May 20, 1994

Health Division

Office of Management and Budget
Executive Office of the President
Washington, DC 20503

Please route to:

Health Division Staff

Decision needed
Please comment
For your information
Per your request
See remarks below

Subject: More Amendments to the Chairman's Mark of the HSA in the Senate LHR Committee

From: Pete Nakahata

Phone: 202/395-4926
Fax: 202/395-3910
Room: #7002

Attached for your information are:

- the Bingaman cost containment amendment that was passed on Thursday, 5/20; and
- the amendments that the committee plans to offer on Titles II, III and V of the Act (LTC, public health, and quality).

The markup will resume on Tuesday morning and will deal with LTC, quality, and PHS issues.

Attachment

Stacy 65586

United States Senate

Committee on Labor and Human Resources

Senator Edward M. Kennedy, Chair

Amendments

to the

Health Security Act

Titles II, III and V

May 19, 1994

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May 18, 1994

Memorandum

To: Labor Committee Members and Staff
From: Minority Health Staff/Senator Kassebaum
Subject: INTENDED AMENDMENTS FOR TOMORROW'S HEALTH REFORM MARKUP SESSION

Listed below are amendments relating to Title III provisions intended to be offered by Senator Kassebaum at tomorrow's markup session of the health reform legislation.

- Two amendments relating to the health care workforce provisions pertaining to the training of physicians, nurses, and nurse practitioners, and the funding of academic health centers. (Senator Kassebaum will only offer one of these.)

- Amendment pertaining to the core functions of public health.

- Amendment relating to school health education.

- Amendment relating to the deletion of unnecessary programs in Title III.

- Amendment relating to employee participation provisions in Sec. 3083.

Senator Kassebaum also serves notice that she may offer the following two amendments.

- Two Amendments relating to providers in medically underserved areas.

HEALTH CARE WORKFORCE AMENDMENT--KEY COMPONENTS--MAY 15, 1994

Contact: Marty Sieg-Ross, MD
Committee on Labor and Human Resources, Minority (Kassebaum)

BACKGROUND

This amendment would be offered as an alternative to the Title III, Subtitle A, Parts 1 and 2 related to the training of physicians and nurses. A more detailed Summary with background information is attached.

KEY COMPONENTS

I. Purpose

- Facilitate changes in the medical education system to train the proper number of physicians, to ensure quality, and to create an improved physician specialty-mix through a stable funding mechanism.

II. All-payer graduate medical education fund

- Set a mechanism to consider the establishment of an all-payer graduate medical education fund which would occur by transferring current Medicare direct medical education funds and capturing current health insurance company funding for such activities, possibly through a voluntary system.

III. National Commission On Graduate Medical Education

- Establish an independent National Commission on Graduate Medical Education. Provide budget neutral funding for the Commission from a transfer of current Medicare indirect medical education payments as necessary.

- Create two proposals for fast track (like the base-closing system) consideration by Congress by May 1, 1997. The first would determine if an all-payer graduate medical education fund should be established and the amount of and how to raise funds. The second proposal would create a process for distributing the all-payer funds through the most decentralized process compatible with meeting the Commission defined goals for specialty-mix and number of residency training positions.

- Develop a prospective payment system for payments from the all-payer fund. In the interim, require that a national average payment be made which is adjusted for regional cost-of-living differences.

- Study current problems medical schools are having with funding in light of the growth of managed care to determine if they would benefit from a new federal subsidy. Recommend on how such a subsidy would be made from the all-payer fund.

- On a continuing basis, advise Congress and the Secretary on all physician health care workforce issues.

IV. Medicare Indirect Medical Education Payments

- Un-link Medicare indirect medical education payments from residency education to cap the growth of such spending, to remove the incentive for teaching hospitals to create sub-specialty training positions over primary care positions, to provide transition funding for teaching hospitals which lose residency positions as a result in the reduction of such positions, and to ensure continued academic health center viability.

V. Facilitate the establishment of Health Care Training Consortia

- Provide start-up grants for and allow the formation of health care training consortia to develop a framework for the decentralized distribution of all-payer funding and to foster community-based training of residents. Require each health care training consortia to determine its own governing structure and to operate with the intention of producing no less than 40% primary care providers. Each consortia would be composed of a medical school(s), community-based training sites (such as rural and community health clinics), and teaching hospitals. To ensure budget neutrality, provide start-up grants from Medicare indirect graduate medical education funds.

VI. Nursing Graduate Medical Education

- Have the Secretary continue to study this issue and recommend to Congress if and how such nursing graduate medical education payments should be made.

HEALTH CARE WORKFORCE AMENDMENT--SUMMARY--MAY 13, 1994

Contact: Marty Sieg-Ross, MD
Committee on Labor and Human Resources, Minority (Kassebaum)
224-6770

Background

This proposal would establish a process to ensure adequate funding of the medical education system and academic health centers. This would ensure a physician workforce oriented for quality, economic efficiency, and underserved area accessibility and the continued viability of academic health centers.

This proposal is offered as an alternative to the physician workforce and academic health center initiatives in the Health Security Act (HSA). The HSA initiative would create a highly regulated and bureaucratic system. Under the physician workforce provisions, the federal government would determine the specific number of residency positions in each of 82 different specialties and distribute all-payer funding to support each of these positions only. The all-payer fund would be funded by a 1.5% premium surcharge and a transfer of $2 billion Medicare direct graduate medical education payments. Under the academic health center initiative, an estimated $4 billion in Medicare indirect graduate medical education payments to teaching hospitals would end. In its place, academic health centers and community-based teaching hospitals, could apply to the Federal government to receive extra funding under a new categorical grant program. In no event would funding to institutions which have traditionally received Medicare indirect medical education payments be guaranteed.

Summary

I. Purpose

- **Facilitate changes in the medical education system to train the proper number of physicians, to ensure quality, and to create an improved physician specialty-mix through a stable funding mechanism.**

II. All-payer graduate medical education fund

- **Set a mechanism to consider the establishment of an all-payer graduate medical education fund which would occur by transferring current Medicare direct medical education funds and capturing current health insurance company funding for such activities.**

  Currently, Medicare explicitly pays for one-third of the direct graduate medical education expenses of residents through an explicit per-resident payment it makes to teaching hospitals (nearly $2 billion). In addition, health insurers are estimated to contribute the other two-thirds of such payments through implicit payments they make to teaching hospitals. With the growth of managed care, the money contributed by health insurers for residency education is being reduced dramatically. This is threatening the ability of teaching hospitals to provide

services and educate quality physicians.

Because there is uncertainty over the amount of the implicit payments third-party payers currently contribute to residency education, this proposal would have the Commission on Graduate Medical Education determine this amount. In addition, the Commission would determine the best mechanism to have insurers or others contribute these funds, and would specifically be asked to explore voluntary mechanisms through tax code changes or other mechanisms.

III. National Commission On Graduate Medical Education

- **Establish an independent National Commission on Graduate Medical Education. Provide budget neutral funding for the Commission from a transfer of current Medicare indirect medical education payments as necessary.**

The Commission would be appointed and operated in a fashion similar to the Physicians Payment Review Commission. It would be composed of 13 experts appointed by the Office of Technology Assessment. Physicians from private practice and medical schools, representatives of health care insurers, including one from a managed care entity, and representatives of health care consumers would be appointed. Funding for the Commission would be budget neutral and would be from funds currently spent on Medicare indirect graduate medical education.

- **Create two proposals for fast track (like the base-closing system) consideration by Congress by May 1, 1997. The first would determine the if an all-payer graduate medical education fund should be established and the amount of and how to raise funds. The second proposal would create a process for distributing the all-payer funds through the most decentralized process compatible with meeting the Commission defined goals for specialty-mix and number of residency training positions.**

This proposal would have the Commission decide if an all-payer fund should be established. If it decides that this is a good idea, the commission would define the size of the all-payer fund, because there currently is discrepancy about how much funding is currently spent by third-party payers and the amount of money actually needed for residency education. In addition, there may be mechanisms through tax-code changes to induce insurance companies to voluntarily contribute to the all-payer fund.

Most experts currently believe that there is, or will soon be, a physician over-supply. This is driving health care spending because physicians tend to increase their services to meet a certain income level. In addition, to improve health care access, and improve the delivery of quality cost-effective medicine, most experts believe more primary care physicians are needed. The Commission would determine supply and specialty-mix goals after reviewing the opinions of experts.

Finally, the recommendation would define a mechanism to meet the

goals established by the Commission by distributing residency funding from the all-payer fund through the most decentralized mechanism compatible with the Commission goals. We have chosen to have a Commission define the distribution system because there currently is not agreement among experts on the best way to distribute such funds. For instance, the Physicians Payment Review Commission recommends a centralized distribution system consistent with the HSA approach. While the Council and Graduate Medical Education would provide minimal planning. Some note that increased salaries for primary care, and other changes in the medical marketplace including the lay-offs of specialists in some markets, will obviate the need for a planned distribution of residency training funds. This proposal serves as an alternative to the HSA proposal which is too bureaucratic and unnecessary in light of changes in the medical market place.

- **Develop a prospective payment system for payments from the all-payer fund. In the interim, require that a national average payment be made which is adjusted for regional cost-of-living differences.**

Currently, residency programs receive hospital specific direct graduate medical education payments. These payments are historically based and may not accurately reflect the true cost of training residents. The Commission developed prospective payment system would provide different payments per-resident based upon the resident's specialty and geographic location of the program. In addition, Medicare indirect graduate medical education payments could be rolled into this new prospective payment system to account for indirect cost of training residents in ambulatory sites. (Medicare indirect graduate medical education payments are currently only made to teaching hospitals which decreases the ability to establish community-based training programs including primary care residencies.)

- **Study current problems medical schools are having with funding in light of the growth of managed care to determine if they would benefit from a new federal subsidy. Recommend on how such a subsidy would be made from the all-payer fund.**

The Kennedy mark adds a new provision not found in the HSA which would provide funding to medical schools. Medical schools argue for such a fund because their faculty are increasingly having to see patients to raise revenue for the schools. This takes away faculty time for teaching and research. Currently, faculty practice plans provide 33% of medical school funding. With the growth of managed care, this amount of funding could only be maintained if the faculty increase their time spent with patients.

Rather than have a medical school fund established, this proposal would study the establishment of such a fund. It is not clear if such a fund is actually needed, or what the size and the exact purpose of the fund should be. After a more detailed examination of this issue by the Commission, Congress would have enough information to adequately consider this issue.

- On a continuing basis, advise Congress and the Secretary on all physician health care workforce issues. Consistent with the recommendations approved by Congress for the distribution of the all-payer funds, the Commission might determine which programs to fund. In no event is the Commission to administer the all-payer fund; that responsibility would continue to lie with the Secretary as it does under the Medicare graduate medical education payment system.

IV. Medicare Indirect Medical Education Payments

- Un-link Medicare indirect medical education payments from residency education to cap the growth of such spending, to remove the incentive for teaching hospitals to create sub-specialty training positions over primary care positions, to provide transition funding for teaching hospitals which lose residency positions as a result in the reduction of such positions, and to ensure continued academic health center viability.

Under this section, hospitals would be capitated based upon the total of all their service-based Medicare indirect medical education payments in 1994. Such capitated payments would be made quarterly and begin in FY 1996. Once the prospective payment system for direct graduate medical education payments is approved, the capitation of such payments would terminate.

V. Facilitate the establishment of Health Care Training Consortia

- Provide start-up grants for and allow the formation of health care training consortia to develop a framework for the decentralized distribution of all-payer funding and to foster community-based training of residents. Require each health care training consortia to determine its own governing structure and to operate with the intention of producing no less than 40% primary care providers. Each consortia would be composed of a medical school(s), community-based training sites (such as rural and community health clinics), and teaching hospitals. To ensure budget neutrality, provide start-up grants from Medicare indirect graduate medical education funds.

Such consortia lead to the integration of residency and medical education. As such, they will lead to changes in the medical education system that would help induce medical students to enter specialties which are more reflective of the needs of the medical marketplace. In addition, this proposal would give authority for consortia to receive Medicare direct graduate medical education payments directly to facilitate ambulatory, out of the hospital, training. This means there would be two places Medicare direct graduate medical education payments could be made, teaching hospitals and health care training consortia. In addition, if such an infrastructure is created, it would serve as a mechanism to distribute all-payer residency funding through a decentralized mechanism.

VI. Nursing Graduate Medical Education

- **Have the Secretary continue to study this issue and recommend to Congress if and how such nursing graduate medical education payments should be made.**

This is included as an alternative to the proposal in the HSA and the Kennedy mark which would for the first time set up a system for nursing graduate medical education payments to mirror the physician graduate medical education payments. This proposal was added at the last minute to the HSA at the insistence of nursing, but still needs to be fleshed out and technically developed further. In addition, Sen. Kassebaum questions the need for establishing nursing GME at this time.

Because nursing GME could facilitate the production of nurse practitioners, which are in short-supply, nursing GME may be a good idea. However, it is not clear how this should be done or if it should be done. This proposal would codify ongoing administration activities to study this issue while not directly authorizing nursing GME as the Kennedy mark does.

AMENDMENT NO. ____ Calendar No. ____

Purpose: To facilitate changes in the medical education system.

IN THE SENATE OF THE UNITED STATES—103d Cong., 2d Sess.

S. 1779

To ensure individual and family security through health care coverage for all Americans in a manner that contains the rate of growth in health care costs and promotes responsible health insurance practices, to promote choice in health care, and to ensure and protect the health care of all Americans.

Referred to the Committee on _____
and ordered to be printed

Ordered to lie on the table and to be printed

AMENDMENT intended to be proposed by Mrs. KASSEBAUM

Viz:

Strike subparagraph (A) of section 1261(b)(2) and insert the following:

(A) such amount multiplied by the administrative allowance percentage, computed under section 1262; and

Strike parts 1 and 2 of subtitle A of title III and insert the following:

PART 1—DIRECT GRADUATE MEDICAL EDUCATION AND INDIRECT GRADUATE MEDICAL EDUCATION

Subpart A—Workforce Priorities for Direct Graduate Medical Education

SEC. 3001. PURPOSE.

It is the purpose of this subpart to facilitate changes in the allopathic and osteopathic medical education system which—

(1) result in training the proper number of physicians necessary to create a national physician supply which provides the greatest degree of economic efficiency while producing quality medicine; and

(2) create a physician specialty mix which improves health care access for rural and inner-city areas, improves economic efficiency, and maintains or improves health care quality.

SEC. 3002. NATIONAL COMMISSION ON GRADUATE MEDICAL EDUCATION.

(a) ESTABLISHMENT.—There is established an independent National Commission on Graduate Medical Education (referred to in this section as the "Commission").

(b) MEMBERSHIP.—

(1) APPOINTMENT.—The Commission shall consist of 13 members appointed by the Director of the Congressional Office of Technology Assessment (re-

ferred to in this section as the "Director") without regard to the provisions of title 5, United States Code, governing appointments in the competitive service. Members of the Commission shall first be appointed no later than May 1, 1995, for a term of 3 years, except that the Director may provide initially for such shorter terms as will ensure that the terms of no more than 4 members expire in any one year.

(2) EXPERTISE.—The membership of the Commission shall be composed of individuals with national recognition in issues relating to physician training and the national physician workforce. The membership of the Commission shall include—

(A) physicians who are faculty members of medical schools or individuals who represent such physicians;

(B) physicians in private practice or individuals who represent such physicians;

(C) individuals who represent health care insurers, including at least 1 individual who represents a managed care entity; and

(D) individuals who represent consumers of health care services.

(c) ACTIVITIES OF THE COMMISSION.—

(1) LEGISLATIVE PROPOSAL ON THE NATIONAL HEALTH CARE WORKFORCE.—

(A) IN GENERAL.—Not later than May 1, 1997, the Commission shall develop and submit to the Congress a legislative proposal containing the Commission's legislative recommendations on—

(i) the national health care workforce (as developed under subparagraph (B));

(ii) payments for residency positions (as developed under subparagraph (C));

(iii) funding for the All-Payer Graduate Medical Education Fund (referred to in this section as the "Fund") established under section 3003 (as developed under subparagraph (D)); and

(iv) terminating payments for direct graduate medical education under section 1886(h) of the Social Security Act.

(B) NATIONAL HEALTH CARE WORKFORCE.—

(i) IN GENERAL.—The Commission shall monitor the national health care workforce and develop legislative recommendations on—

(I) the number of residency positions to be supported by the Fund that is appropriate to ensure a national physician supply which provides the greatest degree of economic efficiency while producing quality medicine;

(II) the national physician specialty mix that is appropriate to ensure improvements in health care access for the nation's underserved areas, to improve cost efficiency, and to maintain or improve health care quality; and

(III) a system for distributing funds to the residency positions that are supported by the Fund that is as decentralized and nonregulatory as possible and that is administered by the Secretary of Health and Human Services (referred to in this section as the "Secretary").

(ii) SPECIAL CONSIDERATIONS.—In developing its legislative recommendations under clause (i), the Commission shall—

(I) consult with the Secretary, the Council on Graduate Medical Education, and the Physician Payment Review Commission;

(II) consider recommendations of organizations representing health care providers, residency educators, academic health centers, health care insurers (including managed care entities), and any other relevant organization;

(III) take into account developments in the health care marketplace and the supply of nonphysician health care providers that affect the need for physicians, the physician specialty mix, and physician distribution;

(IV) address the special issues of implementation, including issues relating to international medical graduates seeking residency positions in the United States and the impact on health care delivery systems in the States that have relied on the medical

residency services of such graduates most;

(V) in developing a system for distributing funds out of the Fund—

(aa) consider the direct distribution of all funds through residency programs, through health care training consortia, through teaching hospitals, or through methods that adjust per resident payments by various weighting factors; and

(bb) give priority to a system which is as decentralized and nonregulatory as possible while achieving the physician supply and specialty mix goals developed under clause (i).

(C) PAYMENTS FOR RESIDENCY POSITIONS.—The Commission shall develop a legislative recommendation under which the amount paid with respect to each residency position allowed is equal to the national average of the per resident direct graduate medical education payments made under section 1886(h) of the Social

Security Act during the 12-month period ending on the date the legislative proposal described in subparagraph (A) is submitted to the Congress. The Commission's legislative recommendation may provide that the amount determined under the preceding sentence is adjusted annually for inflation and to reflect regional cost-of-living differences.

(D) FUNDING FOR THE FUND.—

(i) IN GENERAL.—The Commission shall develop legislative recommendations on the appropriate method of providing funds for the Fund. In developing such legislative recommendations, the Commission shall determine—

(I) the amount necessary to pay for the cost of implementing the legislative recommendations developed by the Commission under subparagraphs (B) and (C); and

(II) if the amount determined under subclause (I) exceeds the amount made available to the Fund pursuant to section 3041(1), the appropriate methods for obtaining funds

to cover such excess, including methods which take into account contributions to the cost of graduate medical education that have historically been made by third-party payors, the medicaid program under title XIX of the Social Security Act, and other sources.

(ii) SPECIAL RULE.—In developing legislative recommendations under clause (i)(II), the Commission shall give priority to methods which foster voluntary contributions to the Fund from insurers through tax incentives or other mechanisms.

(E) ONGOING REPORTS AND RECOMMENDATIONS TO THE CONGRESS AND THE SECRETARY.—After a legislative proposal developed by the Secretary under subparagraph (A) is enacted under section 3004, the Commission shall submit to the Congress and the Secretary biennial reports and legislative recommendations on issues relating to such proposal, including—

(i) the appropriate number of Fund supported residency positions;

(ii) the appropriate amount that should be in the Fund;

(iii) issues related to funding for the Fund;

(iv) issues related to the system for distributing payments from the Fund;

(v) the state of physician distribution among specialties;

(vi) the recommended distribution in residency training positions between primary care and nonprimary care specialties;

(vii) the supply and geographic distribution of physicians in the United States;

(viii) issues relating to foreign medical school graduates; and

(ix) appropriate Federal policies with respect to the matters specified in the preceding clauses.

(2) LEGISLATIVE RECOMMENDATION ON PROSPECTIVE PAYMENT SYSTEM FOR DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS.—

(A) IN GENERAL.—The Commission shall develop and submit to the Congress a legislative recommendation providing for a prospective per resident payment system under which the amount paid with respect to each residency position allowed is equal to the standard cost of training the resident in such position less the standard value of the service provided by the resident. The Commission's legislative recommendation may provide that the amount determined under the preceding sentence is adjusted to reflect the medical specialty of the residency, the year of training, and regional cost-of-living differences.

(B) CONSIDERATIONS BY THE COMMISSION.—

(i) IN GENERAL.—In developing its recommendation under subparagraph (A), the Commission shall consider both direct and indirect costs associated with training medical residents.

(ii) TERMINATION OF IME PAYMENTS.—If the payment system developed by the Commission under subparagraph (A) includes payments for the indirect

costs associated with training medical residents, the Commission's legislative recommendation shall provide for the termination of payments under section 3101.

(C) ONGOING REPORTS AND RECOMMENDATIONS TO THE CONGRESS AND THE SECRETARY.—After a legislative recommendation under subparagraph (A) is first submitted to the Congress, the Commission shall submit to the Congress and the Secretary biennial reports and legislative recommendations on issues relating to such recommendation.

(4) LEGISLATIVE RECOMMENDATIONS ON PAYMENTS TO MEDICAL SCHOOLS.—

(A) IN GENERAL.—The Commission shall develop and submit to the Congress a legislative recommendation on the need for medical schools to receive payments from the Fund for—

(i) the projected increase in the cost of educational initiatives, including teaching in primary care ambulatory settings; and

(ii) the projected loss of clinical revenues due to increased contracting with

managed care insurance plans when such clinical revenues pay for essential academic functions in settings where medical school faculty are organized for maximum health care delivery and educational efficiency.

(B) DEVELOPMENT OF SYSTEM.—If it determines that medical schools should receive the payments referred to in subparagraph (A), the Commission shall determine the amount of, and a system for, such payments. The Commission's legislative recommendation shall include mechanisms intended to ensure that medical schools receiving payments from the Fund make necessary changes in curriculum and admissions processes to increase the number of medical students choosing to enter primary care fields at the completion of their residency training.

(C) ONGOING REPORTS AND RECOMMENDATIONS TO THE CONGRESS AND THE SECRETARY.—After a legislative recommendation under this paragraph is first submitted to the Congress, the Commission shall submit to the Congress and the Secretary biennial reports and legislative recommendations on issues relating to such recommendation.

(d) MATTERS RELATED TO CARRYING OUT FUNCTIONS.—In order to carry out its functions, the Commission shall collect and assess information. In collecting and assessing information, the Commission shall—

(1) utilize existing information (both published and unpublished, where possible) collected and assessed either by the Commission's staff or under other arrangements made in accordance with this section;

(2) carry out, or award grants or contracts for, original research and experimentation if existing information is inadequate for the development of useful and valid guidelines by the Commission;

(3) adopt procedures allowing any interested parties to submit information with respect to physicians services (including new practices, such as the use of new technologies and treatment modalities) which the Commission shall consider in making reports and recommendations to the Congress and the Secretary; and

(4) if existing data bases are insufficient, maintain data bases concerning the supply and distribution of, and postgraduate training programs for, physicians and other primary care providers in the United States.

(e) ADMINISTRATIVE ISSUES RELATED TO THE COMMISSION.—The following provisions of section 1886(e)(6) of the Social Security Act shall apply to the Commission in the same manner as such provisions apply to the Prospective Payment Assessment Commission established under section 1886(e)(2) of such Act:

(1) Subparagraph (C) (relating to staffing and administration).

(2) Subparagraph (D) (relating to compensation of members).

(3) Subparagraph (F) (relating to access to information).

(4) Subparagraph (G) (relating to use of funds).

(5) Subparagraph (H) (relating to periodic GAO audits).

(6) Subparagraph (J) (relating to requests for appropriations).

(g) FUNDING FOR COMMISSION.—Funding for the Commission shall be from the funds made available to the Commission pursuant to section 3041(3)(A).

SEC. 3003. ESTABLISHMENT OF ALL-PAYOR GRADUATE MEDICAL EDUCATION FUND.

(a) ESTABLISHMENT.—The Secretary shall establish an All-Payor Graduate Medical Education Fund (referred to in this section as the "Fund").

(b) ALLOCATIONS TO THE FUND.—

(1) TRANSFERS FROM MEDICARE TRUST FUNDS.—There shall be transferred to the Fund such sums as are made available to the Fund pursuant to section 3041(1).

(2) OTHER ALLOCATIONS.—There shall be transferred to the Fund such other sums as are available under the legislative proposal of the Commission that is enacted.

SEC. 3004. FAST TRACK PROCEDURE FOR CONSIDERATION OF LEGISLATIVE PROPOSAL ON NATIONAL HEALTH CARE WORKFORCE.

(a) IN GENERAL.—The legislative proposal of the National Commission on Graduate Medical Education (referred to in this section as the "Commission") described in section 3002(c)(1) shall be considered by the Congress under the procedures for consideration of an "implementing bill" as described in subsection (b).

(b) PROCEDURES FOR CONSIDERATION OF AN IMPLEMENTING BILL.—

(1) CONGRESSIONAL CONSIDERATION.—

(A) RULES OF HOUSE OF REPRESENTATIVES AND SENATE.—This paragraph is enacted by Congress—

(i) as an exercise of the rulemaking power of the House of Representatives and the Senate, respectively, and as such is deemed a part of the rules of each House, respectively, but applicable only with respect to the procedure to be followed in that House in the case of an implementing bill described in subparagraph (B), and supersedes other rules only to the extent that such rules are inconsistent therewith; and

(ii) with full recognition of the constitutional right of either House to change the rules (so far as relating to the procedure of that House) at any time, in the same manner and to the same extent as in the case of any other rule of that House.

(B) IMPLEMENTING BILL.—For purposes of subparagraph (A), the term "implementing bill" means only a bill of either House of Congress which is introduced as provided in subparagraph (C) with respect to the legislative proposal of the Commission described in section

3002(c)(1)(A) and which contains such provisions necessary or appropriate to implement such proposal either repealing or amending existing laws or providing new statutory authority.

(C) INTRODUCTION AND REFERRAL.—On the day on which the legislative proposal of the Commission described in section 3002(c)(1)(A) is transmitted to the House of Representatives and the Senate, an implementing bill with respect to such proposal shall be introduced (by request) in the House of Representatives by the Majority Leader of the House, for himself and the Minority Leader of the House, or by Members of the House designated by the Majority Leader and Minority Leader of the House; and shall be introduced (by request) in the Senate by the Majority Leader of the Senate, for himself and the Minority Leader of the Senate, or by Members of the Senate designated by the Majority Leader and Minority Leader of the Senate. If either House is not in session on the day on which such proposal is transmitted, the implementing bill with respect to such proposal shall be introduced in the House, as provided in

the preceding sentence, on the first day thereafter on which the House is in session. The implementing bill introduced in the House of Representatives and the Senate shall be referred to the appropriate committees of each House.

(D) AMENDMENTS PROHIBITED.—No amendment to an implementing bill shall be in order in either the House of Representatives or the Senate; and no motion to suspend the application of this paragraph shall be in order in either House, nor shall it be in order in either House for the Presiding Officer to entertain a request to suspend the application of this paragraph by unanimous consent.

(E) PERIOD FOR COMMITTEE AND FLOOR CONSIDERATION.—

(i) IN GENERAL.—Except as provided in clause (ii), if the committee or committees of either House to which an implementing bill has been referred have not reported it at the close of the 45th day after its introduction, such committee or committees shall be automatically discharged from further consideration of the implementing bill and it shall be placed on the

appropriate calendar. A vote on final passage of the implementing bill shall be taken in each House on or before the close of the 45th day after the implementing bill is reported by the committees or committee of that House to which it was referred, or after such committee or committees have been discharged from further consideration of the implementing bill. If prior to the passage by 1 House of an implementing bill of that House, that House receives the same implementing bill from the other House then—

(I) the procedure in that House shall be the same as if no implementing had been received from the other House; but

(II) the vote on final passage shall be on the implementing bill of the other House.

(ii) COMPUTATION OF DAYS.—For purposes of clause (i), in computing a number of days in either House, there shall be excluded—

(I) the days on which either House is not in session because of an adjournment of more than 3 days to a day certain or an adjournment of the Congress sine die, and

(II) any Saturday and Sunday, not excluded under paragraph (1), when either House is not in session.

(F) FLOOR CONSIDERATION IN THE HOUSE OF REPRESENTATIVES.—

(i) MOTION TO PROCEED.—A motion in the House of Representatives to proceed to the consideration of an implementing bill shall be highly privileged and not debatable. An amendment to the motion shall not be in order, nor shall it be in order to move to reconsider the vote by which the motion is agreed to or disagreed to.

(ii) DEBATE.—Debate in the House of Representatives on an implementing bill shall be limited to not more than 20 hours, which shall be divided equally between those favoring and those opposing the bill. A motion further to limit debate shall not be debatable. It shall not be in order to

move to recommit an implementing bill or to move to reconsider the vote by which an implementing bill is agreed to or disagreed to.

(iii) MOTION TO POSTPONE.—Motions to postpone, made in the House of Representatives with respect to the consideration of an implementing bill, and motions to proceed to the consideration of other business, shall be decided without debate.

(iv) APPEALS.—All appeals from the decisions of the Chair relating to the application of the Rules of the House of Representatives to the procedure relating to an implementing bill shall be decided without debate.

(v) GENERAL RULES APPLY.—Except to the extent specifically provided in the preceding provisions of this subsection, consideration of an implementing bill shall be governed by the Rules of the House of Representatives applicable to other bills and resolutions in similar circumstances.

(G) FLOOR CONSIDERATION IN THE SENATE.—

(i) MOTION TO PROCEED.—A motion in the Senate to proceed to the consideration of an implementing bill shall be privileged and not debatable. An amendment to the motion shall not be in order, nor shall it be in order to move to reconsider the vote by which the motion is agreed to or disagreed to.

(ii) GENERAL DEBATE.—Debate in the Senate on an implementing bill, and all debatable motions and appeals in connection therewith, shall be limited to not more than 20 hours. The time shall be equally divided between, and controlled by, the Majority Leader and the Minority Leader or their designees.

(iii) DEBATE OF MOTIONS AND APPEALS.—Debate in the Senate on any debatable motion or appeal in connection with an implementing bill shall be limited to not more than 1 hour, to be equally divided between, and controlled by, the mover and the manager of the implementing bill, except that in the event the manager of the implementing bill is in favor of

any such motion or appeal, the time in opposition thereto, shall be controlled by the Minority Leader or his designee. Such leaders, or either of them, may, from time under their control on the passage of an implementing bill, allot additional time to any Senator during the consideration of any debatable motion or appeal.

(iv) OTHER MOTIONS.—A motion in the Senate to further limit debate is not debatable. A motion to recommit an implementing bill is not in order.

(2) RESUBMISSIONS.—If a legislative proposal of the Commission submitted under paragraph (1) is not approved by Congress or is vetoed by the President (and such veto is not overridden by the Congress), the Commission shall resubmit a new legislative proposal not later than 90 days after Congress failed to approve such legislative proposal or failed to override the President's veto, and such new legislative proposal shall be subject to congressional consideration as provided in paragraph (1).

Subpart B—Interim Consortium Demonstration Projects

SEC. 3011. INTERIM CONSORTIUM GRADUATE MEDICAL EDUCATION DEMONSTRATION PROJECTS.

Part C of title VII of the Public Health Service Act (42 U.S.C. 293j et seq.) is amended by adding at the end the following new section:

"SEC. 753. CONSORTIUM DEMONSTRATION PROJECTS TO INCREASE MEDICAL STUDENT ENTRANCE INTO PRIMARY CARE PRACTICE.

"(a) IN GENERAL.—The Secretary of Health and Human Services (hereafter referred to in this section as the 'Secretary'), acting through the Administrator of the Health Resources and Services Administration, shall provide for the establishment of demonstration projects for health care training consortia for the purpose of testing and evaluating mechanisms to increase the number and percentage of medical students entering primary care practice relative to those entering nonprimary care practice through the use of funds made available pursuant to section 3041(2) of the Health Security Act (in lieu of any funds otherwise available under section 1886(h) of the Social Security Act).

"(b) APPLICATIONS.—

"(1) IN GENERAL.—Each health care training consortium desiring to conduct a demonstration

project under this section shall prepare and submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require, including an explanation of a plan for evaluating the project.

"(2) APPROVAL OF APPLICATIONS.—A consortium that submits an application under paragraph (1) may begin a demonstration project under this section—

"(A) upon approval of such application by the Secretary; or

"(B) at the end of the 60-day period beginning on the date such application is submitted, unless the Secretary denies the application during such period.

"(c) FUNDING FOR DEMONSTRATION PROJECTS.—

"(1) ALLOCATION OF GME FUNDS.—

"(A) IN GENERAL.—For each year a consortium conducts a demonstration project under this section, the Secretary shall pay to such consortium an amount equal to the total amount that would be available to hospitals that are members of the consortium under section 1886(h) of the Social Security Act. The consortium shall designate a teaching hospital

for each resident assigned to the consortium which the Secretary shall use to calculate the consortium's payment amount under such section. Such teaching hospital shall be the hospital where the resident receives the majority of the resident's hospital-based, nonambulatory training experience.

"(B) USE OF FUNDS.—

"(i) TESTING AND EVALUATION.—Each consortium that receives a payment under subparagraph (A) shall use such funds to conduct activities which test and evaluate mechanisms to increase the number and percentage of medical students entering primary care practice relative to those entering nonprimary care practice.

"(ii) ESTABLISHMENT AND OPERATION.—Each consortium that receives a payment under subparagraph (A) may also use such funds for the establishment and operation of the consortium. The Secretary shall make payments to the consortium through an entity identified by the consortium as appropriate for receiving payment on behalf of the consortium. The consor-

tium shall have discretion in determining the purposes for which such payments may be used and may direct such payments to consortium medical schools for primary care medical student education programs.

"(2) GRANTS FOR PLANNING AND EVALUATIONS.—

"(A) IN GENERAL.—The Secretary may award grants to consortia conducting demonstration projects under this section for the purpose of developing and evaluating such projects. Each consortium desiring to receive a grant under this paragraph shall prepare and submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require.

"(B) FUNDING.—Funding for the grants described in subparagraph (A) shall be from the funds available to the Secretary pursuant to section 3041(3)(B).

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

"(e) DURATION.—A demonstration project under this section shall be conducted for a period that may not extend beyond the end of the fiscal year in which the legislative proposal submitted in accordance with section 3002(c)(1)(A) of the Health Security Act is enacted. The Secretary may terminate a project if the Secretary determines that the consortium conducting the project is not in substantial compliance with the terms of the application approved by the Secretary under this section.

"(f) EVALUATIONS AND REPORTS.—

"(1) EVALUATIONS.—Each consortium that conducts a demonstration project under this section and receives a grant under subsection (c)(2) for planning and evaluation shall submit to the Secretary a final evaluation of such project within 360 days of the termination of such project and such interim evaluations as the Secretary may require.

"(2) REPORTS TO CONGRESS.—Not later than 360 days after the first demonstration project under this section begins, and annually thereafter for each year in which a project is conducted under this section, the Secretary shall submit a report to the appropriate committees of the Congress that evaluates the effectiveness of the demonstration projects conducted under this section and includes any legisla-

tive recommendations determined appropriate by the Secretary.

"(g) DEFINITIONS.—For purposes of this section:

"(1) AMBULATORY TRAINING SITES.—The term 'ambulatory training sites' includes, but is not limited to, health maintenance organizations, federally qualified health centers, community health centers, migrant health centers, rural health clinics, nursing homes, hospice, and other community-based providers, including private practices.

"(2) HEALTH CARE TRAINING CONSORTIUM.—The term 'health care training consortium' means a State, regional, or local entity that—

"(A) includes teaching hospitals, ambulatory training sites, and one or more schools of medicine; and

"(B) is operated in a manner intended to ensure that by the end of the demonstration project at least 40 percent of the graduates of the schools included in the entity will become primary care providers during the 1-year period immediately following the date such graduates complete their residency training.

"(3) PRIMARY CARE.—The term 'primary care' means family practice, general internal medicine, and general pediatrics.".

Subpart C—Indirect Graduate Medical Education

SEC. 3021. UNLINKING INDIRECT MEDICAL EDUCATION PAYMENTS FROM RESIDENCY EDUCATION.

(a) PURPOSE.—It is the purpose of this section to—

(1) replace the current indirect medical education incentives under the medicare program under title XVIII of the Social Security Act that have contributed to the growth of hospital-based and specialty-oriented training positions over community-based primary care programs; and

(2) provide for transitional funds for institutions which face changes in their residency training programs.

(b) TRANSITIONAL PAYMENTS.—Beginning October 1, 1995, the Secretary of Health and Human Services (hereafter referred to in this section as the "Secretary") shall provide for a quarterly payment to each hospital described in subsection (c) in an amount determined under subsection (d).

(c) HOSPITAL DESCRIBED.—A hospital described in this subsection is a subsection (d) hospital (as such term

is defined in section 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B))) that—

(1) received payment for indirect costs of medical education under section 1886(d)(5)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)) in fiscal year 1994; or

(2) established a primary care residency program on or after October 1, 1994.

(d) QUARTERLY PAYMENT AMOUNT.—

(1) IN GENERAL.—The amount determined under this subsection is equal to the product of—

(A) one-quarter of the amount determined under paragraph (2); multiplied by

(B) the reduction factor determined under paragraph (3).

(2) ANNUAL BASE AMOUNT PER HOSPITAL.—

(A) HOSPITAL PREVIOUSLY RECEIVING IME PAYMENTS.—In the case of a hospital described in subsection (c)(1), the amount determined under this paragraph is an amount equal to—

(i) for fiscal year 1996, the amount received by the hospital as payment for indirect costs of medical education in fiscal year 1994 under section 1886(d)(5)(B) of

the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)), updated by the estimated percentage change in the Consumer Price Index For All Urban Consumers (United States city average) during the 18-month period ending on March 31, 1996; and

(ii) for fiscal year 1997 and succeeding fiscal years, the amount determined under this subparagraph for the hospital for the preceding fiscal year updated through the midpoint of the fiscal year by the estimated percentage change in the Consumer Price Index For All Urban Consumers (United States city average) during the 12-month period ending March 31 of such fiscal year, with appropriate adjustments to reflect previous underestimations or overestimations under this subparagraph in the projected percentage change in the Consumer Price Index.

(B) NEW PRIMARY CARE RESIDENCY PROGRAM.—In the case of a hospital described in subsection (c)(2), the amount determined under this paragraph is an amount equal to—

(i) in the first fiscal year such residency program is in operation, an amount that the Secretary determines the hospital would have received in fiscal year 1994 as payment for costs of indirect medical education under section 1886(d)(5)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)) (as such section was in effect during fiscal year 1994) for operating the primary care residency program, updated by the estimated percentage change in the Consumer Price Index For All Urban Consumers (United States city average) during the period beginning on April 1, 1994, and ending on March 31 of such first fiscal year; and

(ii) in subsequent fiscal years, the amount determined under this subparagraph for the hospital for the preceding fiscal year updated through the midpoint of the fiscal year by the estimated percentage change in the Consumer Price Index For All Urban Consumers (United States city average) during the 12-month period ending March 31 of such fiscal year, with

appropriate adjustments to reflect previous underestimations or overestimations under this subparagraph in the projected percentage change in the Consumer Price Index.

(3) REDUCTION FACTOR.—The reduction factor determined under this paragraph is an amount equal to—

(A) the difference between—

(i) the sum of the amounts determined under paragraph (2) for all hospitals for the fiscal year, and

(ii) the total funds transferred from the Federal Hospital Insurance Trust Fund to the Secretary for the fiscal year pursuant to subparagraphs (A) and (B) of section 3041(3); divided by

(B) the sum of the amounts determined under paragraph (2) for all hospitals for the fiscal year.

(e) PRIMARY CARE RESIDENCY PROGRAM.—For purposes of this section, the term "primary care residency program" means an approved medical residency program (as such term is defined in section 1886(h)(5)(A) of the Social Security Act (42 U.S.C. 1395ww(h)(5)(A))) in fam-

ily practice, general internal medicine, or general pediatrics.

Subpart D—Sense of the Committee Regarding Funding for Provisions under this Part

SEC. 3041. SENSE OF THE COMMITTEE.

It is the sense of the Committee on Labor and Human Resources of the Senate that when the Health Security Act is enacted it should include the following provisions not within the jurisdiction of the Committee:

(1) TRANSFERS FROM MEDICARE TRUST FUNDS TO ALL-PAYOR GRADUATE MEDICAL EDUCATION FUND.—

(A) IN GENERAL.—A provision providing that for each fiscal year beginning after the date the legislative proposal of the National Commission on Graduate Medical Education (referred to in this section as the "Commission") described in section 3002(c)(1) is enacted, an amount equal to the transfer amount determined under subparagraph (B) shall be transferred to the All-Payor Graduate Medical Education Fund established under section 3003 from—

(i) the Federal Hospital Insurance Trust Fund (established under section 1817 of the Social Security Act); and

(ii) the Federal Supplementary Medical Insurance Trust Fund (established under section 1841 of such Act).

(B) AMOUNT TRANSFERRED.—For purposes of subparagraph (A), the transfer amount with respect to a fund described in clause (i) or (ii) of subparagraph (A) is—

(i) for the first fiscal year beginning after the date the legislative proposal of the Commission is enacted, an amount equal to the aggregate amount of payments made from such fund for direct graduate medical education costs under section 1886(h) of the Social Security Act during fiscal year 1994 updated by the estimated percentage change in the Consumer Price Index for All Urban Consumers (United States city average) during the period beginning October 1, 1994 and ending on the last day of the fiscal year in which such legislative proposal is enacted; and

(ii) for succeeding fiscal years, the amount determined under this subparagraph for the preceding fiscal year updated by the percentage change in the Consumer Price Index for All Urban Consumers (United States city average) during such preceding fiscal year, with appropriate adjustments to reflect previous under or over estimations under this subparagraph.

(2) MEDICARE GRADUATE MEDICAL EDUCATION FUNDS USED FOR DEMONSTRATION PROJECTS.—A provision transferring to the Secretary of Health and Human Services from the Federal Hospital Insurance Trust Fund (established under section 1817 of the Social Security Act) and the Federal Medical Insurance Trust Fund (established under section 1841 of such Act) such sums as are necessary to carry out the provisions of section 753(c)(1) of the Public Health Service Act (as added by section 3011) (relating to interim consortium demonstration projects providing for allocation of graduate medical education funds) for each of fiscal years 1995 through the fiscal year in which the legislative proposal submitted in accordance with section 3002(c)(1) is enacted.

(3) MEDICARE INDIRECT MEDICAL EDUCATION FUNDS USED FOR COMMISSION; DEMONSTRATION PROJECTS, AND PAYMENTS TO HOSPITALS.—A provision transferring to the Secretary of Health and Human Services from the Federal Hospital Insurance Trust Fund (established under section 1817 of the Social Security Act) amounts equal to—

(A) subject to appropriations, for each of fiscal years 1995 through 2000, such sums as may be necessary to carry out the provisions of section 3002(g) (relating to the National Commission on Graduate Medical Education);

(B) subject to appropriations, for each of fiscal years 1995 through the fiscal year in which the legislative proposal submitted in accordance with section 3002(c)(1)(A) is enacted, such sums as may be necessary to carry out the provisions of section 753(c)(2) of the Public Health Service Act (as added by section 3011) (relating to planning and evaluation grants for interim consortium demonstration projects); and

(C) for fiscal year 1996 and each succeeding fiscal year, such sums as may be

necessary to carry out the provisions of section 3101 (relating to unlinking of medicare indirect medical education payments from residency education).

(4) REPEAL OF MEDICARE INDIRECT MEDICAL EDUCATION PAYMENT.—A provision repealing section 1886(d)(5)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)) (relating to indirect medical education), effective October 1, 1995.

PART 2—GRADUATE NURSE TRAINING

SEC. 3051. STUDY AND REPORT ON NEED FOR, AND FEASIBILITY OF, A GRADUATE NURSE TRAINING PROGRAM.

(a) IN GENERAL.—The Secretary of Health and Human Services (hereafter referred to in this section as the "Secretary") shall conduct a study on the need for, and the feasibility of, establishing a graduate nurse training program to foster the training of nurse practitioners, nurse midwives, nurse anesthetists, and clinical nurse specialists. Based on such study, the Secretary shall determine the most appropriate way to obtain funds for such a program and the appropriate method for distributing such funds in a manner that accounts for the clinical training, not the classroom training, of graduate nursing students.

(b) TIMING.—Not later than 2 years after the date of the enactment of this Act, the Secretary shall submit to Congress the results of the study conducted under subsection (a) and any legislative recommendations determined appropriate by the Secretary.

Alternative Health Care Workforce Amendment--Summary--May 18, 1994

Contact: Marty Sieg-Ross, MD
Committee on Labor and Human Resources, Minority (Kassebaum)
224-6770

I. Primary Care Provider Education

Goal: Increase the number of primary care providers in order to improve the nation's health care access and contain health care spending through changes in Medicare GME and Public Health Service health professions training funding.

A. Medicare GME Weighting

1. **Weight primary care residents as 1.5 FTE for the purposes of calculating DME payments.** Health care training institutions receiving such payments shall pay primary care residents 20 percent more than nonprimary care residents. Such weighting and primary care residency payments should increase the number of quality training programs and provide short-term incentives for medical students to enter primary care.

2. **Weight all nonprimary care residents affiliated with health care training consortia as 1.0 FTE for the purposes of DME payments.** Maintaining the 1.0 FTE weight for nonprimary care residents in consortia should help induce the formation of such entities. (See description of consortia below under B(1).)

3. **Annually calculate a weight for all nonprimary care residents not affiliated with a health care training consortia to maintain DME budget neutrality.** As payments for primary care and health care training consortia increase, this weight would eventually become 0, and thus, the number of specialty training programs subsidized by Medicare DME would decrease. As a result, the current overproduction of specialists would decline.

4. **Eliminate the .5 FTE weight Medicare currently applies to fellowship training positions.** Such specialist physicians are currently in oversupply.

B. Expand Ambulatory Training Experiences

1. **Begin DME payments to health care training consortia.** Such consortia would be composed of medical school(s), teaching hospitals, and community-based ambulatory training sites (i.e., physicians offices or community and rural health clinics). The DME payments would be used by a consortium, at its sole discretion, to meet an outcome requirement of producing **50 percent primary care providers** from the consortium medical school(s). In addition to increasing community-based ambulatory experiences, such consortia would lead to changes in the medical school environment which would influence medical students to enter primary care.

2. **Require teaching hospitals which receive DME payments to account for the use of those funds for residency programs.** Currently, many teaching hospitals which receive DME payments for their primary care programs do not transfer those funds to such programs. As such, primary care training programs often receive insufficient financial support.

3. **Allow teaching hospitals to receive DME funding for training received by their residents in nonhospital-owned community-based training facilities such as rural health clinics and private physicians' offices.** Residents trained in such settings have a greater tendency to practice in rural and other underserved areas.

C. Other GME Changes

1. **Establish a national average DME payment.** For historical reasons, DME payments vary by hospital. As such, many residency programs may be overfunded, while others are underfunded.

2. **Maintain GME budget neutrality by establishing a common GME fund with separate DME and IME subfunds.** Transfer funds from the Medicare part A and part B trust funds in an amount equal to 1993 funding adjusted for inflation. In addition, protect the funding base for per-resident DME payments by increasing the DME fund, as needed, to cover the primary care and health care consortia weights, through a transfer of amounts from the IME subfund. As a result, teaching hospitals would be discouraged from increasing the number of their specialty training programs because IME service payments would decrease as the number of specialty training positions increase. Furthermore, protection of the DME funding base for primary care should encourage the formation of such positions.

3. **Approve health care consortia and primary care training programs to receive increased DME weights.** Based upon their curricula, the Health Resources and Services Administration, which currently oversees federal government health professions funding for primary care training programs, would approve primary care programs. HRSA would also approve health care training consortia, if such consortia train 50 percent primary care providers.

D. Nurse Practitioner and Physician Assistant Funding

1. **Increase authorized funding for nurse practitioner and physician assistant training programs under Title VII and Title VIII of the Public Health Service Act.** Increase the authorized funding for physician assistant programs and for nurse practitioner programs.

E. Establish Primary Care Demonstration Grants

1. **Establish a $9 million demonstration grant program for states and nonprofit entities to examine mechanisms to increase primary care.** Grantees could examine one of the following:

   a. State mechanisms, including changes in the scope of practice laws, to enhance the delivery of primary care by nurse practitioners or physician assistants.

   b. The feasibility of, and the most effective means to train subspecialists to deliver primary care as primary care providers.

F. Council on Graduate Medical Education

1. **In addition to its current responsibilities, charge the Council on Graduate Medical Education to evaluate the changes created by this act.** Authorize $8 million for this purpose.

AMENDMENT NO. ____ Calendar No. ____

Purpose: To facilitate changes in the medical education system.

IN THE SENATE OF THE UNITED STATES—103d Cong., 2d Sess.

S. 1779

To ensure individual and family security through health care coverage for all Americans in a manner that contains the rate of growth in health care costs and promotes responsible health insurance practices, to promote choice in health care, and to ensure and protect the health care of all Americans.

Referred to the Committee on _____
and ordered to be printed

Ordered to lie on the table and to be printed

AMENDMENT intended to be proposed by Mrs. KASSEBAUM

Viz:

Strike subtitle A of title III and insert the following: Sections 3001 through and including Section 3081,

Subtitle A—Workforce Priorities Under Federal Payments

SEC. 3000. FINDINGS.

Congress finds that—

(1) not less than 50 percent of all medical residents should complete generalist training programs, and at least 50 percent of all physicians should become primary care providers;

(2) all primary care shortage areas should be eliminated, and disparities between the metropolitan and nonmetropolitan distribution of physicians should be reduced;

(3) the aggregate allopathic and osteopathic physician-to-population ratio should be maintained at 1993 levels;

(4) the total number of entry medical residency positions should be limited;

(5) the number of nurse practitioners and physician assistants should be increased; and

(6) community-based ambulatory training experiences for medical residents should be increased.

SEC. 3002. SENSE OF THE COMMITTEE REGARDING GRADUATE MEDICAL EDUCATION PAYMENTS.

It is the sense of the Committee on Labor and Human Resources of the Senate that when the Health Security Act is enacted it should include the following provisions not within the jurisdiction of the Committee:

(1) PROVISION RELATING TO GRADUATE MEDICAL EDUCATION PAYMENTS.—Subsection (h) of section 1886 of the Social Security Act (42 U.S.C. 1395ww(h)) is amended to read as follows:

"(h) GRADUATE MEDICAL EDUCATION PAYMENTS.—

"(1) NATIONAL HEALTH WORKFORCE EDUCATION FUND.—

"(A) ESTABLISHMENT.—The Secretary shall establish a National Health Workforce Education, Fund (hereafter referred to in this subsection as the 'Fund') to make payments in accordance with this subsection.

"(B) ALLOCATIONS.—

"(i) IN GENERAL.—In providing for the Fund, the Secretary shall annually provide for an allocation of monies to the Fund from the trust funds established under parts A and B as the Secretary determines reasonably reflects the amount of DME payments and IME payments payable under such funds during fiscal year 1993.

"(ii) UPDATING TO THE FIRST COST REPORTING PERIOD.—The Secretary shall update the amount of funds allocated to the Fund under clause (i) by the percentage increase in the consumer price index during the 12-month cost reporting period described in such clause.

"(iii) AMOUNT FOR SUBSEQUENT COST REPORTING PERIODS.—For each cost reporting period, the amount of funds allocated to the Fund shall be equal to the amount determined under this subparagraph for the previous cost reporting period updated, through the midpoint of the period, by projecting the estimated percentage change in the consumer price index during the 12-month period ending at that midpoint, with appropriate adjustments to reflect previous under- or over-estimations under this subparagraph in the projected percentage change in the consumer price index.

"(C) DIVISION OF FUND.—The Secretary shall annually divide the Fund into subfunds. One subfund shall be established for DME payments (hereafter referred to in this subsection as the 'DME subfund') and another subfund for IME payments (hereafter referred to in this subsection as the 'IME subfund'). In determining the annual relative distribution of funds between the DME subfund and the IME subfund, the Secretary shall first consider the amount to

be contained in the DME subfund. The IME subfund shall be equal to the amount of the Fund less the amount of the DME subfund.

"(D) DETERMINATION OF AMOUNT OF DME SUBFUND.—The Secretary shall annually determine the amount of the DME subfund. For the first cost reporting period, the DME subfund shall be equal to the amount of DME payments under parts A and B in 1993, updated by the percentage increase in the consumer price index during that 12-month cost reporting period. For subsequent cost reporting periods, such subfund shall be the greater of—

"(i) the amount of DME payments made from the Fund during the previous cost reporting period updated, through the midpoint of the period, by projecting the estimated percentage change in the consumer price index during the 12-month period ending at that midpoint, with appropriate adjustments to reflect previous under- or over-estimations under this subparagraph in the projected percentage change in the consumer price index; or

"(ii) the projected amount of DME payments for such cost reporting period required for all primary care residents and health care training consortia residents in programs approved by the Administrator of the Health Resources and Services Administration.

"(3) GUIDELINES FOR DISBURSEMENT OF GRADUATE MEDICAL EDUCATION FUNDS.—

"(A) DME PAYMENTS.—

"(i) AMOUNT OF PAYMENT PER FTE RESIDENT.—The Secretary shall develop a payment amount per FTE resident, with respect to DME payments, that is not historically based, but shall accurately reflect the resident stipends, clinical faculty stipends, administrative expenses, and program operation overhead involved. The Secretary shall develop such a formula based upon a national average of such payments during the cost reporting period that ended in 1993.

"(ii) UPDATING TO THE FIRST COST REPORTING PERIOD.—The Secretary shall update the payment amount per FTE resi-

dent determined under clause (i) by the percentage increase in the consumer price index during the 12-month cost reporting period described in such clause.

"(iii) AMOUNT FOR SUBSEQUENT COST REPORTING PERIODS.—For each cost reporting period, the approved payment amount per FTE resident shall be equal to the amount determined under this subparagraph for the previous cost reporting period updated, through the midpoint of the period, by projecting the estimated percentage change in the consumer price index during the 12-month period ending at that midpoint, with appropriate adjustments to reflect previous under- or over-estimations under this subparagraph in the projected percentage change in the consumer price index.

"(B) HEALTH CARE TRAINING INSTITUTION PAYMENT AMOUNT PER RESIDENT.—

"(i) IN GENERAL.—The payment amount, for a health care training institution's cost reporting period shall be equal to the product of—

"(I) the aggregate approved amount (as defined in clause (ii)) for that period; and

"(II) the health care training institution's medicare patient load (as defined in clause (iii)) for that period.

"(ii) AGGREGATE APPROVED AMOUNT.—As used in clause (i), the term 'aggregate approved amount' means, for a health care training institution cost reporting period, the product of—

"(I) the payment amount per FTE resident amount (as determined under subparagraph (A)) for that period; and

"(II) the weighted average number of FTE (as determined under subparagraph (C)) in the health care training institution's approved medical residency training programs in that period.

"(iii) MEDICARE PATIENT LOAD.—As used in clause (i), the term 'medicare patient load' means, with respect to a health care training consortium's or a teaching

hospital's cost reporting period, the fraction of the total number of inpatient-bed-days (as established by the Secretary) during the period which are attributable to patients with respect to whom payment may be under part A. For the purpose of this clause, for a health care training consortium, the fraction of the total number of inpatient-bed-days shall be calculated using the inpatient-bed-days of the teaching hospitals which are members of the consortium.

"(C) DETERMINATION OF FULL-TIME EQUIVALENT RESIDENTS.—

"(i) RULES.—The Secretary shall establish rules consistent with this subparagraph for the computation of the number of FTE residents in an approved medical residency training program.

"(ii) ADJUSTMENT FOR PART-YEAR OR PART-TIME RESIDENTS.—Such rules shall take into account individuals who serve as residents for only a portion of a period with a hospital or simultaneously with more than one hospital.

"(iii) WEIGHTING FACTORS.—Subject to clause (iv), such rules shall provide that, in calculating the number of FTE residents in an approved residency program for a resident who is in the resident's initial residency period—

"(I) with respect to each primary care resident in a primary care training program approved by the Administrator of the Health Resources and Services Administration, the weighting factor is 1.5;

"(II) with respect to each nonprimary care resident in a training program which is part of a health care training consortia, approved by the Administrator of the Health Resources and Services Administration, the weighting factor is 1.0; and

"(III) with respect to each nonprimary care resident in a training program that is not part of a health care training consortia approved by the Administrator of the Health Resources and Services Administration,

the weighting factor shall be the ratio of the subspecialty total divided by the product of the payment amount per FTE resident and the total number of residents who do not train in programs approved under section 753 of the Public Health Service Act as a primary care training program or a health care training consortium.

The subspecialty total for purposes of subclause (III) shall be the sum determined by subtracting the amount of DME payments that would be needed to provide reimbursements for residents who train in programs approved, under section 753 of the Public Health Service Act as a primary care training program or a health care training consortium from the amount of the DME subfund.

"(iv) FOREIGN MEDICAL GRADUATES REQUIRED TO PASS FMGEMS EXAMINATION.—Such rules shall provide that, in the case of an individual who is a foreign medical graduate, the individual shall not be counted as a resident, unless—

"(I) the individual has passed the FMGEMS examination; or

"(II) the individual has previously received certification from, or has previously passed the examination of, the Educational Commission for Foreign Medical Graduates.

"(v) COUNTING TIME SPENT IN OUTPATIENT SETTINGS.—Such rules shall provide that only time spent in activities relating to patient care shall be counted and that all the time so spent by a resident under an approved medical residency training program shall be counted towards the determination of full-time equivalency, without regard to the setting in which the activities are performed.

"(D) ASSURANCES.—In disbursing DME payments from the Fund, the Secretary, shall ensure that following:

"(i) A teaching hospital receiving DME payments from the Fund for its residents, other than those residents that are part of a health care training consortium,

uses those funds to support the training of medical residents.

"(ii) A health care training consortium receiving DME payments may use such funds, at the sole discretion of such consortium, to support the training of medical students and medical residents to meet the training outcome requirements as described under section 753 of the Public Health Service Act.

"(iii) Assurances are obtained from the health care training consortia or teaching hospitals receiving such DME payments that such entities will compensate the appropriate primary care residents at not less than an amount that is 20 percent greater than the compensation paid to other residents.

"(E) COMPENSATION.—As used in subparagraph (D)(iii), the term 'compensation' means the total of salary, benefits, debt forgiveness, and all other presentations provided to residents, both monetary and material. Payments made to residents by a residency program either prior to or following the actual pe-

riod of residency shall also be considered as compensation under this section.

"(4) DETERMINATION AS TO FUNDING OF PROGRAMS.—The Secretary shall, with respect to weighting factors for primary care training programs and health care training consortia under paragraph (3), use only such weights for programs or consortia approved by the Administrator of the Health Resources and Services Administration under section 753 of the Public Health Service Act.

"(5) DEFINITIONS.—As used in this subsection:

"(A) APPROVED MEDICAL RESIDENCY TRAINING PROGRAM.—The term 'approved medical residency training program' means a residency or other postgraduate medical training program in which participation may be counted toward certification in a specialty or subspecialty and includes formal postgraduate training programs in geriatric medicine approved by the Secretary.

"(B) CONSUMER PRICE INDEX.—The term 'consumer price index' refers to the Consumer Price Index for All Urban Consumers (United States city average), as published by the Secretary of Commerce.

"(C) DIRECT MEDICAL EDUCATION PAYMENTS; DME.—The term 'direct medical education payments' means payments to a health care training institution that sponsors a residency program, to enable such institution to provide—

"(i) resident and fellow stipends;

"(ii) the salaries of clinical faculty;

"(iii) administrative expenses; and

"(iv) reimbursement for overhead expenses incurred for residency and fellowship physician training.

"(D) FOREIGN MEDICAL GRADUATE.—The term 'foreign medical graduate' means a resident who is not a graduate of—

"(i) a school of medicine accredited by the Liaison Committee on Medical Education of the American Medical Colleges (or approved by such Committee as meeting the standards necessary for such accreditation);

"(ii) a school of osteopathy accredited by the American Osteopathic Association, or approved by such Association as meet-

ing the standards necessary for such accreditation; or

"(iii) a school of dentistry or podiatry that is accredited (or meets the standards for accreditation) by an organization recognized by the Secretary for such purpose.

"(E) FMGEMS EXAMINATION.—The term 'FMGEMS examination' means parts I and II of the Foreign Medical Graduate Examination in the Medical Sciences recognized by the Secretary for this purpose.

"(F) GENERALISTS.—The term 'generalists' means family physicians, general pediatricians, and general internists.

"(G) HEALTH CARE TRAINING CONSORTIUM.—

"(i) IN GENERAL.—The term 'health care training consortium' means a local, State, or regional association approved by the Administrator of the Health Resources and Services Administration under section 753 of the Public Health Service Act, that includes at least one school of medicine, teaching hospital, and ambulatory training site, organized in a manner so that at least

50 percent of the involved medical school's or schools' graduates become primary care providers during the year after such graduates complete their residency training.

"(ii) AMBULATORY TRAINING SITES.—As used in clause (i), the term 'ambulatory training sites' includes health maintenance organizations, community health centers and federally qualified health centers, migrant health centers, ambulatory offices or other appropriate educational and teaching sites as determined by the Administrator of the Health Resources and Services Administration.

"(H) HEALTH CARE TRAINING INSTITUTION.—The term 'health care training institution' means a teaching hospital or a health care training consortium.

"(I) INDIRECT MEDICAL EDUCATION PAYMENTS; IME.—The term 'indirect medical education payments' means payments to teaching hospitals to enable such hospitals to pay the additional operating costs associated with the training of medical residents under section

1886(d)(5)(B). Such payments shall be referred to as 'IME payments'.

"(J) INITIAL RESIDENCY PERIOD.—(i) The term 'initial residency period' means the period of board eligibility. Except as provided in clause (ii), in no case shall the initial period of residency exceed an aggregate period of formal training of more than five years for any individual. The initial residency period shall be determined, with respect to a resident, as of the time the resident enters the residency training program.

"(ii) Notwithstanding clause (i), a period, of not more than two years, during which an individual is in a geriatric residency or fellowship program that meets such criteria as the Secretary may establish, shall be treated as part of the initial residency period, but shall not be counted against any limitation on the initial residency period.

"(K) PERIOD OF BOARD ELIGIBILITY.—

"(i) GENERAL RULE.—Subject to clauses (ii) and (iii), the term 'period of board eligibility' means, for a resident, the minimum number of years of formal train-

ing necessary to satisfy the requirements for initial board eligibility in the particular specialty for which the resident is training.

"(ii) APPLICATION OF DIRECTORY.—Except as provided in clause (iii), the period of board eligibility shall be such period specified in the Directory of Residency Training Programs published by the Accreditation Council on Graduate Medical Education.

"(iii) CHANGES IN PERIOD OF BOARD ELIGIBILITY.—If the Accreditation Council on Graduate Medical Education, in its Directory of Residency Training Programs—

"(I) increases the minimum number of years of formal training necessary to satisfy the requirements for a specialty, above the period specified in its 1993–1994 Directory, the Secretary may increase the period of board eligibility for that specialty, but not to exceed the period of board eligibility specified in that later Directory; or

"(II) decreases the minimum number of years of formal training necessary to satisfy the requirements for a specialty, below the period specified in its 1993–1994 Directory, the Secretary may decrease the period of board eligibility for that specialty, but not below the period of board eligibility specified in that later Directory.

"(L) PRIMARY CARE.—The term 'primary care' means medical care that is characterized by the following elements:

"(i) First contact care for persons with undifferentiated health care concerns.

"(ii) Person-centered, comprehensive care that is not organ or problem specific.

"(iii) An orientation toward the longitudinal care of the patient.

"(iv) Responsibility for coordination of other health services as they relate to the patient's care.

"(M) PRIMARY CARE COMPETENCIES.—The term 'primary care competencies' means—

"(i) health promotion and disease prevention;

"(ii) the assessment or evaluation of common symptoms and physical signs;

"(iii) the management of common acute and chronic medical conditions, including behavioral conditions; or

"(iv) the identification and appropriate referral for other needed health care services.

"(N) PRIMARY CARE PROVIDERS.—The term 'primary care providers' means generalists and obstetrician/gynecologists, nurse practitioners, and physician assistants who utilize the primary care competencies to deliver primary care.

"(O) PRIMARY CARE RESIDENTS.—The term 'primary care residents' means medical residents in primary care training programs.

"(P) PRIMARY CARE TRAINING PROGRAMS.—The term 'primary care training programs' means—

"(i) all family practice residency programs; and

"(ii) residency programs for primary care providers that are approved by the Administrator of the Health Resources and Services Administration in accordance with

section 753 of the Public Health Service Act.".

(2) PROVISION RELATING TO IME PAYMENTS.—Subparagraph (B) of section 1886(d)(5) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)) is amended—

(A) in the matter preceding clause (i), by inserting "(IME payments under subsection (h)), from the IME subfund established in subsection (h)," after "medical education,"; and

(B) by adding at the end thereof the following new clause:

"(v) In determining the additional payment amount, the Secretary shall reduce the amount of IME payments to teaching hospitals for a hospital cost reporting period by an appropriate across-the-board percentage, in order to maintain IME subfund budget neutrality if—

"(I) such payments for resident provided services are projected to increase during the hospital cost reporting period; or

"(II) the amount of such subfund is reduced in accordance with subsection (h)(1)(C).".

SEC. 3003. APPROVAL OF PRIMARY CARE AND HEALTH CARE CONSORTIUM PROGRAMS FOR GME PAYMENTS.

Part C of title VII of the Public Health Service Act (42 U.S.C. 293j et seq.) is amended by adding at the end thereof the following new section:

"SEC. 753. APPROVAL OF PRIMARY CARE AND HEALTH CARE CONSORTIUM PROGRAMS FOR GME PAYMENTS.

"(a) IN GENERAL.—

"(1) REQUIREMENTS.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, shall, for purposes of section 1886(h) of the Social Security Act—

"(A) establish criteria, based upon program curricula, that shall be utilized to determine which residencies in pediatrics, internal medicine, and obstetrics and gynecology shall be approved as primary care training programs;

"(B) approve primary care training programs, using the criteria established in paragraph (2); and

"(C) approve health care training consortium in accordance with paragraph (2).

"(2) TRANSITION.—

"(A) IN GENERAL.—During the period ending on June 30, 1997, a health care training consortium shall be approved if the consortium demonstrates that not less than 50 percent of the filled residency program positions of such consortium are in primary care training programs.

"(B) 1997–2001.—During the period beginning July 1, 1997, through June 30, 2001, a health care training consortium shall be approved if the consortium demonstrates that not less than 50 percent of the filled residency program positions of such consortium are in primary care training programs and not less than 50 percent of the medical school graduates from such health care training consortium with respect to the year involved enter primary care training programs.

"(C) POST 2001.—For each annual period beginning on July 1, 2001, health care training consortium shall be approved if such consortium demonstrates that not less than 50 percent of the 1997 graduates, and each subsequent class of graduates, from the consortium medical

school or medical schools have become primary care providers.

"(b) DEFINITIONS.—As used in this section:

"(1) GENERALISTS.—The term 'generalists' means family physicians, general pediatricians, and general internists.

"(2) HEALTH CARE TRAINING CONSORTIUM.—

"(A) IN GENERAL.—The term 'health care training consortium' means a local, State, or regional association approved by the Administrator of the Health Resources and Services Administration that includes at least one school of medicine, teaching hospital, and ambulatory training site, organized in a manner so that at least 50 percent of the involved medical school's or schools' graduates become primary care providers during the year after such graduates complete their residency training.

"(B) AMBULATORY TRAINING SITES.—As used in subparagraph (A), the term 'ambulatory training sites' includes health maintenance organizations, community health centers and federally qualified health centers, migrant health centers, ambulatory offices or other appropriate educational and teaching sites as de-

termined by the Administrator of the Health Resources and Services Administration.

"(3) PRIMARY CARE.—The term 'primary care' means medical care that is characterized by the following elements:

"(A) First contact care for persons with undifferentiated health care concerns.

"(B) Person-centered, comprehensive care that is not organ or problem specific.

"(C) An orientation toward the longitudinal care of the patient.

"(D) Responsibility for coordination of other health services as they relate to the patient's care.

"(4) PRIMARY CARE COMPETENCIES.—The term 'primary care competencies' means—

"(A) health promotion and disease prevention;

"(B) the assessment or evaluation of common symptoms and physical signs;

"(C) the management of common acute and chronic medical conditions, including behavioral conditions; or

"(D) the identification and appropriate referral for other needed health care services.

"(5) PRIMARY CARE PROVIDERS.—The term 'primary care providers' means generalists and obstetrician/gynecologists, nurse practitioners, and physician assistants who utilize the primary care competencies to deliver primary care.

"(6) PRIMARY CARE RESIDENTS.—The term 'primary care residents' means medical residents in primary care training programs.

"(7) PRIMARY CARE TRAINING PROGRAMS.—The term 'primary care training programs' means—

"(A) all family practice residency programs; and

"(B) residency programs for primary care providers that are approved by the Administrator of the Health Resources and Service Administrator in accordance with this section.".

SEC. 3004. HEALTH PROFESSIONS FUNDING FOR NURSE PRACTITIONER AND PHYSICIAN ASSISTANTS PROGRAMS.

(a) PHYSICIAN ASSISTANTS.—Section 750(d)(1) of the Public Health Service Act (42 U.S.C. 293n(d)(1)) is amended by striking "for each of the fiscal years 1993 through 1995" and inserting "for fiscal years 1993 and 1994, $20,000,000 for fiscal year 1995, and such sums

as may be necessary for each of the fiscal years 1996 and 1997".

(b) NURSE PRACTITIONERS.—Section 822(d) of such Act (42 U.S.C. 296m(d)) is amended by striking "for each of the fiscal years 1993 and 1994" and inserting "for each of fiscal years 1993 and 1994, $30,000,000 for fiscal year 1995, and such sums as may be necessary for each of the fiscal years 1996 and 1997".

SEC. 3005. PRIMARY CARE DEMONSTRATION GRANTS.

Part B of title III of the Public Health Service Act (42 U.S.C. 243 et seq.) is amended by adding at the end thereof the following new section:

"SEC. 320A. PRIMARY CARE DEMONSTRATION GRANTS.

"(a) AUTHORIZATION.—The Secretary, acting through the Health Resources and Services Administration, shall award grants to States or nonprofit entities to fund not less than 10 demonstration projects to enable such States or entities to evaluate one or more of the following:

"(1) State mechanisms, including changes in the scope of practice laws, to enhance the delivery of primary care by nurse practitioners or physician assistants.

"(2) The feasibility of, and the most effective means to train subspecialists to deliver primary care as primary care providers.

"(3) State mechanisms to increase the supply or improve the distribution of primary care providers.

"(b) APPLICATION.—To be eligible to receive a grant under this section a State or nonprofit entity shall prepare and submit to the Secretary an application at such time, in such manner and containing such information as the Secretary may require.

"(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, $9,000,000 for fiscal year 1995, and such sums as may be necessary for each of the fiscal years 1996 through 1998.".

SEC. 3006. HEALTH WORKFORCE OVERSIGHT.

(a) IN GENERAL.—Section 301(a) of the Health Professions Education Extension Amendments of 1992 (42 U.S.C. 295k note) is amended—

(1) in paragraph (1), by striking "and" at the end thereof;

(2) in paragraph (2), by striking the period and inserting "; and"; and

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

"(3) maintain data bases concerning the supply and distribution of, and postgraduate training programs for, physicians and other primary care providers in the United States in order to make periodic recommendations with respect to subparagraphs (D) and (E) of paragraph (1).".

(b) FINAL REPORT.—Section 301(j) of such Act is amended—

(1) by striking "FINAL" in the subsection heading; and

(2) by striking "final".

(c) AUTHORIZATION OF APPROPRIATIONS.—Section 301(k) of such Act is amended to read as follows:

"(k) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to maintain the data bases required under subsection (a)(3), and for other purposes authorized by this section, $8,000,000 for fiscal year 1995, and such sums as may be necessary for each of the fiscal years 1996 through 1998.".

CORE FUNCTIONS OF PUBLIC HEALTH BLOCK GRANT---SUMMARY---MAY 15, 1994

Contact: Marty Sieg-Ross, MD
Committee on Labor and Human Resources, Minority (Kassebaum)

Background

General Issue

Public health departments generally perform two different functions. First, they provide personal health services through public health clinics. They also perform core functions of public health. Core functions of public health are activities undertaken to protect the health of the entire community. Such activities include, but are not limited to, lead testing of buildings, control of infectious disease outbreaks, and public education to prevent illness such as activities to limit smoking.

Public health experts, including the Institute of Medicine, generally agree that the nation's core functions of public health infrastructure is in disarray due to a lack of funding. This problem has arisen over the last two decades as public health departments shifted their funding focus away from performing core functions to providing personal health services for the uninsured. Currently, 45% of the $11 billion state public health departments spend on public health is devoted to core functions and 55% is devoted to providing personal health services.

HSA and Kennedy Provisions

The HSA and the Kennedy mark would establish a new $300 thousand categorical grant program to states to help them bolster their core functions of public health. In addition, the legislation would also create two other public health categorical grant programs. One would provide $150,000 for community-based prevention activities and another would provide yet another federal school health education grant authorized at $50,000.

Summary of Core Functions of Public Health Block Grant Amendment

As an alternative to the Kennedy provision described above, this amendment would establish a Core Functions of Public Health Block Grant program by consolidating existing Centers for Disease Control and Prevention grant programs. This would strengthen the capacity of state public health agencies to carry out core functions of public health by eliminating administrative barriers, increasing state flexibility, and redirecting state funds which currently provide for personal health services.

I. Core Functions of Public Health Block Grant

- Codify the eight core functions of public health which each state should perform in order to receive its formula grant. These are the same core functions included in the HSA and Kennedy marks under their new categorical program. Each of these activities are recognized as functions any public health department should be undertaking to protect the health of the public.

- The Secretary would develop and implement a formula to distribute funds to each state based upon three equally weighted indices: population, poverty, and years-of-productive-life-lost (a generally accepted indicator of community-wide health status). These parameters were developed through discussions with the General Accounting Office and the Association of State and Territorial Health Officers. Although the Secretary would implement the formula, Congressional authorizing committees could change it after receiving a required report on the impact to states of the formula.

- Through its application, each state would show that it is using its funds to address public health problems unique to its population and would be held accountable by the Secretary. Under this provision, each state would apply to receive the block grant. In its application, it would show, using public health indicators, what its most pressing problems are. If it is determined that the state is not making a good faith effort to address its leading public health problems, the Secretary could reduce the grant award by 10%.

- All existing authorities, except for immunizations, for CDC to make allotments to states would end and this funding would then be used to provide for the formula grant. The CDC immunization program is not terminated because the immunization legislation in 1993 provided for an end of this program once universal insurance for immunizations is attained.

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- Each state would maintain its current funding for core functions of public health and personal health services. After three years, at the discretion of each state, personal health services funding could be redirected to core functions of public health. As insurance coverage is extended to the poor, they would then have more money to devote to core public health functions. This provision could provide up to $1 to $2 billion in new funding for core functions of public health without requiring any new federal or state funding.

II. Continued Centers for Disease Control and Prevention Responsibilities.

- The CDC would provide technical assistance to states to help them implement innovative strategies through their block grant to address public health problems. In addition, the CDC would perform demonstration projects to test solutions for problems of regional and national significance which states could then incorporate through the use of the block grant.

- The Public Health Service would continue to develop a uniform core public health functions reporting system which would measure outcomes attributable to the performance of core public health functions. This system would be used in the state application for a grant. It would also be used to hold states accountable for their use of the block grant.

- The CDC would provide technical assistance to states to help implement comprehensive school health initiatives through the use of the core functions of public health block grant funding.

AMENDMENT NO. ____ Calendar No. ____

Purpose: To strengthen the capacity of State and local public health agencies to carry out core functions of public health, by eliminating administrative barriers, enhancing State flexibility, and redirecting funding from Federal, State, and local programs which currently provide personal health services.

IN THE SENATE OF THE UNITED STATES—103d Cong., 2d Sess.

S.____

To ensure individual and family security through health care coverage for all Americans in a manner that contains the rate of growth in health care costs and promotes responsible health insurance practices, to promote choice in health care, and to ensure and protect the health care of all Americans.

Referred to the Committee on _____
and ordered to be printed

Ordered to lie on the table and to be printed

AMENDMENT intended to be proposed by Mrs. KASSEBAUM

Viz:

Strike subtitle D of title III and insert the following new subtitle:

Subtitle D—Core Functions of Public Health Programs

PART 1—FORMULA GRANTS FOR STATE CORE FUNCTIONS OF PUBLIC HEALTH

SEC. 3301. PURPOSE.

It is the purpose of this part to strengthen the capacity of State and local public health agencies to carry out core functions of public health, by eliminating administrative barriers, enhancing State flexibility, and redirecting funding from Federal, State, and local programs which currently provide personal health services.

SEC. 3302. FORMULA GRANTS TO STATES FOR CORE FUNCTIONS OF PUBLIC HEALTH.

(a) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall make grants to States in accordance with the formula described in subsection (d) for the purpose of carrying out the functions described in subsection (b).

(b) CORE FUNCTIONS OF PUBLIC HEALTH PROGRAMS.—For purposes of subsection (a) and subject to the funding agreement described in subsection (c), the functions described in this subsection are as follows:

(1) Data collection, activities related to population health measurement and outcomes monitoring, including the regular collection and analysis of pub-

lic health data, vital statistics, and personal health services data and analysis for planning and needs assessment purposes.

(2) Activities to protect the environment and to assure the safety of housing, workplaces, food and water, including the following activities:

(A) Monitoring the overall public health quality and safety of communities.

(B) Assessing exposure to high lead levels and water contamination.

(C) Monitoring sewage and solid waste disposal, radiation exposure, radon exposure, and noise levels.

(D) Abatement of lead-related hazards.

(E) Assuring recreation and worker safety.

(F) Enforcing public health safety and sanitary codes.

(G) Other activities relating to promoting the public health of communities.

(3) Investigation and control of adverse health conditions, including improvements in emergency treatment preparedness, cooperative activities to reduce violence levels in communities, activities to control the outbreak of disease, exposure related condi-

tions and other threats to the health status of individuals.

(4) Public information and education programs to reduce risks to health such as use of tobacco, alcohol and other drugs, sexual activities that increase the risk to HIV transmission and sexually transmitted diseases, poor diet, physical inactivity, and low childhood immunization levels.

(5) Accountability and quality assurance activities, including monitoring the quality of personal health services furnished by health plans and providers of medical and health services in a manner consistent with the overall quality of care monitoring activities undertaken under title V, and monitoring communities' overall access to health services.

(6) Provision of public health laboratory services to complement private clinical laboratory services and that screen for diseases and conditions such as metabolic diseases in newborns, provide toxicology assessments of blood lead levels and other environmental toxins, diagnose sexually transmitted diseases, tuberculosis and other diseases requiring partner notification, test for infectious and food-borne diseases, and monitor the safety of water and food supplies.

(7) Training and education to assure provision of care by all health professionals, with special emphasis placed on the training of public health professions including epidemiologists, biostatisticians, health educators, public health administrators, sanitarians and laboratory technicians.

(8) Leadership, policy development and administration activities, including needs assessment, the setting of public health standards, the development of community public health policies, and the development of community public health coalitions.

(c) RESTRICTIONS ON USE OF GRANT.—

(1) IN GENERAL.—A funding agreement for a grant under subsection (a) for a State is that the grant will not be expended—

(A) to provide inpatient services;

(B) to make cash payments to intended recipients of health services;

(C) to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;

(D) to satisfy any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funds; or

(E) to provide financial assistance to any entity other than a public or nonprofit private entity.

(2) LIMITATION ON ADMINISTRATIVE EXPENSES.—A funding agreement for a grant under subsection (a) is that the State involved will not expend more than 10 percent of the grant for administrative expenses with respect to the grant.

(d) FORMULA.—

(1) IN GENERAL.—

(A) WEIGHTED FACTORS.—The Secretary shall develop and implement a formula to distribute funds to each State under this part based on three equally weighted factors that take into account population, poverty rate, and years of productive life lost. The Secretary shall submit the suggested formula and an accompanying report describing the estimated funding impact on States to the appropriate Congressional authorizing committees not later than January 1, 1996.

(B) YEARS OF PRODUCTIVE LIFE LOST.—Recognizing that reductions in years of productive life lost is a desirable goal that could result in a loss of future funding, the Secretary shall

consider a methodology under subparagraph (A) that would encourage States to reduce their years of productive life lost.

(C) TRANSITION DURING FIRST 3 YEARS OF IMPLEMENTATION.—The Secretary shall ensure that a State receives not less than 90 percent of its previous years's allotment from the Centers for Disease Control and Prevention for all programs except those related to immunizations.

(2) ACCOUNTABILITY.—

(A) IN GENERAL.—In determining the actual amount of the award of a grant made to a State, the Secretary may reduce such amount by not to exceed 10 percent of the previous year's award if the Secretary determines that the State is not making a good faith effort to meet the goals the State has established in the State application.

(B) REFUSAL TO AWARD GRANT.—The Secretary is not required to award grant under this section if the Secretary determines that the State application is unacceptable. If the Secretary for 3 consecutive years determines that a State is not making a good faith effort to

meet the State goals, the Secretary may refuse to provide a grant to such State.

(e) AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.—For the purpose of making grants under this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal year 1997 through 2000.

(2) DETERMINATION.—In making a determination of such sums as may be necessary with respect to fiscal year 1997, the Secretary shall submit a report to the Committee on Appropriations of the House of Representatives and the Senate describing the actual allotments made to State or local public health agencies, public, or nonprofit private entities in fiscal years 1995 and 1996 for programs that were not demonstration projects. Such allotments are those made by the Centers for Disease Control and Prevention, in the form of a block grant, categorical grant, contract, or cooperative agreement for activities and purposes similar to those activities carried out under the programs terminated in under subsection (f).

(f) TERMINATION OF STATE AND LOCAL PUBLIC HEALTH DEPARTMENT FUNDING AUTHORITIES FOR CERTAIN PROGRAMS.—With respect to the first fiscal year

for which funds are provided to States under a grant under subsection (a), the Secretary may not make allotments to State, local health departments, public, or nonprofit private entities under the following Public Health Service Act provisions:

(1) Section 1902, preventive health and health services block grants.

(2) Section 318(e) and 318A(q), sexually transmitted diseases and preventable infertility programs.

(3) Sections 301, 307, 310, 311, 327, 352, and 1102, infectious disease prevention program.

(4) Section 317E(a), tuberculosis elimination grants program.

(5) Sections 301, 307, 310, 311, 327, 352, 1102, 1706(e), 317C(d), 317D(1), and 399L, chronic and environmental disease prevention programs, including the specific birth defects, prostate cancer, and cancer registries programs.

(6) Section 317A, lead poisoning prevention program.

(7) Section 1510, breast and cervical cancer prevention program.

(8) Section 394A, injury control program.

(9) Sections 301, 311, 317, 327, 352, and 1102, human immunodeficiency virus program.

(10) Sections 301, 304, 305, 306, 307, 308, and 306(n), health statistics program.

With respect to continuing Centers for Disease Control and Prevention activities relating to the programs described in paragraphs (1) through (10), the Director of such Centers shall continue to provide technical assistance and perform demonstration projects consistent with its existing authorities under such programs.

(g) MAINTENANCE OF EFFORT.—

(1) CURRENT CORE FUNCTIONS OF PUBLIC HEALTH EXPENDITURES.—A funding agreement for a grant under subsection (a) is that the State involved will maintain expenditures of non-Federal amounts for core health functions at a level that is not less than the level of such expenditures, adjusted for changes in the Consumer Price Index, maintained by the State for the fiscal year preceding the first fiscal year for which the State receives such a grant. The Secretary shall develop uniform criteria to help States identify their public health department expenditures that shall be used in calculating core public health function expenditures.

(2) EXPANSION OF CORE FUNCTIONS.—A funding agreement for a grant under subsection (a) is that the State involved will maintain expenditures of

non-Federal amounts, adjusted for changes in the Consumer Price Index, maintained by the State for the fiscal year preceding the first fiscal year for which the State receives such a grant to fund personal health services delivery either by continuing to provide such personal health services or by redirecting such funding to support the core functions of public health identified in subsection (b). The Secretary, in consultation with the Administrator of the Health Resources Services Administration, the Director of the Centers for Disease Control and Prevention and the Administrator of the Substance Abuse and Mental Health Administration, shall develop uniform criteria to help States identify their public health department expenditures that shall be used in calculating personal health services delivery funding expenditures.

(h) PROHIBITION.—In no case shall a State transfer such funds between personal health services and core functions of public health until 3 years after the implementation of the formula grant.

SEC. 3303. APPLICATION.

(a) DEVELOPMENT OF UNIFORM APPLICATION.—The Secretary shall develop a uniform application that States shall use to apply for grants under this part. In

developing such uniform application, the Secretary shall require the provision of information consistent with data on the interventions comprising and the outcomes attributable to, core public health functions as such data is included in the uniform reporting system in part 2. Such a uniform application shall be developed to take into account the requirements in of subsection (b).

(b) STATE ASSURANCES.—An application submitted under this part shall include the following:

(1) A description of the existing deficiencies and successes in the public health system of the State based upon indicators included in the uniform application data set.

(2) A plan to improve such deficiencies and to continue successes. Such plan shall have been developed with the broadest possible input from State and local health departments and public and nonprofit private entities performing core functions of public health in that State. In compiling such plan the State shall describe why funding for a successful intervention continues to be needed, including a description of the detriment that would occur if such funding were not to occur using the indicators found in the uniform application data set.

(3) A description of the activities of the State for the previous year, including the problems addressed and changes made in the relevant health indicators included in the uniform application data set.

(4) Information concerning the maintenance of effort requirements described in subsection (g).

PART 2—CONTINUED CENTERS FOR DISEASE CONTROL AND PREVENTION RESPONSIBILITIES

SEC. 3311. CENTERS FOR DISEASE CONTROL AND PREVENTION PLAN.

Not later than 1 year prior to the date on which the initial grant under part 1 is made, the Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall prepare and submit to the appropriate Congressional committees a plan that contains the following:

(1) A description of the continued role for the Centers for Disease Control and Prevention and other relevant Federal health agencies in the areas of public health assessment and policy development considering the core functions changes resulting from grants under part 1. Such plan shall recommend appropriate changes in the Public Health Service Act to facilitate the implementation of the

plan and to eliminate provisions made obsolete under the plan and under the provisions of Part 1.

(2)(A) A description of the manner in which the Centers for Disease Control and Prevention, in consultation with other relevant Federal health agencies, shall conduct a Federal program to develop innovative strategies for addressing priority health needs of regional and national significance. As a priority, the plan shall provide that such a program be carried out through the provision of technical assistance or demonstration project grants that are time limited.

(B) A description of the process by which such Centers will assist or provide for assistance by other relevant Federal health agencies to State and local health departments to assure that successful approaches learned through such demonstration projects are incorporated by such departments in the expenditure of grant amounts under part 1.

(C) An identification of the current problems of regional and national significance which such Centers, in consultation with other relevant Federal health agencies, seek to redress through such demonstration projects or through the provision of technical assistance.

(D) A description of the changes needed in the Public Health Service Act to carry out such a demonstration program.

SEC. 3312. UNIFORM CORE PUBLIC HEALTH FUNCTIONS REPORTING SYSTEM.

(a) IN GENERAL.—

(1) DEVELOPMENT.—The Secretary, acting through the Director of the Office of Disease Prevention and Health Promotion and the Director of the Centers for Disease Control and Prevention, in consultation with other relevant Federal and State health agencies with data collection responsibilities, shall develop and implement a Uniform Core Public Health Functions Reporting System to collect program and fiscal data concerning the interventions comprising, and the outcomes attributable to, core functions of public health.

(2) REQUIREMENTS.—The system developed under paragraph (1) shall—

(A) use outcomes consistent with the goals of Healthy People 2000;

(B) be designed so that information collected will be relevant to the requirements of part 1; and

(C) be designed and implemented not later than 2 years after the date of enactment of this Act.

(b) STATE PUBLIC HEALTH OFFICERS.—In developing the data set to be used under the Uniform Core Public Health Functions Reporting System the Secretary consult with Federal and State public health agencies with core public health and State public health officials.

SEC. 3313. SCHOOL HEALTH EDUCATION TECHNICAL ASSISTANCE.

(a) PURPOSE.—It is the purpose of this section to support the development and implementation of comprehensive age appropriate health education programs in public schools for children and youth through grade 12.

(b) GRANTS.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention and in consultation with the Secretary of Education, shall provide technical assistance to State educational agencies in eligible States to integrate comprehensive school health education in schools within the State.

(c) ELIGIBLE USES.—Technical assistance made available under this section shall be used—

(1) to assists State in developing and implementing, through the use of their core functions of public health formula payments, comprehensive

school health education programs, as defined in subsection (g)(1) through grants to local educational agencies;

(2) to assist States in providing staff development and technical assistance to local educational agencies, schools, local health agencies, and other community organizations involved in providing comprehensive school health education programs; and

(3) to assist States in conducting such other activities to achieve the objectives of this subpart as the Secretary may require.

(d) DEFINITIONS.—As used in this section:

(1) COMPREHENSIVE SCHOOL HEALTH EDUCATION.—The term "comprehensive school health education" means a planned, sequential program of health education that addresses the physical, emotional and social dimensions of student health in kindergarten through grade 12. Such program shall—

(A) be designed to assist students in developing the knowledge and behavioral skills needed to make positive health choices and maintain and improve their health, prevent disease and injuries, and reduce risk behaviors which adversely impact health;

(B) be comprehensive and include a variety of components addressing personal health, community and environmental health, injury prevention and safety, nutritional health, the effects of substance use and abuse, consumer health regarding the benefits and appropriate use of medical services including immunizations and other clinical preventive services, and other components deemed appropriate by the local educational agencies;

(C) be designed to be linguistically and culturally competent and responsive to the needs of the students served; and

(D) address locally relevant priorities as determined by parents, teachers, and school administrators and health officials.

(2) ELIGIBLE STATE.—The term "eligible State" means a State with a memorandum of understanding or a written cooperative agreement entered into by the agencies responsible for health and education concerning the planning and implementation of comprehensive school health education programs. Among these States a priority shall be given to qualified States as defined in section 3682(c).

(3) STATE EDUCATIONAL AGENCY.—The term "State educational agency" means the officer or agency primarily responsible for the State supervision of public elementary and secondary schools.

(4) LOCAL EDUCATIONAL AGENCY.—The term "local educational agency" means a public board of education or other public authority legally constituted within a State for either administrative control or direction of, or to perform a service function for, public elementary or secondary schools in a city, county, township, school district, or other political subdivision of a State, or such combination of school districts or counties as are recognized in a State as an administrative agency for its public elementary or secondary schools. Such term includes any other public institution or agency having administrative control and direction of a public elementary or secondary school.

SCHOOL HEALTH EDUCATION AMENDMENT---SUMMARY---MAY 15, 1994

Contact: Marty Sieg-Ross, MD
Committee on Labor and Human Resources, Minority (Kassebaum)

Background

The Kennedy mark includes a school health education initiative. This initiative would:

1) Create another comprehensive school health categorical grant program at CDC.
2) Establish a waiver process to create flexibility for entities receiving a variety of grants which provide for school health education from the federal government to use the grants for a comprehensive school health initiative.
3) Codify the existing intra-departmental school health task force.
4) Create a clearinghouse for school health education materials.

Summary of Amendment

1) Eliminate the school health categorical grant from CDC. (This activity is included in the Core Functions of Public Health Block grant amendment.)

2) Add additional programs to the list of programs which qualify for the waiver process (the list is still being compiled). This amendment would increase flexibility at the state and community level.

3) Direct the intra-departmental school health task force to recommend a consolidation of the many different federal school health education initiatives.

4) Strike the amendment relating to the clearinghouse for school health education materials.

AMENDMENT NO. ____ Calendar No. ____

Purpose: To eliminate the school health education grant, and for other purposes.

IN THE SENATE OF THE UNITED STATES—103d Cong., 2d Sess.

S. 1779

To ensure individual and family security through health care coverage for all Americans in a manner that contains the rate of growth in health care costs and promotes responsible health insurance practices, to promote choice in health care, and to ensure and protect the health care of all Americans.

Referred to the Committee on _____
and ordered to be printed

Ordered to lie on the table and to be printed

AMENDMENTS intended to be proposed by Mrs. KASSEBAUM

Viz:

Strike the heading of subtitle G of title III and insert the following:

Subtitle G—Waivers of Statutory and Regulatory Requirements To Promote Comprehensive School Health Education; Interagency Task Force; School Related Health Services

Strike the heading of part 1 of subtitle G of title III and insert the following:

PART 1—WAIVERS OF STATUTORY AND REGULATORY REQUIREMENTS TO PROMOTE COMPREHENSIVE SCHOOL HEALTH EDUCATION; HEALTHY STUDENTS-HEALTHY SCHOOLS INTERAGENCY TASK FORCE

Strike the heading of section 3602 and insert the following:

SEC. 3602. WAIVERS OF STATUTORY AND REGULATORY REQUIREMENTS TO PROMOTE COMPREHENSIVE SCHOOL HEALTH EDUCATION.

Strike section 3601 and insert the following new section:

SEC. 3601. PURPOSE.

It is the purpose of this part to support the development and implementation of comprehensive school health education programs in public schools for children and youth kindergarten through grade 12.

In section 3602(d)(1), strike "under subsection (a) and".

Strike paragraph (3) of section 3602(f) and redesignate the remaining paragraphs, accordingly.

Strike subsections (a), (b), (c), (e), and (g) of section 3602, redesignate the remaining subsections, and modify all references thereto, accordingly.

In section 3602(c)—

(1) strike "and" at the end of paragraph (2);

(2) strike the period at the end of paragraph (3); and

(3) add the following new paragraph at the end:

(4) study and recommend a consolidation of the various Federal Government school health education programs.

Strike section 3604 and modify all references thereto accordingly.

AMENDMENT TO STRIKE UNNEEDED INITIATIVES IN TITLE III--Summary--May 15, 1994

Contact: Marty Sieg-Ross, MD
Committee on Labor and Human Resources, Minority (Kassebaum)

Backaground:

The Kennedy mark includes many initiatives which are not needed and could be better considered outside of the health reform legislation. This amendment would strike all of the unnecessary provision in Title III.

1. Strike subtitle C Sec. 3082 through Sec. 3083 regarding programs at the Department of Labor for the health care workforce.

2. Subtitle G Part 5 regarding school health clinics. This part would create another federal public health clinic system in schools authorized to receive $900 million dollars. Rather than do this, it would be better to link federal and state public health clinics to provide such services in underserved areas.

3. Strike Subtitle J regarding a new CDC categorical grant program to fund the development of domestic violence education initiatives at health professional schools. Generally, the development of medical education curriculum should be left in the hands of the medical schools. In addition, this is yet another CDC categorical program.

4. Strike Subtitle K regarding an initiative between the Departments of Labor and Human Services regarding the prevention of injuries at worksites.

5. Strike Subtitle L regarding full funding of the WIC program.

AMENDMENT NO. ____ Calendar No. ____

Purpose: To eliminate certain public health initiatives.

IN THE SENATE OF THE UNITED STATES—103d Cong., 2d Sess.

S. 1779

To ensure individual and family security through health care coverage for all Americans in a manner that contains the rate of growth in health care costs and promotes responsible health insurance practices, to promote choice in health care, and to ensure and protect the health care of all Americans.

Referred to the Committee on _____
and ordered to be printed

Ordered to lie on the table and to be printed

AMENDMENTS intended to be proposed by Mrs. KASSEBAUM

Viz:

Strike sections 3082 and 3083, redesignate the succeeding sections, and modify all references thereto, accordingly.

Strike part 5 of subtitle G of title III and modify all references thereto, accordingly.

Strike subtitles J, K, and L of title III and modify all references thereto, accordingly.

AMENDMENT REGARDING EMPLOYEE PARTICIPATION COMMITTEES

Senator Kassebaum offers the following amendment:

In Section 3083(c)(2)(B) of the pending health care bill, strike the period at the end of the sentence, insert a comma, and then insert the following:

"provided that employee participation committees established under and operating in conformity with this section shall not constitute a labor organization within the meaning of section 2(5) of the National Labor Relations Act or a representative within the meaning of section 1, sixth, of the Railway Labor Act.".

AMENDMENT NO. ____ Calendar No. ____

Purpose: To improve the health of individuals in rural and underserved areas.

IN THE SENATE OF THE UNITED STATES—103d Cong., 2d Sess.

S.____

To ensure individual and family security through health care coverage for all Americans in a manner that contains the rate of growth in health care costs and promotes responsible health insurance practices, to promote choice in health care, and to ensure and protect the health care of all Americans.

Referred to the Committee on _____
and ordered to be printed

Ordered to lie on the table and to be printed

AMENDMENT intended to be proposed by Mrs. KASSEBAUM

Viz:

In subtitle E of title III, strike part 1 and insert the following new part:

PART 1—FEDERALLY QUALIFIED HEALTH CENTERS

SEC. 3401. GRANTS AND AUTHORIZATION OF APPROPRIATIONS.

(a) GRANTS TO FEDERALLY QUALIFIED HEALTH CENTERS AND OTHER ENTITIES.—From amounts appropriated under this section, the Secretary shall, acting

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

(b) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out subsection (a), there are authorized to be appropriated $100,000,000 for each of the fiscal years 1995 through 2000, subject to the appropriation of not less than 50 percent of the amounts authorized to be appropriated under section 3412.

(c) RELATION TO OTHER FUNDS.—The authorizations of appropriations established in subsection (b) for the purpose described in such subsection are in addition to any other authorizations of appropriations that are available for such purpose.

SEC. 3402. ELIGIBILITY FOR GRANTS AND USE OF FUNDS.

(a) ELIGIBILITY FOR GRANTS.—

(1) IN GENERAL.—The Secretary shall award grants under this section to entities or organizations described in this paragraph and paragraph (2) which

have submitted a proposal to the Secretary to expand such entities or organizations operations (including expansions to new sites (as determined necessary by the Secretary)) to serve medically underserved populations or high impact areas not currently served by a FQHC and which—

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

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

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

(2) NON FQHC ENTITIES.—

(A) ELIGIBILITY.—The Secretary shall also make grants under this section to public or private nonprofit agencies, health care entities or organizations which meet the requirements necessary to qualify as a FQHC except, the requirement that such entity have a consumer majority governing board and which have sub-

mitted a proposal to the Secretary to provide those services provided by a FQHC as defined in section 1905(l)(2)(B) of the Social Security Act and which are designed to promote access to primary care services or to reduce reliance on hospital emergency rooms or other high cost providers of primary health care services, provided such proposal is developed by the entity or organizations (or such entities or organizations acting in a consortium in a community) with the review and approval of the Governor of the State in which such entity or organization is located.

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

(b) APPLICATION REQUIREMENTS.—

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

prescribe and which meets the requirements of this subsection.

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

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

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

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

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

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

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

(c) LIMITATIONS ON USE OF FUNDS.—

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

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

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

(C) development of an implementation plan that addresses—

(i) recruitment and training of personnel; and

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

(2) RECRUITING, TRAINING AND COMPENSATION OF STAFF.—From the amounts awarded to an entity or organization under this section, funds may

be used for the purposes of paying for the costs of recruiting, training and compensating staff (clinical and associated administrative personnel (to the extent such costs are not already reimbursed under title XIX of the Social Security Act or any other State or Federal program)) to the extent necessary to allow the entity to operate at new or expended existing sites.

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

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

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

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

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

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

(A) providing or arranging for the provision of all services through the entity necessary to qualify such entity as a FQHC under section 1905(l)(2)(B) of the Social Security Act;

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

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

(d) PRIORITIES IN THE AWARDING OF GRANTS.—

(1) CERTIFIED FQHC's.—The Secretary shall give priority in awarding grants under this section to entities which have, as of January 1, 1991, been certified as a FQHC under section 1905(l)(2)(B) of the Social Security Act and which have submitted a proposal to the Secretary to expand their operations (including expansion to new sites) to serve medically underserved populations for high impact areas not currently served by a FQHC. The Secretary shall give first priority in awarding grants under this sec-

tion to those FQHCs or other entities which propose to serve populations with the highest degree of unmet need, and which can demonstrate the ability to expand their operations in the most efficient manner.

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

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

(e) RETURN OF FUNDS TO SECRETARY FOR COSTS REIMBURSED FROM OTHER SOURCES.—To the extent

that an entity or organization receiving funds under this section is reimbursed from another source for the provision of services to an individual, and does not use such increased reimbursement to expand services furnished, areas served, to compensate for costs of unreimbursed services provided to patients, or to promote recruitment, training, or retention of personnel, such excess revenues shall be returned to the Secretary.

(f) TERMINATION OF GRANTS.—

(1) FAILURE TO MEET FQHC REQUIREMENTS.—

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

(B) NOTICE.—Prior to any termination of funds under this section to an entity, the entities shall be entitled to 60 days prior notice of

termination and, as provided by the Secretary in regulations, an opportunity to correct any deficiencies in order to allow the entity to continue to receive funds under this section.

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

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

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

AMENDMENT NO. ____ Calendar No. ____

Purpose: To establish a block grant to improve the access of rural and urban medically underserved populations to health care services.

IN THE SENATE OF THE UNITED STATES—103d Cong., 2d Sess.

S. ____

To ensure individual and family security through health care coverage for all Americans in a manner that contains the rate of growth in health care costs and promotes responsible health insurance practices, to promote choice in health care, and to ensure and protect the health care of all Americans.

Referred to the Committee on _____
and ordered to be printed

Ordered to lie on the table and to be printed

AMENDMENT intended to be proposed by Mrs. Kassebaum

Viz:

In part 2 of subtitle E of title III, strike section 3412 and all that follows through the end thereof and insert the following new section:

SEC. 3412. ESTABLISHMENT OF GRANT PROGRAM.

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

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

"(a) ESTABLISHMENT.—The Secretary shall establish and administer a program to provide allotments to States to enable such States to provide grants for the creation or enhancement of community-based primary health care entities that provide services to low-income or medically underserved populations.

"(b) ALLOTMENTS TO STATES.—

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

"(2) GRANT SHARE.—

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

"(B) NEED-ADJUSTED POPULATION.—

"(i) IN GENERAL.—For purposes of subparagraph (A), the need-adjusted population of a State shall be the product of the total population of the State (as estimated by the Secretary of Commerce) multiplied by the need index of the State (as determined under clause (ii)).

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

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

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

"(iii) GEOGRAPHIC PERCENTAGE.—

"(I) IN GENERAL.—For purposes of clause (ii)(I), the geographic percentage of the State shall be the estimated population of the State that is

residing in nonurbanized areas (as determined under subclause (II)) expressed as a percentage of the total nonurbanized population of all States.

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

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

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

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

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

"(v) MULTIPLE GRANT PERCENTAGE.—For purposes of clause (ii)(I), the multiple grant percentage of the State shall be the amount of Federal funding received by the State under grants awarded under sections 329, 330, and 340, expressed as a percentage of the total amounts received under such grants by all

States. With respect to a State, such percentage shall not exceed twice the general population percentage of the State under clause (vi) or be less than one-half of the States general population percentage.

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

"(C) FEDERAL MATCHING PERCENTAGE.—

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

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

population of the State (as determined under subparagraph (B)).

"(iii) TOTAL TAXABLE RESOURCE PERCENTAGE.—For purposes of clause (ii), the total taxable resources percentage of the State shall be the total taxable resources of a State (as determined by the Secretary of the Treasury) expressed as a percentage of the sum of the total taxable resources of all States.

"(3) ANNUAL ESTIMATES.—

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

"(B) DISTRICT OF COLUMBIA.—Notwithstanding subparagraph (A), the calculations required under such subparagraph with respect to the District of Columbia shall be based on the most recent 3-year average of the personal income of individuals residing within the District as a percentage of the personal income for all individuals residing within the District, as determined by the Secretary of Commerce.

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

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

"(ii) 1.25.

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

vided by the Federal matching percentage (as determined under paragraph (2)(C)).

"(c) APPLICATION.—

"(1) IN GENERAL.—To be eligible to receive an allotment under this section, a State shall prepare and submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may by regulation require.

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

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

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

"(d) USE OF FUNDS.—

"(1) GRANTS.—

"(A) IN GENERAL.—The State shall use amounts received under this section to award grants to eligible public and non-profit private entities, or consortia of such entities, within the State to enable such entities and consortia to—

"(i) provide services of the type described in sections 330(b)(1) and 330(b)(2) and any other services deemed appropriate by the administering entity of the State to low-income or medically underserved populations;

"(ii) develop qualified community health plans and qualified community practice networks, in accordance with subparagraphs (B) and (C).

"(iii) provide grants or loans to entities or community health plans and community provider networks for the construction or renovation of facilities essential to ensure access to health services in health professions shortage areas, medically underserved areas, or to a substantial number of a medically underserved population: and

"(iv) plan, develop, and enhance coordinated local and regional emergency and trauma services systems, including emergency air transport services.

"(B) QUALIFIED COMMUNITY HEALTH PLAN.—As used in subparagraph (A)(i) the

term "qualified community health plan" means a health plan that meets the following conditions:

"(i) The health plan is a public or nonprofit private entity whose principal purpose is the provision of primary and supplemental health care services as defined in section 330(b)(1) and 330(b)(2) and any other services deemed appropriate by the administering entity of the State in one or more health professional shortage areas or medically underserved areas or to a significant number of individuals who are members of a medically underserved population.

"(ii) Two or more of the following categories of providers are represented among the entities providing health services through the health plan:

"(I) Physicians, other health professionals, or health care institutions that provide health services in one or more health professions shortage areas or medically underserved areas or to a significant number of individ-

uals who are members of a medically underserved population.

"(II) Entities providing health services under grants under sections 329, 330, 340, and 340.

"(III) Entities providing health services under grants under section 1001 or Title XXVI.

"(IV) Entities providing health services under title V of the Social Security Act.

"(V) Entities providing health services through rural health clinics and other federally qualified health centers.

"(VI) Entities providing services in urban areas through programs under title V of the Indian Health Care Improvement Act, and entities providing outpatient health services through programs under the Indian Self-Determination Act.

"(VII) Programs providing personal health services and operating

through state or local public health agencies.

"(C) QUALIFIED COMMUNITY PRACTICE NETWORK.—The term "qualified community practice network" means a consortium of health care providers that meets the following conditions:

"(i) The consortium is a public or nonprofit private entity whose principal purpose is the provision of primary and supplemental health care services as defined in section 330(b)(1) and 330(b)(2) and any other services deemed appropriate by the administering entity of the state in one or more health professional shortage areas or medically underserved areas or to a significant number of individuals who are members of a medically underserved population.

"(ii) Two or more of the following categories of providers are represented among the entities providing health services through the health plan:

"(I) Physicians, other health professionals, or health care institutions

that provide health services in one or more health professional shortage areas or medically underserved areas or to a significant number of individuals who are members of a medically underserved population.

"(II) Entities providing health services under grants under sections 329, 330, 340, and 340.

"(III) Entities providing health services under grants under section 1001 or title XXVI.

"(IV) Entities providing health services under title V of the Social Security Act.

"(V) Entities providing health services through rural health clinics and other federally qualified health centers.

"(VI) Entities providing services in urban areas through programs under title V of the Indian Health Care Improvement Act, and entities providing outpatient health services

through programs under the Indian Self-Determination Act.

"(VII) Programs providing personal health services and operating through state or local public health agencies.

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

"(A) prepare and submit to the administering entity of the State, an application at such time, in such manner, and containing such information as such administering entity may require, including a plan for the provision of services of the type described in paragraph (3);

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

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

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

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

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

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

"(4) TARGET POPULATIONS.—Entities or consortia receiving grants under paragraph (1) shall, in providing the services described in paragraph (3), substantially target populations of low-income or medically underserved populations within the State who reside in medically underserved or health professional shortage areas, areas certified as underserved under the rural health clinic program, or other areas determined appropriate by the administering entity of the State, within the State.

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

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

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

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

"(iii) in the case of consortia, including community health plans and provider networks, the degree to which the public, private nonprofit, and private health care providers located in a health professional shortage area or a medically underserved area are integrated; and

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

"(e) REPORTS AND AUDITS.—Each State shall prepare and submit to the Secretary annual reports concerning the State's activities under this section which shall be in such form and contain such information as the Secretary determines appropriate. Each such State shall establish fiscal control and fund accounting procedures as may be necessary to assure that amounts received under

this section are being disbursed properly and are accounted for, and include the results of audits conducted under such procedures in the reports submitted under this subsection.

"(f) PAYMENTS.—

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

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

"(3) STATE SPENDING OF PAYMENTS.—Payments to a State from the allotment under subsection (b) for any fiscal year must be expended by the State in that fiscal year or in the succeeding fiscal year.

"(g) DEFINITION.—As used in this section, the term 'administering entity of the State' means the agency or

official designated by the chief executive officer of the State to administer the amounts provided to the State under this section.

"(h) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, $300,000,000 for fiscal year 1995, $700,000,000 for fiscal year 1996, $1,100,000,000 for fiscal year 1997, $1,500,000,000 for fiscal year 1998, and $1,500,000,000 for fiscal year 1999.".

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

Amendment by Senator Wofford to the Chairman's Mark of the Health Security Act

Title V

1. Senator Wofford intends to offer one amendment to Title V, Subtitle B regarding health information systems and privacy standards.

Wednesday, May 18, 1994 -- 8:00am

AMENDMENT NO. ____ Calendar No. ____

Purpose: To require primary care residents to spend a portion of their residency period in a rural area.

IN THE SENATE OF THE UNITED STATES—103d Cong., 2d Sess.

S. 1779

To ensure individual and family security through health care coverage for all Americans in a manner that contains the rate of growth in health care costs and promotes responsible health insurance practices, to promote choice in health care, and to ensure and protect the health care of all Americans.

Referred to the Committee on _____
and ordered to be printed

Ordered to lie on the table and to be printed

AMENDMENT intended to be proposed by Mr. SIMON

Viz:

Strike subsection (c) of section 3031 and insert the following:

(c) QUALIFIED APPLICANT; SUBPART DEFINITION.—

(1) IN GENERAL.—For purposes of this subpart, the term "qualified applicant", with respect to the calendar year involved, means an entity—

(A) that trains individuals in approved physician training programs;

(B) that submits to the Secretary an application for such year in accordance with section 3032; and

(C) if the entity has an approved physician training program in primary health care, that rotates individuals enrolled in the program to health centers or other community programs in rural areas.

(2) ENTITIES INCLUDED.—The term "qualified applicant" may include a teaching hospital, medical school, group practice, an entity representing two or more parties engaged in a formal association, a community health center or another entity operating an approved physician training program.

TO: Labor Committee Members and Staff
FR: Senator Jeffords and Senator Dodd
RE: Amendment to be offered by Senators Jeffords and Dodd on **Title V Subtitle C - Remedies and Enforcement**
Date: May 18,1994

INTENT: This amendment will make the grievance procedure more expeditious and fairer than the current bifurcated system. The process is similar to the Clinton bill in that it will include a process for alternative dispute resolution as well as a more formal administrative hearing procedure. All claimants will go to a state complaint office to file a grievance - no matter what the employer size or from where insurance is purchased. All people will have the same remedies available which will not break the bank.

A. Uniform Benefits Claims Denial Remedies: All individuals will have access to the same grievance procedure within a state using federal standards.

A federal uniform set of rules and remedies are available. Damages include the claim and consequential [excluding pain and suffering and punitive]

The size of the employer will not be determinative of the remedy the employee will receive.

B. Procedures: The process will be swift, fair and equitable:

First, an internal plan determination is made
Second, a plan reconsideration
Third, mediation or administrative hearing
Fourth, Federal Board of Appeal
Fifth, Circuit court

Additionally, an expedited process will be available for urgent claims.

C. Bad Actors: Any health plan that denies a claim in bad faith is subject to civil fines imposed by the Department of Labor. In addition, the number of grievances filed against a claim will be captured by the Department and made public.

AMENDMENT NO. ____ Calendar No. ____

Purpose: To expand the opportunities for careers in rural health.

IN THE SENATE OF THE UNITED STATES—103d Cong., 2d Sess.

S.____

To ensure individual and family security through health care coverage for all Americans in a manner that contains the rate of growth in health care costs and promotes responsible health insurance practices, to promote choice in health care, and to ensure and protect the health care of all Americans.

Referred to the Committee on _____
and ordered to be printed

Ordered to lie on the table and to be printed

AMENDMENT intended to be proposed by Mr. HARKIN

Viz:

In section 3081. insert the following new subsection and redesignate the remaining subsections and references thereto accordingly:

(d) EXPANDING RURAL HEALTH CAREER OPPORTUNITIES.—For purposes of subsection (a), the programs described in this section include a program to support projects to increase the number of individuals living in rural communities who enter the fields of medicine, osteopathy, dentistry, advanced practice nursing, public

health, psychology, and other health professions, including projects—

(1) to provide continuing financial assistance for such persons entering health professions education and training programs;

(2) to increase support for recruitment and retention of such persons in the health professions; and

(3) to increase efforts to foster interest in health careers among such persons at the preprofessional level.

AMENDMENT NO. ____ Calendar No. ____

Purpose: To ensure that in allocating funds among medical education programs the Council consider rural resident participants.

IN THE SENATE OF THE UNITED STATES—103d Cong., 2d Sess.

S.____

To ensure individual and family security through health care coverage for all Americans in a manner that contains the rate of growth in health care costs and promotes responsible health insurance practices, to promote choice in health care, and to ensure and protect the health care of all Americans.

Referred to the Committee on _____
and ordered to be printed

Ordered to lie on the table and to be printed

AMENDMENT intended to be proposed by Mr. HARKIN

Viz:

In section 3013(c)(2), add the following new subparagraph at the end thereof:

(C) The extent to which the population of training participants in the program includes training participants who have resided in rural communities and the proportion of past participants in the program who are practicing in rural communities.

May 18, 1994

TO: Labor Committee Members and Staff

FROM: Senator Dodd

SUBJECT: Possible Amendments for Health Care Reform Markup

Listed below are amendments that may be offered by Senator Dodd. Additional amendments may be filed as the markup process continues.

- An amendment relating to the insertion of language on preventing injuries in Title III and Title V.

- An amendment relating to information systems, privacy and administrative simplification in Title V, Subtitle B.

- An amendment relating to multistate employers and single payer plans in Title I, Sections 1014(b), 1222(3)(C), 1222(3)(E), 1701(b), 1222(4), 1223(d).

- An amendment relating to the medical technology impact study in Title I, Section 1672.

DRAFT

Purpose: To include injury prevention among topics covered by research and grant programs.

Amendments intended to be offered by Mr. Dodd

Title III--PUBLIC HEALTH INITIATIVES is amended by__

In section 3201(a)(5), inserting "the prevention of unintentional injury and the" after "to control health care costs are"; and inserting "prevention of unintentional injury and" after "which holds the promise of".

In section 3202, in new subparagraph (f)(2)(B) of Section 902 of the Public Health Service Act, inserting "unintentional injury prevention;" after "workplace injury and illness prevention;".

In section 3311(3), inserting "preventing injury," after "about their roles in".

In section 3312(b)(2)(A), inserting "and improving" after "Monitoring".

In section 3312(b)(2)(F), inserting ", home" after "recreation".

In section 3312(b)(3), inserting "injury prevention," after "emergency treatment preparedness,".

In section 3312(b), inserting a new paragraph (5):

"(5) Public information and education programs that help to reduce unintentional injuries, including training parents and children on use of safety devices."; and

re-numbering old paragraphs (5) through (8) as new paragraphs (6) through (9).

In section 3331(c)(5), striking "reducing" and inserting "reduce"; and inserting "unintentional injury and" between "the prevalence of" and "chronic diseases".

In section 3685(d)(1), inserting a new subparagraph (C):

"(C) Injury prevention services, including education and training on the recognition and control of recreation, traffic and home safety hazards.";

and re-designating old subparagraphs (C) through (E) as new subparagraphs (D) through (F).

TITLE V--QUALITY AND CONSUMER PROTECTION is amended by__

In section 5002(b)(3), inserting "unintentional injury," after "disorders,".

In section 5006(a)(1), inserting "injuries," after "assist in determining how".

In section 5006(a)(2)(D), inserting "injury," after "management of a given".

In section 5006(a)(2)(E), inserting "injury," after "management of a given".

In section 5007(b), inserting "injuries," after "emphasize research involving".

In section 5007(b)(1), inserting "and prevention" after "treatment".

S.L.C.

Bingaman Amendment passed 17-0 on 5/19.

AMENDMENT NO. ____ Calendar No. ____

Purpose: To provide a mechanism for cost containment in the nation's health care system.

IN THE SENATE OF THE UNITED STATES—103d Cong., 2d Sess.

S. ____

To ensure individual and family security through health care coverage for all Americans in a manner that contains the rate of growth in health care costs and promotes responsible health insurance practices, to promote choice in health care, and to ensure and protect the health care of all Americans.

Referred to the Committee on _____
and ordered to be printed

Ordered to lie on the table and to be printed

AMENDMENT intended to be proposed by Mr. BINGAMAN

Viz:

In section 1101(a), strike "The comprehensive" and insert "Subject to the provisions of section 1608, the comprehensive".

In section 1603(a), insert the following new paragraphs and redesignate the remaining paragraph accordingly:

(2) FISCAL ANALYSIS BY NATIONAL HEALTH BOARD.—

(A) IN GENERAL.—Not later than 6 months prior to the effective date of this Act, the National Health Board, in cooperation with the Congressional Budget Office, shall undertake and conclude a fiscal analysis of—

(i) the cost of the comprehensive benefits package under section 1101;

(ii) the ability of the health care system's cost containment mechanisms, as defined in this Act, to control health care spending and Federal health expenditures based on current economic projections; and

(iii) the impact of new health care financial obligations under this Act on the Federal budget deficit, in current economic terms, and the source of any projected spending increases, including those described in clauses (i) and (ii), provider reimbursement rates, and administrative expenses.

(B) SUBMISSION OR REPORT.—The Board shall prepare and submit a preliminary analysis under this paragraph not later than January 1,

1997, and submit a final report not later than July 1, 1997, and July 1 of each year thereafter.

(C) REQUIREMENT OF REPORT.—In a report submitted under this paragraph, the Board shall specify the source and amount of any Federal budget deficit increases in order that Congress may more adequately assess other sources of funding or spending reductions that may be appropriate to maintain the benefit package without adjustments.

(D) REPORT.—Based on the fiscal analysis contained in a report under this paragraph, if the Board concludes that the Federal government's obligation to contribute to the health care system (through the provision of subsidies to employers and families) will result in previously unprojected increases in the Federal budget deficit, the Board shall report and make corrective recommendations to the President and the Congress.

(3) REPORT AND RECOMMENDATIONS.—

(A) IN GENERAL.—If determined to be necessary by the Board, in consultation with the Congressional Budget Office, to prevent sig-

nificant Federal deficit increases attributable to the provisions of this Act (or subsequent amendments to this Act), the Board shall include in the reports under paragraph (2)(B), adjustments in specific aspects of the comprehensive benefits package (such as scope of benefits, co-payments, deductibles, and phase-in's for additional benefits) or other appropriate programmatic savings to achieve savings consistent with the findings in a report under paragraph (2).

(B) NO BOARD ADJUSTMENTS.—If the report of the Board under paragraph (2) contains no adjustments in the benefit package, the benefit package described in section 1101 shall become effective, except that the President may take action under section 9100(e)(4) as the President determines appropriate.

(C) BOARD ADJUSTMENTS.—If the report of the Board under paragraph (2) contains adjustments in the benefit package or other appropriate program adjustments, the adjustments shall apply unless a joint resolution disapproving the adjustments is passed by Congress within 45 legislative days of the date of

the submission of the report. The provisions of section 2908 of the Defense Base Closure and Realignment Act of 1990 shall apply to Congressional consideration of a joint resolution considered under this paragraph.

(D) AUTHORITY OF PRESIDENT.—The requirements of this section shall not be limited in any way by section 9100(e)(4) or any other provision of this Act.

(4) SCOPE OF RECOMMENDATIONS.—The Board may make adjustments in the services covered under the benefit package, including any periodicity tables; copayment, deductible, and out-of-pocket requirements; phase-in schedules for additional health benefits; and other appropriate programmatic adjustments. The Board may not require co-payments for preventive health services, but may re-classify services described in section 1101 as preventive services.