to medical assistance under the State plan under this title who is entitled to such assistance solely on the basis of blindness or disability.

For purposes of this section, nondisabled medicaid children, nondisabled medicaid adults, nondisabled elderly medicaid beneficiaries, and disabled medicaid beneficiaries each constitutes a separate category of medicaid beneficiaries.

"(c) ESTABLISHMENT OF PER CAPITA LIMITS.—

"(1) IN GENERAL.—The Secretary shall establish for each State a per capita medical assistance limit for each category of medicaid beneficiaries described in subsection (b) and for administrative expenditures for a fiscal year equal to the product of the following:

"(A) PREVIOUS EXPENDITURES.—The average of the amount of the per capita matchable medical assistance expenditures (determined under paragraph (2)(A)) for such category (or the per capita matchable administrative expenditures determined under paragraph (2)(B)) for such State for each of the 3 previous fiscal years.

"(B) INFLATION FACTOR.—The rolling 2-year CPI increase factor (determined under paragraph (3)(A)) for the fiscal year involved.

"(C) TRANSITIONAL ALLOWANCE.—The transitional allowance factor (if any) applicable under paragraph (3)(B) to such limit for the previous fiscal year and for the fiscal year involved.

"(2) PER CAPITA MATCHABLE MEDICAL ASSISTANCE EXPENDITURES.—For purposes of this section—

"(A) MEDICAL ASSISTANCE EXPENDITURES.—The per capita matchable medical assistance expenditures, for a category of medicaid beneficiaries for a State for a fiscal year, is equal to—

"(i) the amount of expenditures for which Federal financial participation is (or may be) provided (consistent with this section) to the State under paragraphs (1) and (5) of section 1903(a) (other than expenditures excluded under subsection (e)) with respect to medical assistance furnished with respect to individuals in such category during the fiscal year, divided by

"(ii) the number of full-year equivalent individuals in such category in the State in such fiscal year.

"(B) PER CAPITA MATCHABLE ADMINISTRATIVE EXPENDITURES.—The per capita matchable administrative expenditures, for a State for a fiscal year, is equal to—

"(i) the amount of expenditures for which Federal financial participation is (or may be) provided (consistent with this section) to the State under section 1903(a) (under paragraphs (1) and (5) of such section) during the fiscal year, divided by

"(ii) the number of full-year equivalent individuals in any category of medicaid beneficiary in the State in such fiscal year.

"(3) INCREASE FACTORS.—In this subsection—

"(A) ROLLING 2-YEAR CPI INCREASE FACTOR.—The rolling 2-year CPI increase factor for a fiscal year is 1 plus the percentage by which—

"(i) the Secretary's estimate of the average value of the consumer price index for all urban consumers (all items, U.S. city average) for months in the particular fiscal year exceeds

"(ii) the average value of such index for months in the 3 previous fiscal years.

"(B) TRANSITIONAL ALLOWANCE FACTORS.—

"(i) FISCAL YEAR 1996.—The transitional allowance factor for fiscal year 1996—

"(I) for the category of nondisabled medicaid children, is 1.051;

"(II) for the category of nondisabled medicaid adults, is 1.067;

"(III) for the category of nondisabled elderly medicaid beneficiaries is 1.031;

"(IV) for the category of disabled medicaid beneficiaries is 1.015; and

"(V) for administrative expenditures, is 1.046.

"(ii) SUBSEQUENT FISCAL YEARS FOR NONDISABLED CHILDREN AND ADULTS AND FOR DISABLED CATEGORIES.—The transitional allowance factor for the categories of nondisabled medicaid children, nondisabled medicaid adults, and disabled medicaid beneficiaries—

"(I) for fiscal years 1997 and 1998 is 1.02;

"(II) for fiscal year 1999 is 1.015;

"(III) for fiscal year 2000 is 1.01;

"(IV) for fiscal year 2001 is 1.005; and

"(V) for each subsequent fiscal year is 1.0.

"(iii) SUBSEQUENT FISCAL YEARS FOR THE ELDERLY AND ADMINISTRATIVE EXPENDITURES.—The transitional allowance factor

for the category of nondisabled elderly medicaid beneficiaries and for administrative extures for fiscal years after fiscal year is 1.0.

"(4) NOTICE.—The Secretary shall notify each State before the beginning of each fiscal year of the per capita limits established under this subsection for the State for the year.

"(d) SPECIAL RULES AND EXCEPTIONS.—For purposes of this section, expenditures attributable to any of the following shall not be subject to the limits established under this section and shall not be taken into account in establishing per capita medical assistance limits under subsection (c)(1):

"(1) DSH.—Payment adjustments under ion 1923.

"(2) MEDICARE COST-SHARING.—Payments for medical assistance for medicare cost-sharing (as defined in section 1905(p)(3)).

"(3) SERVICES THROUGH IHS AND TRIBAL PROVIDERS.—Payments for medical assistance for services described in the last sentence of section 1905(b).

Nothing in this section shall be construed as applying any limitation to expenditures for the purchase and delivery of qualified pediatric vaccines under section 1928.

"(e) DEFINITIONS.—In this section, the term 'medicaid beneficiary' means an individual entitled to medical assistance under the State plan under this title.

"(f) ESTIMATIONS AND NOTICE.—

"(1) IN GENERAL.—The Secretary shall—

"(A) establish a process for estimating the limits established under subsection (a) for each State at the beginning of each fiscal year and adjusting such estimate during such year; and

"(B) notifying each State of the estimations and adjustments referred to in subparagraph (A).

"(2) DETERMINATION OF NUMBER OF FULL-YEAR EQUIVALENT INDIVIDUALS.—For purposes of this section, the number of full-year equivalent individuals in each category described in subsection (b) for a State for a year shall be determined based on actual reports submitted by the State to the Secretary. In the case of individuals who were not entitled to benefits under a State plan for the entire fiscal year for care within a group of individuals for only part of a fiscal year), the number shall take into account only the portion of the year in which they were so entitled or within such group. The Secretary may audit such reports.

"(g) ANTI-GAMING ADJUSTMENT TO REFLECT CHANGES IN ELIGIBILITY.—

"(1) REPORT ON PER CAPITA EXPENDITURES.—If a State makes a change (on or after October 15, 1995) relating to eligibility for medical assistance in its State plan that results in the addition or deletion of individuals eligible for such assistance, the State shall submit to the Secretary, with such change, such information as the Secretary may require in order to carry out paragraph (2).

"(2) ADJUSTMENT FOR CERTAIN ADDITIONS.—If a State makes a change described in paragraph (1) that the Secretary believes will result in making medical assistance available for additional individuals (within a category described in subsection (b)) with respect to whom the Secretary estimates the per capita average medical assistance expenditures will be less the applicable per capita limit established under subsection (c)(1) for such category, the Secretary shall apply the per capita limits under such subsection separately with respect to individuals who are eligible for medical assistance without regard to such addition and with respect to the individuals so added.

"(3) ADJUSTMENT FOR CERTAIN DELETIONS.—If a State makes a change described in paragraph (1) that the Secretary believes will result in denial of medical assistance for individuals (within a category described in subsection (b)) with respect to whom the Secretary estimates the per capita average medical assistance expenditures is greater than the applicable per capita limit established under subsection (c)(1) for such catetory, the Secretary shall adjust the payment limits under subsection (a) to reflect any decrease in average per beneficiary expenditures that would result from such change.

"(h) TREATMENT OF STATES OPERATING UNDER WAIVERS.—The Secretary shall provide for such adjustments to the per capita limits under subsection (c) for a fiscal year as may be appropriate to take into account the case of States which either—

"(1) during any of the 3 previous fiscal years was providing medical assistance to its residents under a waiver granted under section 1115, section 1915, or other provision of law, and, in the fiscal year involved is no longer providing such medical assistance under such waiver; or

"(2) during any of the 3 previous fiscal years was not providing medical assistance to its residents under a waiver granted under section 1115, section 1915, or other provision of law, and, in the fiscal year involved is providing such medical assistance under such a waiver.

(b) ENFORCEMENT-RELATED PROVISIONS.—

(1) ASSURING ACTUAL PAYMENTS TO STATES CONSISTENT WITH LIMITATION.—Section 1903(d) of such Act (42 U.S.C. 1396b(d)) is amended—

(A) in paragraph (2)(A), by striking "The Secretary" and inserting "Subject to paragraph (7), the Secretary"; and

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

"(7)(A) The Secretary shall take such steps as are necessary to assure that payments under this subsection for quarters in a fiscal year are consistent with the payment limits established under section 1931 for the fiscal year. Such steps may include limiting such payments for one or more quarters in a fiscal year based on—

"(i) an appropriate proportion of the payment limits for the fiscal year involved, and

"(ii) numbers of individuals within each category, as reported under subparagraph (B) for a recent previous quarter.

"(B) Each State shall include, in its report filed under paragraph (1)(A) for a calendar quarter—

"(i) the actual number of individuals within each category described in section 1931(b) for the second previous calendar quarter and (based on the data available) for the previous calendar quarter, and

"(ii) an estimate of such numbers for the calendar quarter involved."

(2) RESTRICTION ON AUTHORITY OF STATES TO APPLY LESS RESTRICTIVE INCOME AND RESOURCE METHODOLOGIES.—Section 1902(r)(2) of such Act (42 U.S.C. 1396a(r)(2)) is amended by adding at the end the following new subparagraph:

"(C) Subparagraph (A) shall not apply to plan amendments made on or after October 15, 1995."

(c) CONFORMING AMENDMENT.—Section 1903(i) of such Act (42 U.S.C. 1396b(i)) is amended—

(1) by striking "or" at the end of paragraph (14),

(2) by striking the period at the end of paragraph (15) and inserting "; or", and

(3) by inserting after paragraph (15) the following:

"(16) in accordance with section 1931, with respect to amounts expended to the extent they exceed applicable limits established under section 1931(a)."

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to payments for calendar quarters beginning on or after October 1, 1996.

Subtitle B—Medicaid Managed Care

SEC. 7101. PERMITTING GREATER FLEXIBILITY FOR STATES TO ENROLL BENEFICIARIES IN MANAGED CARE ARRANGEMENTS.

(a) IN GENERAL.—Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), as amended by section 7001(a), is amended—

(1) by redesignating section 1932 as section 1933; and

(2) by inserting after section 1931 the following new section:

"STATE OPTIONS FOR ENROLLMENT OF BENEFICIARIES IN MANAGED CARE ARRANGEMENTS

"SEC. 1932. (a) MANDATORY ENROLLMENT.—

"(1) IN GENERAL.—Subject to the succeeding provisions of this section and notwithstanding paragraphs (1), (10)(B), and (23) of section 1902(a), a State may require an individual eligible for medical assistance under the State plan under this title to enroll with an eligible managed care provider as a condition of receiving such assistance and, with respect to assistance furnished by or under arrangements with such provider, to receive such assistance through the provider, if the following provisions are met:

"(A) The provider meets the requirements of section 1933.

"(B) The provider enters into a contract with the State to provide services for the benefit of individuals eligible for benefits under this title under which prepaid payments to such provider are made on an actuarially sound basis.

"(C) There is sufficient capacity among all providers meeting such requirements to enroll and serve the individuals required to enroll with such providers.

"(D) The individual is not a special needs individual (as defined in subsection (c)).

"(E) The State—

"(i) permits an individual to choose an eligible managed care provider—

"(I) from among not less than 2 medicaid managed care plans; or

"(II) between a medicaid managed care plan and a primary care case management provider;

"(ii) provides the individual with the opportunity to change enrollment among eligible managed care providers, not less than once annually and notifies the individual of such opportunity not later than 90 days prior to the first date on which the individual may change enrollment;

"(iii) establishes a method for establishing enrollment priorities in the case of an eligible managed care provider that does not have sufficient capacity to enroll all such individuals seeking enrollment under which individuals already enrolled with the provider are given priority in continuing enrollment with the provider;

"(iv) establishes a default enrollment process which meets the requirements described in paragraph (2) and under which any such individual who does not enroll with an eligible managed care provider during the enrollment period specified by the State shall be enrolled by the State with such a provider in accordance with such process; and

"(v) establishes the sanctions provided for in section 1934.

"(2) DEFAULT ENROLLMENT PROCESS REQUIREMENTS.—The default enrollment process established by a State under paragraph (1)(E)(iv) shall—

"(A) provide that the State may not enroll individuals with an eligible managed care provider which is not in compliance with the requirements of section 1933; and

"(B) provide for an equitable distribution of individuals among all eligible managed care providers available to enroll individuals

through such default enrollment process, consistent with the enrollment capacities of such providers.

"(b) REENROLLMENT OF INDIVIDUALS WHO REGAIN ELIGIBILITY.—

"(1) IN GENERAL.—If an individual eligible for medical assistance under a State plan under this title and enrolled with an eligible managed care provider with a contract under subsection (a)(1)(B), ceases to be eligible for such assistance for a period of not greater than 2 months, the State may provide for the automatic reenrollment of the individual with the provider as of the first day of the month in which the individual is again eligible for such assistance.

"(2) CONDITIONS.—Paragraph (1) shall only apply if—

"(A) the month for which the individual is to be reenrolled occurs during the enrollment period covered by the individual's original enrollment with the eligible managed care provider,

"(B) the eligible managed care provider continues to have a contract with the State agency under subsection (a)(1)(B) as of the first day of such month; and

"(C) the eligible managed care provider complies with the requirements of section 1933.

"(3) NOTICE OF REENROLLMENT.—The State shall provide timely notice to an eligible managed care provider of any reenrollment of an individual under this subsection.

"(c) SPECIAL NEEDS INDIVIDUALS DESCRIBED.—In this section, a special needs individual means any of the following:

"(1) SPECIAL NEEDS CHILD.—An individual who is under 19 years of age who—

"(A) is eligible for supplemental security income under title XVI;

"(B) is described under section 501(a)(1)(D);

"(C) is a child described in section 1902(e)(3); or

"(D) is in foster care or is otherwise in an out-of-home placement.

"(2) HOMELESS INDIVIDUALS.—An individual who is homeless (without regard to whether the individual is a member of a family), including—

"(A) an individual whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations; or

"(B) an individual who is a resident in transitional housing.

"(3) MIGRANT AGRICULTURAL WORKERS.—A migratory agricultural worker or a seasonal agricultural worker (as such terms are defined in section 329 of the Public Health Service Act), or the spouse or dependent of such a worker.

"(4) INDIANS.—An Indian (as defined in section 4(c) of the Indian Health Care Improvement Act (25 U.S.C. 1603(c))).

"(b) CONFORMING AMENDMENT.—Section 1902(a)(23) of such Act (42 U.S.C. 1396a(a)(23)) is amended—

(1) in the matter preceding subparagraph (A), by striking "subsection (g) and in section 1915" and inserting "subsection (g), section 1915, and section 1931"; and

(2) in subparagraph (B)—

(A) by striking "a health maintenance organization, or a" and inserting "or with an eligible managed care provider as defined in section 1933(g)(1), or"

SEC. 7102. REMOVAL OF BARRIERS TO PROVISION OF MEDICAID SERVICES THROUGH MANAGED CARE.

(a) REPEAL OF CURRENT BARRIERS.—Except as provided in subsection (b), section 1903(m) of the Social Security Act (42 U.S.C. 1396b(m)) is repealed on the date of the enactment of this Act.

(b) EXISTING CONTRACTS.—In the case of any contract under section 1903(m) of such Act which is in effect on the day before the date of the enactment of this Act, the provisions of such section shall apply to such contract until the earlier of—

(1) the day after the date of the expiration of the contract; or

(2) the date which is 1 year after the date of the enactment of this Act.

(c) ELIGIBLE MANAGED CARE PROVIDERS DESCRIBED.—Title XIX of such Act (42 U.S.C. 1396 et seq.), as amended by sections 7001(a) and 7101(a), is amended—

(1) by redesignating section 1933 as section 1934; and

(2) by inserting after section 1932 the following new section:

"ELIGIBLE MANAGED CARE PROVIDERS

"SEC. 1933. (a) DEFINITIONS.—In this section, the following definitions shall apply:

"(1) ELIGIBLE MANAGED CARE PROVIDER.—The term 'eligible managed care provider' means—

"(A) a medicaid managed care plan; or

"(B) a primary care case management provider.

"(2) MEDICAID MANAGED CARE PLAN.—The term 'medicaid managed care plan' means a health maintenance organization, an eligible organization with a contract under Section 1876, a provider sponsored network or any other plan which provides or arranges for the provision of one or more items and services to individuals eligible for medical assistance under the State plan under this title in accordance with a contract with the State under section 1932(a)(1)(B).

"(3) PRIMARY CARE CASE MANAGEMENT PROVIDER.—

"(A) IN GENERAL.—The term primary care case management provider means a health care provider that—

"(i) is a physician, group of physicians, a Federally qualified health center, a rural health clinic, or an entity employing or having other arrangements with physicians that provides or arranges for the provision of one or more items and services to individuals eligible for medical assistance under the State plan under this title in accordance with a contract with the State under section 1932(a)(1)(B);

"(ii) receives payment on a fee-for-service basis (or, in the case of a Federally qualified health center or a rural health clinic, on a reasonable cost per encounter basis) for the provision of health care items and services specified in such contract to enrolled individuals;

"(iii) receives an additional fixed fee per enrollee for a period specified in such contract for providing case management services (including approving and arranging for the provision of health care items and services specified in such contract on a referral basis) to enrolled individuals; and

"(iv) is not an entity that is at risk.

"(B) AT RISK.—In subparagraph (A)(iv), the term 'at risk' means an entity that—

"(i) has a contract with the State under which such entity is paid a fixed amount for providing or arranging for the provision of health care items or services specified in such contract to an individual eligible for medical assistance under the State plan and enrolled with such entity, regardless of whether such items or services are furnished to such individual; and

"(ii) is liable for all or part of the cost of furnishing such items or services, regardless of whether such cost exceeds such fixed payment.

"(b) ENROLLMENT.—

"(1) NONDISCRIMINATION.—An eligible managed care provider may not discriminate on the basis of health status or anticipated need for services in the enrollment, reenrollment, or disenrollment of individuals eligible to receive medical assistance under a State plan under this title or by discouraging enrollment (except as permitted by this section) by eligible individuals.

"(2) TERMINATION OF ENROLLMENT.—

"(A) IN GENERAL.—An eligible managed care provider shall permit an individual eligible for medical assistance under the State plan under this title who is enrolled with the provider to terminate such enrollment for cause at any time, and without cause during the 60-day period beginning on the date the individual receives notice of enrollment, and shall notify each such individual of the opportunity to terminate enrollment under these conditions.

"(B) FRAUDULENT INDUCEMENT OR COERCION AS GROUNDS FOR CAUSE.—For purposes of subparagraph (A), an individual terminating enrollment with an eligible managed care provider on the grounds that the enrollment was based on fraudulent inducement or was obtained through coercion shall be considered to terminate such enrollment for cause.

"(C) NOTICE OF TERMINATION.—

"(i) NOTICE TO STATE.—

"(I) BY INDIVIDUALS.—Each individual terminating enrollment with an eligible managed care provider under subparagraph (A) shall do so by providing notice of the termination to an office of the State agency administering the State plan under this title, the State or local welfare agency, or an office of an eligible managed care provider.

"(II) BY PLANS.—Any eligible managed care provider which receives notice of an individual's termination of enrollment with such provider through receipt of such notice at an office of an eligible managed care provider shall provide timely notice of the termination to the State agency administering the State plan under this title.

"(ii) NOTICE TO PLAN.—The State agency administering the State plan under this title or the State or local welfare agency which receives notice of an individual's termination of enrollment with an eligible managed care provider under clause (i) shall provide timely notice of the termination to such provider.

"(D) REENROLLMENT.—Each State shall establish a process under which an individual terminating enrollment under this paragraph shall be promptly enrolled with another eligible managed care provider and notified of such enrollment.

"(3) PROVISION OF ENROLLMENT MATERIALS IN UNDERSTANDABLE FORM.—Each eligible managed care provider shall provide all enrollment materials in a manner and form which may be easily understood by a typical adult enrollee of the provider who is eligible for medical assistance under the State plan under this title.

"(c) QUALITY ASSURANCE.—

"(1) ACCESS TO SERVICES.—Each eligible managed care provider shall provide or arrange for the provision of all medically necessary medical assistance under this title which is specified in the contract entered into between such provider and the State under section 1932(a)(1)(B) for enrollees who are eligible for medical assistance under the State plan under this title.

"(2) TIMELY DELIVERY OF SERVICES.—Each eligible managed care provider shall respond to requests from enrollees for the delivery of medical assistance in a manner which—

"(A) makes such assistance—

"(i) available and accessible to each such individual, within the area served by the provider, with reasonable promptness and in a manner which assures continuity; and

"(ii) when medically necessary, available and accessible 24 hours a day and 7 days a week; and

"(B) with respect to assistance provided to such an individual other than through the provider or without prior authorization, in

the case of a primary care case management provider, provides for reimbursement to the individual (if applicable under the contract between the State and the provider) if—

"(i) the services were medically necessary and immediately required because of an unforeseen illness, injury, or condition; and

"(ii) it was not reasonable given the circumstances to obtain the services through the provider, or, in the case of a primary care case management provider, with prior authorization.

"(3) EXTERNAL INDEPENDENT REVIEW OF ELIGIBLE MANAGED CARE PROVIDER ACTIVITIES.—

"(A) REVIEW OF MEDICAID MANAGED CARE PLAN CONTRACT.—

"(i) IN GENERAL.—Except as provided in subparagraph (B), each medicaid managed care plan shall be subject to an annual external independent review of the quality and timeliness of, and access to, the items and services specified in such plan's contract with the State under section 1932(a)(1)(B). Such review shall specifically evaluate the extent to which the medicaid managed care plan provides such services in a timely manner.

"(ii) CONTENTS OF REVIEW.—An external independent review conducted under this paragraph shall include the following:

"(I) a review of the entity's medical care through sampling of medical records or other appropriate methods, for indications of quality of care and inappropriate utilization (including overutilization) and treatment.

"(II) a review of enrollee inpatient and ambulatory data, through sampling of medical records or other appropriate methods, to determine trends in quality and appropriateness of care.

"(III) notification of the entity and the State when the review under this paragraph indicates inappropriate care, treatment, or utilization of services (including overutilization), and

"(IV) other activities as prescribed by the Secretary or the State.

"(iii) AVAILABILITY OF RESULTS.—The results of each external independent review conducted under this subparagraph shall be available to participating health care providers, enrollees, and potential enrollees of the medicaid managed care plan, except that the results may not be made available in a manner that discloses the identity of any individual patient.

"(B) DEEMED COMPLIANCE.—

"(i) MEDICARE PLANS.—The requirements of subparagraph (A) shall not apply with respect to a medicaid managed care plan if the plan is an eligible organization with a contract in effect under section 1876.

"(ii) PRIVATE ACCREDITATION.—

"(I) IN GENERAL.—The requirements of subparagraph (A) shall not apply with respect to a medicaid managed care plan if—

"(aa) the plan is accredited by an organization meeting the requirements described in clause (iii); and

"(bb) the standards and process under which the plan is accredited meet such requirements as are established under subclause (II), without regard to whether or not the time requirement of such subclause is satisfied.

"(II) STANDARDS AND PROCESS.—Not later than 180 days after the date of the enactment of this Act, the Secretary shall specify requirements for the standards and process under which a medicaid managed care plan is accredited by an organization meeting the requirements of clause (iii).

"(iii) ACCREDITING ORGANIZATION.—An accrediting organization meets the requirements of this clause if the organization—

"(I) is a private, nonprofit organization—

"(II) exists for the primary purpose of accrediting managed care plans or health care providers; and

"(III) is independent of health care providers or associations of health care providers.

"(C) REVIEW OF PRIMARY CARE CASE MANAGEMENT PROVIDER CONTRACT.—Each primary care case management provider shall be subject to an annual external independent review of the quality and timeliness of, and access to, the items and services specified in the contract entered into between the State and the primary care case management provider under section 1932(a)(1)(B).

"(4) FEDERAL MONITORING RESPONSIBILITIES.—The Secretary shall review the external independent reviews conducted pursuant to paragraph (3) and shall monitor the effectiveness of the State's monitoring and followup activities required under subparagraph (A) of paragraph (2). If the Secretary determines that a State's monitoring and followup activities are not adequate to ensure that the requirements of paragraph (2) are met, the Secretary shall undertake appropriate followup activities to ensure that the State improves its monitoring and followup activities.

"(5) PROVIDING INFORMATION ON SERVICES.—

"(A) REQUIREMENTS FOR MEDICAID MANAGED CARE PLANS.—

"(i) INFORMATION TO THE STATE.—Each medicaid managed care plan shall provide to the State (at such frequency as the Secretary may require), complete and timely information concerning the following:

"(I) The services that the plan provides to (or arranges to be provided to) individuals eligible for medical assistance under the State plan under this title.

"(II) The identity, locations, qualifications, and availability of participating health care providers.

"(III) The rights and responsibilities of enrollees.

"(IV) The services provided by the plan which are subject to prior authorization by the plan as a condition of coverage (in accordance with paragraph (6)(A)).

"(V) The procedures available to an enrollee and a health care provider to appeal the failure of the plan to cover a service.

"(VI) The performance of the plan in serving individuals eligible for medical assistance under the State plan under this title.

"(ii) INFORMATION TO HEALTH CARE PROVIDERS, ENROLLEES, AND POTENTIAL ENROLLEES.—Each medicaid managed care plan shall—

"(I) upon request, make the information described in clause (i) available to participating health care providers, enrollees, and potential enrollees in the plan's service area; and

"(II) provide to enrollees and potential enrollees information regarding all items and services that are available to enrollees under the contract between the State and the plan that are covered either directly or through a method of referral and prior authorization.

"(B) REQUIREMENTS FOR PRIMARY CARE CASE MANAGEMENT PROVIDERS.—Each primary care case management provider shall—

"(i) provide to the State (at such frequency as the Secretary may require), complete and timely information concerning the services that the primary care case management provider provides to (or arranges to be provided to) individuals eligible for medical assistance under the State plan under this title.

"(ii) make available to enrollees and potential enrollees information concerning services available to the enrollee for which prior authorization by the primary care case management provider is required; and

"(iii) provide enrollees and potential enrollees information regarding all items and services that are available to enrollees under the contract between the State and the primary care case management provider that are covered either directly or through a method of referral and prior authorization.

"(iv) provide assurances that such entities and their professional personnel are licensed as required by State law and qualified to provide case management services, through methods such as ongoing monitoring of compliance with applicable requirements and providing information and technical assistance.

"(C) REQUIREMENTS FOR BOTH MEDICAID MANAGED CARE PLANS AND PRIMARY CARE CASE MANAGEMENT PROVIDERS.—Each eligible managed care provider shall provide the State with aggregate encounter data for early and periodic screening, diagnostic, and treatment services under section 1905(r) furnished to individuals under 21 years of age. Any such data provided may be audited by the State and the Secretary.

"(6) TIMELINESS OF PAYMENT.—An eligible managed care provider shall make payment to health care providers for items and services which are subject to the contract under section 1931(a)(1)(B) and which are furnished to individuals eligible for medical assistance under the State plan under this title who are enrolled with the provider on a timely basis and under the claims payment procedures described in section 1902(a)(37)(A), unless the health care provider and the eligible managed care provider agree to an alternate payment schedule.

"(7) ADDITIONAL QUALITY ASSURANCE REQUIREMENTS FOR MEDICAID MANAGED CARE PLANS.—

"(A) CONDITIONS FOR PRIOR AUTHORIZATION.—A medicaid managed care plan may require the approval of medical assistance for nonemergency services before the assistance is furnished to an enrollee only if the system providing for such approval—

"(i) provides that such decisions are made in a timely manner, depending upon the urgency of the situation; and

"(ii) permits coverage of medically necessary medical assistance provided to an enrollee without prior authorization in the event of an emergency.

"(B) INTERNAL GRIEVANCE PROCEDURE.—Each medicaid managed care plan shall establish an internal grievance procedure under which a plan enrollee or a provider on behalf of such an enrollee who is eligible for medical assistance under the State plan under this title may challenge the denial of coverage of or payment for such assistance.

"(C) USE OF UNIQUE PHYSICIAN IDENTIFIER FOR PARTICIPATING PHYSICIANS.—Each medicaid managed care plan shall require each physician providing services to enrollees eligible for medical assistance under the State plan under this title to have a unique identifier in accordance with the system established under section 1902(x).

"(D) PATIENT ENCOUNTER DATA.—

"(i) IN GENERAL.—Each medicaid managed care plan shall maintain sufficient patient encounter data to identify the health care provider who delivers services to patients and to otherwise enable the State plan to meet the requirements of section 1902(a)(37). The plan shall incorporate such information in the maintenance of patient encounter data with respect to such health care provider.

"(ii) COMPLIANCE.—A medicaid managed care plan shall—

"(I) submit the data maintained under clause (i) to the State; or

"(II) demonstrate to the State that the data complies with managed care quality assurance guidelines established by the Secretary in accordance with clause (iii).

"(iii) STANDARDS.—In establishing managed care quality assurance guidelines under clause (ii)(II), the Secretary shall consider—

"(I) managed care industry standards for—

"(aa) internal quality assurance; and

"(bb) performance measures; and

"(II) any managed care quality standards established by the National Association of Insurance Commissioners.

(E) PAYMENTS TO HOSPITALS.—A medicaid managed care plan shall—

"(i) provide the State with assurances that payments for hospital services are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide such services to individuals enrolled with the plan under this title in conformity with applicable State and Federal laws, regulations, and quality and safety standards;

"(ii) report to the State at least annually—

"(I) the rates paid to hospitals by the plan for items and services furnished to such individuals,

"(II) an explanation of the methodology used to compute such rates, and

"(III) a comparison of such rates with the rates used by the State to pay for hospital services furnished to individuals who are eligible for benefits under the program established by the State under this title but are not enrolled in a medicaid managed care plan; and

"(iii) if the rates paid by the plan are lower than the rates paid by the State (as described in clause (ii)(III)), an explanation of why the rates paid by the plan nonetheless meet the standard described in clause (i).

(d) DUE PROCESS REQUIREMENTS FOR ELIGIBLE MANAGED CARE PROVIDERS.—

"(1) DENIAL OR UNREASONABLE DELAY IN DETERMINING COVERAGE AS GROUNDS FOR HEARING.—If an eligible managed care provider—

"(A) denies coverage of or payment for medical assistance with respect to an enrollee who is eligible for such assistance under the State plan under this title, or

"(B) fails to make any eligibility or coverage determination sought by an enrollee or, in the case of a medicaid managed care plan, by a participating health care provider or enrollee, in a timely manner, depending upon the urgency of the situation the enrollee or the health care provider furnishing such assistance to the enrollee (as applicable) may obtain a hearing before the State agency administering the State plan under this title in accordance with section 1902(a)(3), but only with respect to a medicaid managed care plan, after completion of the internal grievance procedure established by the plan under subsection (c)(6)(B).

"(2) COMPLETION OF INTERNAL GRIEVANCE PROCEDURE.—Nothing in this subsection shall require completion of an internal grievance procedure if such procedure does not exist or if the procedure does not provide for timely review of health needs considered by the enrollee's health care provider to be of an urgent nature.

"(e) MISCELLANEOUS.—

"(1) PROTECTING ENROLLEES AGAINST THE INSOLVENCY OF ELIGIBLE MANAGED CARE PROVIDERS AND AGAINST THE FAILURE OF THE STATE TO PAY SUCH PROVIDERS.—Each eligible managed care provider shall provide that an individual eligible for medical assistance under the State plan under this title who is enrolled with the provider may not be held liable—

"(A) for the debts of the eligible managed care provider, in the event of the provider's insolvency;

"(B) for services provided to the individual—

"(i) in the event of the provider failing to receive payment from the State for such services; or

"(ii) in the event of a health care provider with a contractual or other arrangement with the eligible managed care provider failing to receive payment from the State or the eligible managed care provider for such services; or

"(C) for the debts of any health care provider with a contractual or other arrangement with the provider to provide services to the individual, in the event of the insolvency of the health care provider.

"(2) TREATMENT OF CHILDREN WITH SPECIAL HEALTH CARE NEEDS.—

"(A) IN GENERAL.—In the case of an enrollee of an eligible managed care provider who is a child with special health care needs—

"(i) if any medical assistance specified in the contract with the State is identified in a treatment plan prepared for the enrollee by a program described in subparagraph (C), the eligible managed care provider shall provide (or arrange to be provided) such assistance in accordance with the treatment plan either—

"(I) by referring the enrollee to a pediatric health care provider who is trained and experienced in the provision of such assistance and who has a contract with the eligible managed care provider to provide such assistance; or

"(II) if appropriate services are not available through the eligible managed care provider, permitting such enrollee to seek appropriate specialty services from pediatric health care providers outside of or apart from the eligible managed care provider and

"(ii) the eligible managed care provider shall require each health care provider with whom the eligible managed care provider has entered into an agreement to provide medical assistance to enrollees (pursuant to the medical assistance specified in such enrollee's treatment plan to the extent the health care provider is able to carry out such treatment plan.

"(B) PRIOR AUTHORIZATION.—An enrollee referred for treatment under subparagraph (A)(i)(I), or permitted to seek treatment outside of or apart from the eligible managed care provider under subparagraph (A)(i)(II) shall be deemed to have obtained any prior authorization required by the provider.

"(C) CHILD WITH SPECIAL HEALTH CARE NEEDS.—For purposes of subparagraph (A), a child with special health care needs is a child who is receiving services under—

"(i) a program administered under part B or part H of the Individuals with Disabilities Education Act;

"(ii) a program for children with special health care needs under title V;

"(iii) a program under part B or part D of title IV; or

"(iv) any other program for children with special health care needs identified by the Secretary.

"(3) PHYSICIAN INCENTIVE PLANS.—Each medicaid managed care plan shall require that any physician incentive plan covering physicians who are participating in the medicaid managed care plan shall meet the requirements of section 1876(i)(8).

"(4) INCENTIVES FOR HIGH QUALITY ELIGIBLE MANAGED CARE PROVIDERS.—The Secretary and the State may establish a program to reward, through public recognition, incentive payments, or enrollment of additional individuals (or combinations of such rewards), eligible managed care providers that provide the highest quality care to individuals eligible for medical assistance under the State plan under this title who are enrolled with such providers. For purposes of section 1903(a)(7), proper expenses incurred by a State in carrying out such a program shall be considered to be expenses necessary for the proper and efficient administration of the State plan under this title.

"(d) CLARIFICATION OF APPLICATION OF FFP DENIAL RULES TO PAYMENTS MADE PURSUANT TO MEDICAID MANAGED CARE PLANS.—Section 1903(i) of such Act (42 U.S.C. 1396b(i)) is amended by adding at the end the following sentence: "Paragraphs (1)(A), (1)(B), (2), (5), and (12) shall apply with respect to items or services furnished and amounts expended by or through an eligible managed care provider (as defined in section 1933(a)(1)) in the same manner as such paragraphs apply to items or services furnished and amounts expended directly by the State."

(e) CLARIFICATION OF CERTIFICATION REQUIREMENTS FOR PHYSICIANS PROVIDING SERVICES TO CHILDREN AND PREGNANT WOMEN.—Section 1903(i)(12) of such Act (42 U.S.C. 1396b(i)(12)) is amended—

(1) in subparagraph (A)(i), to read as follows:

"(i) is certified in family practice or pediatrics by the medical specialty board recognized by the American Board of Medical Specialties for family practice or pediatrics or is certified in general practice or pediatrics by the medical specialty board recognized by the American Osteopathic Association,";

(2) in subparagraph (B)(i), to read as follows:

"(i) is certified in family practice or obstetrics by the medical specialty board recognized by the American Board of Medical Specialties for family practice or obstetrics or is certified in family practice or obstetrics by the medical specialty board recognized by the American Osteopathic Association,"; and

(3) in both subparagraphs (A) and (B)—

(A) by striking "or" at the end of clause (v),

(B) by redesignating clause (vi) as clause (vii), and

(C) by inserting after clause (v) the following new clause:

"(vi) delivers such services in the emergency department of a hospital participating in the State plan approved under this title, or".

SEC. 7202. ADDITIONAL REQUIREMENTS FOR MEDICAID MANAGED CARE PLANS.

Section 1933 of the Social Security Act, as added by section 7102(e)(2), is amended—

(1) by redesignating subsections (d) and (e) as subsections (e) and (f), respectively, and

(2) by inserting after subsection (c) the following new subsection:

"(d) ADDITIONAL REQUIREMENTS FOR MEDICAID MANAGED CARE PLANS.—

"(1) DEMONSTRATION OF ADEQUATE CAPACITY AND SERVICES.—

"(A) IN GENERAL.—Subject to subparagraph (C), each medicaid managed care plan shall provide the State and the Secretary with adequate assurances (as determined by the Secretary) that the plan, with respect to a service area—

"(i) has the capacity to serve the expected enrollment in such service area;

"(ii) offers an appropriate range of services for the population expected to be enrolled in such service area, including transportation services and translation services (consisting of the principal languages spoken in the service area);

"(iii) maintains sufficient numbers of providers of services included in the contract with the State to ensure that services are available to individuals receiving medical assistance and enrolled in the plan to the same extent that such services are available to individuals enrolled in the plan who are not recipients of medical assistance under the State plan under this title;

"(iv) maintains extended hours of operation with respect to primary care services that are beyond those maintained during a normal business day;

"(v) provides preventive and primary care services in locations that are readily accessible to members of the community; and

"(vi) provides information concerning educational, social, health, and nutritional services offered by other programs for which enrollees may be eligible.

"(vii) complies with such other requirements relating to access to care as the Secretary or the State may impose.

"(B) PROOF OF ADEQUATE PRIMARY CARE CAPACITY AND SERVICES.—Subject to subparagraph (C), a medicaid managed care plan that contracts with a reasonable number of primary care providers (as determined by the Secretary) and whose primary care membership includes a reasonable number (as so determined) of the following providers will be deemed to have satisfied the requirements of subparagraph (A):

"(i) Rural health clinics, as defined in section 1905(l)(1).

"(ii) Federally-qualified health centers, as defined in section 1905(l)(2)(B).

"(iii) Clinics which are eligible to receive payment for services provided under title X of the Public Health Service Act.

"(C) SUFFICIENT PROVIDERS OF SPECIALIZED SERVICES.—Notwithstanding subparagraphs (A) and (B), a medicaid managed care plan may not be considered to have satisfied the requirements of subparagraph (A) if the plan does not have a sufficient number (as determined by the Secretary) of providers of specialized services, including perinatal and pediatric specialty care, to ensure that such services are available and accessible.

"(2) WRITTEN PROVIDER PARTICIPATION AGREEMENTS FOR CERTAIN PROVIDERS.—Each medicaid managed care plan that enters into a written provider participation agreement with a provider described in paragraph (1)(B) shall—

"(A) include terms and conditions that are no more restrictive than the terms and conditions that the medicaid managed care plan includes in its agreements with other participating providers with respect to—

"(i) the scope of covered services for which payment is made to the provider;

"(ii) the assignment of enrollees by the plan to the provider;

"(iii) the limitation on financial risk or availability of financial incentives to the provider;

"(iv) accessibility of care;

"(v) professional credentialing and recredentialing;

"(vi) licensure;

"(vii) quality and utilization management;

"(viii) confidentiality of patient records;

"(ix) grievance procedures; and

"(x) indemnification arrangements between the plans and providers; and

"(B) provide for payment to the provider on a basis that is comparable to the basis on which other providers are paid."

SEC. 7104. PREVENTING FRAUD IN MEDICAID MANAGED CARE.

(a) IN GENERAL.—Section 1933 of the Social Security Act, as added by section 7102(c)(2) and amended by section 7103, is amended—

(1) by redesignating subsection (f) as subsection (g); and

(2) by inserting after subsection (e) the following new subsection:

"(f) ANTI-FRAUD PROVISIONS.—

"(1) PROVISIONS APPLICABLE TO ELIGIBLE MANAGED CARE PROVIDERS.—

"(A) PROHIBITING AFFILIATIONS WITH INDIVIDUALS DEBARRED BY FEDERAL AGENCIES.—

"(i) IN GENERAL.—An eligible managed care provider may not knowingly—

"(I) have a person described in clause (ii) as a director, officer, partner, or person with beneficial ownership of more than 5 percent of the plan's equity, or

"(II) have an employment, consulting, or other agreement with a person described in clause (ii) for the provision of items and services that are significant and material to the organization's obligations under its contract with the State.

"(ii) EFFECT OF NONCOMPLIANCE.—If a State finds that an eligible managed care provider is not in compliance with subclause (I) or (II) of clause (i), the State—

"(I) shall notify the Secretary of such noncompliance;

"(II) may continue an existing agreement with the provider unless the Secretary (in consultation with the Inspector General of the Department of Health and Human Services) directs otherwise; and

"(III) may not renew or otherwise extend the duration of an existing agreement with the provider unless the Secretary (in consultation with the Inspector General of the Department of Health and Human Services) provides to the State and to the Congress a written statement describing compelling reasons that exist for renewing or extending the agreement.

"(iii) PERSONS DESCRIBED.—A person is described in this clause if such person—

"(I) is debarred or suspended by the Federal Government, pursuant to the Federal acquisition regulation, from Government contracting and subcontracting;

"(II) is an affiliate (within the meaning of the Federal acquisition regulation) of a person described in clause (i); or

"(III) is excluded from participation in any program under title XVIII or any State health care program, as defined in section 1128(h).

"(B) RESTRICTIONS ON MARKETING.—

"(i) DISTRIBUTION OF MATERIALS.—

"(I) IN GENERAL.—An eligible managed care provider may not distribute marketing materials within any State—

"(aa) without the prior approval of the State; and

"(bb) that contain false or materially misleading information.

"(II) PROHIBITION.—The State may not enter into or renew a contract with an eligible managed care provider for the provision of services to individuals enrolled under the State plan under this title if the State determines that the provider intentionally distributed false or materially misleading information in violation of subclause (I)(bb).

"(ii) SERVICE MARKET.—An eligible managed care provider shall distribute marketing materials to the entire service area of such provider.

"(iii) PROHIBITION OF TIE-INS.—An eligible managed care provider, or any agency of such provider, may not seek to influence an individual's enrollment with the provider in conjunction with the sale of any other insurance.

"(iv) PROHIBITING MARKETING FRAUD.—Each eligible managed care provider shall comply with such procedures and conditions as the Secretary prescribes in order to ensure that, before an individual is enrolled with the provider, the individual is provided accurate and sufficient information to make an informed decision whether or not to enroll.

"(2) PROVISIONS APPLICABLE ONLY TO MEDICAID MANAGED CARE PLANS.—

"(A) STATE CONFLICT-OF-INTEREST SAFEGUARDS IN MEDICAID RISK CONTRACTING.—A medicaid managed care plan may not enter into a contract with any State under section 1932(a)(1)(B) unless the State has in effect conflict-of-interest safeguards with respect to officers and employees of the State with responsibilities relating to contracts with such plans or to the default enrollment process described in section 1932(a)(1)(D)(iv) that are at least as effective as the Federal safeguards provided under section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423), against conflicts of interest that apply with respect to Federal procurement officials with comparable responsibilities with respect to such contracts.

"(B) REQUIRING DISCLOSURE OF FINANCIAL INFORMATION.—In addition to any requirements applicable under section 1902(a)(27) or 1902(a)(35), a medicaid managed care plan shall—

"(i) report to the State (and to the Secretary upon the Secretary's request) such financial information as the State or the Secretary may require to demonstrate that—

"(I) the plan has the ability to bear the risk of potential financial losses and otherwise has a fiscally sound operation;

"(II) the plan uses the funds paid to it by the State and the Secretary for activities consistent with the requirements of this title and the contract between the State and plan; and

"(III) the plan does not place an individual physician, physician group, or other health care provider at substantial risk (as determined by the Secretary) for services not provided by such physician, group, or health care provider by providing adequate protection (as determined by the Secretary) to limit the liability of such physician, group, or health care provider through measures such as stop loss insurance or appropriate risk corridors;

"(ii) agree that the Secretary and the State (or any person or organization designated by either) shall have the right to audit and inspect any books and records of the plan (and of any subcontractor) relating to the information reported pursuant to clause (i) and any information required to be furnished under section, paragraphs (27) or (35) of section 1902(a);

"(iii) make available to the Secretary and the State a description of each transaction described in subparagraphs (A) through (C) of section 1318(a)(3) of the Public Health Service Act between the plan and a party in interest (as defined in section 1318(b) of such Act); and

"(iv) agree to make available to its enrollees upon reasonable request—

"(I) the information reported pursuant to clause (i); and

"(II) the information required to be disclosed under sections 1124 and 1126.

"(C) ADEQUATE PROVISION AGAINST RISK OF INSOLVENCY.—

"(i) ESTABLISHMENT OF STANDARDS.—The Secretary shall establish standards, including appropriate equity standards, under which each medicaid managed care plan shall make adequate provision against the risk of insolvency.

"(ii) CONSIDERATION OF OTHER STANDARDS.—In establishing the standards described in clause (i), the Secretary shall consider solvency standards applicable to eligible organizations with a risk-sharing contract under section 1876.

"(iii) MODEL CONTRACT ON SOLVENCY.—At the earliest practicable time after the date of enactment of this section, the Secretary shall issue guidelines and regulations concerning solvency standards for risk contracting entities and subcontractors of such risk contracting entities. Such guidelines and regulations shall take into account characteristics that may differ among risk contracting entities including whether such an entity is at risk for inpatient hospital services.

"(D) REQUIRING REPORT ON NET EARNINGS AND ADDITIONAL BENEFITS.—Each medicaid managed care plan shall submit a report to the State and the Secretary not later than 12 months after the close of a contract year containing—

"(i) the most recent audited financial statement of the plan's net earnings, in accordance with guidelines established by the Secretary in consultation with the States,

and consistent with generally accepted accounting principles; and

"(ii) a description of any benefits that are in addition to the benefits required to be provided under the contract that were provided during the contract year to members enrolled with the plan and entitled to medical assistance under the State plan under this title."

SEC. 7105. ASSURING ADEQUACY OF PAYMENTS TO MEDICAID MANAGED CARE PLANS AND PROVIDERS.

Title XIX of the Social Security Act, as amended by sections 7001, 7101(a), and 7102(c), is further amended—

(1) by redesignating section 1934 as section 1935; and

(2) by inserting after section 1933 the following new section:

"ASSURING ADEQUACY OF PAYMENTS TO MEDICAID MANAGED CARE PLANS AND PROVIDERS

"SEC. 1934. As a condition of approval of a State plan under this title, a State shall—

"(1) find, determine, and make assurances satisfactory to the Secretary that—

"(A) the rates it pays medicaid managed care plans for individuals eligible under the State plan are reasonable and adequate to assure access to services meeting professionally recognized quality standards, taking into account—

"(i) the items and services to which the rate applies,

"(ii) the eligible population, and

"(iii) the rate the State pays providers for such items and services; and

"(B) the methodology used to adjust the rate adequately reflects the varying risks associated with individuals actually enrolling in each medicaid managed care plan; and

"(2) report to the Secretary, at least annually, on—

"(A) the rates the States pays to medicaid managed care plans, and

"(B) the rates medicaid managed care plans pay for hospital services (and such other information as medicaid managed care plans are required to submit to the State pursuant to section 1933(c)(5)(E)).

SEC. 7106. SANCTIONS FOR NONCOMPLIANCE BY ELIGIBLE MANAGED CARE PROVIDERS.

(a) SANCTIONS DESCRIBED.—Title XIX of such Act (42 U.S.C. 1396 et seq.), as previously amended, is further amended—

(1) by redesignating section 1934 as section 1935, and

(2) by inserting after section 1934 the following new section:

"SANCTIONS FOR NONCOMPLIANCE BY ELIGIBLE MANAGED CARE PROVIDERS

"SEC. 1935. (a) USE OF INTERMEDIATE SANCTIONS BY THE STATE TO ENFORCE REQUIREMENTS.—Each State shall establish intermediate sanctions, which may include any of the types described in subsection (b) other than the termination of a contract with an eligible managed care provider, which the State may impose against an eligible managed care provider with a contract under section 1932(a)(1)(B) if the provider—

"(1) fails substantially to provide medically necessary items and services that are required (under law or under such provider's contract with the State) to be provided to an enrollee covered under the contract, if the failure has adversely affected (or has a substantial likelihood of adversely affecting) the enrollee;

"(2) imposes premiums on enrollees in excess of the premiums permitted under this title;

"(3) acts to discriminate among enrollees on the basis of their health status or requirements for health care services, including expulsion or refusal to reenroll an individual, except as permitted by sections 1932 and 1933, or engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment with the provider by eligible individuals whose medical condition or history indicates a need for substantial future medical services;

"(4) misrepresents or falsifies information that is furnished

"(A) to the Secretary or the State under section 1932 or 1933; or

"(B) to an enrollee, potential enrollee, or a health care provider under such sections; or

"(5) fails to comply with the requirements of section 1876(i)(8).

"(b) INTERMEDIATE SANCTIONS.—The sanctions described in this subsection are as follows:

"(1) Civil money penalties as follows:

"(A) Except as provided in subparagraph (B), (C), or (D), not more than $25,000 for each determination under subsection (a).

"(B) With respect to a determination under paragraph (3) or (4)(A) of subsection (a), not more than $100,000 for each such determination.

"(C) With respect to a determination under subsection (a)(2), double the excess amount charged in violation of such subsection (and the excess amount charged shall be deducted from the penalty and returned to the individual concerned).

"(D) Subject to subparagraph (B), with respect to a determination under subsection (a)(3), $15,000 for each individual not enrolled as a result of a practice described in such subsection.

"(2) The appointment of temporary management to oversee the operation of the eligible managed care provider and to assure the health of the provider's enrollees, if there is a need for temporary management while—

"(A) there is an orderly termination or reorganization of the eligible managed care provider, or

"(B) improvements are made to remedy the violations found under subsection (a), except that temporary management under this paragraph may not be terminated until the State has determined that the eligible managed care provider has the capability to ensure that the violations shall not recur.

"(3) Permitting individuals enrolled with the eligible managed care provider to terminate enrollment without cause, and notifying such individuals of such right to terminate enrollment.

"(c) TREATMENT OF CHRONIC SUBSTANDARD PROVIDERS.—In the case of an eligible managed care provider which has repeatedly failed to meet the requirements of section 1932 or 1933, the State shall (regardless of what other sanctions are provided) impose the sanctions described in paragraphs (2) and (3) of subsection (b).

"(d) AUTHORITY TO TERMINATE CONTRACT.—In the case of an eligible managed care provider which has failed to meet the requirements of section 1932 or 1933, the State shall have the authority to terminate its contract with such provider under section 1932(a)(1)(B) and to enroll such provider's enrollees with other eligible managed care providers (or to permit such enrollees to receive medical assistance under the State plan under this title other than through an eligible managed care provider).

"(e) AVAILABILITY OF SANCTIONS TO THE SECRETARY.—

"(1) INTERMEDIATE SANCTIONS.—In addition to the sanctions described in paragraph (2) and any other sanctions available under law, the Secretary may provide for any of the sanctions described in subsection (b) if the Secretary determines that—

"(A) an eligible managed care provider with a contract under section 1932(a)(1)(B) fails to meet any of the requirements of section 1932 or 1933; and

"(B) the State has failed to act appropriately to address such failure.

"(2) DENIAL OF PAYMENTS TO THE STATE.—The Secretary may deny payments to the State for medical assistance furnished under the contract under section 1932(a)(1)(B) for individuals enrolled after the date the Secretary notifies an eligible managed care provider of a determination under subsection (a) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur.

"(f) DUE PROCESS FOR ELIGIBLE MANAGED CARE PROVIDERS.—

"(1) AVAILABILITY OF HEARING PRIOR TO TERMINATION OF CONTRACT.—A State may not terminate a contract with an eligible managed care provider under section 1932(a)(1)(B) unless the provider is provided with a hearing prior to the termination.

"(2) NOTICE TO ENROLLEES OF TERMINATION HEARING.—A State shall notify all individuals enrolled with an eligible managed care provider which is the subject of a hearing to terminate the provider's contract with the State of the hearing and that the enrollees may immediately disenroll with the provider for cause.

"(3) OTHER PROTECTIONS FOR ELIGIBLE MANAGED CARE PROVIDERS AGAINST SANCTIONS IMPOSED BY STATE.—Before imposing any sanction against an eligible managed care provider other than termination of the provider's contract, the State shall provide the provider with notice and such other due process protections as the State may provide, except that a State may not provide an eligible managed care provider with a pretermination hearing before imposing the sanction described in subsection (b)(2).

"(4) IMPOSITION OF CIVIL MONETARY PENALTIES BY SECRETARY.—The provisions of section 1128A (other than subsections (a) and (b)) shall apply with respect to a civil money penalty imposed by the Secretary under subsection (b)(1) in the same manner as such provisions apply to a penalty or proceeding under section 1128A.

(b) CONFORMING AMENDMENT RELATING TO TERMINATION OF ENROLLMENT FOR CAUSE.—Section 1933(b)(2)(B) of the Social Security Act, as added by this part, is amended by inserting after "coercion" the following: "or pursuant to the imposition against the eligible managed care provider of the sanction described in section 1935(b)(3)".

SEC. 7107. REPORT ON PUBLIC HEALTH SERVICES.

(a) IN GENERAL.—Not later than January 1, 1997, the Secretary of Health and Human Services (in this subtitle referred to as the "Secretary") shall report to the Committee on Finance of the Senate and the Committee on Commerce of the House of Representatives on the effect of risk contracting entities (as defined in section 1932(a)(3) of the Social Security Act) and primary care case management entities (as defined in section 1932(a)(1) of such Act) on the delivery of and payment for the services listed in subsection (f)(2)(C)(ii) of section 1932 of such Act.

(b) CONTENTS OF REPORT.—The report referred to in subsection (a) shall include—

(1) information on the extent to which enrollees with risk contracting entities and primary care case management programs seek services at local health departments, public hospitals, and other facilities that provide care without regard to a patient's ability to pay,

(2) information on the extent to which the facilities described in paragraph (1) provide services to enrollees with risk contracting entities and primary care case management programs without receiving payment,

(3) information on the effectiveness of systems implemented by facilities described in paragraph (1) for educating such enrollees on services that are available through the risk contracting entities or primary care case management programs with which such enrollees are enrolled;

(4) to the extent possible, identification of the types of services most frequently sought by such enrollees at such facilities; and

(5) recommendations about how to ensure the timely delivery of the services listed in subsection (f)(2)(C)(ii) of section 1931 of the Social Security Act to enrollees of risk contracting entities and primary care case management entities and how to ensure that local health departments, public hospitals, and other facilities are adequately compensated for the provision of such services to such enrollees.

SEC. 7108. REPORT ON PAYMENTS TO HOSPITALS.

(a) IN GENERAL.—Not later than October 1 of each year, beginning with October 1, 1996, the Secretary and the Comptroller General shall analyze and submit a report to the Committee on Finance of the Senate and the Committee on Commerce of the House of Representatives on rates paid for hospital services under coordinated care programs described in section 1932 of the Social Security Act.

(b) CONTENTS OF REPORT.—The information in the report described in subsection (a) shall—

(1) be organized by State, type of hospital, type of service, and

(2) include a comparison of rates paid for hospital services under coordinated care programs with rates paid for hospital services furnished to individuals who are entitled to benefits under a State plan under title XIX of the Social Security Act and are not enrolled in such coordinated care programs.

(c) REPORTS BY STATES.—Each State shall transmit to the Secretary, at such time and in such manner as the Secretary determines appropriate, the information on hospital rates submitted to such State under section 1932(b)(3)(F) of such Act.

SEC. 7109. CONFORMING AMENDMENTS.

(a) EXCLUSION OF CERTAIN INDIVIDUALS AND ENTITIES FROM PARTICIPATION IN PROGRAM.—Section 1128(b)(6)(C) of the Social Security Act (42 U.S.C. 1320a-7(b)(6)(C)) is amended—

(1) in clause (i), by striking "a health maintenance organization (as defined in section 1903(m))" and inserting "an eligible managed care provider, as defined in section 1933(a)(1),"; and

(2) in clause (ii), by inserting "section 1115 or" after "approved under".

(b) STATE PLAN REQUIREMENTS.—Section 1902 of such Act (42 U.S.C. 1396a) is amended—

(1) in subsection (a)(30)(C), by striking "section 1903(m)" and inserting "section 1932(a)(1)(B)"; and

(2) in subsection (a)(57), by striking "hospice program, or health maintenance organization (as defined in section 1903(m)(1)(A))" and inserting "or hospice program";

(3) in subsection (e)(2)(A), by striking "or with an entity described in paragraph (2)(B)(iii), (2)(E), (2)(G), or";

(6) of section 1903(m) under a contract described in section 1903(m)(2)(A);

(4) in subsection (p)(2)—

(A) by striking "a health maintenance organization (as defined in section 1903(m))" and inserting "an eligible managed care provider, as defined in section 1933(a)(1),";

(B) by striking "an organization" and inserting "a provider"; and

(C) by striking "any organization" and inserting "any provider"; and

(5) in subsection (w)(1), by striking "sections 1903(m)(1)(A) and", and inserting "section".

(c) PAYMENT TO STATES.—Section 1903(w)(7)(A)(viii) of such Act (42 U.S.C. 1396b(w)(7)(A)(viii)) is amended to read as follows:

"(viii) Services of an eligible managed care provider with a contract under section 1932(a)(1)(B).".

(d) USE OF ENROLLMENT FEES AND OTHER CHARGES.—Section 1916 of such Act (42 U.S.C. 1396o) is amended in subsections (a)(2)(D) and (b)(2)(D) by striking "a health maintenance organization (as defined in section 1903(m))" and inserting "an eligible managed care provider, as defined in section 1933(a)(1)," each place it appears.

(e) EXTENSION OF ELIGIBILITY FOR MEDICAL ASSISTANCE.—Section 1925(b)(4)(D)(iv) of such Act (42 U.S.C. 1396r-6(b)(4)(D)(iv)) is amended to read as follows:

"(iv) ENROLLMENT WITH ELIGIBLE MANAGED CARE PROVIDER.—Enrollment of the caretaker relative and dependent children with an eligible managed care provider, as defined in section 1933(a)(1), less than 50 percent of the membership (enrolled on a prepaid basis) of which consists of individuals who are (eligible to receive benefits under this title (other than because of the option offered under this clause). The option of enrollment under this clause is in addition to, and not in lieu of, any enrollment option that the State might offer under subparagraph (A)(i) with respect to receiving services through an eligible managed care provider in accordance with sections 1932, 1933, and 1934.".

(f) ASSURING ADEQUATE PAYMENT LEVELS FOR OBSTETRICAL AND PEDIATRIC SERVICES.—Section 1926(a) of such Act (42 U.S.C. 1396r-7(a)) is amended in paragraphs (1) and (2) by striking "health maintenance organizations" under section 1903(m)" and inserting "eligible managed care providers under contracts entered into under section 1932(a)(1)(B)" each place it appears.

(g) PAYMENT FOR COVERED OUTPATIENT DRUGS.—Section 1927(j)(1) of such Act (42 U.S.C. 1396r-8(j)(1)) is amended by striking "Health Maintenance Organizations, including those organizations that contract under section 1903(m)," and inserting "health maintenance organizations and medicaid managed care plans, as defined in section 1933(a)(2),".

(h) DEMONSTRATION PROJECTS TO STUDY EFFECT OF ALLOWING STATES TO EXTEND MEDICAID COVERAGE FOR CERTAIN FAMILIES.—Section 4745(a)(5)(A) of the Omnibus Budget Reconciliation Act of 1990 (42 U.S.C. 1396a note), is amended by striking "(except section 1903(m)" and inserting "(except sections 1932, 1933, and 1934)".

SEC. 7110. EFFECTIVE DATE; STATUS OF WAIVERS.

(a) EFFECTIVE DATE.—Except as provided in subsection (b), the amendments made by this subtitle shall apply to medical assistance furnished—

(1) during quarters beginning on or after October 1, 1996; or

(2) in the case of assistance furnished under a contract described in section 7102(b), during quarters beginning after the earlier of—

(A) the date of the expiration of the contract; or

(B) the expiration of the 1-year period which begins on the date of the enactment of this Act.

(b) APPLICATION TO WAIVERS.—

(1) EXISTING WAIVERS.—If any waiver granted to a State under section 1115 or 1915 of the Social Security Act (42 U.S.C. 1315, 1396n) or otherwise which relates to the provision of medical assistance under a State plan under title XIX of such Act (42 U.S.C. 1396 et seq.) is in effect or approved by the Secretary of Health and Human Services as of the applicable effective date described in subsection (a), the amendments made by this subtitle shall not apply with respect to the State before the expiration (determined without regard to any extensions) of the waiver to the extent such amendments are inconsistent with the terms of the waiver.

(2) SECRETARIAL EVALUATION AND REPORT FOR EXISTING WAIVERS AND EXTENSIONS.—

(A) PRIOR TO APPROVAL.—On and after the applicable effective date described in subsection (a), the Secretary, prior to extending any waiver granted under section 1115 or 1915 of the Social Security Act (42 U.S.C. 1315, 1396n) or otherwise which relates to the provision of medical assistance under a State plan under title XIX of the such Act (42 U.S.C. 1396 et seq.), shall—

(i) conduct an evaluation of—

(I) the waivers existing under such sections or other provision of law as of the date of the enactment of this Act, and

(II) any applications pending, as of the date of the enactment of this Act, for extensions of waivers under such sections or other provision of law, and

(ii) submit a report to the Congress recommending whether the extension of a waiver under such sections or provision of law should be conditioned on the State submitting the request for an extension complying with the provisions of sections 1932, 1933, and 1934 of the Social Security Act (as added by this subtitle).

(B) DEEMED APPROVAL.—If the Congress has not enacted legislation based on a report submitted under subparagraph (A)(ii) within 120 days after the date such report is submitted to the Congress, the recommendations contained in such report shall be deemed to be approved by the Congress.

Subtitle C—Additional Reforms of Medicaid Acute Care Program

SEC. 7201. PERMITTING INCREASED FLEXIBILITY IN MEDICAID COST-SHARING.

(a) IN GENERAL.—Subsections (a)(3) and (b)(3) of section 1916 of the Social Security Act (42 U.S.C. 1396o) are amended by striking everything that follows "other care and services" and inserting the following: "will be established pursuant to a public schedule of charges and will be adjusted to reflect the income, resources, and family size of the individual provided the item or service.".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to items and services furnished on or after the first day of the first calendar quarter beginning after the date of the enactment of this Act.

SEC. 7202. LIMITS ON REQUIRED COVERAGE OF ADDITIONAL TREATMENT SERVICES UNDER EPSDT.

(a) REGULATIONS.—The Secretary of Health and Human Services shall define, by regulation promulgated after consultation with States and organizations representing health care providers, those treatment services (in addition to those otherwise covered under a State plan under title XIX of the Social Security Act) that must be covered under section 1905(r)(5) of such Act.

(b) CONSTRUCTION.—Nothing in subsection (a) shall be construed as limiting the scope of such treatment services a State may cover under such section.

SEC. 7203. DELAY IN APPLICATION OF NEW REQUIREMENTS.

(a) DELAY IN IMPLEMENTATION.—

(1) IN GENERAL.—Notwithstanding any other provision of law, no change in law—

(A) which has the effect of imposing a requirement on a State under a State plan under title XIX of the Social Security Act, and

(B) with respect to the Secretary of Health and Human Services is required to issue regulations to carry out such requirement,

shall take effect until the date the Secretary promulgates such regulation as a final regulation.

(2) STATE OPTION.—Except as otherwise provided by the Secretary, a State may elect to have a change in a law described in paragraph (1) apply with respect to the State during the period (or portion thereof) in which the change would have taken effect but for paragraph (1).

(b) PROHIBITION OF CHANGES IN FINAL REGULATIONS DURING A FISCAL YEAR.—

(1) IN GENERAL.—Except as provided in paragraph (2), any change in a regulation of the Secretary of Health and Human Services relating to the medicaid program under title XIX of the Social Security Act shall not become effective until the beginning of the fiscal year following the fiscal year in which the change was promulgated.

(2) STATE OPTION.—Except as otherwise provided by the Secretary, a State may elect to have a change in a regulation described in paragraph (1) apply with respect to the State during the period (or portion thereof) in which the change would have taken effect but for paragraph (1).

(c) SENSE OF CONGRESS REGARDING FEDERAL PAYMENT FOR NEW MEDICAID MANDATES.—It is the sense of Congress that if a State is required by future legislation to provide for additional services, eligible individuals, or otherwise incur additional costs under its medicaid program under title XIX of the Social Security Act, the Federal Government shall provide for full payment of any such additional costs for at least the first two years in which such requirement applies.

SEC. 7304. DEADLINE ON ACTION ON WAIVERS.

(a) IN GENERAL.—In considering applications for medicaid waivers—

(1) the application shall be deemed granted unless the Secretary of Health and Human Services, within ninety days after the date of the submission of the application of the Secretary, either denies the application in writing or informs the applicant in writing with respect to any additional information which is needed in order to make a final determination with respect to the application, and

(2) after the date the Secretary receives such additional information, the application shall be deemed granted unless the Secretary within ninety days of such date, denies such application.

(b) MEDICAID WAIVERS.—In this section, the term "medicaid waiver" means the request of a State for a waiver of a provision of title XIX of the Social Security Act (or of another provision of law that applies to State plans under such title), and includes such a waiver under the authority of section 1115 or section 1915 of the Social Security Act or under section 222 of the Social Security Amendments of 1972 and section 402(a) of the Social Security Amendments of 1967.

Subtitle D—National Commission on Medicaid Restructuring

SEC. 7301. ESTABLISHMENT OF COMMISSION.

(a) IN GENERAL.—There is hereby established the National Commission on Medicaid Restructuring (in this subtitle referred to as the "Commission").

(b) COMPOSITION.—The Commission shall be composed as follows:

(1) 2 FEDERAL OFFICIALS.—The President shall appoint 2 Federal officials, one of whom the President shall designate as chairperson of the Commission.

(2) 4 MEMBERS OF CONGRESS.—(A) The Speaker of the House of Representatives shall appoint one Member of the House as a member.

(B) The minority leader of the House of Representatives shall appoint one Member of the House as a member.

(C) The majority leader of the Senate shall appoint one Member of the Senate as a member.

(D) The minority leader of the Senate shall appoint one Member of the Senate as a member.

(3) 6 STATE GOVERNMENT REPRESENTATIVES.—(A) The majority leaders of the House of Representatives and the Senate shall jointly appoint 3 individuals who are governors, State legislators, or State medicaid officials.

(B) The minority leaders of the House of Representatives and the Senate shall jointly appoint 3 individuals who are governors, State legislators, or State medicaid officials.

(4) 6 EXPERTS.—(A) The majority leaders of the House of Representatives and the Senate shall jointly appoint 4 individuals who are not officials of the Federal or State governments and who have expertise in a health-related field, such as medicine, public health, or delivery and financing of health care services.

(B) The President shall appoint 2 individuals who are not officials of the Federal or State governments and who have expertise in a health-related field, such as medicine, public health, or delivery and financing of health care services.

(c) INITIAL APPOINTMENT.—Members of the Commission shall first be appointed by not later than February 1, 1996.

(d) COMPENSATION AND EXPENSES.—

(1) COMPENSATION.—Each member of the Commission shall serve without compensation.

(2) TRAVEL EXPENSES.—Members of the Commission shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Commission.

SEC. 7302. DUTIES OF COMMISSION.

(a) STUDY OF MEDICAID PROGRAM.—

(1) IN GENERAL.—The Commission shall study and make recommendations to the Congress, the President, and the Secretary regarding the need for changes (in addition to the changes effected under this title) in the laws and regulations regarding the medicaid program under title XIX of the Social Security Act.

(2) SPECIFIC CONCERNS.—The Commission shall specifically address each of the following:

(A) Changes needed to ensure adequate access to health care for low-income individuals.

(B) Promotion of quality care.

(C) Deterrence of fraud and abuse.

(D) Providing States with additional flexibility in implementing their medicaid plans.

(E) Methods of containing Federal and State costs.

(b) REPORTS.—

(1) FIRST REPORT.—The Commission shall issue a first report to Congress by not later than December 31, 1996.

(2) SUBSEQUENT REPORTS.—The Commission shall issue subsequent reports to Congress by not later than December 31, 1997, and December 31, 1998.

SEC. 7303. ADMINISTRATION.

(a) APPOINTMENT OF STAFF.—

(1) EXECUTIVE DIRECTOR.—The Commission shall have an Executive Director who shall be appointed by the Chairperson with the approval of the Commission. The Executive Director shall be paid at a rate not to exceed the rate of basic pay payable for level III of the Executive Schedule.

(2) STAFF.—With the approval of the Commission, the Executive Director may appoint and determine the compensation of such staff as may be necessary to carry out the duties of the Commission. Such appointments and compensation may be made without regard to the provisions of title 5, United States Code, that govern appointments in the competitive services, and the provisions of chapter 51 and subchapter III of chapter 53 of such title that relate to classifications and the General Schedule pay rates.

(3) CONSULTANTS.—The Commission may procure such temporary and intermittent services of consultants under section 3109(b) of title 5, United States Code, as the Commission determines to be necessary to carry out the duties of the Commission.

(b) PROVISION OF ADMINISTRATIVE SUPPORT SERVICES BY HHS.—Upon the request of the Commission, the Secretary of Health and Human Services shall provide to the Commission on a reimbursable basis such administrative support services as the Commission may request.

SEC. 7304. AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated to carry out this subtitle $3,000,000 for fiscal year 1996, $4,000,000 for each of fiscal years 1997 and 1998, and $2,000,000 for fiscal year 1999.

SEC. 7305. TERMINATION.

The Commission shall terminate on December 31, 1999.

Subtitle E—Restrictions on Disproportionate Share Payments

SEC. 7401. REFORMING DISPROPORTIONATE SHARE PAYMENTS UNDER STATE MEDICAID PROGRAMS.

(a) TARGETING PAYMENTS.—Section 1923 of the Social Security Act (42 U.S.C. 1396r-3) is amended—

(1) in subsection (a)(1)—

(A) by redesignating subparagraphs (A) and (B) as clauses (i) and (ii),

(B) by striking "(1)" and inserting "(1)(A)",

(C) in clause (i) (as so redesignated) by striking "(b)(1)" and inserting "(b)(1)(A)", and

(D) by adding at the end the following:

"(B) A State plan under this title shall not be considered to meet the requirement of section 1902(a)(13)(A) (insofar as it requires payments to hospitals to take into account the situation of hospitals that serve a disproportionate number of low-income patients with special needs), as of July 1, 1996, unless the State has submitted to the Secretary, by not later than such date, an amendment to such plan that utilizes the definition of such hospitals specified in subsection (b)(1)(B) in lieu of the definition established by the State under subparagraph (a)(1).";

(2) in subsection (a)(2)(A)—

(A) by inserting "(i)" after "(2)(A)",

(B) by striking "paragraph (1)" and inserting "paragraph (1)(A)(i)", and

(C) by adding at the end the following:

"(ii) In order to be considered to have met such requirement of section 1902(a)(13)(A) as of July 1, 1996, the State must submit to the Secretary by not later than April 1, 1996, the State plan amendment described in paragraph (1)(B), consistent with subsection (c), effective for inpatient hospital services furnished on or after July 1, 1996.";

(3) in subsection (b)—

(A) in the heading, by striking "HOSPITALS DEEMED DISPROPORTIONATE SHARE" and inserting "DISPROPORTIONATE SHARE HOSPITALS",

(B) in paragraph (1)—

(i) by redesignating subparagraphs (A) and (B) as clauses (i) and (ii),

(ii) by striking "(1) For purposes of subsection (a)(1)" and inserting "(1)(A) For purposes of subsection (a)(1)(A)", and

(iii) by adding at the end the following:

"(B) For purposes of subsection (a)(1)(B), a hospital that meets the requirements of subsection (d) is a disproportionate share hospital only if—

"(i) in the case of a hospital that is not described in subsection (d)(2)(A)(1), the hospital's low-income utilization rate (as defined in paragraph (3)) exceeds 25 percent; or

"(ii) in the case of a hospital that is described in subsection (d)(2)(A)(1)—

"(I) the hospital meets the requirement of clause (i), or

"(II) the hospital's medicaid inpatient utilization rate (as defined in paragraph (2)) exceeds 20 percent.";

(C) in paragraph (2) by striking "(1)(A)" and inserting "(1)";

(D) in paragraph (3) by striking "(1)(B)" and inserting "(1)"; and

(E) by striking paragraph (4);

(4) in subsection (c)—

(A) in paragraph (3), by striking "subparagraph (A) or (B) of subsection (b)(1)" and inserting "clause (i) or (ii) of subsection (b)(1)(A)";

(B) by striking paragraph (3); and

(C) in the matter following paragraph (3)—

(i) by striking "(1)(B)" each place it appears and inserting "(1)(A)(ii)"; and

(ii) by striking "(2)(A)" each place it appears and inserting "(2)(A)(i)"; and

(5) in subsection (f)—

(A) in paragraph (1)(C), by striking "meets the requirement of subsection (d)(3)" and inserting "makes payments under this section only to hospitals described in subsection (b)(1)(B)"; and

(B) in paragraph (2)—

(i) by inserting "and" at the end of subparagraph (B); and

(ii) by striking subparagraph (C).

(b) DIRECT PAYMENT BY STATE.—Section 1923(a) of such Act (42 U.S.C. 1396r-4(a)), as amended by subsection (a), is further amended—

(1) in paragraph (1), by adding at the end the following:

"(C) A State plan under this title shall not be considered to meet the requirement of section 1902(a)(13)(A) (insofar as it requires payments to hospitals to take into account the situation of hospitals that serve a disproportionate number of low-income patients with special needs) as of July 1, 1996, unless the State provides that any payments made under this section with respect to individuals who are—

"(i) entitled to benefits under the State plan; and

"(ii) enrolled with a health maintenance organization or other managed care plan,

are, at the option of the hospital, made directly to such hospital by the State."; and

(2) in paragraph (2)(A)(ii), by striking "amendment described in paragraph (1)(B)" and inserting "amendments described in subparagraphs (B) and (C) of paragraph (1)".

(c) ADJUSTMENT TO NATIONAL DSH LIMIT; STATE ALLOCATIONS.—The Secretary of Health and Human Services shall make appropriate adjustments in—

(1) the national DSH payment limit established under section 1923(f)(1)(B) of the Social Security Act, and

(2) the State DSH allotments established under section 1923(f)(2) of such Act,

to reflect the amendments made by subsection (a).

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to payments to States under section 1903(a) of the Social Security Act for payments to hospitals made under State plans after—

(1) July 1, 1996, or

(2) in the case of a State with a State legislature that is not scheduled to have a regular legislative session in 1996, July 1, 1997.

Subtitle F—Fraud Reduction

SEC. 7501. MONITORING PAYMENTS FOR DUAL ELIGIBLES.

The Administrator of the Health Care Financing Administration shall develop mechanisms to better monitor and prevent inappropriate payments under the medicaid program in the case of individuals who are dually eligible for benefits under such program and under the medicare program.

SEC. 7502. IMPROVED IDENTIFICATION SYSTEMS.

The Administrator of the Health Care Financing Administration shall develop improved mechanisms, such as picture identification documents and smart documents, to provide methods of improved identification and tracking of beneficiaries and providers that perpetrate fraud against the medicaid program.

TITLE VIII—MEDICARE

SEC. 8000. SHORT TITLE; REFERENCES IN TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE OF TITLE.—This title may be cited as the "Medicare Preservation Act of 1995".

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

(c) REFERENCES TO OBRA.—In this title, the terms "OBRA 1986", "OBRA 1987", "OBRA 1989", "OBRA 1990", and "OBRA 1993" refer to the Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509), the Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203), the Omnibus Budget Reconciliation Act of 1989 (Public Law 101-239), the Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508), and the Omnibus Budget Reconciliation Act of 1993 (Public Law 103-66), respectively.

(d) TABLE OF CONTENTS.—The table of contents of this title is as follows:

The VA Health Care System: An Unrecognized National Safety Net

Veterans who use the VA health care system have a higher level of illness than the general population, and 60 percent have no private or Medigap insurance.

by Nancy J. Wilson and Kenneth W. Kizer

ABSTRACT: The dominance of local health care markets in conjunction with variable public funding results in a national patchwork of "safety nets" and beneficiaries in the United States rather than a uniform system. This DataWatch describes how the recently reorganized Department of Veterans Affairs serves as a coordinated, national safety-net provider and characterizes the veterans who are not supported by the market-based system.

THE ROLE OF THE DEPARTMENT of Veterans Affairs (VA) as a health care safety net is largely unrecognized. Many think of VA medical care as a benefit awarded only to veterans who are "service-connected"—that is, veterans who are disabled by illness or injury in the line of duty during military service. However, 60 percent of veterans who received VA medical care in 1992 had no private or Medigap insurance and would likely be considered the responsibility of the health care safety net.[1]

Unfortunately, the availability of federal, state, and local government funds to subsidize the care of persons left without services varies by state and community and may not match community need. The result is a national patchwork of safety nets and beneficiaries that strains existing alternatives. Within this collage, the VA health care system stands out as a significant, coordinated, nationwide safety net for veterans.

VA Service Networks

Organization. The VA health care system recently reorganized into twenty-two Veterans Integrated Service Networks (VISNs) on the basis of geographic referral patterns to maximize patients' access to care while improving efficiencies in service delivery.[2] Appro-

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priated funds are distributed according to the VA's new Veterans Equitable Resource Allocation capitation model that bases network funding on the volume of service-connected and low-income veterans served.[3] *Low income* is defined as less than $21,610 a year for a single veteran.[4] VISNs offer a full continuum of care to patients within their boundaries through direct delivery or contractual agreements with other networks or providers. A typical network consists of six to ten hospitals that provide acute inpatient medical and surgical, psychiatric, and substance abuse services, along with subacute and rehabilitation services. Each network also manages twenty to thirty freestanding outpatient clinics, nine to ten readjustment counseling centers, six to eight home-based primary care programs, five to seven VA nursing homes, one or more residential housing facilities (domiciliaries), and contracts with 140–150 community nursing homes and several state veterans' homes.[5]

Performance measurement. VA headquarters manages the twenty-two networks by setting goals and designing strategies to maximize health care value throughout the nation. *Value* is defined as balanced performance of five factors: cost, access, technical quality, patient functional ability, and patient satisfaction.[6] Headquarters focuses on developing a standardized measurement and monitoring system that supports risk-adjusted comparative analyses among networks.[7] Networks are held accountable for results through a newly implemented performance contract system that rewards excellent performance on clinical as well as cost outcomes.[8] These efforts are designed to assure that high-quality care is consistently delivered by VA providers nationwide.

Veterans' Health Status And Special Care Needs

The core mission of the VA is to provide primary care, specialized care, and related medical and social support services to veterans. The VA health care system is a safety net because many of the veterans served are psychologically and economically disadvantaged and have a high disease burden (Exhibits 1 and 2).[9] Veterans' average scores on the Short Form 36-Item Health Survey for Veterans (SF-36V) are significantly worse (lower) than those for either the general population or the Medical Outcomes Study population (Exhibit 3). Having scores at least ten points lower on either the physical or mental component scales has been shown to be equivalent to having approximately two additional chronic conditions, 30 percent more hospitalizations, and 20 percent more outpatient visits.[10] Comorbidity from psychiatric illness is common among VA health care users (Exhibit 4) and requires 14 percent of the VA's total $17 billion medical care budget.[11] In addition, on a given day in 1996, homeless

EXHIBIT 1
Characteristics Of Veteran VA Health Care Users And Nonusers Compared With The General Population

Characteristic	Veteran VA user	Veteran non-VA user	General population
Age 65 and older	35.6%	31.3%	17.0%
Non-Caucasian	25.4	12.5	22.8
Not married	35.7	19.4	39.0
Education less than high school	26.0	15.0	24.8
Income less than $20,000	70.5	25.7	32.9
Income less than $10,000	38.5	8.7	14.6
No private or Medigap insurance	59.3	14.9	32.0
No health care coverage	21.0	5.2	17.0
Poor or fair perceived health status	60.5	25.4	11.3
Unable to work for pay/limited ADLs	79.4	40.1	7.0

SOURCE: *1992 National Survey of Veterans* (Washington: Department of Veterans Affairs, 1994); and 1996 Medical Expenditure Panel Survey (Rockville, Md.: Agency for Health Care Policy and Research, 1996).
NOTES: VA is Veterans Affairs. ADLs are activities of daily living.

patients accounted for 13.5 percent of all admissions, 24 percent of general psychiatry admissions, and 47 percent of substance abuse admissions.[12]

The VA also cares for small vulnerable populations for whom care is expensive but generally unprofitable in the private sector, in part because of the absence of economies of scale (Exhibit 5). The VA's capacity to provide this care is based on the occurrence of many of these conditions during, or as a consequence of, military service. Recently enacted veterans' health care eligibility reform legislation has reinforced the VA's continued role as a safety-net provider for these populations. In addition to veterans with service-connected illnesses, injuries, and exposures and former prisoners of war, the VA is legislated to treat veterans with special disabilities of spinal cord dysfunction, blindness, amputation, traumatic brain injury,

EXHIBIT 2
Disease Prevalence Among VA Health Care Users, 1996

Disease	Prevalence
Ischemic heart disease	50%
Obesity	50
Hypertension	45
Smoking	34
Psychiatric illness	23
Diabetes mellitus	19
COPD	15
Substance abuse	9

SOURCE: VA National Patient Care Database.
NOTES: VA is Veterans Affairs. COPD is chronic obstructive pulmonary disease.

EXHIBIT 3
Health Status Of Veteran VA Health Care Users Compared With Medical Outcomes Study (MOS) Population And General U.S. Population, As Measured By SF-36V

	VA (n = 32,960)	MOS (n = 22,462)	General U.S. (n = 2,474)
Physical component summary score	31	44	50
Mental component summary score	41	52	50

SOURCE: N.J. Wilson and L. Kazis, "Health Status of Veterans: Physical and Mental Component Summary Scores (SF-36V)," *1996 National Survey of Ambulatory Care Patients Executive Report* (Washington: Department of Veterans Affairs, February 1997).
NOTES: VA is Veterans Affairs. SF-36V is Short Form 36-Item Health Survey for Veterans.

catastrophic disability, post-traumatic stress disorder, and serious mental illness, including substance abuse and homelessness resulting from mental illness. Low-income veterans without any of the above disabilities will be cared for to the extent that funding allows.[13]

Conclusion

As long as local market forces dominate the health care industry and state and local funding vary, the stabilizing influence of a national safety net like the VA health care system becomes ever more important. The VA, in the midst of its own transformation, serves part of that role by providing comprehensive services to approximately 1.7 million veterans who are not well supported by a market-based system. Also, as long as the patchwork of safety nets remains, fluctuations in the availability of one system will cause repercussions for others. Significant changes in the VA's safety-net function would be felt in every corner of the nation, in that any decrease in the VA's ability to care for veterans would most likely fall to Medicare, Medicaid, or other publicly funded programs. The converse is also

EXHIBIT 4
VA Psychiatric And Substance Abuse Inpatient And Outpatient Workload, 1996

Service	Inpatient acute care hospital		Inpatient long-term care		Outpatient visits
	Episodes	Bed days	Episodes	Bed days	
Psychiatry	149,550 (13.2%)	8,308,876 (39.1%)	722 (1.2%)	62,836 (0.3%)	6,445,707 (21.4%)
Substance abuse	61,099 (5.4%)	1,039,069 (4.9%)	5,073 (8.7%)	488,720 (2.0%)	1,709,626 (5.7%)
All other	925,537 (81.5%)	11,887,892 (56.0%)	52,836 (90.0%)	23,433,316 (97.7%)	21,899,379 (72.9%)
Total	1,136,186	21,235,837	58,631	23,984,872	30,054,712

SOURCE: VA National Patient Care Database.
NOTE: VA is Veterans Affairs.

EXHIBIT 5
VA Care For Small Vulnerable Populations, 1996

Disability	Persons	Bed days	Clinic visits	Dollars
Spinal cord dysfunction	21,145	671,391	644,419	$556,515,255
Blindness	22,392	209,228	739,185	326,564,928
Traumatic brain injury	1,925	83,240	81,516	47,686,100
Amputation	7,573	313,432	301,183	286,350,276

SOURCE: VA National Patient Care Database.
NOTE: VA is Veterans Affairs.

true. Society has made an investment in a medical care system for veterans in recognition of the continuing cost of war and national security and the special contributions that veterans have made to the nation. The VA's role as a national health care safety net provides an additional social benefit that is often overlooked. This role should be more widely recognized.

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Projections for reachin

by Donald L. Libby, Zi

ABSTRACT: We project th physician workforce unde reaching racial and ethni quirement of 218 physicia of first-year residents to r for Native American phys physicians and two-thirds

PHYSICIAN WOR lic attention as predictions of subspecialists.[1] A 199 Education (COGME was that "the racial/e should reflect the ov lease a new report in

The rationale for it is based primarily likely to locate thei tions, are more like better able to provi ing importance as v tion strategies.[3] Ex physicians reveals cians' race and eth

A number of pri of racial/ethnic ec including the Ass the Bureau of He and Services Adm (IOM).[5] Howeve

Donald Libby is an a search, University of an associate professo Beijing Medical Univ cine at the Universit

The Safety-Net Role Of International Medical Graduates

Efforts to restrain physician supply could undo the migration of IMGs to locales that U.S.-trained physicians often ignore.

BY STEPHEN S. MICK AND SHOOU-YIH DANIEL LEE

FOR NEARLY FIFTY YEARS, the United States has had a relatively liberal policy of welcoming foreign-trained physicians (international medical graduates, or IMGs) as hospital residents and then often as permanent additions to the workforce. In 1996, about 23.4 percent of the active postresident physician workforce were graduates of foreign medical schools.[1]

IMGs have encountered an ambiguous welcome from their American hosts: On the one hand, they have been welcomed by many communities and hospitals that are hard-pressed to find a U.S.-trained physician willing to practice there. IMGs have integrated themselves into U.S. medicine, steadily increasing their political weight as evidenced by the formation within the American Medical Association (AMA) of a section dedicated to their specific concerns and by the creation in many states of professional associations of foreign-trained physicians.[2]

Yet, there are efforts both to restrict their arrival in the United States and to impede their permanent residence here. For instance, both the Pew Health Professions Commission and the Institute of Medicine have issued high-profile statements about how to reshape the physician workforce; both groups agreed that the nation's use of foreign-trained physicians should be diminished.[3] Most recently, a "consensus statement" issued by the Association of American Medical Colleges (AAMC), the AMA, and four other national professional associations echoed the view that restrictions on the training of IMGs should be implemented.[4] What accounts for this unprecedented convergence of views?

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Concerns About IMGs

■ **The numbers.** First, the sheer number of IMGs engaged in hospital residencies is probably the foremost factor provoking concern: In 1990, 14,914 IMGs were in training, a 21.7 percent jump from 12,259 in the preceding year. This compares with 73,071 and 67,988 U.S. medical graduates (USMGs) in residency training in 1989 and 1990, respectively, a decrease of 0.07 percent. By 1995 this trend had escalated: 24,982 IMGs in residency training, a 104 percent increase from 1989, versus 71,053 USMGs, a 2.8 percent decrease. In short, during 1989–1995 virtually all of the increase in the number of residents in the United States was attributable to IMGs, not USMGs.

The underlying issue is the physician surplus, a phenomenon now believed to exist by most medical leaders, medical associations, and federal government agencies concerned with the physician workforce and health care reimbursement. The surplus is so large that a study based on the opinions of residency program directors contended that as many as 10 percent of resident physicians fail to find full-time positions in their specialty or subspecialty.[5] Whether IMGs compete for these same positions and directly contribute to this problem is unclear. But, there can be no gainsaying that the addition of more than 140,000 IMGs in nearly half a century to the physician workforce is numerically significant.

■ **GME reimbursement.** A second factor accounting for the current climate of concern regarding IMGs arises from reimbursement for graduate medical education (GME). Many observers are convinced that lucrative Medicare payment for direct and indirect GME costs is the primary reason for the sharp increase in IMG residents since 1989. The Congressional Budget Office (CBO) recently argued that because IMG residents are not, for the most part, U.S. citizens, the federal government has no business paying for their graduate education during periods of budget deficit. The CBO calculated that 1993 Medicare payments to hospitals were about $88,000 per resident.[6] In New York State, the state with the largest number of IMG residents, training hospitals in 1995 received $2.9 billion in GME payments from both state and federal payers.[7] This worked out to about $188,000 for each resident in the state.

Hence, the roughly $6 billion of GME Medicare funds are an attractive target for those who question the need to spend so much money on supporting teaching hospitals.[8] There is now an overwhelming argument to control GME reimbursement to reduce health care costs, restrict the overall supply of physicians, and limit the nation's reliance on physicians from abroad.

■ **The "110 percent" solution.** The tack urged by many organi-

zations is generally like that of the AAMC: that "the number of first year residency positions in the country [be] more closely into alignment with the current number of graduates from accredited [U.S.] medical and osteopathic schools."[9] The Council on Graduate Medical Education (COGME), although it urged moderation regarding the IMG presence in U.S. medicine in its first report in 1988, is now considering stringent recommendations that would curtail IMG residency training in U.S. hospitals.[10] COGME's approach is illustrative of most proposals, including, for example, that of Medicare's Physician Payment Review Commission (PPRC): a limitation on the total number of residency positions to 110 percent of the annual number of graduating U.S. medical students.[11] More precisely, there would be a limitation of the federal subsidy to the prescribed 110 percent residency slots.[12]

Safety-Net Function Of IMGs

Efforts to constrain physician growth and GME expenses notwithstanding, there is a lurking question regarding IMGs: What is IMGs' "safety-net" function, if any, in the health care system? The possible safety-net role of IMGs is the notion that IMGs have been and are practicing medicine in places that are avoided by USMGs, so that even though a physician surplus may exist, maldistribution of USMGs has created pockets of opportunity for IMGs.

■ **State differences in USMG and IMG distributions.** We report here data that suggest more firmly than past studies do that IMGs and USMGs have differed in their distribution within the physician workforce. Based on merged 1996 AMA Physician Masterfile and Area Resource File data on all active postresident USMGs and IMGs, we present several analyses that were part of a more comprehensive study undertaken for the Bureau of Health Professions and COGME.[13] The key question was whether the distribution of IMGs was different from what one would have expected if the USMG distribution were taken as the standard. A derivative question was whether the distribution of IMGs relative to USMGs varied according to selected geographical indicators of need or underservice. The key measure was the difference between the proportions of USMGs and IMGs in a given state's counties that were classified as likely to exhibit need for medical services.

Methods. Taking infant mortality in Michigan as an example, we compared USMGs and IMGs in counties with an infant mortality rate of at least 8.9 per thousand live births annualized over the period 1988–1992 (the national county average). With nearly twice as many USMGs as IMGs located in such counties one might conclude that there was no IMG safety-net function. Indeed, if one were

to compute the physician-to-population ratio of USMGs and IMGs in such counties, the former would be larger than the latter. (This would turn out to be the case throughout the United States: USMGs normally outnumber IMGs, regardless of the geographical boundary selected.) Based on this measure, one would almost always conclude that IMGs have no safety-net role. However, in the Michigan example, the relative propensity of USMGs to locate in counties with average to above-average infant mortality rates was lower than that of IMGs (43.5 percent and 48.6 percent, respectively).[14]

Several points that are important to our methodology should be mentioned here. First, the AMA location data were based on a physician's mailing address, which was not necessarily the same as the address of practice. We assumed that this potential source of error was equivalent for IMGs and USMGs and thus had no impact on the percentage difference. Second, the AMA Physician Masterfile did not include data on osteopaths. Whether the results of the analyses would have been different had osteopaths been included is the focus of one of our next research efforts. We suspect that there would have been some effect, but it would have been concentrated geographically because about half of the roughly 30,000 active osteopaths are located in just five states.[15] Third, the data are displayed with states grouped together into four categories: states with fewer than 300 IMGs, states with 300–999 IMGs, states with 1,000–4,999 IMGs, and states with at least 5,000 IMGs. This enabled us to avoid comparing a state with few IMGs with one with many IMGs and to assess whether USMG/IMG differences were concentrated in only very small IMG states or were more widely present.

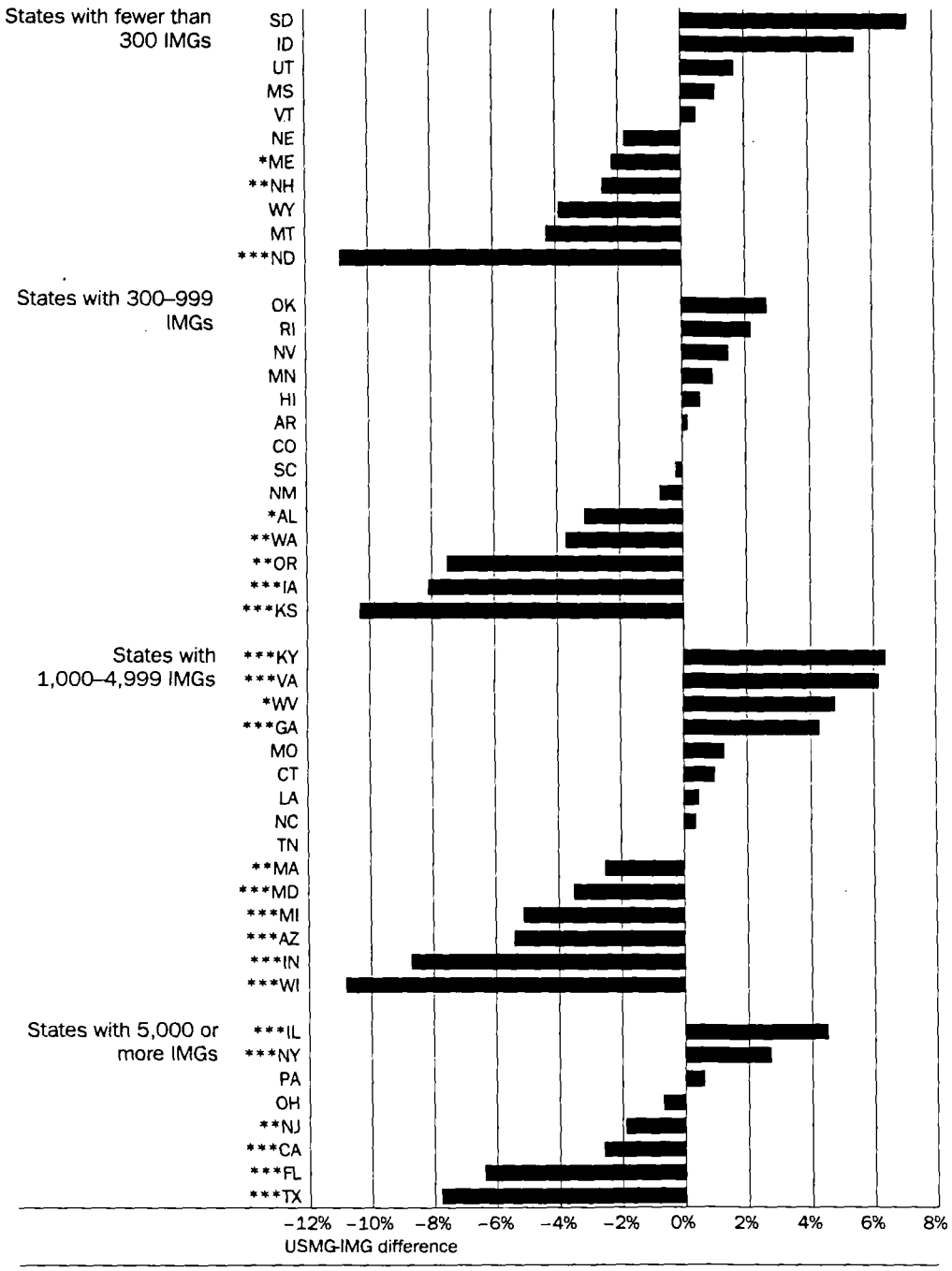
IMG/USMG distributions by infant mortality rate. Twenty-four of forty-eight states had larger proportions of IMGs in counties with infant mortality rates of 8.9 per thousand live births or higher; eighteen of these USMG/IMG differences were statistically significant (Exhibit 1).[16] Significantly larger proportions of IMGs were present across all four state groups. Three states with fewer than 300 IMGs had significantly larger proportions of IMGs. Five states with 300–999 IMGs, six states with 1,000–4,999 IMGs, and four states with at least 5,000 IMGs had significantly larger proportions of IMGs.

By contrast, only six states had proportions of USMGs that were significantly larger. These findings underscore the importance of examining USMG and IMG distributions at a smaller level of aggregation than the United States as a whole. Although many more states had IMG differences, important exceptions existed.

USMG/IMG distributions by physician-to-population ratio. Exhibit 2 presents data sorted as in Exhibit 1 but shows USMG/IMG differ-

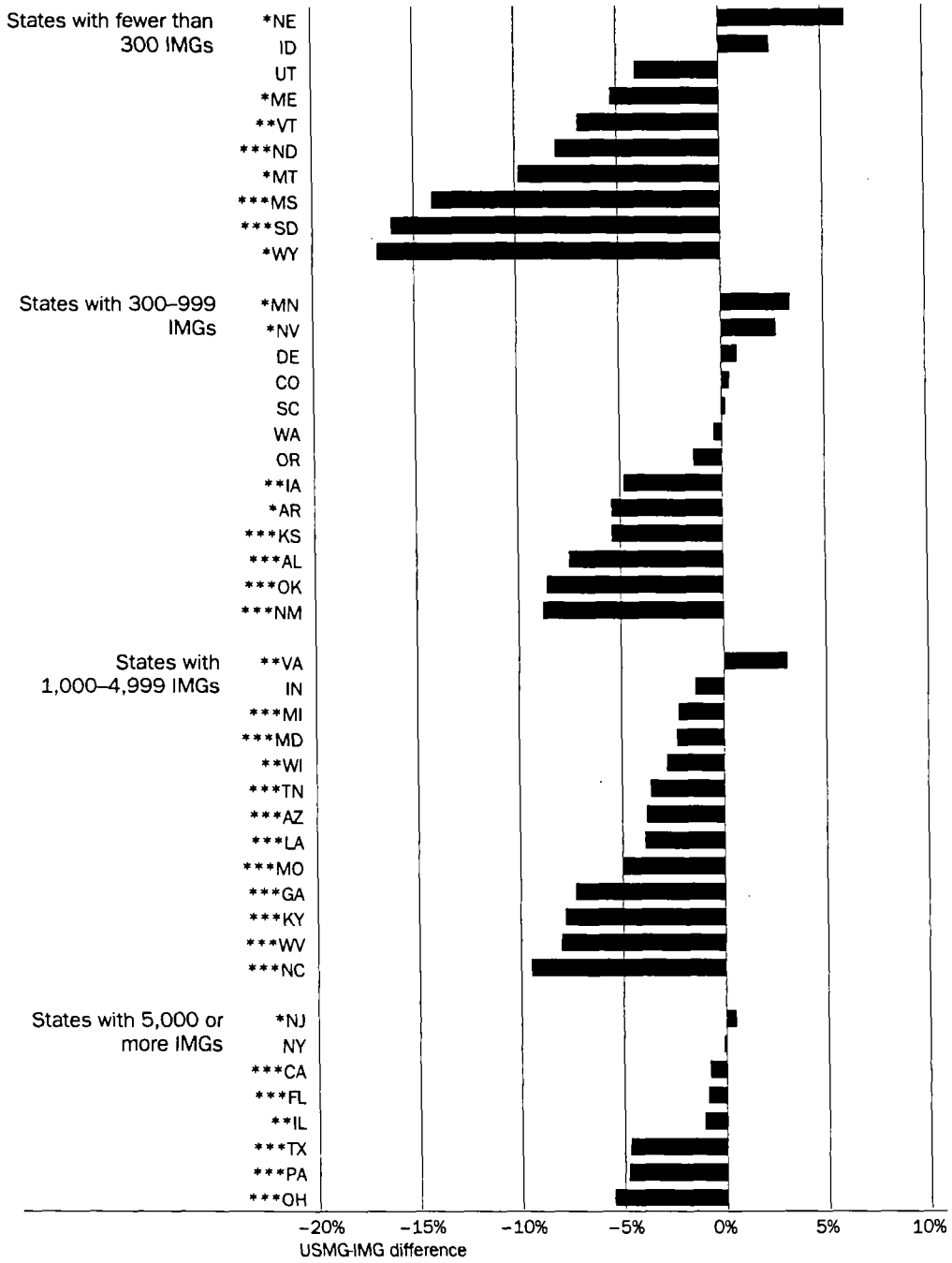
EXHIBIT 1

Differences In Proportions Of Active Postresident USMGs And IMGs In Counties With An Infant Mortality Rate Of At Least 8.9 Per Thousand Live Births, 1996



SOURCE: Authors' analysis, 1996.
NOTES: USMG is U.S. medical graduate. IMG is international medical graduate. Omits Alaska, District of Columbia, and Delaware. Montana, Wyoming, Idaho, and South Dakota did not have significant differences in proportions because the number of cases for each of these states was so small.
* = $p < .05$ ** = $p < .01$ *** = $p < .001$

EXHIBIT 2
Differences In Proportions Of Active Postresident USMGs And IMGs In Counties With Fewer Than 120 Physicians Per 100,000 Population, 1996



SOURCE: Authors' analysis, 1996.
NOTES: USMG is U.S. medical graduate. IMG is international medical graduate. Omits Alaska, Connecticut, District of Columbia, Hawaii, New Hampshire, Massachusetts, and Rhode Island.
* = $p < .05$ ** = $p < .01$ *** = $p < .001$

ences in counties with physician-to-population ratios of less than 120 physicians per 100,000 population, an extremely low level when compared with the U.S. average of approximately 220 physicians per 100,000 population.[17] About 9 percent of U.S. counties fell into the less than 120 per 100,000 grouping.

Of the forty-four states for which comparisons could be made (omitted states had no counties with physician-to-population ratios this low), thirty-five states (79.5 percent) had differences favoring IMGs, thirty of which were statistically significant. Nine states had differences favoring USMGs, five of which were significant. Again although larger IMG proportions predominated, this was not universal.

These two indicators revealed that IMGs were frequently overrepresented in counties where high infant mortality existed or where the physician-to-population ratio was well below average. Analyses not shown here also revealed significantly larger IMG proportions in counties that were classified according to five other indicators of potential need, always with, as above, major exceptions.[18]

Conclusions And Implications

These results, although highly suggestive, are not definitive because the location of a physician—IMG or USMG—in a county characterized by need does not necessarily mean that the physician is actually serving the population in need. However, the results do support the hypothesis that IMGs and USMGs have been and probably are distributed differently across the United States. What is needed now is analysis of data that link physicians to patients in such a way that the characteristics of both can be determined and assessed. Such databases are difficult to find, particularly at the national level. Therefore, we assume, as others do, that IMGs and USMGs are equally likely to serve the population in need within a given geographic boundary.[19] This is the safest assumption to make in the absence of data showing the contrary.

■ **Supply versus maldistribution.** These findings underscore a major dilemma confronting physician workforce reform. The United States is experiencing an increasing supply of physicians relative to population, yet maldistribution of the supply continues to exist. IMGs, although very likely to be in safety-net practices in many (but not all) states, are adding to the total number of physicians.

Knowledgeable physician workforce analysts understand this twin issue. For example, a close reading of the eight reports issued by COGME between 1988 and 1996 shows that the United States had an adequate physician-to-population ratio, that further in-

creases in the supply of physicians were neither desirable nor necessary, and that the United States had too few generalists and too many specialists. However, COGME also recognized that problems of access that were attributable to maldistribution of physician supply persisted in some areas of the nation. The council has consistently called for improved medical practice conditions so that U.S.-trained physicians would locate in underserved areas.[20] The "consensus statement" of the AAMC, the AMA, and others also emphasizes the need to eliminate maldistribution.[21] However, improving practice conditions in underserved areas has been difficult, especially in rural areas.[22] Over much of this century, policies and programs have been less successful than was hoped.[23]

■ **Old and new solutions.** If growth in the workforce is to be reduced, the challenge will probably be even greater than before to align the overall physician supply with changing levels of need and demand for services. Solutions tried in the past could be improved with more political and financial strength: A renewed National Health Service Corps, more vigorous efforts to instill in medical students and residents a sense of obligation to serve in areas of need, or improvements in medical education in emphasizing primary care medicine and in sensitizing students to cultural diversity are three examples that come to mind.[24]

Some new possibilities may also help to resolve maldistribution problems. These include advances in telemedicine, diffusion of integrated health care systems into rural areas, and expansion of Medicaid managed care plans into inner cities. Market-oriented policy analysts argue that the growth of managed care will take care of some of these distribution problems.[25] Signs of a change of heart among U.S. medical students toward primary care specialties are now clear. For the third straight year, more than half of graduating medical school seniors have selected a primary care specialty for at least the first year of training.[26] Many attribute this trend to the market power of managed care plans that are favoring primary care physicians over specialists.

■ **A warning.** We conclude with a warning: Change in the status quo will probably occur, but an overzealous effort to restrain physician supply may succeed at the possible expense of remedies for maldistribution. Our research has shown that a pattern of social differentiation and stratification—two terms sociologists use to characterize status and occupational distinctions among groups—is clear among IMGs and USMGs. The very texture of the physician workforce consists of IMGs practicing in locales that are often ignored by their U.S.-trained counterparts. This is the outcome of processes and forces that are nearly fifty years old, and they may not

change quickly, whatever the outcome of policy deliberations at the state and national levels.

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NOTES

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BY PAUL

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Safety-Net Providers: Who Are They?

Formally, **safety-net** providers are only those who are legally required to provide health care for free or at reduced rates to those who cannot afford to pay. But from a practical point of view, the **net** is significantly broader. Here are some of the key elements of the health care **safety net**.

Public Hospitals
Of the nation's 6,500 community hospitals, about 1,400 are "public" in that they are owned and operated by states, cities or counties. Their funding sources include payments by Medicare, Medicaid, insurance companies and patients themselves, as well as direct subsidies from state and local tax monies. Most public hospitals also offer services to the community at large that are often underfunded by private insurance , trauma care, burn centers, neonatal intensive care un its, poison control units, emergency psychiatric care and disaster response teams.

Community Health Centers and Migrant Health Centers
The informal network of nearly 600 community and migrant health centers provides comprehensive, case-managed primary and preventive care. With 2,500 delivery sites, the centers are key outpatient components of the health care **safety net**. Located primarily in inner-city and rural areas with shortages of health care professionals, they serve an estimated 9 million people each year. Community health centers are thought to provide care to about 20% of those they could serve, while migrant health centers serve only about 14% of migrant and seasonal farm workers.

Family Planning Clinics
With more than 4,000 clinics in this federally funded program, an estimated 4 million women and teenagers receive primary care, cancer screening and sexually transmitted disease prevention services, as well as fami ly planning services. Some 85% of clinic clients have incomes under 150% of poverty.

Ryan White AIDS Program
The federal Ryan White CARE Act provides a variety of health care and social services, including testing, risk reduction, counseling, transmission prevention and clinical care through 136 projects with 500 delivery sites serving an estimated 80,000 patients who have AIDS or are HIV-positive.

Health Care for the Homeless
This federal program funds 129 projects that give primary care health services to 420,000 individuals at 500 delivery sites. About half of the projects are administered by community health centers; the other h alf are run by non-profit coalitions, inner-city hospitals and local public health departments.

Public Health Departments
Local governments spent $13.7 billion in 1992 on public health, which includes a wide variety of services primarily aimed at preventing the spread of communicable diseases and educating people about personal heal th risks, ranging from child

immunizations to home health care to mosquito abatement and rat control. Public health departments also deliver some personal health care services, including maternal and child services.

Rural Health Clinics

Largely privately owned and operated, the nearly 2,500 federally designated rural health clinics provide critical access to health care services for some 4 million patients each year. These clinics are paid by Medica re and Medicaid under special rules, reflecting the fact that 70% of their patients are insured under one of the two programs and that the clinics frequently are the sole source of medical care in the community.

Who Uses the Health Care Safety Net?

While **safety-net** providers are the primary source of care for the poor and the uninsured, they also provide critical access to health services in areas where health care can be difficult to obtain. Nearly 30% of patients who use federally designated Rura l Health Clinics, for example, have private insurance, as do 12% of those who use community and migrant health centers.

Medicaid beneficiaries have a symbiotic relationship with health care **safety-net** providers , the facilities provide needed inpatient and outpatient care, while the income from Medicaid reimbursement is critical to the budgets of many clinics and hosp itals. Indeed, Medicaid covers 40% of patients at community and migrant health centers, and provides half the inpatient funding of many public hospitals. And while most Medicaid dollars are spent on long-term care services for the elderly and disabled, most Medicaid beneficiaries , 50% in 1993 , are children in low-income families. Indeed, Medicaid is the health insurer for one of every four children in the United States.

People with special needs also rely on **safety-net** providers. Medicaid, for example, covers nearly 40% of all AIDS patients.

The Uninsured: A Growing Problem

With the demise of federal health care reform, the uninsured are no longer in the national spotlight. But that doesn't mean that the problems of Americans who lack insurance have improved , in fact, there is reason to believe the situation is worsening.

According to the US Census Bureau, on any given day in 1994, some 39.7 million people , about 15% of the population , had no health insurance. And if not for recent expansions in Medicaid coverage, that number would be even higher. Indeed, employer -provided health insurance continues to decline. In 1994, 57% of Americans received health insurance through their jobs, compared to 61% as recently as 1990.

Spells of uninsurance are getting longer, too. A recent RWJF-sponsored report by the Council on the Economic Impact of Health System Change cites an estimate that three-fourths of those who lack insurance will be without coverage for more than a year , and half will be uninsured for more than two years.

Researchers from the Council project that the number of uninsured could reach 66.8 million by 2002. The result, their report concludes, will be "increased demand for uncompensated care, and a decreased capacity of the delivery system to meet this nee d."

"(I) evidence of capability and expertise in network planning, health plans and management.

"(2) CONSIDERATION OF APPLICATIONS.—The Secretary shall develop a system for determining the priority for distributing grants under this section and such grants shall be distributed in accordance with such system.

"(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary for the purposes of awarding grants under this section.

"(d) DEFINITIONS.—For purposes of this section, the term "health network" has the same meaning given such term in section 311(c)(1) of the America's Health Care Option Act.".

SEC. 313. COMMUNITY-BASED PRIMARY HEALTH CARE GRANT PROGRAM.

Subpart I of part D of title III of the Public Health Service Act (42 U.S.C. 254b et seq.) is amended by adding at the end the following new section:

"SEC. 330A. COMMUNITY-BASED PRIMARY HEALTH CARE GRANT PROGRAM.

"(a) ESTABLISHMENT.—The Secretary shall establish and administer a program to provide allotments to

States to enable such States to provide grants for the creation or enhancement of community-based primary health care entities that provide services to low-income or medically underserved populations.

"(b) ALLOTMENTS TO STATES.—

"(1) IN GENERAL.—From the amount available for allotment under subsection (h) for a fiscal year, the Secretary shall allot to each State an amount equal to the product of the grant share of the State (as determined under paragraph (2)) multiplied by such amount available.

"(2) GRANT SHARE.—

"(A) IN GENERAL.—For purposes of paragraph (1), the grant share of a State shall be the product of the need-adjusted population of the State (as determined under subparagraph (B)) multiplied by the Federal matching percentage of the State (as determined under subparagraph (C)), expressed as a percentage of the sum of the products of such factors for all States.

"(B) NEED-ADJUSTED POPULATION.—

"(i) IN GENERAL.—For purposes of subparagraph (A), the need-adjusted population of a State shall be the product of

the total population of the State (as estimated by the Secretary of Commerce) multiplied by the need index of the State (as determined under clause (ii)).

"(ii) NEED INDEX.—For purposes of clause (i), the need index of a State shall be the ratio of—

"(I) the weighted sum of the geographic percentage of the State (as determined under clause (iii)), the poverty percentage of the State (as determined under clause (iv)), and the multiple grant percentage of the State (as determined under clause (v)); to

"(II) the general population percentage of the State (as determined under clause (vi)).

"(iii) GEOGRAPHIC PERCENTAGE.—

"(I) IN GENERAL.—For purposes of clause (ii)(I), the geographic percentage of the State shall be the estimated population of the State that is residing in nonurbanized areas (as determined under subclause (II)) ex-

pressed as a percentage of the total nonurbanized population of all States.

"(II) NONURBANIZED POPULATION.—For purposes of subclause (I), the estimated population of the State that is residing in nonurbanized areas shall be one minus the urbanized population of the State (as determined using the most recent decennial census), expressed as a percentage of the total population of the State (as determined using the most recent decennial census), multiplied by the current estimated population of the State.

"(III) STATE OF ALASKA.—Notwithstanding subclause (I), the geographic percentage for the State of Alaska shall be the relative population density of the State expressed as the ratio of—

"(aa) the average number of individuals residing in Alaska per square mile; to

"(bb) the average number of individuals residing in the United States per square mile.

"(iv) POVERTY PERCENTAGE.—For purposes of clause (ii)(I), the poverty percentage of the State shall be the estimated number of people residing in the State with incomes below 200 percent of the income official poverty line (as adjusted for actual costs and incomes in each State and as determined by the Office of Management and Budget) expressed as a percentage of the total number of such people residing in all States.

"(v) MULTIPLE GRANT PERCENTAGE.—For purposes of clause (ii)(I), the multiple grant percentage of the State shall be the amount of Federal funding received by the State under grants awarded under sections 329, 330, and 340, expressed as a percentage of the total amounts received under such grants by all States. With respect to a State, such percentage shall not exceed twice the general population percentage of the State under

clause (vi) or be less than one-half of the States general population percentage.

"(vi) GENERAL POPULATION PERCENTAGE.—For purposes of clause (ii)(II), the general population percentage of the State shall be the total population of the State (as determined by the Secretary of Commerce) expressed as a percentage of the total population of all States.

"(C) FEDERAL MATCHING PERCENTAGE.—

"(i) IN GENERAL.—For purposes of subparagraph (A), the Federal matching percentage of the State shall be equal to one, less the State matching percentage (as determined under clause (ii)).

"(ii) STATE MATCHING PERCENTAGE.—For purposes of clause (i), the State matching percentage of the State shall be 0.25 multiplied by the ratio of the total taxable resource percentage (as determined under clause (iii)) to the need-adjusted population of the State (as determined under subparagraph (B)).

"(iii) TOTAL TAXABLE RESOURCE PERCENTAGE.—For purposes of clause (ii),

the total taxable resources percentage of the State shall be the total taxable resources of a State (as determined by the Secretary of the Treasury) expressed as a percentage of the sum of the total taxable resources of all States.

"(3) ANNUAL ESTIMATES.—

"(A) IN GENERAL.—If the Secretary of Commerce does not produce the annual estimates required under paragraph (2)(B)(iv), such estimates shall be determined by multiplying the percentage of the population of the State that is below 200 percent of the income official poverty line as determined using the most recent decennial census by the most recent estimate of the total population of the State. Except as provided in subparagraph (B), the calculations required under this subparagraph shall be made based on the most recent 3-year average of the total taxable resources of individuals within the State.

"(B) DISTRICT OF COLUMBIA.—Notwithstanding subparagraph (A), the calculations required under such subparagraph with respect to the District of Columbia shall be based on the

most recent 3-year average of the personal income of individuals residing within the District as a percentage of the personal income for all individuals residing within the District, as determined by the Secretary of Commerce.

"(C) STATE OF ALASKA.—Notwithstanding subparagraph (A), the calculations required under such subparagraph with respect to the State of Alaska shall be based on the quotient of—

"(i) the most recent 3-year average of the per capita income of individuals residing in the State; divided by

"(ii) 1.25.

"(4) MATCHING REQUIREMENT.—A State that receives an allotment under this section shall make available State resources (either directly or indirectly) to carry out this section in an amount that shall equal the State matching percentage for the State (as determined under paragraph (2)(C)(ii)) divided by the Federal matching percentage (as determined under paragraph (2)(C)).

"(c) APPLICATION.—

"(1) IN GENERAL.—To be eligible to receive an allotment under this section, a State shall prepare

and submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may by regulation require.

"(2) ASSURANCES.—A State application submitted under paragraph (1) shall contain an assurance that—

"(A) the State will use amounts received under its allotment consistent with the requirements of this section; and

"(B) the State will provide, from non-Federal sources, the amounts required under subsection (b)(4).

"(d) USE OF FUNDS.—

"(1) IN GENERAL.—The State shall use amounts received under this section to award grants to eligible public and nonprofit private entities, or consortia of such entities, within the State to enable such entities or consortia to provide services of the type described in paragraph (2) of section 329(h) to low-income or medically underserved populations.

"(2) ELIGIBILITY.—To be eligible to receive a grant under paragraph (1), an entity or consortium shall—

"(A) prepare and submit to the administering entity of the State, an application at

such time, in such manner, and containing such information as such administering entity may require, including a plan for the provision of services of the type described in paragraph (3);

"(B) provide assurances that services will be provided under the grant at fee rates established or determined in accordance with section 330(e)(3)(F); and

"(C) provide assurances that in the case of services provided to individuals with health insurance, such insurance shall be used as the primary source of payment for such services.

"(3) SERVICES.—The services to be provided under a grant awarded under paragraph (1) shall include—

"(A) one or more of the types of primary health services described in section 330(b)(1);

"(B) one or more of the types of supplemental health services described in section 330(b)(2); and

"(C) any other services determined appropriate by the administering entity of the State.

"(4) TARGET POPULATIONS.—Entities or consortia receiving grants under paragraph (1) shall, in providing the services described in paragraph (3),

substantially target populations of low-income or medically underserved populations within the State who reside in medically underserved or health professional shortage areas, areas certified as underserved under the rural health clinic program, or other areas determined appropriate by the administering entity of the State, within the State.

"(5) PRIORITY.—In awarding grants under paragraph (1), the State shall—

"(A) give priority to entities or consortia that can demonstrate through the plan submitted under paragraph (2) that—

"(i) the services provided under the grant will expand the availability of primary care services to the maximum number of low-income or medically underserved populations who have no access to such care on the date of the grant award; and

"(ii) the delivery of services under the grant will be cost-effective; and

"(B) ensure that an equitable distribution of funds is achieved among urban and rural entities or consortia.

"(e) REPORTS AND AUDITS.—Each State shall prepare and submit to the Secretary annual reports concern-

ing the State's activities under this section which shall be in such form and contain such information as the Secretary determines appropriate. Each such State shall establish fiscal control and fund accounting procedures as may be necessary to assure that amounts received under this section are being disbursed properly and are accounted for, and include the results of audits conducted under such procedures in the reports submitted under this subsection.

"(f) PAYMENTS.—

"(1) ENTITLEMENT.—Each State for which an application has been approved by the Secretary under this section shall be entitled to payments under this section for each fiscal year in an amount not to exceed the State's allotment under subsection (b) to be expended by the State in accordance with the terms of the application for the fiscal year for which the allotment is to be made.

"(2) METHOD OF PAYMENTS.—The Secretary may make payments to a State in installments, and in advance or by way of reimbursement, with necessary adjustments on account of overpayments or underpayments, as the Secretary may determine.

"(3) STATE SPENDING OF PAYMENTS.—Payments to a State from the allotment under sub-

section (b) for any fiscal year must be expended by the State in that fiscal year or in the succeeding fiscal year.

"(g) DEFINITION.—As used in this section, the term 'administering entity of the State' means the agency or official designated by the chief executive officer of the State to administer the amounts provided to the State under this section.

"(h) FUNDING.—Notwithstanding any other provision of law, the Secretary shall use 50 percent of the amounts that the Secretary is required to utilize under section 330B(h) in each fiscal year to carry out this section.".

Subtitle B—Technical Assistance Grants

SEC. 321. TECHNICAL ASSISTANCE GRANTS.

(a) IN GENERAL.—The Secretary shall award grants to public and private entities submitting applications that are approved under subsection (b) for the purpose of providing technical assistance in the establishment of the infrastructure for health networks and plans in underserved areas certified under section 302.

(b) APPLICATION PROCESS.—

(1) SUBMISSION OF APPLICATION.—Each entity desiring to receive a grant under this section shall

Subtitle C—Capital Assistance Loans and Loan Guarantees

SEC. 331. RURAL, FRONTIER AND URBAN UNDERSERVED AREA HEALTH LOAN PROGRAM.

(a) IN GENERAL.—The Secretary shall make loans to—

(1) health networks (as defined in section 311(c));

(2) health plans (as defined in section 21003(a) of the Social Security Act) that cover individuals residing in rural, frontier or urban underserved areas; or

(3) health care providers that serve rural, frontier or underserved urban areas;

for the capital costs of developing health delivery systems and expanding existing health delivery sites to make health care services available to individuals residing in underserved areas certified under section 302.

(b) USE OF ASSISTANCE.—

(1) IN GENERAL.—The capital costs for which loans made pursuant to subsection (a) may be expended are, subject to paragraphs (2) and (3), the following:

(A) The modernization or expansion of facilities to reduce the inpatient characteristics of

(3) LIMITATION.—The Secretary may authorize the use of loans under subsection (a) for the construction of new buildings only if the Secretary determines that appropriate facilities are not available through acquiring, modernizing, expanding or converting existing buildings, or that construction new buildings will cost less.

(c) AMOUNT OF ASSISTANCE.—The principal amount of loans under subsection (a) may cover up to 100 percent of the costs involved.

SEC. 332. CERTAIN REQUIREMENTS.

(a) IN GENERAL.—The Secretary may approve a loan under section 331 only if—

(1) an application for such assistance is submitted to the Secretary in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this subtitle;

(2) the Secretary is reasonably satisfied that the applicant for the project for which the loan would be made will be able to make payments of principal and interest thereon when due; and

(3) the applicant provides the Secretary with reasonable assurances that there will be available to it such additional funds as may be necessary to com-

plete the project or undertaking with respect to which such loan is requested.

(b) TERMS AND CONDITIONS.—Any loan made under section 331 shall, subject to the Federal Credit Reform Act of 1990, meet such terms and conditions (including provisions for recovery in case of default) as the Secretary, in consultation with the Secretary of the Treasury, determines to be necessary to carry out the purposes of such section while adequately protecting the financial interests of the United States. Terms and conditions for such loans shall include provisions regarding the following:

(1) Security.

(2) Maturity date.

(3) Amount and frequency of installments.

(4) Rate of interest, which shall be at a rate comparable to the rate of interest prevailing on the date the loan is made.

SEC. 333. DEFAULTS.

(a) IN GENERAL.—The Secretary may take such action as may be necessary to prevent a default on loans under section 331, including the waiver of regulatory conditions, deferral of loan payments, renegotiation of loans, and the expenditure of funds for technical and consultative assistance, for the temporary payment of the interest and principal on such a loan, and for other purposes.

(b) FORECLOSURE.—The Secretary may take such action, consistent with State law respecting foreclosure procedures, as the Secretary deems appropriate to protect the interest of the United States in the event of a default on a loan made pursuant to section 331, including selling real property pledged as security for such a loan and for a reasonable period of time taking possession of, holding, and using real property pledged as security for such a loan.

(c) WAIVERS.—The Secretary may, for good cause, but with due regard to the financial interests of the United States, waive any right of recovery which the Secretary has by reasons of the failure of a borrower to make payments of principal of and interest on a loan made pursuant to section 331, except that if such loan is sold and guaranteed, any such waiver shall have no effect upon the Secretary's guarantee of timely payment of principal and interest.

Subtitle D—Increasing Primary Care Providers

SEC. 341. NONREFUNDABLE CREDIT FOR CERTAIN PRIMARY HEALTH SERVICES PROVIDERS.

(a) IN GENERAL.—Subpart A of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to nonrefundable personal credits) is

amended by inserting after section 22 the following new section:

"SEC. 23. PRIMARY HEALTH SERVICES PROVIDERS.

"(a) ALLOWANCE OF CREDIT.—There shall be allowed as a credit against the tax imposed by this chapter for the taxable year an amount equal to the product of—

"(1) the number of months during such taxable year—

"(A) during which the taxpayer is a qualified primary health services provider, and

"(B) which are within the taxpayer's mandatory service period, and

"(2) $1,000 ($500 in the case of a qualified practitioner who is not a physician).

"(b) QUALIFIED PRIMARY HEALTH SERVICES PROVIDER.—For purposes of this section, the term 'qualified primary health services provider' means, with respect to any month, any qualified practitioner who—

"(1) has in effect a certification by the Bureau as a provider of primary health services and such certification is, when issued, for a health professional shortage area in which the qualified practitioner is commencing the providing of primary health services,

"(2) is providing primary health services full time in the health professional shortage area identified in such certification, and

"(3) has not received a scholarship under the National Health Service Corps Scholarship Program or any loan repayments under the National Health Service Corps Loan Repayment Program.

For purposes of paragraph (2) and subsection (e)(3), a provider shall be treated as providing services in a health professional shortage area when such area ceases to be such an area if it was such an area when the provider commenced providing services in the area.

"(c) MANDATORY SERVICE PERIOD.—For purposes of this section, the term 'mandatory service period' means the period of 60 consecutive calendar months beginning with the first month the taxpayer is a qualified primary health services provider. A taxpayer shall not have more than 1 mandatory service period.

"(d) DEFINITIONS AND SPECIAL RULES.—For purposes of this section—

"(1) BUREAU.—The term 'Bureau' means the Bureau of Primary Health Care, Health Resources and Services Administration of the United States Public Health Service.

"(2) QUALIFIED PRACTITIONER.—The term 'qualified practitioner' means a physician, a physician assistant, a nurse practitioner, or a certified nurse-midwife.

"(3) PHYSICIAN.—The term 'physician' has the meaning given to such term by section 1861(r) of the Social Security Act.

"(4) PHYSICIAN ASSISTANT; NURSE PRACTITIONER.—The terms 'physician assistant' and 'nurse practitioner' have the meanings given to such terms by section 1861(aa)(5) of the Social Security Act.

"(5) CERTIFIED NURSE-MIDWIFE.—The term 'certified nurse-midwife' has the meaning given to such term by section 1861(gg)(2) of the Social Security Act.

"(6) PRIMARY HEALTH SERVICES.—The term 'primary health services' has the meaning given such term by section 330(b)(1) of the Public Health Service Act.

"(7) HEALTH PROFESSIONAL SHORTAGE AREA.—The term 'health professional shortage area' has the meaning given such term by section 332(a)(1)(A) of the Public Health Service Act.

"(e) RECAPTURE OF CREDIT.—

"(1) IN GENERAL.—If there is a recapture event during any taxable year, then—

"(A) no credit shall be allowed under subsection (a) for such taxable year and any succeeding taxable year, and

"(B) the tax of the taxpayer under this chapter for such taxable year shall be increased by an amount equal to the product of—

"(i) the applicable percentage, and

"(ii) the aggregate unrecaptured credits allowed to such taxpayer under this section for all prior taxable years.

"(2) APPLICABLE RECAPTURE PERCENTAGE.—

"(A) IN GENERAL.—For purposes of this subsection, the applicable recapture percentage shall be determined from the following table:

"If the recapture event occurs during:	The applicable recaptrue percentage is:
Months 1–24	100
Months 25–36	75
Months 37–48	50
Months 49–60	25
Month 61 or thereafter	0.

"(B) TIMING.—For purposes of subparagraph (A), month 1 shall begin on the first day of the mandatory service period.

"(3) RECAPTURE EVENT DEFINED.—

"(A) IN GENERAL.—For purposes of this subsection, the term 'recapture event' means

the failure of the taxpayer to be a qualified primary health services provider for any month during the taxpayer's mandatory service period.

"(B) SECRETARIAL WAIVER.—The Secretary, in consultation with the Secretary of Health and Human Services, may waive any recapture event caused by extraordinary circumstances.

"(4) NO CREDITS AGAINST TAX; MINIMUM TAX.—Any increase in tax under this subsection shall not be treated as a tax imposed by this chapter for purposes of determining the amount of any credit under subpart A, B, or D of this part or for purposes of section 55."

(b) CLERICAL AMENDMENT.—The table of sections for subpart A of part IV of subchapter A of chapter 1 of such Code is amended by inserting after the item relating to section 22 the following new item:

"Sec. 23. Primary health services providers."

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1994.

SEC. 342. EXPENSING OF MEDICAL EQUIPMENT.

(a) IN GENERAL.—Paragraph (1) of section 179(b) of the Internal Revenue Code of 1986 (relating to dollar

(as amended by section 313) is amended by adding at the end the following new section:

"SEC. 330B. EXPANDED SERVICES FOR MEDICALLY UNDERSERVED INDIVIDUALS.

"(a) ESTABLISHMENT OF HEALTH SERVICES ACCESS PROGRAM.—From amounts appropriated under this section, the Secretary shall, acting through the Bureau of Health Care Delivery Assistance, award grants under this section to federally qualified health centers (hereinafter referred to in this section as 'FQHC's') and other entities and organizations submitting applications under this section (as described in subsection (c)) for the purpose of providing access to services for medically underserved populations (as defined in section 330(b)(3)) or in high impact areas (as defined in section 329(a)(5)) not currently being served by a FQHC.

"(b) ELIGIBILITY FOR GRANTS.—

"(1) IN GENERAL.—The Secretary shall award grants under this section to entities or organizations described in this paragraph and paragraph (2) which have submitted a proposal to the Secretary to expand such entities or organizations operations (including expansions to new sites (as determined necessary by the Secretary)) to serve medically under-

served populations or high impact areas not currently served by a FQHC and which—

"(A) have as of January 1, 1991, been certified by the Secretary as a FQHC under section 1905(l)(2)(B) of the Social Security Act; or

"(B) have submitted applications to the Secretary to qualify as FQHC's under such section 1905(l)(2)(B); or

"(C) have submitted a plan to the Secretary which provides that the entity will meet the requirements to qualify as a FQHC when operational.

"(2) NON FQHC ENTITIES.—

"(A) ELIGIBILITY.—The Secretary shall also make grants under this section to public or private nonprofit agencies, health care entities or organizations which meet the requirements necessary to qualify as a FQHC except, the requirement that such entity have a consumer majority governing board and which have submitted a proposal to the Secretary to provide those services provided by a FQHC as defined in section 1905(l)(2)(B) of the Social Security Act and which are designed to promote access

to primary care services or to reduce reliance on hospital emergency rooms or other high cost providers of primary health care services, provided such proposal is developed by the entity or organizations (or such entities or organizations acting in a consortium in a community) with the review and approval of the Governor of the State in which such entity or organization is located.

"(B) LIMITATION.—The Secretary shall provide in making grants to entities or organizations described in this paragraph that no more than 10 percent of the funds provided for grants under this section shall be made available for grants to such entities or organizations.

"(c) APPLICATION REQUIREMENTS.—

"(1) IN GENERAL.—In order to be eligible to receive a grant under this section, a FQHC or other entity or organization must submit an application in such form and at such time as the Secretary shall prescribe and which meets the requirements of this subsection.

"(2) REQUIREMENTS.—An application submitted under this section must provide—

"(A)(i) for a schedule of fees or payments for the provision of the services provided by the entity designed to cover its reasonable costs of operations; and

"(ii) for a corresponding schedule of discounts to be applied to such fees or payments, based upon the patient's ability to pay (determined by using a sliding scale formula based on the income of the patient);

"(B) assurances that the entity or organization provides services to persons who are eligible for benefits under title XVIII of the Social Security Act, for medical assistance under title XIX of such Act or for assistance for medical expenses under any other public assistance program or private health insurance program; and

"(C) assurances that the entity or organization has made and will continue to make every reasonable effort to collect reimbursement for services—

"(i) from persons eligible for assistance under any of the programs described in subparagraph (B); and

"(ii) from patients not entitled to benefits under any such programs.

"(d) LIMITATIONS ON USE OF FUNDS.—

"(1) IN GENERAL.—From the amounts awarded to an entity or organization under this section, funds may be used for purposes of planning but may only be expended for the costs of—

"(A) assessing the needs of the populations or proposed areas to be served;

"(B) preparing a description of how the needs identified will be met; and

"(C) development of an implementation plan that addresses—

"(i) recruitment and training of personnel; and

"(ii) activities necessary to achieve operational status in order to meet FQHC requirements under 1905(l)(2)(B) of the Social Security Act.

"(2) RECRUITING, TRAINING AND COMPENSATION OF STAFF.—From the amounts awarded to an entity or organization under this section, funds may be used for the purposes of paying for the costs of recruiting, training and compensating staff (clinical and associated administrative personnel (to the extent such costs are not already reimbursed under title XIX of the Social Security Act or any other

State or Federal program)) to the extent necessary to allow the entity to operate at new or expended existing sites.

"(3) FACILITIES AND EQUIPMENT.—From the amounts awarded to an entity or organization under this section, funds may be expended for the purposes of acquiring facilities and equipment but only for the cost of—

"(A) construction of new buildings (to the extent that new construction is found to be the most cost-efficient approach by the Secretary);

"(B) acquiring, expanding, and modernizing of existing facilities;

"(C) purchasing essential (as determined by the Secretary) equipment; and

"(D) amortization of principal and payment of interest on loans obtained for purposes of site construction, acquisition, modernization, or expansion, as well as necessary equipment.

"(4) SERVICES.—From the amounts awarded to an entity or organization under this section, funds may be expanded for the payment of services but only for the costs of—

"(A) providing or arranging for the provision of all services through the entity necessary

to qualify such entity as a FQHC under section 1905(l)(2)(B) of the Social Security Act;

"(B) providing or arranging for any other service that a FQHC may provide and be reimbursed for under title XIX of such Act; and

"(C) providing any unreimbursed costs of providing services as described in section 330(a) to patients.

"(e) PRIORITIES IN THE AWARDING OF GRANTS.—

"(1) CERTIFIED FQHC's.—The Secretary shall give priority in awarding grants under this section to entities which have, as of January 1, 1991, been certified as a FQHC under section 1905(l)(2)(B) of the Social Security Act and which have submitted a proposal to the Secretary to expand their operations (including expansion to new sites) to serve medically underserved populations for high impact areas not currently served by a FQHC. The Secretary shall give first priority in awarding grants under this section to those FQHCs or other entities which propose to serve populations with the highest degree of unmet need, and which can demonstrate the ability to expand their operations in the most efficient manner.

"(2) QUALIFIED FQHC's.—The Secretary shall give second priority in awarding grants to entities which have submitted applications to the Secretary which demonstrate that the entity will qualify as a FQHC under section 1905(l)(2)(B) of the Social Security Act before it provides or arranges for the provision of services supported by funds awarded under this section, and which are serving or proposing to serve medically underserved populations or high impact areas which are not currently served (or proposed to be served) by a FQHC.

"(3) EXPANDED SERVICES AND PROJECTS.—The Secretary shall give third priority in awarding grants in subsequent years to those FQHCs or other entities which have provided for expanded services and project and are able to demonstrate that such entity will incur significant unreimbursed costs in providing such expanded services.

"(f) RETURN OF FUNDS TO SECRETARY FOR COSTS REIMBURSED FROM OTHER SOURCES.—To the extent that an entity or organization receiving funds under this section is reimbursed from another source for the provision of services to an individual, and does not use such increased reimbursement to expand services furnished, areas served, to compensate for costs of unreimbursed

services provided to patients, or to promote recruitment, training, or retention of personnel, such excess revenues shall be returned to the Secretary.

"(g) TERMINATION OF GRANTS.—

"(1) FAILURE TO MEET FQHC REQUIREMENTS.—

"(A) IN GENERAL.—With respect to any entity that is receiving funds awarded under this section and which subsequently fails to meet the requirements to qualify as a FQHC under section 1905(l)(2)(B) or is an entity that is not required to meet the requirements to qualify as a FQHC under section 1905(l)(2)(B) of the Social Security Act but fails to meet the requirements of this section, the Secretary shall terminate the award of funds under this section to such entity.

"(B) NOTICE.—Prior to any termination of funds under this section to an entity, the entities shall be entitled to 60 days prior notice of termination and, as provided by the Secretary in regulations, an opportunity to correct any deficiencies in order to allow the entity to continue to receive funds under this section.

"(2) REQUIREMENTS.—Upon any termination of funding under this section, the Secretary may (to the extent practicable)—

"(A) sell any property (including equipment) acquired or constructed by the entity using funds made available under this section or transfer such property to another FQHC, provided, that the Secretary shall reimburse any costs which were incurred by the entity in acquiring or constructing such property (including equipment) which were not supported by grants under this section; and

"(B) recoup any funds provided to an entity terminated under this section.

"(h) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, $100,000,000 for each of the fiscal years 1996 through 1999.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall become effective with respect to services furnished by a federally qualified health center or other qualifying entity described in this section beginning on or after October 1, 1995.

(g) MAINTENANCE OF EFFORT.—Any funds available for the activities covered by a demonstration project conducted under this section shall supplement, and shall not supplant, funds that are expended for similar purposes under any State, regional, or local program.

(h) EVALUATIONS.—Each eligible entity that conducts a demonstration project under this section shall submit to the Secretary such information and interim evaluations as the Secretary may require. The Secretary shall provide the Interagency Task Force on Rural Telemedicine with such evaluations and information submitted under the previous sentence as the Task Force may required to carry out its duties under section 345(b).

(i) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, $10,000,000 for each of the fiscal years 1995 through 1997.

Subtitle E—Payment Flexibility

SEC. 351. ESSENTIAL ACCESS COMMUNITY HOSPITAL (EACH) AMENDMENTS.

(a) UNLIMITED PARTICIPATING STATES; ELIMINATION OF GRANT TIE-IN.—

(1) IN GENERAL.—Section 1820(a) of the Social Security Act (42 U.S.C. 1395i–4(a)) is amended to read as follows:

"(a) IN GENERAL.—

"(1) PROGRAM DESCRIBED.—There is hereby established a program under which the Secretary—

"(A) shall permit States that have submitted an application in accordance with subsection (b) to carry out the activities described in subsections (e) and (f); and

"(B) shall designate (under subsection (i)) hospitals and facilities located in States participating in a program under this section as essential access community hospitals or rural primary care hospitals.

"(2) AVAILABILITY OF GRANTS.—

"(A) STATES.—The Secretary shall make grants available to selected States described in paragraph (1)(A) to carry out the activities described in subsection (d)(1).

"(B) ELIGIBLE HOSPITALS AND FACILITIES.—The Secretary shall make grants available to selected eligible hospitals and facilities (or consortia of hospitals and facilities) to carry out the activities described in subsection (d)(2).".

(2) CONFORMING AMENDMENTS.—

(A) Section 1820(b) of such Act (42 U.S.C. 1395i–4(b)) is amended by striking "ELIGIBILITY OF STATES FOR GRANTS.—" through "subsection (a)(1)" and inserting "APPLICATION.—A State is eligible to participate in the program described in this section".

(B) Section 1820(c) of such Act (42 U.S.C. 1395i–4(c)) is amended—

(i) in paragraph (1)—

(I) in the matter preceding subparagraph (A), by striking "(a)(2)" and inserting "(a)(2)(B)", and

(II) in subparagraph (A), by striking "receiving a grant under subsection (a)(1)" and inserting "participating in the program under this section"; and

(ii) in paragraph (3)—

(I) by striking "STATE RECEIVING GRANT.—" and inserting "STATE PARTICIPATING IN THE PROGRAM.—", and

(II) by striking "(a)(2)" and inserting "(a)(2)(B)".

(C) Section 1820(d) of such Act (42 U.S.C. 1395i–4(d)) is amended—

(i) in paragraph (1), by striking "(a)(1)" and inserting "(a)(2)(A)"; and

(ii) in paragraph (2), by striking "(a)(2)" each place it appears and and inserting "(a)(2)(B)".

(C) Section 1820(i) of such Act (42 U.S.C. 1395i–4(i)) is amended—

(i) in paragraph (1)(A)(i), by striking "receiving a grant under subsection (a)(1)" and inserting "participating in the program under this section"; and

(ii) in paragraph (2)(A)(i), by striking "receiving a grant under subsection (a)(1)" and inserting "participating in the program under this section".

(b) TREATMENT OF INPATIENT HOSPITAL SERVICES PROVIDED IN RURAL PRIMARY CARE HOSPITALS.—

(1) IN GENERAL.—Section 1820(f)(1)(F) of the Social Security Act (42 U.S.C. 1395i–4(f)(1)(F)) is amended to read as follows:

"(F) subject to paragraph (4), provides not more than 6 inpatient beds (meeting such conditions as the Secretary may establish) for pro-

viding inpatient care to patients requiring stabilization before discharge or transfer to a hospital, except that the facility may not provide any inpatient hospital services consisting of surgery or any other service requiring the use of general anesthesia (other than surgical procedures specified by the Secretary under section 1833(i)(1)(A)) unless the attending physician certifies that the risk associated with transferring the patient to a hospital for such services outweighs the benefits of transferring the patient to a hospital for such services.".

(2) LIMITATION ON AVERAGE LENGTH OF STAY.—Section 1820(f) of such Act (42 U.S.C. 1395i–4(f)) is amended by adding at the end the following new paragraph:

"(4) LIMITATION ON AVERAGE LENGTH OF INPATIENT STAYS.—The Secretary may terminate a designation of a rural primary care hospital under paragraph (1) if the Secretary finds that the average length of stay for inpatients at the facility during the previous year in which the designation was in effect exceeded 72 hours. In determining the compliance of a facility with the requirement of the previous sentence, there shall not be taken into account

periods of stay of inpatients in excess of 72 hours to the extent such periods exceed 72 hours because transfer to a hospital is precluded because of inclement weather or other emergency conditions.".

(3) CONFORMING AMENDMENT.—Section 1814(a)(8) of such Act (42 U.S.C. 1395f(a)(8)) is amended by striking "such services" and all that follows and inserting "the individual may reasonably be expected to be discharged or transferred to a hospital within 72 hours after admission to the rural primary care hospital.".

(4) GAO REPORTS.—Not later than 2 years after the date of the enactment of this Act, the Comptroller General shall submit reports to Congress on—

(A) the application of the requirement under section 1820(f) of the Social Security Act (as amended by this subsection) that rural primary care hospitals maintain an average length of inpatient stay during a year that does not exceed 72 hours; and

(B) the extent to which such requirement has resulted in such hospitals providing inpatient care beyond their capabilities or have lim-

ited the ability of such hospitals to provide needed services.

(c) DESIGNATION OF HOSPITALS.—

(1) PERMITTING DESIGNATION OF HOSPITALS LOCATED IN URBAN AREAS.—

(A) IN GENERAL.—Section 1820 of the Social Security Act (42 U.S.C. 1395i–4) is amended—

(i) by striking paragraph (1) of subsection (e) and redesignating paragraphs (2) through (6) as paragraphs (1) through (5);

(ii) in subsection (e)(1)(A) (as redesignated by subparagraph (A))—

(I) by striking "is located" and inserting "except in the case of a hospital located in an urban area, is located",

(II) by striking ", (ii)" and inserting "or (ii)", and

(III) by striking "or (iii)" and all that follows through "section,"; and

(iii) in subsection (i)(1)(B), by striking "paragraph (3)" and inserting "paragraph (2)".

(B) NO CHANGE IN MEDICARE PROSPECTIVE PAYMENT.—Section 1886(d)(5)(D) of such Act (42 U.S.C. 1395ww(d)(5)(D)) is amended—

(i) in clause (iii)(III), by inserting "located in a rural area and" after "that is", and

(ii) in clause (v), by inserting "located in a rural area and" after "in the case of a hospital".

(2) PERMITTING HOSPITALS LOCATED IN ADJOINING STATES TO PARTICIPATE IN STATE PROGRAM.—

(A) IN GENERAL.—Section 1820 of such Act (42 U.S.C. 1395i–4) is amended—

(i) by redesignating subsection (k) as subsection (l); and

(ii) by inserting after subsection (j) the following new subsection:

"(k) ELIGIBILITY OF HOSPITALS NOT LOCATED IN PARTICIPATING STATES.—Notwithstanding any other provision of this section—

"(1) for purposes of including a hospital or facility as a member institution of a rural health network, a State may designate a hospital or facility

that is not located in the State as an essential access community hospital or a rural primary care hospital if the hospital or facility is located in an adjoining State and is otherwise eligible for designation as such a hospital;

"(2) the Secretary may designate a hospital or facility that is not located in a State receiving a grant under subsection (a)(1) as an essential access community hospital or a rural primary care hospital if the hospital or facility is a member institution of a rural health network of a State receiving a grant under such subsection; and

"(3) a hospital or facility designated pursuant to this subsection shall be eligible to receive a grant under subsection (a)(2).".

(B) CONFORMING AMENDMENTS.—(i) Section 1820(c)(1) of such Act (42 U.S.C. 1395i–4(c)(1)) is amended by striking "paragraph (3)" and inserting "paragraph (3) or subsection (k)".

(ii) Paragraphs (1)(A) and (2)(A) of section 1820(i) of such Act (42 U.S.C. 1395i–4(i)) are each amended—

(I) in clause (i), by striking "(a)(1)" and inserting "(a)(1) (except as provided in subsection (k))", and

(II) in clause (ii), by striking "subparagraph (B)" and inserting "subparagraph (B) or subsection (k)".

(d) SKILLED NURSING SERVICES IN RURAL PRIMARY CARE HOSPITALS.—Section 1820(f)(3) of the Social Security Act (42 U.S.C. 1395i–4(f)(3)) is amended by striking "because the facility" and all that follows and inserting the following: "because, at the time the facility applies to the State for designation as a rural primary care hospital, there is in effect an agreement between the facility and the Secretary under section 1883 under which the facility's inpatient hospital facilities are used for the furnishing of extended care services, except that the number of beds used for the furnishing of such services may not exceed the total number of licensed inpatient beds at the time the facility applies to the State for such designation (minus the number of inpatient beds used for providing inpatient care pursuant to paragraph (1)(F)). For purposes of the previous sentence, the number of beds of the facility used for the furnishing of extended care services shall not include any beds of a unit of the facility that is licensed as a distinct-part skilled nursing facility at the

time the facility applies to the State for designation as a rural primary care hospital.".

(e) DEADLINE FOR DEVELOPMENT OF PROSPECTIVE PAYMENT SYSTEM FOR INPATIENT RURAL PRIMARY CARE HOSPITAL SERVICES.—Section 1814(l)(2) of the Social Security Act (42 U.S.C. 1395f(l)(2)) is amended by striking "January 1, 1993" and inserting "January 1, 1996".

(f) PAYMENT FOR OUTPATIENT RURAL PRIMARY CARE HOSPITAL SERVICES.—

(1) IMPLEMENTATION OF PROSPECTIVE PAYMENT SYSTEM.—Section 1834(g) of the Social Security Act (42 U.S.C. 1395m(g)) is amended—

(A) in paragraph (1), by striking "during a year before 1993" and inserting "during a year before the prospective payment system described in paragraph (2) is in effect"; and

(B) in paragraph (2), by striking "January 1, 1993," and inserting "January 1, 1996,".

(2) NO USE OF CUSTOMARY CHARGE IN DETERMINING PAYMENT.—Section 1834(g)(1) of such Act (42 U.S.C. 1395m(g)(1)) is amended by adding at the end the following new flush sentence:

"The amount of payment shall be determined under either method without regard to the amount of the customary or other charge.".

(g) CLARIFICATION OF PHYSICIAN STAFFING REQUIREMENT FOR RURAL PRIMARY CARE HOSPITALS.—Section 1820(f)(1)(H) of the Social Security Act (42 U.S.C. 1395i–4(f)(1)(H)) is amended by striking the period and inserting the following: ", except that in determining whether a facility meets the requirements of this subparagraph, subparagraphs (E) and (F) of that paragraph shall be applied as if any reference to a 'physician' is a reference to a physician as defined in section 1861(r)(1).".

(h) TECHNICAL AMENDMENTS RELATING TO PART A DEDUCTIBLE, COINSURANCE, AND SPELL OF ILLNESS.—(1) Section 1812(a)(1) of the Social Security Act (42 U.S.C. 1395d(a)(1)) is amended—

(A) by striking "inpatient hospital services" the first place it appears and inserting "inpatient hospital services or inpatient rural primary care hospital services";

(B) by striking "inpatient hospital services" the second place it appears and inserting "such services"; and

(C) by striking "and inpatient rural primary care hospital services".

(2) Sections 1813(a) and 1813(b)(3)(A) of such Act (42 U.S.C. 1395e(a), 1395e(b)(3)(A)) are each amended by striking "inpatient hospital services" each place it appears and inserting "inpatient hospital services or inpatient rural primary care hospital services".

(3) Section 1813(b)(3)(B) of such Act (42 U.S.C. 1395e(b)(3)(B)) is amended by striking "inpatient hospital services" and inserting "inpatient hospital services, inpatient rural primary care hospital services".

(4) Section 1861(a) of such Act (42 U.S.C. 1395x(a)) is amended—

(A) in paragraph (1), by striking "inpatient hospital services" and inserting "inpatient hospital services, inpatient rural primary care hospital services"; and

(B) in paragraph (2), by striking "hospital" and inserting "hospital or rural primary care hospital".

(i) AUTHORIZATION OF APPROPRIATIONS.—Section 1820(e) of the Social Security Act (42 U.S.C. 1395i–4(e)), as redesignated by subsection (c)(2)(A), is amended—

(1) in the matter preceding paragraph (1), by striking "1990, 1991, and 1992" and inserting "1990 through 1998";

(2) in paragraph (1), by striking "$10,000,000" and "(a)(1)" and inserting "$30,000,000" and "(a)(2)(A)", respectively; and

(3) in paragraph (2), by striking "$15,000,000" and "(a)(2)" and inserting "$45,000,000" and "(a)(2)(B)", respectively.

(j) NO LIMITATION ON NUMBER OF RURAL PRIMARY CARE HOSPITALS IN NON-EACH STATES.—Section 1820(i)(2)(C) of the Social Security Act (42 U.S.C. 1395i–4(i)(2)(C)) is amended—

(1) by striking "15"; and

(2) by striking "(f)(1), except that nothing" and inserting "(f)(1) and establishes a relationship with a full-service rural hospital that meets the requirements described in paragraph (1) through (6) of subsection (e), except that such hospital need not meet the 75 bed requirement described in paragraph (3) of such subsection. Nothing".

(k) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of the enactment of this Act.

SEC. 352. DEMONSTRATION PROJECTS TO IMPROVE ACCESS IN RURAL AREAS.

(a) IN GENERAL.—Part A of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by adding at the end the following new section:

"DEMONSTRATION PROJECTS TO IMPROVE ACCESS IN RURAL AREAS

"SEC. 1821. (a) MEDICAL ASSISTANCE FACILITY DEMONSTRATION PROJECT.—

(1) ESTABLISHMENT.—The Secretary shall provide for the establishment of demonstration projects in States providing that medical assistance facilities located in such States may receive payment in accordance with paragraph (4).

"(2) APPLICATIONS.—

"(A) IN GENERAL.—Each State desiring to conduct a demonstrationproject under this subsection shall prepare and submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require, including an explanation of a plan for evaluating the project.

"(B) APPROVAL OF APPLICATIONS.—A State that submits an application under subparagraph (A) may begin a demonstration project under this subsection—

"(i) upon approval of such application by the Secretary; or

"(ii) at the end of the 60-day period beginning on the date such application is submitted, unless the Secretary denies the application during such period.

"(3) MEDICAL ASSISTANCE FACILITY.—The term 'medical assistance facility' means for a fiscal year, a facility with respect to which the Secretary finds the following:

"(A) The facility is located in a county (or equivalent unit of local government) with fewer than 6 residents per square mile or is located more than a 35 mile drive from a hospital, a rural primary care hospital, or another facility described in this subsection.

"(B) The facility furnishes services to ill or injured individuals prior to the transportation of such individuals to a hospital or furnishes inpatient care to individuals needing such care for a period not longer than 96 hours.

"(C) The facility permits a physician assistant or nurse practitioner to admit and treat patients under the supervision of a physician not present in such facility.

"(D) The facility meets the requirements of section 1861(e) that are applicable to a hospital located in a rural area except that—

"(i) with respect to any requirements relating to the number of hours that the facility must be open on a daily or weekly basis, the facility is only required to meet the requirement to provide emergency care on a 24-hour basis;

"(ii) with respect to any services required under such section to be furnished by a dietician, pharmacist, laboratory technician, medical technologist, and radiological technologist, the facility may furnish such services on a part-time, off-site basis; and

"(iii) the inpatient care described in subparagraph (B) may be furnished by a physician assistant or nurse practitioner as provided in subparagraph (C).

"(E) The facility receives a certification of medical necessity and appropriateness by a peer review organization (or the equivalent of a peer review organization) upon admitting each patient on an inpatient basis or, in the case of ad-

missions that do not occur during regular business hours, receives such a certification at the earliest possible time.

"(F) The facility may enter into an agreement with the Secretary under section 1883 under which the facility's inpatient hospital facilities may be used for the furnishing of services of the type which, if furnished by a skilled nursing facility, would constitute extended care services.

"(4) PAYMENT FOR SERVICES.—Each medical assistance facility located in a State participating in a demonstration project under this subsection shall receive payment for inpatient medical assistance facility services (as defined in section 1861(oo)(2)) in accordance with section 1814(m) and outpatient medical assistance facility services (as defined in section 1861(oo)(3)) in accordance with section 1834(i).

"(5) GRANTS.—The Secretary shall award grants to—

"(A) selected States participating in a demonstration project under this subsection for the purpose of assisting such States in promot-

ing the establishment of medical assistance facilities; and

"(B) selected facilities in States participating in a demonstration project under this section for the purpose of financing the costs a facility incurs in converting itself to a medical assistance facility.

"(6) MAINTENANCE OF EFFORT.—Any funds available for the activities covered by a demonstration project conducted under this subsection shall supplement, and shall not supplant, funds that are expended for similar purposes under any State, regional, or local program.

"(7) DURATION.—A demonstration project under this subsection shall be conducted for a period not to exceed 8 years.

"(8) EVALUATIONS AND REPORTS.—

"(A) EVALUATIONS.—Each State that conducts a demonstration project under this subsection shall submit to the Secretary a final evaluation of such project within 360 days of the termination of such project and such interim evaluations as the Secretary may require.

"(B) REPORTS TO CONGRESS.—Not later than 360 days after the first demonstration

project under this subsection begins, and annually thereafter for each year in which a project is conducted under this subsection, the Secretary shall submit a report to the appropriate committees of the Congress which evaluates the effectiveness of the demonstration projects conducted under this subsection and includes any legislative recommendations determined appropriate by the Secretary.

"(9) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated for each of the fiscal years 1995 through 2000 from the Federal Hospital Insurance Trust Fund—

"(A) $20,000,000 for grants to States under paragraph (5)(A); and

"(B) $20,000,000 for grants to facilities under paragraph (5)(B).

"(b) RURAL EMERGENCY ACCESS CARE HOSPITAL DEMONSTRATION PROJECT.—

"(1) IN GENERAL.—

"(A) ESTABLISHMENT.—The Secretary shall provide for the establishment of demonstration projects in States providing that rural emergency access care hospitals located in such States may receive payment in accordance

with paragraph (5) for rural emergency access care hospital services provided to medicare beneficiaries.

"(2) APPLICATIONS.—

"(A) IN GENERAL.—Each State desiring to conduct a demonstration project under this subsection shall prepare and submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require, including an explanation of a plan for evaluating the project.

"(B) APPROVAL OF APPLICATIONS.—A State that submits an application under subparagraph (A) may begin a demonstration project under this subsection—

"(i) upon approval of such application by the Secretary; or

"(ii) at the end of the 60-day period beginning on the date such application is submitted, unless the Secretary denies the application during such period.

"(3) RURAL EMERGENCY ACCESS CARE HOSPITAL.—For purposes of this subsection, the term 'rural emergency access care hospital' means, for a

fiscal year, a facility with respect to which the Secretary finds the following:

"(A) The facility is located in a rural area (as defined in section 1886(d)(2)(D)).

"(B) The facility was a hospital under this title at any time during the 5-year period that ends on the date of the enactment of this subsection.

"(C) The facility is in danger of closing due to low inpatient utilization rates and negative operating losses, and the closure of the facility would limit the access of individuals residing in the facility's service area to emergency services.

"(D) The facility has entered into (or plans to enter into) an agreement with a hospital with a participation agreement in effect under section 1866(a), and under such agreement the hospital shall accept patients transferred to the hospital from the facility and receive data from and transmit data to the facility.

"(E) There is a practitioner who is qualified to provide advanced cardiac life support services (as determined by the State in which

the facility is located) on-site at the facility on a 24-hour basis.

"(F) A physician is available on-call to provide emergency medical services on a 24-hour basis.

"(G) The facility meets such staffing requirements as would apply under section 1861(e) to a hospital located in a rural area, except that—

"(i) the facility need not meet hospital standards relating to the number of hours during a day, or days during a week, in which the facility must be open, except insofar as the facility is required to provide emergency care on a 24-hour basis under subparagraphs (E) and (F); and

"(ii) the facility may provide any services otherwise required to be provided by a full-time, on-site dietician, pharmacist, laboratory technician, medical technologist, or radiological technologist on a part-time, off-site basis.

"(H) The facility meets the requirements applicable to clinics and facilities under subparagraphs (C) through (J) of paragraph (2) of

section 1861(aa) and of clauses (ii) and (iv) of the second sentence of such paragraph (or, in the case of the requirements of subparagraph (E), (F), or (J) of such paragraph, would meet the requirements if any reference in such subparagraph to a 'nurse practitioner' or to 'nurse practitioners' was deemed to be a reference to a 'nurse practitioner or nurse' or to 'nurse practitioners or nurses'), except that in determining whether a facility meets the requirements of this subparagraph, subparagraphs (E) and (F) of that paragraph shall be applied as if any reference to a 'physician' is a reference to a physician as defined in section 1861(r)(1).

"(4) RURAL EMERGENCY ACCESS CARE HOSPITAL SERVICES.—For purposes of this subsection, the term 'rural emergency access care hospital services' means the following services provided by a rural emergency access care hospital:

"(A) An appropriate medical screening examination (as described in section 1867(a)).

"(B) Necessary stabilizing examination and treatment services for an emergency medical condition and labor (as described in section 1867(b))."

"(5) PAYMENT FOR SERVICES.—Each rural emergency access care hospital located in a State participating in a demonstration project under this subsection shall receive payment for rural emergency access care hospital services in accordance with section 1833(a)(6).

"(6) GRANTS.—The Secretary shall award grants to—

"(A) selected States participating in a demonstration project under this subsection for the purpose of assisting such States in promoting the establishment of rural emergency access care hospitals; and

"(B) selected facilities in States participating in a demonstration project under this section for the purpose of financing the costs a facility incurs in converting itself to a rural emergency access care hospitals.

"(7) MAINTENANCE OF EFFORT.—Any funds available for the activities covered by a demonstration project conducted under this subsection shall supplement, and shall not supplant, funds that are expended for similar purposes under any State, regional, or local program.

"(8) DURATION.—A demonstration project under this subsection shall be conducted for a period not to exceed 8 years.

"(9) EVALUATIONS AND REPORTS.—

"(A) EVALUATIONS.—Each State that conducts a demonstration project under this subsection shall submit to the Secretary a final evaluation of such project within 360 days of the termination of such project and such interim evaluations as the Secretary may require.

"(B) REPORTS TO CONGRESS.—Not later than 360 days after the first demonstration project under this subsection begins, and annually thereafter for each year in which a project is conducted under this subsection, the Secretary shall submit a report to the appropriate committees of the Congress which evaluates the effectiveness of the demonstration projects conducted under this subsection and includes any legislative recommendations determined appropriate by the Secretary.

"(10) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated for each of the fiscal years 1995 through 2000 from the Federal Hospital Insurance Trust Fund—

"(A) $20,000,000 for grants to States under paragraph (6)(A); and

"(B) $20,000,000 for grants to facilities under paragraph (6)(B).

(b) COVERAGE OF, AND PAYMENT FOR, MEDICAL ASSISTANCE FACILITY SERVICES.

(1) AMENDMENTS TO PART A.—

(A) DEFINITIONS.—Section 1861 of the Social Security Act (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

"Medical Assistance Facility; Medical Assistance Facility Services

"(oo)(1) The term 'medical assistance facility' means a facility which is located in a State that is participating in a demonstration project under section 1820(a) and for which the Secretary finds that the criteria described in subparagraphs (A) through (F) of section 1820(a) are met with respect to the facility.

(2) The term 'inpatient medical assistance facility services' means items and services furnished to an inpatient of a medical assistance facility by such facility that would be inpatient hospital services if furnished to an inpatient of a hospital by a hospital.".

HHS SAFETY NET PROPOSAL

SUMMARY

This initiative establishes a grant program providing funds to public and private entities to enhance the ability of safety-net providers to provide comprehensive, coordinated health care to a greater number of uninsured people. Funds would be available to assist safety-net providers to develop and expand integrated systems of care, and within such integrated systems, to address service gaps so that more uninsured have access to a continuum of health care services.

QUESTIONS

1. To some extent, the safety net is working to save itself, which is part of the reason why HHS has been able to find so many local models that work. Why would we invest when States and local communities are often willing to shoulder this burden?

2. How would our existing grant programs coexist with these new grants? Would they be getting their standard grant funds (through HRSA or other parts of PHS) and then be eligible to receive additional funds through this new grant for the same services? (There is a part of the proposal that states that HHS would not provide funds to supplement existing resources, but I am curious as to how we would ensure that to be the case -- it gets very fuzzy at the local level.)

3. It sounds like grant money would subsidize the provision of services "within an integrated system of care". What exactly does that mean?

4. Grant funds can be used to develop data systems. What kind of information would these systems collect? Would they collect outcomes information? Process information? Would they be standardized nationally, so that we could get national data about the impact of this initiative?

5. Grant funds should be used to establish systems of care that effectively manage patients with multiple needs across treatment settings. Does that mean that only systems that can offer a full range of services (primary, secondary, tertiary care) can be funded? Will systems have to offer social support services as well?

6. Safety net providers are technically providers who have a legal responsibility to provide care regardless of the patient's ability to pay. Will grant funds be limited to those providers, or will the definition be broader? Who can participate in this grant program? How would they be asked to "demonstrate their committment to the provision of care to uninsured people"?

ABOUT THE SAFETY NET

What is the safety net? The safety net ensures that any American experiencing a medical emergency will receive essential health care services. Safety net providers are providers who are legally required to provide health care services to patients regardless of their ability to pay for the services they receive. Services are provided for free or on a sliding fee scale. Public hospitals, community health centers, family planning clinics, Ryan White providers, public health departments, and rural health clinics are critical components of the safety net. In addition, although it is not a stated part of their mission, many academic health centers often provide free or low cost health care to those who cannot afford to pay for it.

Who does the safety net serve? Safety net providers are the primary source of health care for the 43 million people who are presently uninsured, as well as for the ___ individuals living in rural or urban areas with a shortage of health care providers. Many of these individuals have a broad range of complex health and psychosocial needs, exacerbated by limited access to primary care services.

What services does the safety net provide? In some areas, the safety net provides the full range of health care services. In others, it is limited to the primary care provided by public health departments and community health centers and the emergency care provided by public hospitals. [lack of secondary care services here -- primary through outpatient clinics, emergency/tertiary through emergency room and public hospitals, but lack of providers for secondary care services...is this right?]

How is the safety net financed? Safety net providers have diverse funding sources. Although some of the funding for the care delivered by safety net providers comes from private insurers and patients, most of their funding comes from Federal sources. The PHS funds community health centers, family planning clinics, maternal and child health block grants, and other specicial programs to provide preventive and treatment services individuals. In addition, both Medicaid and Medicare provide funds to hospitals serving disproportionate numbers of low income patients; in 1992, these payments totaled more than $17 billion. Most States also make significant investments in the safety net, sponsoring bad debt and charity care pools to help reimburse providers for care provided to the uninsured. Local governments also play an important role in funding the safety net; in 1992, counties spent nearly $85 billion on health care, representing approximately 17 percent of their budgets. Of that amount, almost 40% was used to support public hospitals, with smaller amounts used to support public health departments and to finance the State share of Medicaid spending. In thirty States, counties are legally reponsible for care for the uninsured. In the end, however, many safety net providers bear the ultimate financial responsibility for those who are unable to afford the cost of their own care. According to CBO, hospitals and other providers delivered an estimated $28 billion in uncompensated care in 1995.

HOLES IN THE SAFETY NET

The safety net is financially unstable. Regional safety net systems face high demand for services. Approximately 43.4 million people (16.1 percent of the total population) in the United States were without health insurance coverage during the entire 1997 calendar year, an increase of 1.7 million from the previous year. In addition, as more and more States enroll their Medicaid beneficiaries in managed care plans in order to save money, safety net providers are forced to compete with other local providers to serve the only segment of their patient base that provided a stable source of financing. Local sources of funding, which often fluctuate from year to year, are becoming increasingly important to the financial viability of the health care safety net. This makes these critical providers vulnerable to an economic downturn that could threaten their financial health.

Pressure on the safety net is increasing. [The implicit cross subsidy of care for the uninsured is eroding as a result of the Federal, State, and private industry's aggressive approach to seeking low cost care for a defined population excluding the uninsured, reductions in employer sponsored coverage or declines in Medicaid rolls re: welfare reform; economy growth may end; public health departments moving to more population based services, although personal health care services still consume largest share of local health department's staffing and funds] The number of uninsured is increasing rapidly, up 1.7 million from 1996. Although CHIP and Medicaid can potentially provide coverage to many of the approximately 11 million uninsured children, roughly 32 million adults remain uninsured. Over half of those have incomes below 200 percent of the poverty level. Since Medicaid does not provide [coverage below 100% FPL], these individuals have no option but to rely on the safety net for care, as health insurance and health care services are often unaffordable. In addition, marketplace pressures have made it increasingly difficult for hospitals to make up these losses. Traditionally, hospitals and other providers have paid for uncompensated care by charging paying patients more (cost shifting). However, with increasing market competition in the health care sector, the increasing dominance of managed care in both the private sector and Medicaid, and the phase-out of Medicaid cost based reimbursement for community health centers, insurers are less willing to pay inflated prices for health care services, making it much more difficult to cross subsidize care for the uninsured internally.

Financial concerns have reduced the range of services delivered by safety net providers. Although little quantitative information exists regarding the impact of safety net responses to market changes on care to the uninsured, a number of studies indicate that safety net providers have not reduced their committment to care for this population. However, their attempts to reduce costs as a result of financial pressures may have reduced comprehensive services delivered to the low-income uninsured. For instance, a review of FQHCs in States that were implementing mandatory managed care demonstrations found that they significantly reduced the range of services provided to patients.

Care delivered by safety net providers is often uncoordinated and fragmented. While the acute and emergency care component

Safety net providers do not have coordinated data systems and cannot be held accountable for health care outcomes.

If the safety net collapses, access to critical tertiary care services are compromised.

ADDITIONAL INFORMATION ON SAFETY NET PROVIDERS

- **Public Hospitals.** Of the nation's 6,500 community hospitals, about 1,400 are "public" in that they are owned and operated by states, cities or counties. Most public hospitals also offer services to the community at large that are often underfunded by private insurance , trauma care, burn centers, neonatal intensive care units, poison control units, emergency psychiatric care and disaster response teams. Between 1980 and 1990, urban public hospitals accounted for approximately 7 percent of all hospitals, but provided 19 percent of all emergency room visits and 18 percent of outpatient visits, nearly half of which were provided to patients who were uninsured.

- **Community Health Centers and Migrant Health Centers.** The national network of nearly 600 community and migrant health centers provides comprehensive, case-managed primary and preventive care. With 2,500 delivery sites, the centers are key outpatient components of the health care safety net. Located primarily in inner-city and rural areas with shortages of health care professionals, they serve an estimated 9 million people each year. Community health centers are thought to provide care to about 20% of those they could serve, while migrant health centers serve only about 14% of migrant and seasonal farm workers.

- **Family Planning Clinics.** More than 4,000 clinics in this federally funded program, provide primary care, cancer screening, sexually transmitted disease prevention services, and family planning services to approximately 4 million women and teenagers. Approximately 85% of clinic clients have incomes under 150% of poverty.

- **Ryan White AIDS Program.** The federal Ryan White CARE Act provides a variety of health care and social services, including testing, risk reduction, counseling, transmission prevention and clinical care through 136 projects with 500 delivery sites serving an estimated 80,000 patients who have AIDS or are HIV-positive.

- **Public Health Departments.** Local governments spent $13.7 billion in 1992 on public health, which includes a wide variety of services primarily aimed at preventing the spread of communicable diseases and educating people about personal health risks ranging from child immunizations to home health care to rat control. Public health departments also deliver some personal health care services, including maternal and child services.

- **Rural Health Clinics.** Largely privately owned and operated, the nearly 2,500 federally designated rural health clinics provide critical access to health care services for some 4 million patients each year. These clinics are paid by Medicare and Medicaid under special rules, reflecting the fact that 70% of their patients are insured under one of the two programs and that the clinics frequently are the sole source of medical care in the community.

SAFETY NET MODELS THAT WORK

DETERMINANTS OF SAFETY NET VIABILITY

--DRAFT FACT SHEET--
IMPROVING HEALTH CARE ACCESS FOR THE UNINSURED
January 15, 1999

Overview: The U.S. Department of Health and Human Services has taken a number of important steps since 1993 to expand coverage and respond to rapid changes in the U.S. health care system. We have given states the flexibility to insure more low-income workers, allowed Americans to take their health care with them when they change jobs, expanded health coverage to the children of low-income families, and proposed making Medicare available to Americans aged 55 to 65.

This new initiative complements these strategies by addressing the need for health care delivery systems serving the 32 million adult Americans still without insurance. Many providers of free or low-cost health care services currently do not have the resources or technical capacity necessary to coordinate their efforts with other providers. This initiative, funded at $1 billion over 5 years, fills that gap. The bulk of the funding would provide federal grants to help clinics, county hospitals, public health departments, and other providers of free or low cost health services to create networks that foster comprehensive care for the uninsured. This coordination of services will help uninsured Americans receive more efficient and higher quality care and move toward a more "seamless" system of care for low-income working families.

A key emphasis in the early years of the program will be assisting communities and providers in the development of the infrastructure necessary to participate in networks or other coordinated care arrangements. Funds will be available for the development of the financial, information, and telecommunications systems needed to appropriately monitor and manage patient needs. The initiative will also target substantial funding toward service gaps that can be identified within coordinated systems of care for the uninsured. Although need will vary by community, the focus will be on expanding access to primary health care and ensuring that it is coordinated with other health care needs, including mental health and substance abuse services.

Millions of Americans still lack health insurance. In 1997, the number of Americans without health insurance stood at over 43 million. While the Children's Health Insurance Program and increased Medicaid outreach can potentially provide insurance coverage for more than half of the approximately 11 million uninsured children, roughly 32 million adults between the ages of 19 and 64 remain uninsured. Among these uninsured adults, about 17 million have incomes below 200 percent of the poverty level. Many of them receive their care at public clinics and local hospitals.

Many of these Americans suffer from multiple health problems and require access to a coordinated set of health care services. Yet data show that these needs are not being met. In 1997, 30% of uninsured adults did not receive needed medical care and 55% postponed needed medical care because they could not afford it. They were only about half as likely to receive a routine check-up as insured adults. Among those who

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did have a regular source of care, the uninsured adults were about five times more likely than insured adults to use the emergency room as their regular source of care.

Yet, health care providers that help uninsured Americans face many pressures. These providers consist of institutions, facilities, and individual health professionals who provide a significant volume of health care services either without payment or on a reduced fee basis to those who are uninsured. They face a number of challenges, such as increases in the number of uninsured Americans, reduced Medicaid revenues due to the pressures of Medicaid managed care, and a growing need for mental health and substance abuse services.

The Clinton Administration proposes strengthening health services for uninsured Americans. To respond to these needs, the President's FY 2000 budget will propose a competitive grant program that would provide $1 billion over five years to public and private entities, increasing the availability of comprehensive, coordinated health care for hundreds of thousands of uninsured Americans. The President will request $25 million for the first year of this initiative in his FY 2000 budget proposal, which will be sent to Congress on February 1, 1999. The intent of these grants is to establish patient-focused systems of care to serve low-income, uninsured Americans with greater efficiency and improved quality of care.

Those who provide health care to the uninsured will get help to create the infrastructure they need to provide quality care. A key emphasis in the early years of the program will be assisting communities and providers to develop the infrastructure necessary to participate in networks or other coordinated care arrangements. Funds will be available for the development of the financial, information, and telecommunications systems needed to appropriately monitor and manage patient needs. This support will improve the ability of providers to track patient care needs and receipt of service over time, permit more clients to be served, and strengthen the financial standing of providers by enhancing their ability to compete for business from Medicaid and commercial managed care organizations.

Once health services are coordinated in a community, gaps in service can be identified and filled. The initiative will also target substantial funding toward service gaps that can be identified within coordinated systems of care for the uninsured. Although need will vary by community, the emphasis will be on expanding access to primary health care and insuring coordination with other health care needs, including mental health and substance abuse services.

Some grants will build on existing model programs. Grants will be available to public or private entities, including state and local governments. A number of communities have already developed successful models of integration that have effectively coordinated care and expanded service delivery that will serve as models for others.

The Clinton Administration builds on a strong record of extending health care services to more Americans. President Clinton is committed to raising health care standards for all Americans. Since 1993, HHS has approved Medicaid demonstration programs to extend health insurance coverage to 2.2 million Americans who would otherwise be uninsured. In 1996, the President signed the Kennedy-Kassebaum bill, which ensured that Americans could take their health care with them when they changed jobs. In 1997, under the Balanced Budget Act, the Administration successfully supported the Children's Health Insurance Program (CHIP). Since then, 48 states and territories have had their CHIP plan approved by the U.S. Department of Health and Human Services.