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1 been read. The total time for considering all
2 amendments shall be limited to 26 hours of
3 which the total time for debating each amend-
4 ment under the 5-minute rule shall not exceed
5 one hour.

6 (C) RISE AND REPORT.—At the conclusion
7 of the consideration of the implementing bill for
8 amendment, the Committee of the Whole on the
9 State of the Union shall rise and report the bill
10 to the House with such amendments as may
11 have been adopted, and the previous question
12 shall be considered as ordered on the bill and
13 the amendments thereto, and the House shall
14 proceed to vote on final passage without inter-
15 vening motion except one motion to recommit.

16 (6) COMPUTATION OF DAYS.—For purposes of
17 this subsection, in computing a number of days in
18 either House, there shall be excluded—

19 (A) the days on which either House is not
20 in session because of an adjournment of more
21 than 3 days to a day certain, or an adjourn-
22 ment of the Congress sine die, and

23 (B) any Saturday and Sunday not ex-
24 cluded under subparagraph (A) when either
25 House is not in session.

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1 **TITLE III—ENTITLEMENT**
2 **REFORMS**

3 **SEC. 3000. REFERENCES IN TITLE.**

4 Except as otherwise specifically provided, whenever in
5 this title an amendment is expressed in terms of an
6 amendment to or repeal of a section or other provision,
7 the reference shall be considered to be made to that sec-
8 tion or other provision of the Social Security Act.

9 **Subtitle A—Medicaid**

10 **PART 1—REFORMS**

11 **Subpart A—Coordination of the Medicaid Program**
12 **With Reformed Health Care System**

13 **SEC. 3001. STATE PLAN REQUIREMENT REGARDING ELIGI-**
14 **BILITY FOR MEDICAL ASSISTANCE.**

15 (a) IN GENERAL.—Section 1902(a) (42 U.S.C.
16 1369a(a)) is amended—

17 (1) by striking “and” at the end of paragraph

18 (61);

19 (2) by striking the period at the end of para-
20 graph (62) and inserting “; and”; and

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

23 “(63) provide that the State will continue to
24 make eligible for medical assistance under section
25 1902(a)(10) any class or category of individuals eli-

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1 gible for medical assistance under such section as of
2 the date of the enactment of the Health Reform
3 Act.”

4 (b) EFFECTIVE DATE.—The amendment made by
5 subsection (a) shall be effective with respect to calendar
6 quarters beginning on or after the date of the enactment
7 of this Act.

8 **SEC. 3002. INTEGRATION OF CERTAIN MEDICAID ELIGI-**
9 **BLES INTO REFORMED HEALTH CARE SYS-**
10 **TEM THROUGH STATE PREMIUM AND COST-**
11 **SHARING ASSISTANCE PROGRAM.**

12 (a) IN GENERAL.—Title XIX (42 U.S.C. 1396 et
13 seq.) is amended by redesignating section 1931 as section
14 1932 and by inserting after section 1930 the following new
15 section:

16 “INTEGRATION OF CERTAIN MEDICAID ELIGIBLES INTO
17 REFORMED HEALTH CARE SYSTEM

18 “SEC. 1931. (a) IN GENERAL.—

19 “(1) REQUIREMENT ON STATES.—

20 “(A) IN GENERAL.—Except as provided in
21 subparagraph (B), with respect to calendar
22 quarters beginning on or after January 1,
23 1999, a State with a State plan under this
24 part—

25 “(i) shall not furnish medical assist-
26 ance consisting of acute medical services

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1 described in paragraph (3) to any individ-
2 uals not described in subsection (b) who
3 are otherwise eligible for medical assist-
4 ance under the plan; and

5 “(ii) shall integrate such individuals
6 into the State’s premium and cost-sharing
7 assistance program under subtitle B of
8 title II of the Health Reform Act.

9 “(B) SPECIAL RULE.—Subparagraph (A)
10 shall not apply if—

11 “(i) the eligibility percentage (as de-
12 scribed in section 2102(a)(2)(A)(ii) of the
13 Health Reform Act) for premium assist-
14 ance for individuals with incomes below
15 certain income thresholds (described in
16 section 2102(a)(2)(A) of such Act) does
17 not equal or exceed 110 percent, and

18 “(ii) the eligibility percentage (as de-
19 scribed in section 2102(a)(2)(B)(ii) of the
20 Health Reform Act) for premium assist-
21 ance for children and pregnant women (de-
22 scribed in section 2102(a)(2)(B) of such
23 Act) does not equal or exceed 240 percent.

24 “(2) STATE OPTION.—

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1 “(A) IN GENERAL.—For 1997, 1998, and
2 for any succeeding year during which paragraph
3 (1)(B) applies, a State may elect to integrate
4 individuals into the State’s premium and cost-
5 sharing assistance program, as described in
6 paragraph (1)(A) if the State notifies the Sec-
7 retary of such election not later than October 1
8 of the year preceding the year the State intends
9 to begin such integration.

10 “(B) STATES FURNISHING SERVICES
11 UNDER A WAIVER.—If a State making an elec-
12 tion under subparagraph (A) is furnishing med-
13 ical assistance consisting of acute medical serv-
14 ices described in paragraph (3) under a waiver
15 legally in effect under section 1115 and granted
16 pursuant to an application submitted on or be-
17 fore the date of the enactment of the Health
18 Reform Act to individuals who would otherwise
19 be integrated into the State’s premium and
20 cost-sharing assistance program, such State
21 may continue to furnish such services to such
22 individuals until the earliest of—

23 “(i) the termination of the waiver by
24 the State or the Secretary;

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1 “(ii) a determination that the waiver
2 is not legally in effect; or

3 “(iii) January 1, 1999.

4 “(3) ACUTE MEDICAL SERVICES.—The term
5 ‘acute medical services’ means items and services de-
6 scribed in section 1905(a) other than the following:

7 “(A) Nursing facility services (as defined
8 in section 1905(f)).

9 “(B) Intermediate care facility for the
10 mentally retarded services (as defined in section
11 1905(d)).

12 “(C) Personal care services (as described
13 in section 1905(a)(24)).

14 “(D) Private duty nursing services (as re-
15 ferred to in section 1905(a)(8)).

16 “(E) Home or community-based services
17 furnished under a waiver granted under sub-
18 section (c), (d), or (e) of section 1915.

19 “(F) Home and community care furnished
20 to functionally disabled elderly individuals
21 under section 1929.

22 “(G) Community supported living arrange-
23 ments services under section 1930.

24 “(H) Case-management services (as de-
25 scribed in section 1915(g)(2)).

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1 “(I) Home health care services (as referred
2 to in section 1905(a)(7)), clinic services, and re-
3 habilitation services that are furnished to an in-
4 dividual who has a condition or disability that
5 qualifies the individual to receive any of the
6 services described in a previous subparagraph.

7 “(J) Services furnished in an institution
8 for mental diseases (as defined in section
9 1905(i)).

10 “(b) INDIVIDUALS DESCRIBED.—

11 “(1) IN GENERAL.—The individuals described
12 in this subsection are—

13 “(A) SSI-eligible individuals (as defined in
14 paragraph (2));

15 “(B) individuals who are eligible for bene-
16 fits under part A of title XVIII; and

17 “(C) certain aliens with respect to whom
18 emergency services are furnished under section
19 1903(v)(2).

20 “(2) SSI-ELIGIBLE INDIVIDUAL.—The term
21 ‘SSI-eligible individual’ means an individual who is
22 eligible for medical assistance under the State plan
23 and—

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1 “(A) with respect to whom supplemental
2 security income benefits are being paid under
3 title XVI,

4 “(B) who is receiving a supplementary
5 payment under section 1616 or under section
6 212 of Public Law 93-66, or

7 “(C) who is receiving monthly benefits
8 under section 1619(a) (whether or not pursuant
9 to section 1616(c)(3)).

10 “(c) STATE MAINTENANCE OF EFFORT.—

11 “(1) IN GENERAL.—

12 “(A) REDUCTION IN QUARTERLY PAY-
13 MENTS.—For any calendar quarter in an inte-
14 gration year (as defined in subparagraph (B)),
15 the amount otherwise payable to a State under
16 section 1903 for the quarter shall be reduced by
17 the State maintenance of effort amount for the
18 quarter determined under paragraph (2).

19 “(B) INTEGRATION YEAR.—For purposes
20 of this paragraph, the term ‘integration year’
21 means the first year that the State integrates
22 individuals into the State’s premium and cost-
23 sharing assistance program and any succeeding
24 year.

25 “(2) MAINTENANCE OF EFFORT AMOUNT.—

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1 “(A) IN GENERAL.—The maintenance of
2 effort amount for a State for a calendar quarter
3 in an integration year shall be equal to 25 per-
4 cent of the State’s base payment amount (de-
5 termined under subparagraph (B)), updated by
6 the percentage change in the State inflation
7 index (described in subparagraph (C)(i)) and
8 the State population index (described in sub-
9 paragraph (C)(ii)) during the period beginning
10 on January 1, 1995, and ending on December
11 31 of the applicable integration year (as deter-
12 mined by the Secretary).

13 “(B) STATE BASE PAYMENT AMOUNT.—
14 The base payment amount for a State for an
15 integration year shall be an amount, as deter-
16 mined by the Secretary, equal to the total ex-
17 penditures from State funds made under the
18 State plan during fiscal year 1994 with respect
19 to medical assistance consisting of items and
20 services of the type included in the standard
21 benefits package (as defined in section
22 1101(1)(A) of the Health Reform Act) of the
23 Health Reform Act) for individuals who would
24 not have received such medical assistance if the
25 provisions of this section and the State’s pre-

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1 mium and cost-sharing assistance program (as
2 in effect in the applicable integration year) had
3 been in effect in 1994.

4 “(C) INDEXES.—

5 “(i) STATE INFLATION INDEX.—For
6 purposes of this paragraph, the Secretary
7 shall establish an inflation index which
8 measures the medical component of the
9 consumer price index for a State from year
10 to year.

11 “(ii) STATE POPULATION INDEX.—

12 The Secretary shall establish a State popu-
13 lation index which measures the change in
14 the number of individuals residing in a
15 State from year to year.”

16 (b) NO FEDERAL FINANCIAL PARTICIPATION.—Sec-
17 tion 1903(i) (42 U.S.C. 1396b(i)) is amended—

18 (1) by striking “or” at the end of paragraph

19 (14),

20 (2) by striking the period at the end of para-
21 graph (15) and inserting “; or”, and

22 (3) by inserting after paragraph (15) the fol-
23 lowing new paragraph:

24 “(16) with respect any medical assistance con-
25 sisting of acute medical services described in section

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1 1931(a)(3) furnished to individuals who are not de-
2 scribed in section 1931(b).”

3 (c) EFFECTIVE DATE.—The amendments made by
4 this section shall be effective with respect calendar quar-
5 ters beginning on or after January 1, 1997.

6 **SEC. 3003. STATE PROGRAMS FOR PROVIDING SUPPLE-**
7 **MENTAL BENEFITS.**

8 (a) MEDICAID STATE PLAN REQUIREMENT.—Section
9 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)),
10 as amended by section 3001, is amended—

11 (1) by striking “and” at the end of paragraph
12 (62);

13 (2) by striking the period at the end of para-
14 graph (63) and inserting “; and”; and

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

17 “(64) provide for a State program furnishing
18 supplemental benefits in accordance with part B.”

19 (b) STATE PROGRAMS FOR SUPPLEMENTAL BENE-
20 FITS.—Title XIX (42 U.S.C. 1396 et seq.) is amended by
21 adding at the end the following new part:

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1 **“PART B—STATE PROGRAMS FOR**
2 **SUPPLEMENTAL BENEFITS**

3 **“SEC. 1961. REQUIREMENT TO OPERATE STATE PROGRAM.**

4 “(a) IN GENERAL.—A State with a State plan ap-
5 proved under part A shall have in effect a program for
6 furnishing supplemental benefits (as defined in section
7 1962(c)) in accordance with this part in calendar years
8 beginning after 1996.

9 “(b) DESIGNATION OF STATE AGENCY.—A State
10 may designate any appropriate State agency to administer
11 the program under this part.

12 **“SEC. 1962. PROGRAM DESCRIBED.**

13 “(a) IN GENERAL.—A State program under this part
14 shall furnish supplemental benefits to such classes and
15 categories of the individuals eligible for premium assist-
16 ance under the State’s program for premium and cost-
17 sharing assistance under subtitle B of title II of the
18 Health Reform Act, as determined appropriate by the
19 State.

20 “(b) PRIORITIES.—

21 “(1) IN GENERAL.—A State must give priority
22 to children and pregnant women and may give prior-
23 ity to individuals residing in medically underserved
24 areas in furnishing services under this part.

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1 “(2) DEFINITION.—For purposes of paragraph
2 (1), the term “children” means individuals who have
3 not attained 19 years of age.

4 “(c) SUPPLEMENTAL BENEFITS DEFINED.—The
5 term ‘supplemental benefits’ means the acute medical
6 services described in section 1931(a)(3) that are not in-
7 cluded in the items and services provided under the stand-
8 ard benefits package (as defined in section 1101(1)(A) of
9 the Health Reform Act).

10 “SEC. 1963. PAYMENTS TO STATES.

11 “From its allotment under section 1964(b), the Sec-
12 retary shall pay to each State for each quarter beginning
13 with the quarter commencing January 1, 1997, an amount
14 equal to—

15 “(1) an amount equal to the State’s Federal
16 medical assistance percentage (as defined in section
17 1905(b)) of the amount demonstrated by State
18 claims to have been expended during the quarter for
19 furnishing services to eligible individuals under this
20 part; plus

21 “(2) an amount equal to 50 percent of the re-
22 mainder of the amounts expended during the quar-
23 ter as found necessary by the Secretary for the prop-
24 per and efficient administration of the State program.

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1 "SEC. 1964. FUNDING.

2 "(a) IN GENERAL.—The total amount of Federal
3 funds available for State programs under this part for
4 each fiscal year is—

5 "(1) for fiscal year 1997, \$7,000,000,000; and

6 "(2) for succeeding fiscal years, the amount de-
7 termined under this subsection for the preceding fis-
8 cal year updated by the estimated percentage change
9 in the State inflation index described in section
10 1931(c)(2)(C)(i) and the State population index de-
11 scribed in section 1931(c)(2)(C)(ii).

12 "(b) ALLOTMENTS TO STATES.—

13 "(1) IN GENERAL.—The Secretary shall allot
14 the amounts available under subsection (a) for the
15 fiscal year to the States in accordance with an allo-
16 cation formula developed by the Secretary which
17 takes into account—

18 "(A) the number of individuals who are eli-
19 gible for premium assistance under a State's
20 program for premium and cost-sharing assist-
21 ance compared to the number of such individ-
22 uals in all States; and

23 "(B) a State's matching percentage (as de-
24 fined in paragraph (3)).

25 "(2) REALLOCATIONS.—Any amounts allotted
26 to States under this subsection for a year that are

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1 not expended in such year shall remain available for
2 State programs under this part and may be reallo-
3 cated to States as the Secretary determines appro-
4 priate.

5 “(3) STATE MATCHING PERCENTAGE.—The
6 term ‘State matching percentage’ means, with re-
7 spect to a State, the amount (expressed as a per-
8 centage) equal to 1 minus the State’s Federal medi-
9 cal assistance percentage.

10 “(c) STATE ENTITLEMENT.—This part constitutes
11 budget authority in advance of appropriations Acts, and
12 represents the obligation of the Federal Government to
13 provide for the payment to States of amounts described
14 in section 1963.”

15 (c) CONFORMING AMENDMENTS.—(1) Title XIX (42
16 U.S.C. 1396 et seq.) is amended by striking the title and
17 inserting the following:

18 **“TITLE XIX—MEDICAL ASSIST-**
19 **ANCE PROGRAMS AND STATE**
20 **PROGRAMS FOR SUPPLE-**
21 **MENTAL BENEFITS”.**

22 (2) Title XIX (42 U.S.C. 1396 et seq.) is amended
23 by striking each reference to “this title” and inserting
24 “this part”.

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1 **SEC. 3004. DEMONSTRATION PROJECTS PERMITTING COV-**
2 **ERAGE UNDER CERTIFIED HEALTH PLANS OF**
3 **SSI-ELIGIBLE INDIVIDUALS.**

4 (a) **IN GENERAL.**—Pursuant to section 1115 of the
5 Social Security Act, the Secretary of Health and Human
6 Services shall conduct demonstration projects under which
7 a State may provide that a SSI-eligible individual has the
8 option to receive medical assistance consisting of the items
9 or services covered under the standard benefits package
10 (as defined in section 1101(1)(A) of the Health Reform
11 Act) through enrollment with a certified health plan pro-
12 viding such package instead of through enrollment in the
13 State plan under title XIX of the Social Security Act.

14 (b) **APPLICATION.**—A State desiring to participate in
15 a demonstration project under this section shall submit
16 an application to the Secretary at such time, in such man-
17 ner, and containing such information as the Secretary de-
18 termines appropriate.

19 (c) **REQUIREMENTS.**—A State participating in a
20 demonstration project under this section shall, in addition
21 to any requirements imposed by the Secretary, meet the
22 following requirements with respect to SSI-eligible individ-
23 uals:

24 (1) **CHOICE OF PLANS.**—The State must offer
25 individuals a choice of a certified health plans, ex-
26 cept that nothing in this paragraph may be con-

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1 strued to waive any limits on the capacity of a cer-
2 tified health plan applicable under title II of this
3 Act.

4 (2) INFORMED CHOICE.—The State shall en-
5 sure that each SSI-eligible individual is provided suf-
6 ficient information to make an informed choice
7 about enrolling in a certified health plan and select-
8 ing such a plan.

9 (3) COORDINATION OF BENEFITS.—The State
10 shall ensure that benefits covered under the stand-
11 ard benefits package and provided by a certified
12 health plan are coordinated with any supplemental
13 benefits provided by the State to an SSI-eligible in-
14 dividual.

15 (4) PAYMENTS TO CERTIFIED HEALTH PLANS
16 BY STATES.—The State shall make all necessary
17 payments of premiums, copayments, and deductibles
18 applicable under a certified health plan on behalf of
19 a SSI-eligible individual who enrolls in a certified
20 health plan.

21 (d) LIMITATION ON NUMBER OF INDIVIDUALS PER-
22 MITTED TO MAKE ELECTION.—

23 (1) IN GENERAL.—

24 (A) LIMITATION.—The number of SSI-eli-
25 gible individuals electing to enroll in a certified

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1 health plan under a demonstration project con-
2 ducted in a State during a year may not exceed
3 the applicable percentage determined under
4 subparagraph (B) of the Secretary's estimate of
5 the total number of such individuals in the
6 State who are eligible to enroll in certified
7 health plans under the project during the year.

8 (B) APPLICABLE PERCENTAGE DE-
9 SCRIBED.—The 'applicable percentage' deter-
10 mined under this subparagraph with respect to
11 a State for a year—

12 (i) for each of the first 3 years for
13 which the State participates in a dem-
14 onstration project, 15 percent; and

15 (ii) for each succeeding year in which
16 the State participates in a such a project,
17 the applicable percentage under this sub-
18 paragraph for the preceding year, in-
19 creased by 10 percent.

20 (2) WAIVER OF LIMITATION.—The limit on the
21 number of individuals provided in paragraph (1)
22 may be waived by the Secretary with respect to a
23 State if the Secretary determines that such a waiver
24 is appropriate.

25 (e) DEFINITIONS.—

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1 (1) CERTIFIED HEALTH PLAN.—The term “cer-
2 tified health plan” means a certified health plan (as
3 defined in section 3(a)(2) of the Health Reform Act)
4 that provides a standard benefits package (as de-
5 scribed in section 1101(1)(A) of such Act).

6 (2) SSI-ELIGIBLE INDIVIDUAL.—The term
7 “SSI-eligible individual” means an individual who is
8 eligible for medical assistance under the State plan
9 and—

10 (A) with respect to whom supplemental se-
11 curity income benefits are being paid under title
12 XVI of the Social Security Act,

13 (B) who is receiving a supplementary pay-
14 ment under section 1616 of such Act or under
15 section 212 of Public Law 93-66, or

16 (C) who is receiving monthly benefits
17 under section 1619(a) of the Social Security
18 Act (whether or not pursuant to section
19 1616(c)(3) of such Act).

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1 **Subpart B—State Eligibility to Contract for**
2 **Coordinated Care Services**

3 **SEC. 3011. MODIFICATION OF FEDERAL REQUIREMENTS TO**
4 **ALLOW STATES MORE FLEXIBILITY IN CON-**
5 **TRACTING FOR COORDINATED CARE SERV-**
6 **ICES UNDER MEDICAID.**

7 (a) IN GENERAL.—

8 (1) PAYMENT PROVISIONS.—Section 1903(m)
9 (42 U.S.C. 1396b(m)) is amended to read as follows:

10 “(m)(1) No payment shall be made under this title
11 to a State with respect to expenditures incurred by such
12 State for payment to an entity which is at risk (as defined
13 in section 1932(a)(4)) for services provided by such entity
14 to individuals eligible for medical assistance under the
15 State plan under this title, unless the entity is a risk con-
16 tracting entity (as defined in section 1932(a)(3)) and the
17 State and such entity comply with the applicable provi-
18 sions of section 1932.

19 “(2) No payment shall be made under this title to
20 a State with respect to expenditures incurred by such
21 State for payment for services provided to an individual
22 eligible for medical assistance under the State plan under
23 this title if such payment by the State is contingent upon
24 the individual receiving such services from a specified
25 health care provider or subject to the approval of a speci-
26 fied health care provider, unless the entity receiving pay-

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1 ment is a primary care case management entity (as de-
2 fined in section 1932(a)(2)) and the State and such entity
3 comply with the applicable provisions of section 1932.”

4 (2) REQUIREMENTS FOR COORDINATED CARE
5 SERVICES.—Title XIX (42 U.S.C. 1396 et seq.), as
6 amended by sections 3002, is amended by redesignig-
7 nating section 1932 as section 1933 and by inserting
8 after section 1931 the following new section:

9 “REQUIREMENTS FOR COORDINATED CARE SERVICES

10 “SEC. 1932. (a) DEFINITIONS.—For purposes of this
11 title—

12 “(1) PRIMARY CARE CASE MANAGEMENT PRO-
13 GRAM.—The term ‘primary care case management
14 program’ means a program operated by a State
15 agency under which such State agency enters into
16 contracts with primary care case management enti-
17 ties for the provision of health care items and serv-
18 ices which are specified in such contracts and the
19 provision of case management services to individuals
20 who are—

21 “(A) eligible for medical assistance under
22 the State plan,

23 “(B) enrolled with such primary care case
24 management entities, and

25 “(C) entitled to receive such specified
26 health care items and services and case man-

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1 agement services only as approved and ar-
2 ranged for, or provided, by such entities.

3 “(2) PRIMARY CARE CASE MANAGEMENT EN-
4 TITY.—The term ‘primary care case management
5 entity’ means a health care provider which—

6 “(A) must be a physician, group of physi-
7 cians, a Federally qualified health center, a
8 rural health clinic, or an entity employing or
9 having other arrangements with physicians op-
10 erating under a contract with a State to provide
11 services under a primary care case management
12 program,

13 “(B) receives payment on a fee for service
14 basis (or, in the case of a Federally qualified
15 health center or a rural health clinic, on a rea-
16 sonable cost per encounter basis) for the provi-
17 sion of health care items and services specified
18 in such contract to enrolled individuals,

19 “(C) receives an additional fixed fee per
20 enrollee for a period specified in such contract
21 for providing case management services (includ-
22 ing approving and arranging for the provision
23 of health care items and services specified in
24 such contract on a referral basis) to enrolled in-
25 dividuals, and

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1 “(D) is not an entity that is at risk (as de-
2 fined in paragraph (4)) for such case manage-
3 ment services.

4 “(3) RISK CONTRACTING ENTITY.—The term
5 ‘risk contracting entity’ means an entity which has
6 a contract with the State agency (or a health insur-
7 ing organization described in subsection (n)(2))
8 under which the entity—

9 “(A) provides or arranges for the provision
10 of health care items or services which are speci-
11 fied in such contract to individuals eligible for
12 medical assistance under the State plan, and

13 “(B) is at risk (as defined in paragraph
14 (4)) for part or all of the cost of such items or
15 services furnished to individuals eligible for
16 medical assistance under such plan.

17 “(4) AT RISK.—The term ‘at risk’ means an
18 entity which—

19 “(A) has a contract with the State agency
20 under which such entity is paid a fixed amount
21 for providing or arranging for the provision of
22 health care items or services specified in such
23 contract to an individual eligible for medical as-
24 sistance under the State plan and enrolled with

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1 such entity, regardless of whether such items or
2 services are furnished to such individual, and

3 “(B) is liable for all or part of the cost of
4 furnishing such items or services, regardless of
5 whether such cost exceeds such fixed payment.

6 “(5) **FEDERALLY QUALIFIED HEALTH CEN-**
7 **TER.**—The term ‘Federally qualified health center’
8 means a Federally qualified health center as defined
9 in section 1905(l)(2)(B).

10 “(6) **RURAL HEALTH CLINIC.**—The term ‘rural
11 health clinic’ means a rural health clinic as defined
12 in section 1905(l)(1).

13 “(b) **GENERAL REQUIREMENTS FOR RISK CON-**
14 **TRACTING ENTITIES.**—

15 “(1) **ORGANIZATION.**—A risk contracting entity
16 meets the requirements of this section only if such
17 entity—

18 “(A)(i) is a qualified health maintenance
19 organization as defined in section 1310(d) of
20 the Public Health Service Act, as determined by
21 the Secretary pursuant to section 1312 of such
22 Act; or

23 “(ii) is described in subparagraph (C), (D),
24 (E), (F), or (G) of subsection (e)(4);

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1 “(B) is a Federally qualified health center
2 or a rural health clinic which has made ade-
3 quate provision against the risk of insolvency
4 (pursuant to the guidelines and regulations is-
5 sued by the Secretary under this section), and
6 ensures that individuals eligible for medical as-
7 sistance under the State plan are not held liable
8 for such entity's debts in case of such entity's
9 insolvency; or

10 “(C) is an entity which meets all applicable
11 State licensing requirements and has made ade-
12 quate provision against the risk of insolvency
13 (pursuant to the guidelines and regulations is-
14 sued by the Secretary under this section), and
15 ensures that individuals eligible for medical as-
16 sistance under the State plan are not held liable
17 for such entity's debts in case of such entity's
18 insolvency.

19 “(2) GUARANTEES OF ENROLLEE ACCESS.—A
20 risk contracting entity meets the requirements of
21 this section only if—

22 “(A) the geographic locations, hours of op-
23 eration, patient to staff ratios, and other rel-
24 evant characteristics of such entity are suffi-
25 cient to afford individuals eligible for medical

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1 assistance under the State plan access to such
2 entities that is at least equivalent to the access
3 to health care providers that would be available
4 to such individuals if such individuals were not
5 enrolled with such entity;

6 “(B) such entity has reasonable and ade-
7 quate hours of operation, including 24-hour
8 availability of—

9 “(i)(I) treatment for an unforeseen ill-
10 ness, injury, or condition of an individual
11 eligible for medical assistance under the
12 State plan and enrolled with such entity;
13 or

14 “(II) referral to other health care pro-
15 viders for such treatment; and

16 “(ii) other information, as determined
17 by the Secretary or the State; and

18 “(C) such entity complies with such other
19 requirements relating to access to care as the
20 Secretary or the State may impose.

21 “(3) CONTRACT WITH STATE AGENCY.—A risk
22 contracting entity meets the requirements of this
23 section only if such entity has a written contract
24 with the State agency which provides—

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1 “(A) that the entity will comply with all
2 applicable provisions of this section, that the
3 State has the right to penalize the entity for
4 failure to comply with such requirements and to
5 terminate the contract in accordance with sub-
6 section (j), and that the entity will be subject
7 to penalties imposed by the Secretary under
8 subsection (i) for failure to comply with such
9 requirements;

10 “(B) for a payment methodology based on
11 experience rating or another actuarially sound
12 methodology approved by the Secretary, which
13 guarantees (as demonstrated by such models or
14 formulas as the Secretary may approve) that—

15 “(i) payments to the entity under the
16 contract shall not exceed an amount equal
17 to 100 percent of the costs (which shall in-
18 clude administrative costs and which may
19 include costs for inpatient hospital services
20 that would have been incurred in the ab-
21 sence of such contract) that would have
22 been incurred by the State agency in the
23 absence of the contract; and

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1 “(ii) the financial risk for inpatient
2 hospital services is limited to an extent es-
3 tablished by the State;

4 “(C) that the Secretary and the State (or
5 any person or organization designated by ei-
6 ther) shall have the right to audit and inspect
7 any books and records of the entity (and of any
8 subcontractor) that pertain—

9 “(i) to the ability of the entity (or a
10 subcontractor) to bear the risk of potential
11 financial losses; or

12 “(ii) to services performed or deter-
13 minations of amounts payable under the
14 contract;

15 “(D) that in the entity's enrollment,
16 reenrollment, or disenrollment of individuals eli-
17 gible for medical assistance under the State
18 plan and eligible to enroll, reenroll, or disenroll
19 with the entity pursuant to the contract, the en-
20 tity will not discriminate among such individ-
21 uals on the basis of such individuals' health sta-
22 tus or requirements for health care services;

23 “(E)(i) individuals eligible for medical as-
24 sistance under the State plan who have enrolled
25 with the entity are permitted to terminate such

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1 enrollment without cause as of the beginning of
2 the first calendar month (or in the case of an
3 entity described in subsection (e)(4), as of the
4 beginning of the first enrollment period) follow-
5 ing a full calendar month after a request is
6 made for such termination;

7 “(ii) that when an individual has relocated
8 outside the entity’s service area, and the entity
9 has been notified of the relocation, services
10 (within reasonable limits) furnished by a health
11 care provider outside the service area will be re-
12 imbursed either by the entity or by the State
13 agency; and

14 “(iii) for written notification of each such
15 individual’s right to terminate enrollment,
16 which shall be provided at the time of such indi-
17 vidual’s enrollment, and, in the case of a child
18 with special health care needs as defined in sub-
19 section (e)(1)(B)(ii), at the time the entity iden-
20 tifies such a child;

21 “(F) in the case of services immediately re-
22 quired to treat an unforeseen illness, injury, or
23 condition, of an individual eligible for medical
24 assistance under the State plan and enrolled
25 with the entity—

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1 “(i) that such services shall not be
2 subject to a preapproval requirement; and

3 “(ii) where such services are furnished
4 by a health care provider other than the
5 entity, for reimbursement of such provider
6 either by the entity or by the State agency;

7 “(G) for disclosure of information in ac-
8 cordance with subsection (h) and section 1124;

9 “(H) that any physician incentive plan op-
10 erated by the entity meets the requirements of
11 section 1876(i)(8);

12 “(I) for maintenance of sufficient patient
13 encounter data to identify the physician who de-
14 livers services to patients;

15 “(J) that the entity will comply with the
16 requirement of section 1902(w) with respect to
17 each enrollee;

18 “(K) that the entity will implement a
19 grievance system, inform enrollees in writing
20 about how to use such grievance system, ensure
21 that grievances are addressed in a timely man-
22 ner, and report grievances to the State at inter-
23 vals to be determined by the State;

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1 “(L) that contracts between the entity and
2 each subcontractor of such entity will require
3 each subcontractor—

4 “(i) to cooperate with the entity in the
5 implementation of its internal quality as-
6 surance program under paragraph (4) and
7 adhere to the standards set forth in the
8 quality assurance program, including
9 standards with respect to access to care,
10 facilities in which patients receive care,
11 and availability, maintenance, and review
12 of medical records;

13 “(ii) to cooperate with the Secretary,
14 the State agency and any contractor to the
15 State in monitoring and evaluating the
16 quality and appropriateness of care pro-
17 vided to enrollees as required by Federal or
18 State laws and regulations; and

19 “(iii) where applicable, to adhere to
20 regulations and program guidance with re-
21 spect to reporting requirements under sec-
22 tion 1905(r);

23 “(M) that, where the State deems it nec-
24 essary to ensure the timely provision to enroll-
25 ees of the services listed in subsection

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1 (f)(2)(C)(ii), the State may arrange for the pro-
2 vision of such services by health care providers
3 other than the entity and may adjust its pay-
4 ments to the entity accordingly;

5 “(N) that the entity and the State will
6 comply with guidelines and regulations issued
7 by the Secretary with respect to procedures for
8 marketing and information that must be pro-
9 vided to individuals eligible for medical assist-
10 ance under the State plan;

11 “(O) that the entity must provide pay-
12 ments to hospitals for inpatient hospital serv-
13 ices furnished to infants who have not attained
14 the age of 1 year, and to children who have not
15 attained the age of 6 years and who receive
16 such services in a disproportionate share hos-
17 pital, in accordance with paragraphs (2) and
18 (3) of section 1902(s);

19 “(P) that the entity shall report to the
20 State, at such time and in such manner as the
21 State shall require, on the rates paid for hos-
22 pital services (by type of hospital and type of
23 service) furnished to individuals enrolled with
24 the entity;

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1 “(Q) detailed information regarding the
2 relative responsibilities of the entity and the
3 State, for providing (or arranging for the provi-
4 sion of), and making payment for, the following
5 items and services:

6 “(i) immunizations;

7 “(ii) the purchase of vaccines;

8 “(iii) lead screening and treatment
9 services;

10 “(iv) screening and treatment for tu-
11 berculosis;

12 “(v) screening and treatment for, and
13 preventive services related to, sexually
14 transmitted diseases, including HIV infec-
15 tion;

16 “(vi) screening, diagnostic, and treat-
17 ment services required under section
18 1905(r);

19 “(vii) family planning services;

20 “(viii) services prescribed under—

21 “(I) an Individual Education
22 Plan or Individualized Family Service
23 Plan under part B or part H of the
24 Individuals with Disabilities Edu-
25 cation Act; and

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1 “(II) any other individual plan of
2 care or treatment developed under
3 this title or title V;

4 “(ix) transportation needed to obtain
5 services to which the enrollee is entitled
6 under the State plan or pursuant to an in-
7 dividual plan of care or treatment de-
8 scribed in subclauses (I) and (II) of clause
9 (viii); and

10 “(x) such other services as the Sec-
11 retary may specify;

12 “(R) detailed information regarding the
13 procedures for coordinating the relative respon-
14 sibilities of the entity and the State to ensure
15 prompt delivery of, compliance with any appli-
16 cable reporting requirements related to, and ap-
17 propriate record keeping with respect to, the
18 items and services described in subparagraph
19 (Q); and

20 “(S) such other provisions as the Secretary
21 may require.

22 “(4) INTERNAL QUALITY ASSURANCE.—A risk
23 contracting entity meets the requirements of this
24 section only if such entity has in effect a written in-
25 ternal quality assurance program which includes a

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1 systematic process to achieve specified and measur-
2 able goals and objectives for access to, and quality
3 of, care, which—

4 “(A) identifies the organizational units re-
5 sponsible for performing specific quality assur-
6 ance functions, and ensures that such units are
7 accountable to the governing body of the entity
8 and that such units have adequate supervision,
9 staff, and other necessary resources to perform
10 these functions effectively,

11 “(B) if any quality assurance functions are
12 delegated to other entities, ensures that the risk
13 contracting entity remains accountable for all
14 quality assurance functions and has mecha-
15 nisms to ensure that all quality assurance ac-
16 tivities are carried out,

17 “(C) includes methods to ensure that phy-
18 sicians and other health care professionals
19 under contract with the entity are licensed or
20 certified as required by State law, or are other-
21 wise qualified to perform the services such phy-
22 sicians and other professionals provide, and
23 that these qualifications are ensured through
24 appropriate credentialing and recredentialing
25 procedures;

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1 “(D) provides for continuous monitoring of
2 the delivery of health care, through—

3 “(i) identification of clinical areas to
4 be monitored, including immunizations,
5 prenatal care, services required under sec-
6 tion 1905(r), and other appropriate clinical
7 areas, to reflect care provided to enrollees
8 eligible for medical assistance under the
9 State plan,

10 “(ii) use of quality indicators and
11 standards for assessing the quality and ap-
12 propriateness of care delivered, and the
13 availability and accessibility of all services
14 for which the entity is responsible under
15 such entity's contract with the State,

16 “(iii) use of epidemiological data or
17 chart review, as appropriate, and patterns
18 of care overall,

19 “(iv) patient surveys, spot checks, or
20 other appropriate methods to determine
21 whether—

22 “(I) enrollees are able to obtain
23 timely appointments with primary
24 care providers and specialists, and

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1 “(II) enrollees are otherwise
2 guaranteed access and care as pro-
3 vided under paragraph (2),

4 “(v) provision of written information
5 to health care providers and other person-
6 nel on the outcomes, quality, availability,
7 accessibility, and appropriateness of care,
8 and

9 “(vi) implementation of corrective ac-
10 tions,

11 “(E) includes standards for timely enrollee
12 access to information and care which at a mini-
13 mum shall incorporate standards used by the
14 State or professional or accreditation bodies for
15 facilities furnishing perinatal and neonatology
16 care and other forms of specialized medical and
17 surgical care,

18 “(F) includes standards for the facilities in
19 which patients receive care,

20 “(G) includes standards for managing and
21 treating medical conditions prevalent among
22 such entity's enrollees eligible for medical as-
23 sistance under the State plan,

24 “(H) includes mechanisms to ensure that
25 enrollees eligible for medical assistance under

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1 the State plan receive services for which the en-
2 tity is responsible under the contract which are
3 consistent with standards established by the ap-
4 plicable professional societies or government
5 agencies,

6 “(I) includes standards for the availability,
7 maintenance, and review of medical records
8 consistent with generally accepted medical prac-
9 tice,

10 “(J) provides for dissemination of quality
11 assurance procedures to health care providers
12 under contract with the entity, and

13 “(K) meets any other requirements pre-
14 scribed by the Secretary or the State.

15 “(c) GENERAL REQUIREMENTS FOR PRIMARY CARE
16 CASE MANAGEMENT PROGRAMS.—A primary care case
17 management program implemented by a State under this
18 section shall—

19 “(1) provide that each primary care case man-
20 agement entity participating in such program has a
21 written contract with the State agency,

22 “(2) include methods for selection and monitor-
23 ing of participating primary care case management
24 entities to ensure—

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1 “(A) that the geographic locations, hours
2 of operation, patient to staff ratio, and other
3 relevant characteristics of such entities are suf-
4 ficient to afford individuals eligible for medical
5 assistance under the State plan access to such
6 entities that is at least equivalent to the access
7 to health care providers that would be available
8 to such individuals if such individuals were not
9 enrolled with such entity,

10 “(B) that such entities and their profes-
11 sional personnel are licensed as required by
12 State law and qualified to provide case manage-
13 ment services, through methods such as ongo-
14 ing monitoring of compliance with applicable re-
15 quirements and providing information and tech-
16 nical assistance, and

17 “(C) that such entities—

18 “(i) provide timely and appropriate
19 primary care to such enrollees consistent
20 with standards established by applicable
21 professional societies or governmental
22 agencies, or such other standards pre-
23 scribed by the Secretary or the State, and

24 “(ii) where other items and services
25 are determined to be medically necessary,

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1 give timely approval of such items and
2 services and referral to appropriate health
3 care providers,

4 “(3) provide that no preapproval shall be re-
5 quired for emergency health care items or services,
6 and

7 “(4) permit individuals eligible for medical as-
8 sistance under the State plan who have enrolled with
9 a primary care case management entity to terminate
10 such enrollment without cause not later than the be-
11 ginning of the first calendar month following a full
12 calendar month after the request is made for such
13 termination.

14 “(d) EXEMPTIONS FROM STATE PLAN REQUIRE-
15 MENTS.—A State plan may permit or require an individ-
16 ual eligible for medical assistance under such plan to en-
17 roll with a risk contracting entity or a primary care case
18 management entity without regard to the requirements set
19 forth in the following paragraphs of section 1902(a):

20 “(1) Paragraph (1) (concerning statewideness).

21 “(2) Paragraph (10)(B) (concerning com-
22 parability of benefits), to the extent benefits not in-
23 cluded in the State plan are provided.

24 “(3) Paragraph (23) (concerning freedom of
25 choice of provider), except with respect to services

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1 described in section 1905(a)(4)(C) and except as re-
2 quired under subsection (e).

3 “(e) STATE OPTIONS WITH RESPECT TO ENROLL-
4 MENT AND DISENROLLMENT.—

5 “(1) MANDATORY ENROLLMENT.—

6 “(A) IN GENERAL.—Except as provided in
7 subparagraph (B), a State plan may require an
8 individual eligible for medical assistance under
9 such plan to enroll with a risk contracting en-
10 tity or a primary care case management entity
11 only if the individual is permitted a choice with-
12 in a reasonable service area (as defined by the
13 State)—

14 “(i) between or among 2 or more risk
15 contracting entities,

16 “(ii) among a risk contracting entity
17 and a primary care case management pro-
18 gram, or

19 “(iii) among primary care case man-
20 agement entities.

21 “(B) SPECIAL NEEDS CHILDREN.—

22 “(i) IN GENERAL.—A State may not
23 require a child with special health care
24 needs (as defined in clause (ii)) to enroll

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1 with a risk contracting entity or a primary
2 care case management entity.

3 “(ii) DEFINITION.—For purposes of
4 this subparagraph, the term ‘child with
5 special health care needs’ refers to an indi-
6 vidual eligible for supplemental security in-
7 come under title XVI, a child described
8 under section 501(a)(1)(D), or a child de-
9 scribed in section 1902(e)(3).

10 “(2) REENROLLMENT OF INDIVIDUALS WHO
11 REGAIN ELIGIBILITY.—In the case of an individual
12 who—

13 “(A) in a month is eligible for medical as-
14 sistance under the State plan and enrolled with
15 a risk contracting entity with a contract under
16 this section,

17 “(B) in the next month (or next 2 months)
18 is not eligible for such medical assistance, but

19 “(C) in the succeeding month is again eli-
20 gible for such benefits,

21 the State agency (subject to subsection (b)(3)(E))
22 may enroll the individual for that succeeding month
23 with such entity, if the entity continues to have a
24 contract with the State agency under this sub-
25 section.

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1 “(3) DISENROLLMENT.—

2 “(A) RESTRICTIONS ON DISENROLLMENT
3 WITHOUT CAUSE.—Except as provided in sub-
4 paragraph (C), a State plan may restrict the
5 period in which individuals enrolled with risk
6 contracting entities described in paragraph (4)
7 may terminate such enrollment without cause to
8 the first month of each period of enrollment (as
9 defined in subparagraph (B)), but only if the
10 State provides notification, at least once during
11 each such enrollment period, to individuals en-
12 rolled with such entity of the right to terminate
13 such enrollment and the restriction on the exer-
14 cise of this right. Such restriction shall not
15 apply to requests for termination of enrollment
16 for cause.

17 “(B) PERIOD OF ENROLLMENT.—For pur-
18 poses of this paragraph, the term ‘period of en-
19 rollment’ means—

20 “(i) a period not to exceed 6 months
21 in duration, or

22 “(ii) a period not to exceed 1 year in
23 duration, in the case of a State that, on
24 the effective date of this paragraph, had in
25 effect a waiver under section 1115 of re-

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1 quirements under this title under which
2 the State could establish a 1-year mini-
3 mum period of enrollment with risk con-
4 tracting entities.

5 “(C) SPECIAL NEEDS CHILDREN.—A State
6 may not restrict disenrollment of a child with
7 special health care needs (as defined in para-
8 graph (1)(B)(ii)).

9 “(4) ENTITIES ELIGIBLE FOR DISENROLLMENT
10 RESTRICTIONS.—A risk contracting entity described
11 in this paragraph is—

12 “(A) a qualified health maintenance orga-
13 nization as defined in section 1310(d) of the
14 Public Health Service Act,

15 “(B) an eligible organization with a con-
16 tract under section 1876,

17 “(C) an entity that is receiving (and has
18 received during the previous 2 years) a grant of
19 at least \$100,000 under section 329(d)(1)(A)
20 or 330(d)(1) of the Public Health Service Act,

21 “(D) an entity that—

22 “(i) received a grant of at least
23 \$100,000 under section 329(d)(1)(A) or
24 section 330(d)(1) of the Public Health
25 Service Act in the fiscal year ending June

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1 30, 1976, and has been a grantee under ei-
2 ther such section for all periods after that
3 date, and

4 “(ii) provides to its enrollees, on a
5 prepaid capitation or other risk basis, all
6 of the services described in paragraphs (1),
7 (2), (3), (4)(C), and (5) of section 1905(a)
8 (and the services described in section
9 1905(a)(7), to the extent required by sec-
10 tion 1902(a)(10)(D)),

11 “(E) an entity that is receiving (and has
12 received during the previous 2 years) at least
13 \$100,000 (by grant, subgrant, or subcontract)
14 under the Appalachian Regional Development
15 Act of 1965,

16 “(F) a nonprofit primary health care en-
17 tity located in a rural area (as defined by the
18 Appalachian Regional Commission)—

19 “(i) which received in the fiscal year
20 ending June 30, 1976, at least \$100,000
21 (by grant, subgrant, or subcontract) under
22 the Appalachian Regional Development Act
23 of 1965, and

24 “(ii) which, for all periods after such
25 date, either has been the recipient of a

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1 grant, subgrant, or subcontract under such
2 Act or has provided services on a prepaid
3 capitation or other risk basis under a con-
4 tract with the State agency initially en-
5 tered into during a year in which the entity
6 was the recipient of such a grant,
7 subgrant, or subcontract,

8 “(G) an entity that had contracted with
9 the State agency prior to 1970 for the provi-
10 sion, on a prepaid risk basis, of services (which
11 did not include inpatient hospital services) to
12 individuals eligible for medical assistance under
13 the State plan,

14 “(H) a program pursuant to an undertak-
15 ing described in subsection (n)(3) in which at
16 least 25 percent of the membership enrolled on
17 a prepaid basis are individuals who—

18 “(i) are not insured for benefits under
19 part B of title XVIII or eligible for medical
20 assistance under the State plan, and

21 “(ii) (in the case of such individuals
22 whose prepayments are made in whole or
23 in part by any government entity) had the
24 opportunity at the time of enrollment in
25 the program to elect other coverage of

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1 health care costs that would have been
2 paid in whole or in part by any govern-
3 mental entity,

4 “(I) an entity that, on the date of enact-
5 ment of this provision, had a contract with the
6 State agency under a waiver under section 1115
7 or 1915(b) and was not subject to a require-
8 ment under this title to permit disenrollment
9 without cause, or

10 “(J) an entity that has a contract with the
11 State agency under a waiver under section
12 1915(b)(5).

13 “(f) STATE MONITORING AND EXTERNAL REVIEW.—

14 “(1) STATE GRIEVANCE PROCEDURE.—A State
15 contracting with a risk contracting entity or a pri-
16 mary care case management entity under this sec-
17 tion shall provide for a grievance procedure for en-
18 rollees of such entity with at least the following ele-
19 ments:

20 “(A) A toll-free telephone number for en-
21 rollee questions and grievances.

22 “(B) Periodic notification of enrollees of
23 their rights with respect to such entity or pro-
24 gram.

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1 “(C) Periodic sample reviews of grievances
2 registered with such entity or program or with
3 the State.

4 “(D) Periodic survey and analysis of en-
5 rollee satisfaction with such entity or program,
6 including interviews with individuals who
7 disenroll from the entity or program.

8 “(2) STATE MONITORING OF QUALITY AND AC-
9 CESS.—

10 “(A) RISK CONTRACTING ENTITIES.—A
11 State contracting with a risk contracting entity
12 under this section shall provide for ongoing
13 monitoring of such entity's compliance with the
14 requirements of subsection (b), including com-
15 pliance with the requirements of such entity's
16 contract under subsection (b)(3), and shall un-
17 dertake appropriate followup activities to ensure
18 that any problems identified are rectified and
19 that compliance with the requirements of sub-
20 section (b) and the requirements of the contract
21 under subsection (b)(3) is maintained.

22 “(B) PRIMARY CARE CASE MANAGEMENT
23 ENTITIES.—A State electing to implement a
24 primary care case management program shall
25 provide for ongoing monitoring of the pro-

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1 gram's compliance with the requirements of
 2 subsection (c) and shall undertake appropriate
 3 followup activities to ensure that any problems
 4 identified are rectified and that compliance with
 5 subsection (c) is maintained.

6 "(C) SERVICES.—

7 "(i) IN GENERAL.—The State shall
 8 establish procedures (in addition to those
 9 required under subparagraphs (A) and
 10 (B)) to ensure that the services listed in
 11 clause (ii) are available in a timely manner
 12 to an individual enrolled with a risk con-
 13 tracting entity or a primary care case man-
 14 agement entity. Where necessary to ensure
 15 the timely provision of such services, the
 16 State shall arrange for the provision of
 17 such services by health care providers
 18 other than the risk contracting entity or
 19 the primary care case management entity
 20 in which an individual is enrolled.

21 "(ii) SERVICES LISTED.—The services
 22 listed in this clause are—

23 "(I) prenatal care;

24 "(II) immunizations;

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1 “(III) lead screening and treat-
2 ment;

3 “(IV) prevention, diagnosis and
4 treatment of tuberculosis, sexually
5 transmitted diseases (including HIV
6 infection), and other communicable
7 diseases; and

8 “(V) such other services as the
9 Secretary may specify.

10 “(iii) REPORT.—The procedures re-
11 ferred to in clause (i) shall be described in
12 an annual report to the Secretary provided
13 by the State.

14 “(3) EXTERNAL INDEPENDENT REVIEW.—

15 “(A) IN GENERAL.—Except as provided in
16 paragraph (4), a State contracting with a risk
17 contracting entity under this section shall pro-
18 vide for an annual external independent review
19 of the quality and timeliness of, and access to,
20 the items and services specified in such entity's
21 contract with the State agency. Such review
22 shall be conducted by a utilization control and
23 peer review organization with a contract under
24 section 1153 or another organization unaffili-
25 ated with the State government or with any

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1 risk contracting entity and approved by the
2 Secretary.

3 “(B) CONTENTS OF REVIEW.—An external
4 independent review conducted under this para-
5 graph shall include the following:

6 “(i) A review of the entity’s medical
7 care, through sampling of medical records
8 or other appropriate methods, for indica-
9 tions of quality of care and inappropriate
10 utilization (including overutilization) and
11 treatment.

12 “(ii) A review of enrollee inpatient
13 and ambulatory data, through sampling of
14 medical records or other appropriate meth-
15 ods, to determine trends in quality and ap-
16 propriateness of care.

17 “(iii) Notification of the entity and
18 the State when the review under this para-
19 graph indicates inappropriate care, treat-
20 ment, or utilization of services (including
21 overutilization).

22 “(iv) Other activities as prescribed by
23 the Secretary or the State.

24 “(C) AVAILABILITY.—The results of each
25 external independent review conducted under

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1 this paragraph shall be available to the public
2 consistent with the requirements for disclosure
3 of information contained in section 1160.

4 “(4) DEEMED COMPLIANCE WITH EXTERNAL
5 INDEPENDENT QUALITY OF CARE REVIEW REQUIRE-
6 MENTS.—

7 “(A) IN GENERAL.—The Secretary may
8 deem the State to have fulfilled the requirement
9 for independent external review of quality of
10 care with respect to an entity which has been
11 accredited by an organization described in sub-
12 paragraph (B) and approved by the Secretary.

13 “(B) ACCREDITING ORGANIZATION.—An
14 accrediting organization described in this sub-
15 paragraph must—

16 “(i) exist for the primary purpose of
17 accrediting coordinated care organizations;

18 “(ii) be governed by a group of indi-
19 viduals representing health care providers,
20 purchasers, regulators, and consumers (a
21 minority of which shall be representatives
22 of health care providers);

23 “(iii) have substantial experience in
24 accrediting coordinated care organizations,

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1 including an organization's internal quality
2 assurance program;

3 "(iv) be independent of health care
4 providers or associations of health care
5 providers;

6 "(v) be a nonprofit organization; and

7 "(vi) have an accreditation process
8 which meets requirements specified by the
9 Secretary.

10 "(5) FEDERAL MONITORING RESPONSIBIL-
11 ITIES.—The Secretary shall review the external inde-
12 pendent reviews conducted pursuant to paragraph
13 (3) and shall monitor the effectiveness of the State's
14 monitoring and followup activities required under
15 subparagraph (A) of paragraph (2). If the Secretary
16 determines that a State's monitoring and followup
17 activities are not adequate to ensure that the re-
18 quirements of paragraph (2) are met, the Secretary
19 shall undertake appropriate followup activities to en-
20 sure that the State improves its monitoring and fol-
21 lowup activities.

22 "(g) PARTICIPATION OF FEDERALLY QUALIFIED
23 HEALTH CENTERS AND RURAL HEALTH CLINICS.—

24 "(1) IN GENERAL.—Each risk contracting en-
25 tity shall, with respect to each electing essential

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1 community provider (as defined in paragraph (5))
2 located within the plan's service area, either—

3 “(A) enter into a written provider partici-
4 pation agreement (described in paragraph (2))
5 with the provider, or

6 “(B) enter into a written agreement under
7 which the plan shall make payment to the pro-
8 vider in accordance with paragraph (3).

9 “(2) PARTICIPATION AGREEMENT.—A partici-
10 pation agreement between a risk contracting entity
11 and an electing essential community provider under
12 this subsection shall provide that the entity agrees to
13 treat the provider in accordance with terms and con-
14 ditions at least as favorable as those that are appli-
15 cable to other participating providers with the risk
16 contracting entity with respect to each of the follow-
17 ing:

18 “(A) The scope of services for which pay-
19 ment is made by the entity to the provider.

20 “(B) The rate of payment for covered care
21 and services.

22 “(C) The availability of financial incentives
23 to participating providers.

24 “(D) Limitations on financial risk provided
25 to other participating providers.

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1 “(E) Assignment of enrollees to participat-
2 ing providers.

3 “(F) Access by the provider's patients to
4 providers in medical specialties or subspecialties
5 participating in the plan.

6 “(3) PAYMENTS FOR PROVIDERS WITHOUT PAR-
7 TICIPATION AGREEMENTS.—Payment in accordance
8 with this paragraph is payment based on payment
9 methodologies and rates used under the applicable
10 Medicare payment methodology and rates (or the
11 most closely applicable methodology under such pro-
12 gram as the Secretary of Health and Human Serv-
13 ices specifies in regulations).

14 “(4) ELECTION.—

15 “(A) IN GENERAL.—In this subsection, the
16 term ‘electing essential community provider’
17 means, with respect to a risk contracting entity,
18 an essential community provider that elects this
19 subpart to apply to the entity.

20 “(B) FORM OF ELECTION.—An election
21 under this paragraph shall be made in a form
22 and manner specified by the Secretary, and
23 shall include notice to the risk contracting en-
24 tity involved. Such an election may be made an-
25 nually with respect to an entity, except that the

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1 entity and provider may agree to make such an
2 election on a more frequent basis.

3 “(5) PROVIDERS DESCRIBED.—The categories
4 of providers and organizations described in this sub-
5 section are as follows:

6 “(A) MIGRANT HEALTH CENTERS.—A re-
7 cipient or subrecipient of a grant under section
8 329 of the Public Health Service Act.

9 “(B) COMMUNITY HEALTH CENTERS.—A
10 recipient or subrecipient of a grant under sec-
11 tion 330 of the Public Health Service Act.

12 “(C) HOMELESS PROGRAM PROVIDERS.—A
13 recipient or subrecipient of a grant under sec-
14 tion 340 of the Public Health Service Act.

15 “(D) PUBLIC HOUSING PROVIDERS.—A re-
16 cipient or subrecipient of a grant under section
17 340A of the Public Health Service Act.

18 “(E) FAMILY PLANNING CLINICS.—A re-
19 cipient or subrecipient of a grant under title X
20 of the Public Health Service Act.

21 “(F) INDIAN HEALTH PROGRAMS.—A serv-
22 ice unit of the Indian Health Service, a tribal
23 organization, or an urban Indian program, as
24 defined in the Indian Health Care Improvement
25 Act.

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1 “(G) AIDS PROVIDERS UNDER RYAN
2 WHITE ACT.—A public or private nonprofit
3 health care provider that is a recipient or sub-
4 recipient of a grant under title XXIII of the
5 Public Health Service Act.

6 “(H) MATERNAL AND CHILD HEALTH PRO-
7 VIDERS.—A public or private nonprofit entity
8 that provides prenatal care, pediatric care, or
9 ambulatory services to children, including chil-
10 dren with special health care needs, and that
11 receives funding for such care or services under
12 title V of the Social Security Act.

13 “(I) FEDERALLY QUALIFIED HEALTH CEN-
14 TER; RURAL HEALTH CLINIC.—A Federally-
15 qualified health center or a rural health clinic
16 (as such terms are defined in section 1861(aa)).

17 “(6) SUBRECIPIENT DEFINED.—In this sub-
18 section, the term ‘subrecipient’ means, with respect
19 to a recipient of a grant under a particular author-
20 ity, an entity that—

21 “(A) is receiving funding from such a
22 grant under a contract with the principal recipi-
23 ent of such a grant, and

24 “(B) meets the requirements established to
25 be a recipient of such a grant.

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1 “(7) SUNSET OF REQUIREMENT.—The require-
2 ments of this subsection shall only apply to risk con-
3 tracting entities during calendar years 1995 through
4 2000.

5 “(h) TRANSACTIONS WITH PARTIES IN INTEREST.—

6 “(1) IN GENERAL.—Each risk contracting en-
7 tity which is not a qualified health maintenance or-
8 ganization (as defined in section 1310(d) of the
9 Public Health Service Act) must report to the State
10 and, upon request, to the Secretary, the Inspector
11 General of the Department of Health and Human
12 Services, and the Comptroller General of the United
13 States a description of transactions between the en-
14 tity and a party in interest (as defined in section
15 1318(b) of such Act), including the following trans-
16 actions:

17 “(A) Any sale or exchange, or leasing of
18 any property between the entity and such a
19 party.

20 “(B) Any furnishing for consideration of
21 goods, services (including management serv-
22 ices), or facilities between the entity and such
23 a party, but not including salaries paid to em-
24 ployees for services provided in the normal
25 course of their employment.

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1 “(C) Any lending of money or other exten-
 2 sion of credit between the entity and such a
 3 party.

4 The State or the Secretary may require that infor-
 5 mation reported with respect to a risk contracting
 6 entity which controls, or is controlled by, or is under
 7 common control with, another entity be in the form
 8 of a consolidated financial statement for the risk
 9 contracting entity and such entity.

10 “(2) AVAILABILITY OF INFORMATION.—Each
 11 risk contracting entity shall make the information
 12 reported pursuant to paragraph (1) available to its
 13 enrollees upon reasonable request.

14 “(i) REMEDIES FOR FAILURE TO COMPLY.—

15 “(1) IN GENERAL.—If the Secretary determines
 16 that a risk contracting entity or a primary care case
 17 management entity—

18 “(A) fails substantially to provide services
 19 required under section 1905(r), when such an
 20 entity is required to do so, or provide medically
 21 necessary items and services that are required
 22 to be provided to an individual enrolled with
 23 such an entity, if the failure has adversely af-
 24 fected (or has substantial likelihood of adversely
 25 affecting) the individual;

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1 “(B) imposes premiums on individuals en-
2 rolled with such an entity in excess of the pre-
3 miums permitted under this title;

4 “(C) acts to discriminate among individ-
5 uals in violation of the provision of subsection
6 (b)(3)(D), including expulsion or refusal to
7 reenroll an individual or engaging in any prac-
8 tice that would reasonably be expected to have
9 the effect of denying or discouraging enrollment
10 (except as permitted by this section) by eligible
11 individuals with the entity whose medical condi-
12 tion or history indicates a need for substantial
13 future medical services;

14 “(D) misrepresents or falsifies information
15 that is furnished—

16 “(i) to the Secretary or the State
17 under this section; or

18 “(ii) to an individual or to any other
19 entity under this section; or

20 “(E) fails to comply with the requirements
21 of section 1876(i)(8),

22 the Secretary may provide, in addition to any other
23 remedies available under law, for any of the rem-
24 edies described in paragraph (2).

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1 “(2) ADDITIONAL REMEDIES.—The remedies
2 described in this paragraph are—

3 “(A) civil money penalties of not more
4 than \$25,000 for each determination under
5 paragraph (1), or, with respect to a determina-
6 tion under subparagraph (C) or (D)(i) of such
7 paragraph, of not more than \$100,000 for each
8 such determination, plus, with respect to a de-
9 termination under paragraph (1)(B), double the
10 excess amount charged in violation of such
11 paragraph (and the excess amount charged
12 shall be deducted from the penalty and returned
13 to the individual concerned), and plus, with re-
14 spect to a determination under paragraph
15 (1)(C), \$15,000 for each individual not enrolled
16 as a result of a practice described in such para-
17 graph, or

18 “(B) denial of payment to the State for
19 medical assistance furnished by a risk contract-
20 ing entity or a primary care case management
21 entity under this section for individuals enrolled
22 after the date the Secretary notifies the entity
23 of a determination under paragraph (1) and
24 until the Secretary is satisfied that the basis for

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1 such determination has been corrected and is
2 not likely to recur.

3 The provisions of section 1128A (other than sub-
4 sections (a) and(b)) shall apply to a civil money pen-
5 alty under subparagraph (A) in the same manner as
6 such provisions apply to a penalty or proceeding
7 under section 1128A(a).

8 “(j) TERMINATION OF CONTRACT BY STATE.—Any
9 State which has a contract with a risk contracting entity
10 or a primary care case management entity may terminate
11 such contract if such entity fails to comply with the terms
12 of such contract or any applicable provision of this section.

13 “(k) FAIR HEARING.—Nothing in this section shall
14 affect the rights of an individual eligible to receive medical
15 assistance under the State plan to obtain a fair hearing
16 under section 1902(a)(3) or under applicable State law.

17 “(l) DISPROPORTIONATE SHARE HOSPITALS.—Noth-
18 ing in this section shall affect any requirement on a State
19 to comply with section 1923.

20 “(m) REFERRAL PAYMENTS.—For 1 year following
21 the date on which individuals eligible for medical assist-
22 ance under the State plan in a service area are required
23 to enroll with a risk contracting entity or a primary care
24 case management entity, Federally qualified health cen-
25 ters and rural health centers located in such service area

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1 or providing care to such enrollees, shall receive a fee for
2 educating such enrollees about the availability of services
3 from the risk contracting entity or primary care case man-
4 agement entity with which such enrollees are enrolled.

5 “(n) SPECIAL RULES.—

6 “(1) NONAPPLICABILITY OF CERTAIN PROVI-
7 SIONS TO CERTAIN RISK CONTRACTING ENTITIES.—

8 In the case of any risk contracting entity which—

9 “(A)(i) is an individual physician or a phy-
10 sician group practice of less than 50 physicians,
11 and

12 “(ii) is not described in paragraphs (A)
13 and (B) of subsection (b)(1), and

14 “(B) is at risk only for the health care
15 items and services directly provided by such en-
16 tity,

17 paragraphs (3)(K), (3)(L), (3)(O), (3)(P), and (4)
18 of subsection (b), and paragraph (3) of subsection
19 (f), shall not apply to such entity.

20 “(2) EXCEPTION FROM DEFINITION OF RISK
21 CONTRACTING ENTITY.—For purposes of this sec-
22 tion, the term ‘risk contracting entity’ shall not in-
23 clude a health insuring organization which was used
24 by a State before April 1, 1986, to administer a por-

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1 tion of the State plan of such State on a statewide
2 basis.

3 “(3) NEW JERSEY.—The rules under section
4 1903(m)(6) as in effect on the day before the effec-
5 tive date of this section shall apply in the case of an
6 undertaking by the State of New Jersey (as de-
7 scribed in such section 1903(m)(6)).

8 “(o) CONTINUATION OF CERTAIN COORDINATED
9 CARE PROGRAMS.—The Secretary may provide for the
10 continuation of any coordinated care program operating
11 under section 1115 or 1915 without requiring compliance
12 with any provision of this section which conflicts with the
13 continuation of such program and without requiring any
14 additional waivers under such sections 1115 and 1915 if
15 the program has been successful in assuring quality and
16 containing costs (as determining by the Secretary) and is
17 likely to continue to be successful in the future.

18 “(p) GUIDELINES, REGULATIONS, AND MODEL CON-
19 TRACT.—

20 “(1) GUIDELINES AND REGULATIONS ON SOL-
21 VENCY.—At the earliest practicable time after the
22 date of enactment of this section, the Secretary shall
23 issue guidelines and regulations concerning solvency
24 standards for risk contracting entities and sub-
25 contractors of such risk contracting entities. Such

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1 guidelines and regulations shall take into account
2 characteristics that may differ among risk contract-
3 ing entities including whether such an entity is at
4 risk for inpatient hospital services.

5 “(2) GUIDELINES AND REGULATIONS ON MAR-
6 KETING.—At the earliest practicable time after the
7 date of enactment of this section, the Secretary shall
8 issue guidelines and regulations concerning—

9 “(A) marketing undertaken by any risk
10 contracting entity or any primary care case
11 management program to individuals eligible for
12 medical assistance under the State plan, and

13 “(B) information that must be provided by
14 States or any such entity to individuals eligible
15 for medical assistance under the State plan
16 with respect to—

17 “(i) the options and rights of such in-
18 dividuals to enroll with, and disenroll from,
19 any such entity, as provided in this section,
20 and

21 “(ii) the availability of services from
22 any such entity (including a list of services
23 for which such entity is responsible or
24 must approve and information on how to

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1 obtain services for which such entity is not
2 responsible).

3 In developing the guidelines and regulations under
4 this paragraph, the Secretary shall address the spe-
5 cial circumstances of children with special health
6 care needs (as defined in subsection (e)(1)(B)(ii))
7 and other individuals with special health care needs.

8 “(3) MODEL CONTRACT.—The Secretary shall
9 develop a model contract to reflect the requirements
10 of subsection (b)(3) and such other requirements as
11 the Secretary determines appropriate.”

12 (b) WAIVERS FROM REQUIREMENTS ON COORDI-
13 NATED CARE PROGRAMS.—Section 1915(b) (42 U.S.C.
14 1396n) is amended—

15 (1) in the matter preceding paragraph (1), by
16 striking “as may be necessary” and inserting “, and
17 section 1932 as may be necessary”;

18 (2) in paragraph (1), by striking “a primary
19 care case-management system or”;

20 (3) by striking “and” at the end of paragraph
21 (3);

22 (4) by striking the period at the end of para-
23 graph (4) and inserting “, and”; and

24 (5) by inserting after paragraph (4) the follow-
25 ing new paragraph:

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1 “(5) to permit a risk contracting entity (as de-
2 fined in section 1932(a)(3)) to restrict the period in
3 which individuals enrolled with such entity may ter-
4 minate such enrollment without cause in accordance
5 with section 1932(e)(3)(A).”

6 (c) STATE OPTION TO GUARANTEE MEDICAID ELIGI-
7 BILITY.—Section 1902(e)(2) (42 U.S.C. 1396a(e)(2)) is
8 amended—

9 (1) in subparagraph (A), by striking all that
10 precedes “(but for this paragraph)” and inserting
11 “In the case of an individual who is enrolled—

12 “(i) with a qualified health maintenance
13 organization (as defined in title XIII of the
14 Public Health Service Act), or with a risk con-
15 tracting entity (as defined in section
16 1932(a)(3)), or

17 “(ii) with any risk contracting entity (as
18 defined in section 1932(a)(3)) in a State that,
19 on the effective date of this provision, had in ef-
20 fect a waiver under section 1115 of require-
21 ments under this title under which the State
22 could extend eligibility for medical assistance
23 for enrollees of such entity, or

24 “(iii) with an eligible organization with a
25 contract under section 1876,

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1 and who would",

2 (2) in subparagraph (B), by striking "organiza-
3 tion or" each place it appears, and

4 (3) by adding at the end the following new sub-
5 paragraph:

6 "(C) The State plan may provide, notwith-
7 standing any other provision of this title, that
8 an individual shall be deemed to continue to be
9 eligible for benefits under this title until the end
10 of the month following the month in which such
11 individual would (but for this paragraph) lose
12 such eligibility because of excess income and re-
13 sources, if the individual is enrolled with a risk
14 contracting entity or primary care case manage-
15 ment entity (as those terms are defined in sec-
16 tion 1932(a))."

17 (d) ENHANCED MATCH RELATED TO QUALITY
18 REVIEW.—Section 1903(a)(3)(C) (42 U.S.C.
19 1396b(a)(3)(C)) is amended—

20 (1) by striking "organization or by" and insert-
21 ing "organization, by"; and

22 (2) by striking "section 1152, as determined by
23 the Secretary," and inserting "section 1152, as de-
24 termined by the Secretary, or by another organiza-
25 tion approved by the Secretary which is unaffiliated

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1 with the State government or with any risk contract-
2 ing entity (as defined in section 1932(a)(3)),”

3 (e) ACCUMULATION OF RESERVES BY CERTAIN EN-
4 TITIES.—Any organization referred to in section 329, 330,
5 or 340, of the Public Health Service Act which has con-
6 tracted with a State agency as a risk contracting entity
7 under section 1932(g)(3)(A) of the Social Security Act
8 may accumulate reserves with respect to payments made
9 to such organization under section 1932(g)(3)(C) of such
10 Act.

11 (f) CONFORMING AMENDMENTS.—

12 (1) Section 1128(b)(6)(C)(i) (42 U.S.C. 1320a-
13 7(b)(6)(C)(i)) is amended by striking “health main-
14 tenance organization” and inserting “risk contract-
15 ing entity”.

16 (2) Section 1902(a)(23) (42 U.S.C.
17 1396a(a)(23)) is amended by striking “primary care
18 case-management system (described in section
19 1915(b)(1)), a health maintenance organization,”
20 and inserting “primary care case management pro-
21 gram (as defined in section 1932(a)(1)), a risk con-
22 tracting entity (as defined in section 1932(a)(3)),”.

23 (3) Section 1902(a)(30)(C) (42 U.S.C.
24 1396a(a)(30)(C)) is amended by striking “use a uti-
25 lization” and all that follows through “with the re-

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1 sults” and inserting “provide for independent review
2 and quality assurance of entities with contracts
3 under section 1932, in accordance with subsection
4 (f) of such section 1932, with the results”.

5 (4) Section 1902(a)(57) (42 U.S.C.
6 1396a(a)(57)) is amended by striking “or health
7 maintenance organization (as defined in section
8 1903(m)(1)(A))” and inserting “risk contracting en-
9 tity, or primary care case management entity (as de-
10 fined in section 1932(a))”.

11 (5) Section 1902(a) (42 U.S.C. 1396a), as
12 amended by sections 3001 and 3003, is amended—

13 (A) by striking “and” at the end of para-
14 graph (63);

15 (B) by striking the period at the end of
16 paragraph (64) and inserting “; and”; and

17 (C) by adding at the end the following new
18 paragraphs:

19 “(65) at State option, provide for a primary
20 care case management program in accordance with
21 section 1932; and

22 “(66) at State option, provide for a program
23 under which the State contracts with risk contract-
24 ing entities in accordance with section 1932.”

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1 (6) Section 1902(p)(2) (42 U.S.C. 1396a(p)(2))
2 is amended by striking "health maintenance organi-
3 zation (as defined in section 1903(m))" and insert-
4 ing "risk contracting entity (as defined in section
5 1932(a)(3))".

6 (7) Section 1902(w) (42 U.S.C. 1396a(w)) is
7 amended—

8 (A) in paragraph (1), by striking "section
9 1903(m)(1)(A)" and inserting "section
10 1932(a)(3)", and

11 (B) in paragraph (2)(E)—

12 (i) by striking "health maintenance
13 organization" and inserting "risk contract-
14 ing entity", and

15 (ii) by striking "organization" and in-
16 serting "entity".

17 (8) Section 1903(k) (42 U.S.C. 1396b(k)) is
18 amended by striking "health maintenance organiza-
19 tion which meets the requirements of subsection (m)
20 of this section" and inserting "risk contracting en-
21 tity which meets the requirements of section 1932".

22 (9) Section 1903(w)(7)(A)(viii) (42 U.S.C.
23 1396b(w)(7)(A)(viii)) is amended by striking "health
24 maintenance organizations (and other organizations
25 with contracts under section 1903(m))" and insert-

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1 ing "risk contracting entities with contracts under
2 section 1932".

3 (10) Section 1905(a) (42 U.S.C. 1396d(a)) is
4 amended, in the matter preceding clause (i), by in-
5 serting "(which may be on a prepaid capitation or
6 other risk basis)" after "payment".

7 (11) Section 1916(b)(2)(D) (42 U.S.C.
8 1396o(b)(2)(D)) is amended by striking "health
9 maintenance organization (as defined in section
10 1903(m))" and inserting "risk contracting entity (as
11 defined in section 1932(a)(3))".

12 (12) Section 1925(b)(4)(D)(iv) (42 U.S.C.
13 1396r-6(b)(4)(D)(iv)) is amended—

14 (A) in the heading, by striking "HMO"
15 and inserting "**RISK CONTRACTING ENTITY**",

16 (B) by striking "health maintenance orga-
17 nization (as defined in section 1903(m)(1)(A))"
18 and inserting "risk contracting entity (as de-
19 fined in section 1932(a)(3))", and

20 (C) by striking "health maintenance orga-
21 nization in accordance with section 1903(m)"
22 and inserting "risk contracting entity in accord-
23 ance with section 1932".

24 (13) Paragraphs (1) and (2) of section 1926(a)
25 (42 U.S.C. 1396r-7(a)) are each amended by strik-

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1 ing "health maintenance organizations under section
2 1903(m)" and inserting "risk contracting entities
3 under section 1932".

4 (14) Section 1927(j)(1) is amended by striking
5 "* * * Health Maintenance Organizations, includ-
6 ing those organizations that contract under section
7 1903(m)" and inserting "risk contracting entities
8 (as defined in section 1932(a)(3))".

9 (g) EFFECTIVE DATE.—The amendments made by
10 this section shall become effective with respect to calendar
11 quarters beginning on or after January 1, 1995.

12 **PART 2—FINANCING PROVISIONS**

13 **SEC. 3101. REPLACEMENT OF DSH PAYMENT PROVISIONS**
14 **WITH PROVISIONS RELATING TO PAYMENTS**
15 **TO HOSPITALS SERVING VULNERABLE POPU-**
16 **LATIONS.**

17 (a) AMENDMENTS TO PROVISIONS REQUIRING
18 STATES TO MAKE DSH PAYMENT ADJUSTMENTS.—

19 (1) ADJUSTMENTS TO NATIONAL DSH PAYMENT
20 LIMIT.—Section 1923(f)(1)(B) (42 U.S.C. 1396r-
21 4(f)(1)(B)) is amended to read as follows:

22 "(B) NATIONAL DSH PAYMENT LIMIT.—

23 "(i) IN GENERAL.—Except as pro-
24 vided in clause (ii), the national DSH pay-
25 ment limit for a fiscal year is equal to 12

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1 percent of the total amount of expenditures
2 under the State plans under this part for
3 medical assistance during the fiscal year.

4 “(ii) REDUCTION IN LIMIT.—For fis-
5 cal years during which the eligibility per-
6 centage for premium assistance under sec-
7 tion 2102(a)(2)(A)(ii) of the Health Re-
8 form Act—

9 “(I) equals or exceeds 125 per-
10 cent but is less than 150 percent, ‘10
11 percent’ shall be substituted for ‘12
12 percent’ in clause (i);

13 “(II) equals or exceeds 150 per-
14 cent but is less than 175 percent, ‘8
15 percent’ shall be substituted for ‘12
16 percent’ in clause (i);

17 “(III) equals or exceeds 175 per-
18 cent but is less than 200 percent, ‘6
19 percent’ shall be substituted for ‘12
20 percent’ in clause (i); and

21 “(IV) equals 200 percent, ‘4 per-
22 cent’ shall be substituted for ‘12 per-
23 cent’ in clause (i).

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1 (2) ADJUSTMENTS TO STATE ALLOTMENT LIM-
2 ITS.—Section 1923(f)(2)(B) (42 U.S.C. 1396r-
3 4(f)(2)(B)) is amended to read as follows:

4 “(B) EXCEPTIONS.—

5 “(i) IN GENERAL.—Except as pro-
6 vided in clause (ii), a State DSH allotment
7 under subparagraph (A) for a fiscal year
8 shall not exceed 12 percent of the total
9 amount of expenditures under the State
10 plan for medical assistance during the fis-
11 cal year.

12 “(ii) REDUCTION IN LIMIT.—For fis-
13 cal years during which the eligibility per-
14 centage for premium assistance under sec-
15 tion 2102(a)(2)(A)(ii) of the Health Re-
16 form Act—

17 “(I) equals or exceeds 125 per-
18 cent but is less than 150 percent, ‘10
19 percent’ shall be substituted for ‘12
20 percent’ in clause (i);

21 “(II) equals or exceeds 150 per-
22 cent but is less than 175 percent, ‘8
23 percent’ shall be substituted for ‘12
24 percent’ in clause (i);

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1 “(III) equals or exceeds 175 per-
2 cent but is less than 200 percent, ‘6
3 percent’ shall be substituted for ‘12
4 percent’ in clause (i); and

5 “(IV) equals 200 percent, ‘4 per-
6 cent’ shall be substituted for ‘12 per-
7 cent’ in clause (i).

8 (3) ELIMINATION OF HIGH DSH STATES AND
9 STATE SUPPLEMENTAL AMOUNTS.—

10 (A) IN GENERAL.—Section 1923(f)(2)(A)
11 (42 U.S.C. 1396r-4(f)(2)(A)) is amended to
12 read as follows:

13 “(A) IN GENERAL.—Subject to subpara-
14 graph (B), the State DSH allotment for a fiscal
15 year is equal to the State DSH allotment for
16 the previous fiscal year increased by the State
17 growth factor (as defined in paragraph (3)(B))
18 for the fiscal year.”.

19 (B) CONFORMING AMENDMENTS.—(i) Sec-
20 tion 1923(f) (42 U.S.C. 1396r-4(f)) is amended
21 by striking paragraph (3) and redesignating
22 paragraph (4) as paragraph (3).

23 (ii) Section 1923(f)(3) (42 U.S.C. 1396r-
24 4(f)(3)), as redesignated by clause (i), is
25 amended by striking subparagraphs (A) and

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1 (C) and redesignating subparagraphs (B), (D),
2 and (E) as subparagraphs (A), (B), and (C).

3 (iii) Section 1923(f)(3)(B) (42 U.S.C.
4 1396r-4(f)(3)(B)), as redesignated by clauses
5 (i) and (ii), is amended to read as follows:

6 “(B) STATE GROWTH AMOUNT.—The term
7 ‘State growth amount’ means, with respect to a
8 State for a fiscal year, the product of the State
9 growth factor and the State DSH payment
10 limit for the previous fiscal year.”

11 (iv) Section 1923(f)(1)(A) (42 U.S.C.
12 1396r-4(f)(1)(A) is amended by striking “(as
13 defined in paragraph (4)(B))” and inserting
14 “(as defined in paragraph (3)(A))”.

15 (3) TERMINATION OF REQUIREMENT ON
16 STATES TO MAKE DSH PAYMENT ADJUSTMENTS.—
17 Section 1923 (42 U.S.C. 1396r-4) is amended by
18 adding at the end the following new subsection:

19 “(h) TERMINATION OF REQUIREMENT TO MAKE
20 PAYMENT ADJUSTMENTS.—

21 “(1) IN GENERAL.—Any requirement imposed
22 by this section on a State to increase the rate or
23 amount of payment for inpatient hospital services
24 provided by a hospital which serves a disproportion-
25 ate number of low income patients with special

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1 needs shall terminate in the year described in para-
2 graph (2).

3 “(2) YEAR DESCRIBED.—The year described in
4 this paragraph is the first year beginning after the
5 year in which the eligibility percentage for premium
6 assistance under section 2102(a)(2)(A)(ii) of the
7 Health Reform Act equals 200 percent.”

8 (4) NO FEDERAL FINANCIAL PARTICIPATION.—
9 Section 1903(i) (42 U.S.C. 1396b(i)), as amended
10 by section 3002(b), is amended—

11 (1) by striking “or” at the end of paragraph
12 (15),

13 (2) by striking the period at the end of para-
14 graph (16) and inserting “; or”, and

15 (3) by inserting after paragraph (16) the fol-
16 lowing new paragraph:

17 “(17) during or after the year described in sec-
18 tion 1923(h)(2) with respect to any payment made
19 by a State to a hospital which serves a dispro-
20 portionate number of low income patients with special
21 needs that is in excess of the payment otherwise re-
22 quired under this part.”

23 (5) EFFECTIVE DATE.—The amendments made
24 by this section shall be effective for calendar quar-
25 ters beginning on or after October 1, 1997.

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1 (b) PAYMENTS TO HOSPITALS SERVING VULNER-
2 ABLE POPULATIONS.—Title XIX, as amended by section
3 3003, is amended by adding at the end the following new
4 part:

5 **“PART C—PAYMENTS TO HOSPITALS SERVING**
6 **VULNERABLE POPULATIONS**

7 **“SEC. 1991. PAYMENTS TO HOSPITALS.**

8 “(a) ENTITLEMENT STATUS.—The Secretary shall
9 make payments in accordance with this part to eligible
10 hospitals described in section 1992. The preceding sen-
11 tence constitutes budget authority in advance of appro-
12 priations Acts and represents the obligation of the Federal
13 Government to provide funding for such payments in the
14 amounts, and for the fiscal years, specified in subsection
15 (b):

16 “(b) AMOUNT OF ENTITLEMENT.—For purposes of
17 subsection (a), the amounts and fiscal years specified in
18 this subsection are (in the aggregate for all eligible hos-
19 pitals) \$2,500,000,000 for the first applicable fiscal year
20 (as defined in section 1994) and for each subsequent fiscal
21 year:

22 “(c) PAYMENTS MADE ON QUARTERLY BASIS.—Pay-
23 ments to an eligible hospital under this section for a fiscal
24 year shall be made on a quarterly basis during the year.

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1 **"SEC. 1992. IDENTIFICATION OF ELIGIBLE HOSPITALS.**

2 “(a) HOSPITALS IN PARTICIPATING STATES.—In
3 order to be an eligible hospital under this part for a fiscal
4 year, a hospital must be located in a State that is a par-
5 ticipating State under title I of the Health Reform Act.

6 “(b) STATE IDENTIFICATION.—In accordance with
7 the criteria described in subsection (c) and such proce-
8 dures as the Secretary may require, each State shall iden-
9 tify the hospitals in the State that meet such criteria for
10 a fiscal year and provide the Secretary with a list of such
11 hospitals.

12 “(c) CRITERIA FOR ELIGIBILITY.—A hospital meets
13 the criteria described in this subsection if the hospital's
14 low-income utilization rate for the previous year under sec-
15 tion 1923(b)(3) (as such section is in effect on the day
16 before the date of the enactment of this part) is not less
17 than 25 percent.

18 **"SEC. 1993. AMOUNT OF PAYMENTS.**

19 “(a) IN GENERAL.—The total amount available for
20 payments under this part in a fiscal year shall be allocated
21 to hospitals for low-income assistance in accordance with
22 this subsection.

23 “(b) DETERMINATION OF HOSPITAL PAYMENT
24 AMOUNT.—The amount of payment to an eligible hospital
25 during a year shall be the equal to the hospital's low-in-
26 come percentage (as defined in subsection (c)) of the total

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1 amount available for payments under this part for the
2 year.

3 “(c) LOW-INCOME PERCENTAGE DEFINED.—

4 “(1) IN GENERAL.—For purposes of this sec-
5 tion, an eligible hospital’s ‘low-income’ percentage
6 for a year is equal to the amount (expressed as a
7 percentage) of the total low-income days for all eligi-
8 ble hospitals for the year that are attributable to the
9 hospital.

10 “(2) LOW-INCOME DAYS DESCRIBED.—For pur-
11 poses of paragraph (1), an eligible hospital’s low-in-
12 come days for a year shall be equal to the product
13 of—

14 “(A) the total number of inpatient days for
15 the hospital for the year (as reported to the
16 Secretary by the State in which the hospital is
17 located, in accordance with a reporting schedule
18 and procedures established by the Secretary);
19 and

20 “(B) the hospital’s low-income utilization
21 rate for the previous year under section
22 1923(b)(3) (as such section is in effect on the
23 day before the date of the enactment of this
24 part).

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1 "SEC. 1994. DEFINITION.

2 "For purposes of this part, the term 'first applicable
3 fiscal year' means first fiscal year that begins after the
4 fiscal year in which the eligibility percentage for premium
5 assistance under section 2102(a)(2)(A)(ii) of the Health
6 Reform Act equals 200 percent."

7 (c) CONFORMING AMENDMENT.—Title XIX (42
8 U.S.C. 1396 et seq.), as amended by section 3003, is
9 amended by striking the title inserting the following:

10 **"TITLE XIX—MEDICAL ASSIST-**
11 **ANCE PROGRAMS, STATE**
12 **PROGRAMS FOR SUPPLE-**
13 **MENTAL BENEFITS, AND PAY-**
14 **MENTS TO HOSPITALS SERV-**
15 **ING VULNERABLE POPU-**
16 **LATIONS".**

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Subtitle B—Medicare**PART 1—REFORMS****SEC. 3201. IMPROVEMENTS TO RISK CONTRACTS.**

(a) **RATING AREAS.**—Section 1876(a)(1)(F)(ii) (42 U.S.C. 1395mm(a)(1)(F)(ii)) is amended by striking “county (or equivalent area)” and inserting “Metropolitan Statistical Area (as defined by the Office of Management and Budget), New England County Metropolitan Area, or other appropriate geographic area outside a Metropolitan Statistical Area or a New England County Metropolitan Area subject to review and approval by the Secretary after a period of notice and comment (hereafter in this section referred to as a ‘rating area’)”.

(b) **PERIOD OF ENROLLMENT.**—Section 1876(c)(3)(A)(i) (42 U.S.C. 1395mm(c)(3)(A)(i)) is amended—

(1) by inserting “(which may be specified by the Secretary)” after “open enrollment period”; and

(2) by adding at the end the following new sentence: “An eligible organization may offer open enrollment periods in addition to the open enrollment periods described in the previous sentence.”

(c) **COMPARATIVE MATERIALS.**—Section 1876(c)(3)(C) (42 U.S.C. 1395mm(c)(3)(C)) is amended by adding at the end the following: “The Secretary shall

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1 develop comparative materials with respect to all eligible
2 organizations in an area (and with respect to the program
3 established under this title for individuals not enrolled
4 with such an organization) for distribution by such organi-
5 zations or the Secretary to individuals eligible to enroll
6 under this section.”

7 (d) FIFTY-FIFTY RULE.—Section 1876(f) (42 U.S.C.
8 1395mm(f)) is amended—

9 (1) by amending paragraph (2) to read as fol-
10 lows:

11 “(2) The Secretary may modify or waive the re-
12 quirement imposed by paragraph (1) if an eligible
13 organization demonstrates that it provides for ade-
14 quate quality of care for individuals enrolled under
15 this section by—

16 “(A) meeting the quality standards for or-
17 ganizations with contracts under this section;

18 “(B) meeting the fiscal soundness require-
19 ments under this section;

20 “(C) demonstrating successful operational
21 experience as an eligible organization under this
22 section for at least the 3 years immediately pre-
23 ceding an application for a waiver under this
24 paragraph; and

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1 “(D) demonstrating that the number of in-
2 dividuals enrolled in the plan or its parent orga-
3 nization is at least 50,000 at the time of appli-
4 cation for a waiver under this paragraph.

5 In making a determination under subparagraph (A)
6 with respect to an eligible organization, the Sec-
7 retary may accept quality performance standards as
8 measured by private organizations acceptable to the
9 Secretary or organizations designated by the Sec-
10 retary, including peer review organizations.”; and

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

13 “(4) The Secretary may terminate the require-
14 ment under paragraph (1) when the Secretary deter-
15 mines that health plans have established alternative
16 quality assurance mechanisms that effectively pro-
17 vide sufficient quality safeguards.”.

18 (e) REBATES.—Section 1876(g)(2) (42 U.S.C.
19 1395mm(g)(2)) is amended in the matter following sub-
20 paragraph (B) by striking “community rate (as so re-
21 duced); except” and inserting “community rate (as so re-
22 duced) or, at the election of the plan, a cash rebate equal
23 to such difference; except”.

24 (f) DIRECT CALCULATION OF AAPCC.—Section
25 1876(a)(4) (42 U.S.C. 1395mm(a)(4)) is amended by

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1 striking "actual experience" and all that follows through
2 "actuarial equivalence)" and inserting "actual experience
3 in a rating area".

4 (g) EFFECTIVE DATE.—The amendments made by
5 this section shall apply on and after January 1, 1996.

6 SEC. 3202. ADDITIONAL IMPROVEMENTS TO RISK CON-
7 TRACTS AND INCORPORATION OF INSUR-
8 ANCE REFORMS.

9 (a) IN GENERAL.—Section 1876 (42 U.S.C.
10 1395mm) is amended to read as follows:

11 "MEDICARE CHOICE

12 "SEC. 1876. (a) IN GENERAL.—

13 "(1) GENERAL PERMISSION TO CONTRACT.—

14 "(A) RISK CONTRACTS.—The Secretary
15 may enter into a risk contract with any certified
16 standard health plan (as defined in paragraph
17 (4)(A)) in a community rating area (as defined
18 in paragraph (4)(B)) if—

19 "(i) the plan has at least 5,000 enroll-
20 ees (except that the Secretary may enter
21 into such a contract with a certified stand-
22 ard health plan that has fewer enrollees if
23 the plan primarily serves members residing
24 outside of urbanized areas); and

25 "(ii) the plan—

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1 “(I) meets the requirements of
2 this section with respect to individuals
3 enrolled under this section; and

4 “(II) meets the requirements nec-
5 essary to maintain its status as a cer-
6 tified standard health plan with re-
7 spect to individuals enrolled under
8 this section that do not conflict with
9 any of the requirements under this
10 section.

11 “(B) REASONABLE COST REIMBURSEMENT
12 CONTRACTS.—The Secretary may enter into a
13 reasonable cost reimbursement contract (as de-
14 fined in paragraph (4)(C)) with any certified
15 standard health plan in a community rating
16 area if—

17 “(i)(I) the plan so elects;

18 “(II) the Secretary is not satisfied
19 that the plan has the capacity to bear the
20 risk of potential losses under a risk con-
21 tract under this section, or

22 “(III) the plan has an insufficient
23 number of individuals enrolled to be eligi-
24 ble to enter into a risk contract; and

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1 “(ii) the Secretary is otherwise satis-
2 fied that the plan is able to perform its
3 contractual obligations effectively and effi-
4 ciently.

5 “(2) AVAILABILITY OF PLANS.—

6 “(A) IN GENERAL.—Subject to the provi-
7 sions of subsection (e), every individual entitled
8 to benefits under part A and enrolled under
9 part B or enrolled under part B only shall be
10 eligible to enroll under this section with any
11 certified standard health plan with a contract
12 under this section which serves the community
13 rating area in which the individual resides.

14 “(B) ENROLLMENT BY AN INDIVIDUAL.—
15 An individual may enroll under this section with
16 a certified standard health plan with a contract
17 under this section in such manner as may be
18 prescribed in regulations (including enrollment
19 through a third party) and the individual may
20 terminate enrollment—

21 “(i) during an annual period as pre-
22 scribed by the Secretary,

23 “(ii) as specified by the Secretary if
24 the plan is financially insolvent, if the indi-
25 vidual moves from the community rating

III-B-7

1 area served by the plan, if other special
2 circumstances exist, or if the plan offers
3 additional open enrollment periods, as pre-
4 scribed by the Secretary, and

5 “(iii) for cause as defined by the Sec-
6 retary in regulations.

7 “(C) MARKETING MATERIALS.—

8 “(i) DISTRIBUTION BY PLANS.—The
9 Secretary may prescribe the procedures
10 and conditions under which a certified
11 standard health plan with a contract under
12 this section may provide individuals eligible
13 to enroll under this section with informa-
14 tion about the plan. No brochures, applica-
15 tion forms, or other promotional or infor-
16 mational material may be distributed by a
17 plan to (or for the use of) individuals eligi-
18 ble to enroll with the plan under this sec-
19 tion unless—

20 “(I) at least 45 days before its
21 distribution, the plan has submitted
22 the material to the Secretary for re-
23 view, and

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1 “(II) the Secretary has not dis-
2 approved the distribution of the mate-
3 rial.

4 The Secretary shall review all such mate-
5 rial submitted and shall disapprove such
6 material if the Secretary determines, in the
7 Secretary's discretion, that the material is
8 materially inaccurate or misleading or oth-
9 erwise makes a material misrepresentation.

10 “(ii) DISTRIBUTION BY THE SEC-
11 RETARY.—The Secretary shall develop and
12 distribute comparative materials to individ-
13 uals eligible to enroll under this section re-
14 garding all certified standard health plans
15 with contracts under this section and the
16 program established under this title for in-
17 dividuals not enrolled with such a plan.

18 “(3) PAYMENTS.—

19 “(A) PAYMENTS IN LIEU OF NORMAL PAY-
20 MENTS.—Subject to subsection (i)(3), payments
21 under a contract to a certified standard health
22 plan under this section shall be instead of the
23 amounts which (in the absence of the contract)
24 would be otherwise payable, pursuant to sec-
25 tions 1814(b) and 1833(a), for services fur-

III-B-9

1 nished by or through the plan to individuals en-
2 rolled with the plan under this section.

3 “(B) SOURCE OF PAYMENT.—The payment
4 to a certified standard health plan under this
5 section for individuals enrolled under this sec-
6 tion with the plan and entitled to benefits under
7 part A and enrolled under part B shall be made
8 from the Federal Hospital Insurance Trust
9 Fund and the Federal Supplementary Medical
10 Insurance Trust Fund. The portion of that pay-
11 ment to the plan for a month to be paid by
12 each trust fund shall be determined as follows:

13 “(i) With respect to expenditures by
14 certified standard health plans with risk
15 contracts under this section, the allocation
16 shall be determined each year by the Sec-
17 retary based on the ratio of expenditures
18 from each trust fund for the preceding
19 year to the expenditures from both trust
20 funds for the preceding year.

21 “(ii) With respect to expenditures by
22 a certified standard health plan with a rea-
23 sonable cost reimbursement contract under
24 this section, the initial allocation shall be
25 based on the plan’s most recent budget,

III-B-10

1 such allocation to be adjusted, as needed,
2 after cost settlement to reflect the distribu-
3 tion of actual expenditures.

4 “(4) DEFINITIONS.—For purposes of this sec-
5 tion:

6 “(A) CERTIFIED STANDARD HEALTH
7 PLAN.—The term ‘certified standard health
8 plan’ shall have the meaning given such term in
9 section 3(a)(2)(A) of the Health Reform Act.

10 “(B) COMMUNITY RATING AREA.—The
11 term ‘community rating area’ means the com-
12 munity rating areas designated by a State
13 under section 1303 of the Health Reform Act.

14 “(C) REASONABLE COST REIMBURSEMENT
15 CONTRACT.—The term ‘reasonable cost reim-
16 bursement contract’ means a contract with a
17 certified standard health plan pursuant to
18 which such plan is reimbursed on the basis of
19 its reasonable cost (as defined in section
20 1861(v)) in the manner prescribed in subsection
21 (e)(2).

22 “(b) PAYMENT RULES UNDER RISK CONTRACTS.—

23 “(1) IN GENERAL.—

24 “(A) PAYMENTS.—Except as provided in
25 subparagraph (C), with respect to any calendar

III-B-11

1 year, each certified standard health plan with a
2 risk contract under this section shall receive a
3 payment under this title with respect to each
4 individual enrolled with the plan for each month
5 such individual is enrolled equal to the average
6 medicare per capita rate determined under
7 paragraph (2) for the plan's community rating
8 area adjusted by the rate factor determined
9 under subparagraph (B) for the class of such
10 individual.

11 “(B) DETERMINATION OF CLASSES OF IN-
12 DIVIDUALS AND RATE FACTORS FOR SUCH
13 CLASSES.—

14 “(i) DETERMINATION OF CLASSES.—
15 For purposes of this section, the Secretary
16 shall define appropriate classes of individ-
17 uals, based on age, disability status, usage
18 or nonusage of Veterans' Administration
19 or military treatment facilities and associ-
20 ated physicians, providers, and suppliers,
21 and such other factors as the Secretary de-
22 termines to be appropriate.

23 “(ii) RATE FACTORS.—The Secretary
24 shall annually determine the rate factors
25 for each class of individuals defined in

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clause (i) reflecting the differences in the average per capita spending for benefits under parts A and B among individuals in such classes. The Secretary shall announce such rate factors (in a manner intended to provide notice to interested parties) not later than July 1 before the calendar year concerned.

“(C) MAXIMUM PER CAPITA RATE.—

“(i) IN GENERAL.—Except as provided in clause (v), the average medicare per capita rate in any community rating area may not exceed the product of—

“(I) 95 percent of the projected average monthly fee-for-service costs for a community rating area determined under paragraph (2)(D) in all community rating areas, and

“(II) an adjustment factor for such community rating area.

“(ii) ADJUSTMENT FACTOR.—For purposes of clause (i)(II), and except as provided in clause (iv):

“(I) FFSPCC RATIO LESS THAN .8.—For community rating areas with

III-B-13

1 a FFSPCC ratio less than or equal to
2 .8, the adjustment factor shall be .8.

3 “(II) FFSPCC RATIO BETWEEN
4 .8 AND .95.—For community rating
5 areas with a FFSPCC ratio less than
6 .95 but greater than .8, the adjust-
7 ment factor shall be the sum of .85,
8 plus—

9 “(aa) .1, multiplied by

10 “(bb) the ratio of the excess
11 of the FFSPCC ratio over .8, to
12 .15.

13 “(III) FFSPCC RATIO BETWEEN
14 .95 AND 1.05.—For community rating
15 areas with a FFSPCC ratio of at
16 least .95 but less than 1.05, the ad-
17 justment factor shall be the FFSPCC
18 ratio.

19 “(IV) FFSPCC RATIO BETWEEN
20 1.05 AND 1.2.—For community rating
21 areas with a FFSPCC ratio of at
22 least 1.05 but less than 1.2, the ad-
23 justment factor shall be the sum of
24 1.05, plus—

25 “(aa) .1, multiplied by

III-B-14

1 “(bb) the ratio of the excess
2 of the FFSPCC ratio over 1.05,
3 to .15.

4 “(V) FFSPCC RATIO BETWEEN
5 1.2 AND 1.5.—For community rating
6 areas with a FFSPCC ratio of at
7 least 1.2 but less than 1.5, the adjust-
8 ment factor shall be the sum of 1.2,
9 plus—

10 “(aa) .1, multiplied, by

11 “(bb) the ratio of the excess
12 of the FFSPCC ratio over 1.2, to
13 .3.

14 “(VI) FFSPCC RATIO GREATER
15 THAN 1.5.—For community rating
16 areas with a FFSPCC ratio greater
17 than or equal to 1.5, the adjustment
18 factor shall be 1.5.

19 “(iii) FFSPCC RATIO.—For purposes
20 of clause (ii), for each community rating
21 area, the Secretary shall determine a
22 FFSPCC ratio by dividing the projected
23 average monthly fee-for-service costs for a
24 community rating area determined under
25 paragraph (2)(D) in such community rat-

III-B-15

1 ing area by the projected average monthly
2 fee-for-service costs for a community rat-
3 ing area determined under paragraph
4 (2)(D) for all community rating areas.

5 “(iv) BUDGET NEUTRALITY.—The
6 Secretary shall change the adjustment fac-
7 tors as necessary to ensure that total
8 spending under this title shall not exceed
9 the level of spending that would occur if
10 the average medicare per capita rate in
11 each community rating area were equal to
12 the projected average monthly fee-for-serv-
13 ice costs for a community rating area in
14 each such community rating area.

15 “(v) ALTERNATIVE FORMULA.—The
16 Secretary may substitute an alternative
17 formula for determining the maximum rate
18 in each community rating area. Such an
19 alternative formula shall generally conform
20 to the pattern of adjustment factors speci-
21 fied in clause (ii), except that such formula
22 shall maintain a consistent mathematical
23 relationship between the adjustment factor
24 and the FFSPCC ratio in each such com-

III-B-16

1 community rating area in a manner that
2 achieves budget neutrality.

3 “(2) DETERMINATION OF AVERAGE MEDICARE
4 PER CAPITA RATE.—

5 “(A) DETERMINATION BY SECRETARY.—

6 The Secretary shall annually determine under
7 subparagraph (B), and shall announce (in a
8 manner intended to provide notice to interested
9 parties) not later than October 1 before the cal-
10 endar year concerned, the average medicare per
11 capita rate of payment for each community rat-
12 ing area.

13 “(B) FORMULA FOR AVERAGE MEDICARE
14 PER CAPITA RATE.—

15 “(i) IN GENERAL.—The monthly aver-
16 age medicare per capita rate of payment
17 for a community rating area served by a
18 certified standard health plan shall be
19 equal to the sum of—

20 “(I) the plan component deter-
21 mined under clause (ii); and

22 “(II) the fee-for-service compo-
23 nent determined under clause (iii).

24 “(ii) PLAN COMPONENT.—The
25 amount determined under this clause is the

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1 sum of the following amounts determined
2 with respect to each certified standard
3 health plan with a risk contract in the
4 community rating area—

5 “(I) the amount of the uniform
6 monthly premium submitted by the
7 plan to the Secretary under subpara-
8 graph (C), adjusted by a factor deter-
9 mined by the Secretary to normalize
10 the difference in the distribution of in-
11 dividuals projected to be enrolled in
12 the plan among the various classes of
13 individuals defined by the Secretary to
14 the community rating area distribu-
15 tion of all individuals in the program
16 under this title among such classes;
17 multiplied by

18 “(II) a fraction (expressed as a
19 percentage), the numerator of which
20 is the number of all medicare eligible
21 individuals enrolled in the plan (as
22 projected by the plan using either his-
23 torical experience or some other meth-
24 odology developed by the Secretary),
25 and the denominator of which is the

III-B-18

1 number of all medicare eligible indi-
2 viduals in the community rating area.

3 “(iii) FEE-FOR-SERVICE COMPO-
4 NENT.—The amount determined under
5 this clause is—

6 “(I) the projected average
7 monthly per capita fee-for-service
8 costs (as defined in subparagraph
9 (D)) for the community rating area
10 for medicare eligible individuals not
11 enrolled in certified standard health
12 plans with contracts under this sec-
13 tion, adjusted by the factor described
14 in clause (ii)(I); multiplied by

15 “(II) a fraction (expressed as a
16 percentage), the numerator of which
17 is equal to the number of all medicare
18 eligible individuals in the community
19 rating area minus the number of such
20 individuals who are enrolled in cer-
21 tified standard health plans with risk
22 contracts under this section (as deter-
23 mined in accordance with subclause
24 (I)), and the denominator of which is
25 the number of all medicare eligible in-

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1 dividuals in the community rating
2 area.

3 “(iv) ALTERNATIVE FORMULA.—The
4 Secretary may substitute an alternative
5 formula for determining the average medi-
6 care per capita rate in each community
7 rating area. Such alternative formula shall
8 be based on competitive bids submitted by
9 participating certified standard health
10 plans.

11 “(C) UNIFORM MONTHLY PREMIUMS; PRE-
12 MIUM FOR SUPPLEMENTARY COVERAGE
13 PLANS.—

14 “(i) IN GENERAL.—Each certified
15 standard health plan with a risk contract
16 under this section shall, not later than Au-
17 gust 1 of each year, submit to the Sec-
18 retary a bid for the next calendar year for
19 each community rating area with respect
20 to which the plan has a risk contract. A
21 bid with respect to a community rating
22 area shall include the following:

23 “(I) UNIFORM MONTHLY PRE-
24 MIUM.—A statement of the uniform
25 monthly premium amount that the

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plan intends to charge for individuals enrolled under this section with the plan and entitled to benefits under part A and enrolled in part B or enrolled in part B only and a projection of the plan's enrollment by class for such services in the community rating area.

“(II) PREMIUM FOR ADDITIONAL HEALTH CARE SERVICES.—A statement of the premium amount that the plan intends to charge for each supplementary coverage plan described in subsection (d)(1)(B) offered by the plan.

“(ii) ACTUARIAL BASIS.—The uniform monthly premium and any premiums for supplemental plans described in subsection (d)(1)(B) must have an actuarial basis in the community rate for such services in the community rating area in accordance with regulations developed by the Secretary.

“(iii) NOTICE BEFORE BID SUBMISSIONS.—At least 45 days before the date for submitting bids under clause (ii) for a

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1 year, the Secretary shall provide for notice
2 to certified standard health plans with risk
3 contracts of proposed changes to be made
4 in the methodology or benefit coverage as-
5 sumptions from the methodology and as-
6 sumptions used in the previous calendar
7 year and shall provide such plans an op-
8 portunity to comment on such proposed
9 changes.

10 “(D) PROJECTED AVERAGE MONTHLY PER
11 CAPITA FEE-FOR-SERVICE COSTS.—

12 “(i) IN GENERAL.—For purposes of
13 subparagraph (B), the term ‘projected av-
14 erage monthly per capita fee-for-service
15 costs’ means, with respect to a community
16 rating area, the amount, prorated to be ex-
17 pressed as a monthly amount, that the
18 Secretary estimates in advance would be
19 payable in any contract year for services
20 covered under parts A and B or part B
21 only and types of expenses otherwise reim-
22 bursable under parts A and B or part B
23 only (including administrative costs in-
24 curred by organizations described in sec-
25 tions 1816 and 1842), if the services were

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1 to be furnished by other than a certified
2 standard health plan with a contract under
3 this section.

4 “(ii) BASIS FOR ESTIMATES.—

5 “(I) DIRECT CALCULATIONS.—

6 Except as provided in subclause (II),
7 the estimate made by the Secretary
8 under clause (i) shall be made on the
9 basis of actual experience of the com-
10 munity rating area and shall include
11 experience with actual expenditures
12 under this title (trended forward) for
13 individuals who are entitled to such
14 services under this title and are not
15 enrolled with a plan in such area (in-
16 cluding individuals who receive serv-
17 ices from a facility operated by the
18 Veterans' Administration or a military
19 treatment facility).

20 “(II) INADEQUATE DATA.—If the
21 Secretary determines that the data in
22 that community rating area is inad-
23 equate to make an accurate estimate,
24 the Secretary may use the actual ex-
25 perience of a similar area, with appro-

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1 appropriate adjustments to assure actuarial
2 equivalence, including adjustments the
3 Secretary may determine appropriate
4 to adjust for demographics, health
5 status, and the presence of specific
6 medical conditions.

7 “(3) PAYMENT RULES.—

8 “(A) AMOUNT OF PREMIUM.—Each cer-
9 tified standard health plan with a contract
10 under this section must provide to individuals
11 enrolled with the plan under this section, for
12 the duration of such enrollment during each
13 contract period, a fixed monthly premium equal
14 to the uniform monthly premium amount deter-
15 mined by the plan with respect to the individual
16 under paragraph (2)(C). An individual enrolled
17 in the plan shall be responsible for paying to
18 the plan the difference between the fixed
19 monthly premium amount described in the pre-
20 ceding sentence and the average medicare per
21 capita rate paid to the plan in accordance with
22 subparagraph (B).

23 “(B) AVERAGE MEDICARE PER CAPITA
24 RATE.—

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“(i) IN GENERAL.—The Secretary shall make monthly payments in advance and in accordance with the rate determined under paragraph (2) to each certified standard health plan with a risk contract under this section for each individual enrolled with the plan under this section.

“(ii) ADJUSTMENTS.—

“(I) IN GENERAL.—The amount of payment under this paragraph may be retroactively adjusted to take into account any difference between the actual number of individuals enrolled in the plan under this section and the number of such individuals estimated to be so enrolled in determining the amount of the advance payment.

“(II) SPECIAL RULE.—The Secretary may make retroactive adjustments under subclause (I) to take into account individuals enrolled during the period beginning on the date on which the individual enrolls with a certified standard health plan with a risk contract under this section under

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1 a health benefit plan operated, spon-
2 sored, or contributed to, by the indi-
3 vidual's employer or former employer
4 (or the employer or former employer
5 of the individual's spouse) and ending
6 on the date on which the individual is
7 enrolled in the plan under this section,
8 except that for purposes of making
9 such retroactive adjustments under
10 this clause, such period may not ex-
11 ceed 90 days. No adjustment may be
12 made under the preceding sentence
13 with respect to any individual who
14 does not certify that the plan provided
15 the individual with the explanation de-
16 scribed in subsection (e)(6) at the
17 time the individual enrolled with the
18 plan.

19 "(iii) PAYMENT TO PLAN ONLY.—Sub-
20 ject to subsection (i)(3), if an individual is
21 enrolled under this section with a certified
22 standard health plan with a risk contract
23 under this section, only the plan shall be
24 entitled to receive payments from the Sec-

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1 retary under this title for services fur-
2 nished to the individual.

3 “(C) PAYMENT GREATER THAN FIXED
4 MONTHLY PREMIUM.—If, with respect to any
5 individual enrolled in a certified standard health
6 plan with a risk contract under this section, the
7 average medicare per capita rate paid under
8 this section to the plan exceeds the fixed
9 monthly premium amount described in subpara-
10 graph (A), the plan shall apply such excess to
11 the individual as a contribution to a premium
12 for any policy for any supplemental plan offered
13 by the plan and described in subsection
14 (d)(1)(B) that the individual may elect.

15 “(e) PAYMENT RULES FOR REASONABLE COST RE-
16 IMBURSEMENT CONTRACTS.—

17 “(1) REIMBURSEMENT.—

18 “(A) IN GENERAL.—A certified standard
19 health plan with a reasonable cost reimburse-
20 ment contract under this section may, at the
21 option of such plan, provide that the
22 Secretary—

23 “(i) will reimburse hospitals and
24 skilled nursing facilities either for the rea-
25 sonable cost (as determined under section

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1 1861(v)) or for payment amounts deter-
2 mined in accordance with section 1886, as
3 applicable, of services furnished to individ-
4 uals enrolled with such plan, and

5 “(ii) will deduct the amount of such
6 reimbursement from payment which would
7 otherwise be made to such plan.

8 “(B) DIRECT PAYMENTS.—If a certified
9 standard health plan with a reasonable cost re-
10 imbursement contract under this section pays a
11 hospital or skilled nursing facility directly, the
12 amount paid shall not exceed the reasonable
13 cost of the services (as determined under sec-
14 tion 1861(v)) or the amount determined under
15 section 1886, as applicable, unless such plan
16 demonstrates to the satisfaction of the Sec-
17 retary that such excess payments are justified
18 on the basis of advantages gained by the plan.

19 “(2) PAYMENTS TO PLANS.—Payments made to
20 a certified standard health plan with a reasonable
21 cost reimbursement contract under this section shall
22 be subject to appropriate retroactive corrective ad-
23 justment at the end of each contract year so as to
24 assure that such plan is paid for the reasonable cost
25 actually incurred (excluding any part of incurred

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1 cost found to be unnecessary in the efficient delivery
2 of health services) or the amounts otherwise deter-
3 mined under section 1886 for the types of expenses
4 otherwise reimbursable under this title for providing
5 services covered under this title to individuals en-
6 rolled in the plan.

7 “(3) REPORTS BY PLANS.—A certified standard
8 health plan with a reasonable cost reimbursement
9 contract under this subsection shall provide that the
10 Secretary shall require, at such time following the
11 expiration of each accounting period of the plan
12 (and in such form and in such detail) as the Sec-
13 retary may prescribe—

14 “(A) that the plan report to the Secretary
15 in an independently certified financial state-
16 ment its per capita incurred cost based on the
17 types of components of expenses otherwise re-
18 imburseable under this title for providing serv-
19 ices under parts A and B, including therein, in
20 accordance with accounting procedures pre-
21 scribed by the Secretary, its methods of allocat-
22 ing costs between individuals enrolled under
23 this section and other individuals enrolled with
24 such plan;

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1 “(B) that failure to report such informa-
2 tion as may be required may be deemed to con-
3 stitute evidence of likely overpayment on the
4 basis of which appropriate collection action may
5 be taken;

6 “(C) that in any case in which a plan is re-
7 lated to another plan by common ownership or
8 control, a consolidated financial statement shall
9 be filed and that the allowable costs for such
10 organization may not include costs for the types
11 of expense otherwise reimbursable under this
12 title, in excess of those which would be deter-
13 mined to be reasonable in accordance with regu-
14 lations (providing for limiting reimbursement to
15 costs rather than charges to the plan by related
16 plans and owners) issued by the Secretary; and

17 “(D) that in any case in which compensa-
18 tion is paid by a plan substantially in excess of
19 what is normally paid for similar services by
20 similar practitioners (regardless of method of
21 compensation), such compensation may as ap-
22 propriate be considered to constitute a distribu-
23 tion of profits.

24 “(d) COVERAGE OF BENEFITS.—

25 “(1) IN GENERAL.—

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1 “(A) STANDARD PACKAGE OF SERVICES.—

2 A certified standard health plan with a contract
3 under this section must provide to individuals
4 enrolled in the plan under this section, through
5 providers and other persons that meet the ap-
6 plicable requirements of this title and part A of
7 title XI—

8 “(i) only those services covered under
9 parts A and B of this title for those mem-
10 bers entitled to benefits under part A and
11 enrolled under part B, or

12 “(ii) only those services covered under
13 part B for those members enrolled only
14 under such part.

15 “(B) SUPPLEMENTARY COVERAGE
16 PLANS.—

17 “(i) REQUIREMENT TO ENROLL IN
18 MINIMUM SUPPLEMENTARY COVERAGE
19 PLAN.—Each individual enrolled in a cer-
20 tified standard health plan must enroll in
21 a supplementary coverage plan that offers
22 at least the benefits described in
23 subclauses (I) and (II) of clause (iii).

24 “(ii) REQUIREMENT TO OFFER SUP-
25 PLEMENTARY COVERAGE PLANS.—A cer-

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1 tified standard health plan with a contract
2 under this section must offer individuals
3 enrolled with the plan under this section at
4 least the 2 supplemental coverage plans de-
5 scribed in clauses (iii) and (iv).

6 “(iii) MINIMUM SUPPLEMENTARY COV-
7 ERAGE PLAN.—The minimum supple-
8 mentary coverage plan described under this
9 clause provides—

10 “(I) coverage for preventive care
11 services (as defined by the Secretary);
12 and

13 “(II) the following additions to
14 part A coverage under the standard
15 package of services described in sub-
16 paragraph (A)(i):

17 “(aa) Inpatient hospital
18 services shall not be limited to
19 150 days pursuant to section
20 1812(a)(1).

21 “(bb) The requirement that
22 an individual be an inpatient in a
23 hospital for 3 consecutive days
24 prior to the individual’s receipt of
25 posthospital extended care serv-

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1 ices pursuant to section 1861(i)
2 shall not apply.

3 “(iv) OUTPATIENT PRESCRIPTION
4 DRUG SUPPLEMENTARY COVERAGE
5 PLAN.—The supplementary coverage plan
6 described in this clause provides coverage
7 for outpatient prescription drugs (as de-
8 fined by the Secretary).

9 “(v) ONE SPONSOR.—A sponsor of a
10 certified standard health plan may not
11 offer a supplementary coverage plan to an
12 individual that is enrolled in a certified
13 standard health plan of another sponsor,
14 except that sponsors of supplementary cov-
15 erage plans may offer such supplementary
16 coverage plans to any individual that is en-
17 titled to benefits under part A that does
18 not enroll with a certified standard health
19 plan under this section or pursuant to sec-
20 tion 3203 of the Health Reform Act.

21 “(vi) SUPPLEMENTARY COVERAGE
22 PLAN.—The term ‘supplementary coverage
23 plan’ means any health insurance coverage
24 offered by a certified standard health plan
25 or medicare supplemental policy (as de-

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1 fined in section 1882) that covers health
2 care costs not covered under parts A and
3 B and for which the enrollee in such plan
4 must pay a premium.

5 “(2) PROVISION OF MEDICALLY NECESSARY
6 CARE.—Each certified standard health plan with a
7 contract under this section must—

8 “(A) make the services described in para-
9 graph (1)(A) (and such other health care serv-
10 ices as enrolled individuals have contracted for
11 under a supplemental plan described in para-
12 graph (1)(B))—

13 “(i) available and accessible to en-
14 rolled individuals within the community
15 rating area with reasonable promptness
16 and in a manner which assures continuity,
17 and

18 “(ii) when medically necessary, avail-
19 able and accessible twenty-four hours a
20 day and seven days a week, and

21 “(B) provide for reimbursement with re-
22 spect to services which are described in sub-
23 paragraph (A) (and such other health care serv-
24 ices as enrolled individuals have contracted for
25 under a supplemental plan described in para-

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1 graph (1)(B)) and which are provided to such
2 an individual other than through the plan, if—

3 “(i) the services were medically nec-
4 essary and immediately required because of
5 an unforeseen illness, injury, or condition,
6 and

7 “(ii) it was not reasonable given the
8 circumstances to obtain the services
9 through the plan.

10 “(3) SPECIAL EXCEPTION.—If there is a na-
11 tional coverage determination made in the period be-
12 ginning on the date for the submission of bids under
13 subsection (b)(2)(C) and ending on the next such
14 date of submission that the Secretary projects will
15 result in a significant change in the costs to a cer-
16 tified standard health plan with a risk contract
17 under this section of providing the benefits that are
18 the subject of such national coverage determination
19 and that was not incorporated in the determination
20 of the bid for such period, and if such coverage de-
21 termination provides for coverage of additional bene-
22 fits or under additional circumstances, subsection
23 (a)(3)(A) shall not apply to payment for such addi-
24 tional benefits or benefits provided under such addi-
25 tional circumstances until the first contract year

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1 that begins after the end of such period, unless oth-
2 erwise required by law.

3 “(4) COST SHARING.—

4 “(A) IN GENERAL.—Each certified stand-
5 ard health plan with a contract under this sec-
6 tion must provide to individuals enrolled under
7 this section with respect to the services de-
8 scribed in paragraph (1)(A), standard cost
9 sharing requirements to be determined by the
10 Secretary consistent with cost sharing require-
11 ments imposed under a health maintenance or-
12 ganization delivery system.

13 “(B) COST SHARING FIXED DURING CON-
14 TRACT PERIOD.—Each certified standard plan
15 must provide to individuals enrolled under this
16 section, for the duration of such enrollment
17 during each contract period, cost sharing that
18 is fixed during the duration of the contract pe-
19 riod.

20 “(e) ENROLLMENT PERIODS.—

21 “(1) IN GENERAL.—Each certified standard
22 health plan with a contract under this section must
23 have an open enrollment period (which may be speci-
24 fied by the Secretary), for the enrollment of individ-
25 uals under this section, of at least 30 days duration

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1 every year and for the additional periods specified
2 under paragraphs (2) through (4), and must provide
3 that at any time during which enrollments are ac-
4 cepted, the plan will accept up to the limits of its
5 capacity (as determined by the Secretary) and with-
6 out restrictions, except as may be authorized in reg-
7 ulations, individuals who are eligible to enroll in the
8 plan in the order in which they apply for enrollment,
9 unless to do so would result in failure to meet the
10 requirements of subsection (f) or would result in the
11 enrollment of enrollees substantially
12 nonrepresentative, as determined in accordance with
13 regulations of the Secretary, of the population in the
14 community rating area served by the plan.

15 “(2) NONRENEWAL OR TERMINATION.—

16 “(A) IN GENERAL.—If a contract under
17 this section is not renewed or is otherwise ter-
18 minated, certified standard health plans with
19 contracts under this section and serving the
20 same community rating area as under the ter-
21 minated contract are required to have an open
22 enrollment period for individuals who were en-
23 rolled under the terminated contract as of the
24 date of notice of such termination.

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1 “(B) OPEN ENROLLMENT PERIOD.—The
2 open enrollment periods required under sub-
3 paragraph (A) shall be for 30 days and shall
4 begin 30 days after the date that the Secretary
5 provides notice of such requirement.

6 “(C) EFFECTIVENESS OF ENROLLMENT.—
7 Enrollment under this paragraph shall be effec-
8 tive 30 days after the end of the open enroll-
9 ment period, or, if the Secretary determines
10 that such date is not feasible, such other date
11 as the Secretary specifies.

12 “(3) SPECIAL RULE.—Each certified standard
13 health plan with a contract under this section shall
14 have an open enrollment period for each individual
15 who enrolls in a plan during any enrollment period
16 specified by section 1837 that applies to that indi-
17 vidual. Enrollment under this clause shall be effec-
18 tive as specified by section 1838.

19 “(4) RESIDENTS OUTSIDE COMMUNITY RATING
20 AREA.—Each certified standard health plan with a
21 contract under this section shall have an open enroll-
22 ment period for each individual eligible to enroll in
23 such a plan who has previously resided outside the
24 community rating area. The enrollment period shall
25 begin with the beginning of the month that precedes

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1 the month in which the individual becomes a resi-
2 dent of that community rating area and shall end at
3 the end of the following month. Enrollment under
4 this subparagraph shall be effective as of the first of
5 the month following the month in which the individ-
6 ual enrolls.

7 “(5) CONTINUED ENROLLMENT PROTECTED.—
8 Each certified standard health plan with a contract
9 under this section must provide assurances to the
10 Secretary that it will not expel or refuse to re-enroll
11 any enrolled individual because of the individual’s
12 health status or requirements for health care serv-
13 ices, and that it will notify each such individual of
14 such fact at the time of the individual’s enrollment.

15 “(6) NOTICE OF RIGHTS, ETC.—Each certified
16 standard health plan with a contract under this sec-
17 tion shall provide each enrollee, at the time of enroll-
18 ment and not less frequently than annually there-
19 after, an explanation of the enrollee’s rights under
20 this section, including an explanation of—

21 “(A) the enrollee’s rights to benefits from
22 the plan,

23 “(B) the restrictions on payments under
24 this title for services furnished other than by or
25 through the plan,

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1 “(C) out-of-area coverage provided by the
2 plan,

3 “(D) the plan’s coverage of emergency
4 services and urgently needed care, and

5 “(E) appeal rights of enrollees.

6 “(7) CONTINUATION OF COVERAGE.—Each cer-
7 tified standard plan that provides items and services
8 pursuant to a contract under this section shall pro-
9 vide assurances to the Secretary that in the event
10 the plan ceases to provide such items and services,
11 the plan shall provide or arrange for supplemental
12 coverage of benefits under this title related to a pre-
13 existing condition with respect to any exclusion pe-
14 riod, to all individuals enrolled with the plan who re-
15 ceive benefits under this title, for the lesser of 6
16 months or the duration of such period.

17 “(8) NOTICE OF RIGHT OF TERMINATION.—

18 “(A) IN GENERAL.—Each certified stand-
19 ard health plan with a risk contract under this
20 section shall notify individuals eligible to enroll
21 with the plan under this section and individuals
22 enrolled with the plan under this section that—

23 “(i) the plan is authorized by law to
24 terminate or refuse to renew the contract,
25 and