TITLE VI—STANDBY COST CONTAINMENT IN THE PRIVATE SECTOR

Subtitle A—National Health Expenditure Estimates

SEC. 6001. NATIONAL PRIVATE SECTOR PER CAPITA HEALTH EXPENDITURE ESTIMATE.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—For each calendar year (beginning with 1996), there is established a national private sector per capita health expenditure estimate (in this subtitle referred to as the "national private per capita estimate") determined under paragraph (2).

(2) AMOUNT.—Subject to subsection (e)—

(A) 1996.—The national private per capita estimate for 1996 is equal to the private sector per capita budget baseline for 1995 (determined under subsection (b)) multiplied by the national private sector growth factor (specified under subsection (c)) for 1996.

(B) SUBSEQUENT YEARS.—The total amount of the national private per capita estimate for each year after 1996 is equal to the national private per capita estimate determined under this paragraph for the previous year multiplied by the national private sector growth factor (specified under subsection (c)) for the year involved.

(3) PUBLICATION.—The Secretary of Health and Human Services shall publish in the Federal Register and report to the Congress—

(A) by not later than April 1 before each year, an initial estimate of the national private per capita estimate for the year; and

(B) by not later than October 1 before each year, a final determination of the national private per capita estimate for such year.

(b) PRIVATE SECTOR PER CAPITA BUDGET BASELINE.—The Secretary shall compute a private sector per capita budget baseline under this subsection for 1995 as follows:

(1) 1993 ACTUAL EXPENDITURES.—The Secretary shall determine (on the basis of the best data available) the amount of the private sector per capita expenditures (as determined under subsection (d)) for 1993.

(2) PROJECTION FOR 1995.—The Secretary shall increase such amount by the Secretary's estimate of the percentage increase in the national private per capita estimate between the midpoint of 1993 and the midpoint of 1995.

(c) NATIONAL PRIVATE SECTOR GROWTH FACTOR.—The national private sector growth factor under this subsection for each year is 1 plus the sum (expressed as a fraction) of—

(1) the average annual percentage increase in the per capita gross domestic product (in current dollars, as published by the Secretary of Commerce) during the 5-year period ending with the second previous year; and

(2)(A) for 1996, 2.4 percentage points,

(B) for 1997, 0.6 percentage points, and

(C) for each year thereafter, 0 percentage points.

(d) DETERMINATION OF NATIONAL PRIVATE PER CAPITA EXPENDITURES FOR 1993.—

(1) IN GENERAL.—The Secretary shall determine for 1993 the national private per capita expenditures equal to—

(A) total covered health care expenditures (described in paragraph (2)), divided by

(B) the estimated average population in the United States of individuals in 1993 who are eligible individuals (and would be subject to the individual mandate in 1998)

(other than medicare part A beneficiaries and individuals entitled to medical assistance under a State plan under title XIX of the Social Security Act) for whom such expenditures were determined.

(2) COVERED HEALTH CARE EXPENDITURES.—For purposes of paragraph (1)(A), the Secretary shall determine covered health care expenditures for 1993 as follows:

(A) DETERMINATION OF TOTAL EXPENDITURES.—

(i) IN GENERAL.—The Secretary shall first determine the amount of total payments made for items and services included in the guaranteed national benefit package (determined without regard to cost sharing) or included in any standard benefit package for supplemental health benefit policies established under subtitle C of title V (determined without regard to cost sharing) in the United States in 1993.

(ii) INCLUSION OF ALL PAYERS.—Except as provided in clause (iii), the amount of total payments described in clause (i) shall be determined without regard to the source of payment and shall include (as specified by the Secretary) direct patient expenditures and payments made by third party payers (including Government health programs and health maintenance organizations).

(iii) EXCLUSIONS.—In computing such payment amounts, there shall be excluded, as specified by the Secretary—

(I) nonoperating revenues (such as interest);

(II) receipts attributable to personal comfort and convenience items described in section 6002(a)(5);

(III) direct payments from the Federal Government, from State government, from units of local government for research to the extent unrelated (and not attributable) to the provision of health care services;

(IV) receipts attributable to the program for the provision of hospital care and medical services by the Department of Veterans' Affairs under chapter 17 of title 38, United States Code;

(V) payments made to health care facilities and providers of the Department of Defense and of the Indian Health Service; and

(VI) such other receipts unrelated to the provision of health care services as the Secretary specifies.

(B) REMOVAL OF CERTAIN EXPENDITURES NOT INCLUDED IN PRIVATE SECTOR.—The amount so determined shall be decreased by the proportion of such amount that is attributable to any of the following:

(i) Medicare beneficiaries.

(ii) Medicaid beneficiaries.

(iii) Expenditures which are paid for through workers' compensation or automobile or other liability insurance.

(iv) Expenditures which are paid for items and services excluded from classes of services under section 6002(a)(4).

(v) Expenditures by parties (including the Federal Government) that the Secretary determines will not be payable by private health plans for coverage either of the guaranteed national benefit package or under any supplemental health benefit policy under this Act.

(e) ADJUSTMENTS.—

(1) IN GENERAL.—Except as provided in this subsection, the Secretary is not authorized to adjust the national private

per capita estimate for a year once it is published before October of the previous year.

(2) RECOMMENDATIONS FOR CHANGES.—Except as permitted under paragraphs (3) and (4), the Secretary may submit to Congress recommendations for changes in the national private per capita estimate, but may not implement such recommendations without the approval of Congress.

(3) CORRECTION PERMITTED FOR ESTIMATION ERRORS IN PRIVATE SECTOR PER CAPITA BUDGET BASELINE.—Insofar as the Secretary determines that the amounts used in estimating initially the private sector per capita budget baseline described in subsection (b) did not accurately reflect the actual amount described in subsection (b)(1) and the actual percentage increase described in subsection (b)(2), the Secretary shall adjust the national private per capita estimate to correct for such estimation errors.

(4) SPECIAL RULE FOR 1998.—The Secretary shall adjust the national private per capita estimate for 1998 in order to reflect the impact of universal coverage on the national private per capita estimate, including—

(A) the elimination from the private sector per capita budget baseline under subsection (b) of amounts attributable to uncompensated care or to a differential between payment rates under title XIX of the Social Security Act and payment rates in the private sector; and

(B) increased utilization of, and expenditures for, items and services covered under the guaranteed national benefit package likely to occur, as a result of coverage of individuals under certified health plans who, as of 1997 were uninsured or underinsured with respect to such package.

(5) SPECIAL RULE FOR YEARS AFTER 2002.—The Secretary shall adjust the national private per capita estimate for each year after 2002 in order to reflect the impact of establishing an annual out-of-pocket limit on cost-sharing under the guaranteed national benefit package under section 3001.

SEC. 6002. CLASSES OF HEALTH CARE SERVICES.

(a) ESTABLISHMENT OF CLASSES.—

(1) IN GENERAL.—

(A) SPECIFIED SERVICES.—

(i) IN GENERAL.—Subject to subparagraph (B)(ii), in the case of items and services specified in a subparagraph under paragraph (2), all of the items and services described in that subparagraph shall be considered to be a "separate" class of health care services.

(ii) OVERLAPPING SERVICES.—Except as the Secretary may provide, items and services specified in a subparagraph of paragraph (2) shall be considered to be excluded from the subsequent subparagraphs of that paragraph.

(B) OTHER ITEMS AND SERVICES.—

(i) IN GENERAL.—In the case of items and services included as health care services under paragraph (3), the Secretary shall group such items and services into such class or classes of health care services as may be appropriate.

(ii) INCLUSION IN CLASSES OF SPECIFIED HEALTH CARE SERVICES.—In carrying out clause (i), the Secretary may include an item or service described in paragraph (3) within a class of services established under subparagraph (A).

(iii) UNIFORM DEFINITION OF CLASSES.—The Secretary shall define classes under this section in a manner identical to the definition of classes under section 8202.

(2) SPECIFIED HEALTH CARE SERVICES.—Subject to paragraph (4), the items and services specified in this paragraph are as follows:

(A) Inpatient hospital services, other than mental health services.

(B) Outpatient hospital services and ambulatory facility services (including renal dialysis facility services), other than mental health services.

(C) Diagnostic testing services (including clinical laboratory services and x-ray services).

(D) Physicians' services and other professional medical services, other than mental health services.

(E) Home health services and hospice care.

(F) Rehabilitation services, such as physical therapy, occupational and speech therapy.

(G) Durable medical equipment and supplies.

(H) Prescription drugs and biologicals and insulin.

(I) Nursing facility services, including skilled nursing facility services and intermediate care facility services, other than mental health services.

(J) Mental health services.

(3) CLASSIFICATION OF ADDITIONAL ITEMS AND SERVICES.—Subject to paragraph (4), with respect to items and services (not described in paragraph (2)) which are included under the guaranteed national benefit package or included in any standard benefit package for supplemental health benefit policies established under subtitle C of title V, the Secretary may classify them either within a class specified in paragraph (2) or within a new class established by the Secretary for such an item or service.

(4) EXCLUSIONS.—The following items and services shall not be considered to be health care services and shall not be included in a class of services under paragraph (1) or (3):

(A) Over-the-counter medications and medical equipment and devices.

(B) Homemaker and home health aide services and personal care services, and other services described in section 1915(c)(4)(B), section 1929(a), or section 1930(a) of the Social Security Act.

(C) Inpatient mental health services of a custodial nature.

(5) EXCLUSION OF INSTITUTIONAL CHARGES FOR PERSONAL COMFORT AND CONVENIENCE ITEMS.—Payments received (and amounts charged) by a facility which are attributable to items (such as private rooms, telephones, and television rentals) provided for the personal comfort and convenience of patients shall not be counted as receipts (nor subject to limitations on amounts that may be charged) for purposes of this title.

(b) PUBLICATION.—

(1) IN GENERAL.—The Secretary shall publish—

(A) by not later than April 1, 1995, proposed regulations defining the health care services and establishing the classes of services under this section, and

(B) by not later than October 1, 1995, final regulations defining the health care services and establishing such classes.

(2) ITEMS INCLUDED IN REGULATIONS.—In such regulations, the Secretary shall define—

(A) the class or classes to be established under subsection (a)(1),

(B) the services to be included within each class, and

(C) the methods and sources of data for computing, for purposes of this title, the national private per capita estimate within the class.

(3) CHANGES.—

(A) NO CHANGES AUTHORIZED.—After the Secretary has established classes of services under paragraph (1)(B), the Secretary may not change such classes (or the services included in such classes), except in the case of services not previously classified. Any such services not previously classified shall be classified within one of the classes previously established.

(B) RECOMMENDED CHANGES.—If the Secretary determines that a change in the classification established under this section may be appropriate, the Secretary shall submit to the Congress a report proposing such change. The Secretary shall include in the report an explanation of—

(i) the rationale for such change, and

(ii) the impact of such change on the national private per capita estimate permitted for classes of services that would be affected by the change.

(4) COMMISSION REPORTS.—

(A) INITIAL REPORTS.—With respect to the establishment of classes of services under this section, each applicable Commission (as defined in section 8202(c)), by not later than June 1, 1995, shall report to the Congress its comments concerning the classification proposed by the Secretary under paragraph (1)(A).

(B) PERIODIC REPORTS.—Each applicable Commission shall periodically report to Congress on changes in the system of classification under this section that should be made to promote the more efficient provision of medically appropriate health care services.

(c) APPLICABLE COMMISSION DEFINED.—In this title, the term "applicable Commission" has the meaning given such term in section 8202(c).

SEC. 6003. ALLOCATION OF PER CAPITA ESTIMATES BY CLASS OF SERVICE.

(a) ALLOCATION.—

(1) IN GENERAL.—The Secretary shall allocate the national private per capita estimate under section 6001 for a year among classes of services specified under section 6002.

(2) PROPORTIONAL ALLOCATION BASED ON HISTORICAL PROJECTED EXPENDITURES.—

(A) IN GENERAL.—The amount allocated to each class for a year shall be equal to the national private per capita estimate allocated for the year multiplied by the ratio (expressed as a percentage) of—

(i) the historical projected private expenditures for the class for the year (as determined under subsection (b)(2)), to

(ii) the sum of such historical projected private expenditures for all the classes for the year.

(B) NATIONAL ANNUAL RATE OF INCREASE FOR A CLASS OF SERVICES.—In this Act, the term "national annual rate of increase" means, with respect to a class of services for a year, the percentage by which—

(i) the amount determined under subparagraph (A) for the class for the year, exceeds

(ii) the amount determined under such subparagraph for the class for the preceding year.

(3) PUBLICATION.—

(A) IN GENERAL.—The Secretary shall, in conjunction with the publication of the initial estimate and final determination of the national private per capita estimate under section 6001(a)(3) for a year, publish in the Federal Register and report to the Congress the allocation of the national private per capita estimate among the classes of services under this subsection.

(B) EXCEPTION FOR 1996.—For 1996, the Secretary shall publish and report the allocation of the national pri-

vate per capita estimate among the classes of services under this subsection not later than August 1, 1995.

(b) HISTORICAL PROJECTED PRIVATE EXPENDITURES.—

(1) IN GENERAL.—

(A) DETERMINATION.—For purposes of subsection (a)—

(i) FOR 1995.—The historical projected private expenditures for a class of services for 1995 is equal to the portion of the national private per capita estimate during 1993 (as determined under section 6001(b)(2)(A)) which is attributable to the class of services, multiplied by the private trend factor (described in subparagraph (B)) for the class. In computing such portion for classes, the Secretary shall take into account the allocation of expenditures by health maintenance organizations among the different classes of services.

(ii) SUBSEQUENT YEARS.—The historical projected private expenditures for a class of services for a year after 1995 is equal to the amount of the allocation for the class under subsection (a)(2)(B) for the preceding year multiplied by the trend factor (described in subparagraph (B)) for the class and multiplied by the adjustment factor described in subparagraph (C) for the year..

(B) PRIVATE TREND FACTOR.—In subparagraph (A), subject to subsection (c)(1)(B), the "private trend factor", for a class of services, is 1 plus the average annual rate of increase in per capita private expenditures for the class of services during the 5-year period ending with 1995.

(C) ADJUSTMENT FACTOR.—The adjustment factor described in this subparagraph for a year is equal to the ratio of—

(i) the national private per capita estimate for the year (as determined under section 6001(a)(2)), or, for 1995, the private sector per capita budget baseline for 1995 (as determined under section 6001(b)(2)), to

(ii) the sum of the historical projected private expenditures projected for all the classes for the year (determined under subparagraph (A) without regard to this subparagraph).

(2) PUBLICATION OF TREND FACTORS.—The Secretary shall publish, by not later than August 1, 1995, the private trend factors for the different classes of services.

(c) REVIEW AND CHANGES IN ALLOCATION.—

(1) IN GENERAL.—

(A) NO ADMINISTRATIVE AUTHORITY TO CHANGE.—Except as specifically provided in this paragraph or by law enacted after the enactment of this Act, the Secretary has no authority to change the allocation or private trend factors from the allocation and private trend factors provided under this section.

(B) ADJUSTMENT IN PRIVATE TREND FACTORS.—The Secretary shall make such adjustments in the private trend factors under subsection (b)(1)(B) as the Secretary determines to be appropriate to reflect changes in patterns of use of health care services among the different classes of services. Such adjustment shall be made by regulation published not later than August 1, 1998, and shall be effective for determining allocations for years beginning with 1999.

(C) RECOMMENDED CHANGES.—Subject to subparagraph (D), if the Secretary determines that a change in the allocation of an estimate among classes is appropriate, the Secretary shall submit to the Congress a report proposing such change. The Secretary shall include in the report an explanation of—

(i) the rationale for such change, and

(ii) the impact of such change on the national private per capita estimate permitted for classes of services that would be affected by the change.

(D) CORRECTION PERMITTED FOR ESTIMATION ERRORS.—Insofar as the Secretary determines that the amounts used in estimating initially the historical projected private expenditures under this subsection did not accurately reflect the actual portions described in subsection (b)(1)(A)(i) or the actual private trend factors described in subsection (b)(1)(B), the Secretary shall adjust the allocation of the national private per capita estimate among classes of services to correct for such estimation errors.

(2) COMMISSION REVIEW.—Each applicable Commission shall annually review and report to Congress, in its report submitted under section 6002(b)(4), on the effect of the private trend factors used in the allocation of the national private per capita estimate among classes of services. Such report shall include such recommendations for appropriate adjustments in the private trend factors as the applicable Commission considers appropriate to properly take into account at least—

(A) changes in health care technology,

(B) changes in the patterns and practices relating to health care delivery found to be appropriate,

(C) changes in the distribution of health care services, and

(D) the special health care needs of underserved rural and inner city populations.

SEC. 6004. NATIONAL HEALTH EXPENDITURES REPORTING SYSTEM.

(a) IN GENERAL.—The Secretary shall establish a national health expenditures reporting system (in this section referred to as the "system") for purposes of—

(1) establishing the national private per capita estimate,

(2) allocating the national private per capita estimate among classes of services,

(3) determining maximum payment rates,

(4) monitoring of any State cost containment and benefit management programs established by States pursuant to title IV, and

(5) otherwise carrying out this title.

(b) INFORMATION REPORTING.—

(1) ANNUAL REPORT BY PROVIDERS.—

(A) IN GENERAL.—Under the system, providers of health care services (including such providers within provider networks) shall submit (by not later than April 15 of each year, beginning with 1997) a report.

(B) CONTENTS.—Such a report shall include such information as the Secretary specifies relating to the provision of health care services in the previous year, including—

(i) the volume and receipts for such services,

(ii) cost and revenue data for hospitals and other institutional providers and revenue data for other providers, and

(iii) information by class of service, type of payer, and State of residence of individual provided the services.

Information on revenues for activities not related to the provision of direct patient care, such as teaching or research or for services that are explicitly excluded from the system of national health expenditures estimates, shall be reported separately.

(C) FORM.—The report shall be submitted in such form and manner (including the use of electronic transmission) as the Secretary shall specify in regulation. Such form shall permit the reporting of information by health plans

on behalf of providers who are in provider networks in the plan.

(D) USE OF REPORTING MECHANISMS.—To the maximum extent practicable and appropriate, reporting under such system shall be done through reporting mechanisms (such as uniform hospital reports provided under section 9105) and using data bases otherwise in use.

(E) USE OF SURVEYS.—The Secretary may, where appropriate, provide for the collection of information under the system through surveys of a sample of health care providers or with respect to a sample of information with respect to such providers.

(2) CONFIDENTIALITY.—Information gathered pursuant to the authority provided under this section shall not be disclosed in a manner that identifies individual providers of services.

(3) TRANSITION.—Before April 15, 1997, for purposes of this title, the Secretary may use such other data collection and estimation techniques as may be appropriate for purposes described in subsection (a).

(c) ENFORCEMENT.—If a provider of health services is required, under the system under this section, to report information and refuses, after being requested by the Secretary, to provide the information required, or deliberately provides information that is false, the Secretary may impose a civil money penalty of not to exceed $10,000 for each such refusal or provision of false information. The provisions of section 1128A of the Social Security Act (other than subsections (a) and (b)) shall apply to civil money penalties under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a) of such Act.

Subtitle B—State Health Expenditure Estimates

SEC. 6101. STATE PRIVATE SECTOR PER CAPITA HEALTH EXPENDITURE ESTIMATE.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—For each calendar year (beginning with 1996), the Secretary shall establish a State private sector per capita health expenditure estimate (in this title referred to as a "State private per capita estimate") for each State under paragraph (2).

(2) AMOUNT.—Subject to subsection (e), the State private per capita estimate for a State for a year is equal to the national private per capita estimate for the year, established under section 6001, multiplied by the applicable State adjustment factor (specified under subsection (b)) for the State.

(3) PUBLICATION.—The Secretary shall publish in the Federal Register and report to the Congress and to each State—

(A) by not later than April 1 before each year, an initial estimate of the State private per capita estimate for each State for the year, and

(B) by not later than October 1 before each year, a final determination of the State private per capita estimate for each State for the year.

(4) PERIODIC COMMISSION REPORTS ON STATE ESTIMATES.—Each applicable Commission shall periodically review and report to Congress on the State private per capita estimates established under this section. Such a report shall include such recommendations as the respective Commission deems appropriate.

(b) STATE ADJUSTMENT FACTORS.—

(1) IN GENERAL.—The Secretary shall compute a State adjustment factor for each State consistent with this subsection.

(2) UTILIZATION AND PRICE FACTORS.—In establishing State adjustment factors, the Secretary shall take into account the following:

(A) RATIO OF STATE PRIVATE SECTOR PER CAPITA EXPENDITURES TO NATIONAL PRIVATE SECTOR PER CAPITA EXPENDITURES.—Subject to adjustments to reflect subparagraphs (B) and (C), the ratio of a State private sector per capita expenditures (that would be computed for the State under section 6001(d) if computations under such section were made for that State rather than for the United States) to the national private per capita expenditures determined under such section.

(B) HISTORIC UTILIZATION.—With respect to utilization of services, differences among the States in demographic composition and historic utilization of different services in the private sector in 1993.

(C) MAXIMUM PAYMENT RATES UNDER THIS TITLE.—With respect to the price of services, the price of such services that would be allowed in the State in 1995 if the maximum payment rates (provided under subtitle D) were to apply in the State in 1995.

(3) ADJUSTMENT TO REFLECT HEALTH CARE EXPENDITURES FOR STATE RESIDENTS.—The Secretary shall provide for an adjustment to take into account differences among States in the in-State, and out-of-State, use of services by residents and nonresidents of the State, in order that the per capita amount reflects per capita health care expenditures for residents of the State for services provided anywhere in the United States.

(4) AVERAGE.—The Secretary shall establish the State adjustment factors in such a manner as assures that the population weighted average of such factors is 1.

(c) ADJUSTMENT.—

(1) IN GENERAL.—Subject to paragraph (3), the provisions of section 6001(e) shall apply to the State private per capita estimates under this section in the same manner as they apply to the national private per capita estimate.

(2) ADJUSTMENT TO CORRECT ESTIMATION ERRORS.—Insofar as the Secretary determines that the amounts used in estimating initially the State private per capita estimates did not accurately reflect the correct values for the factors used in computing State adjustments factors under subsection (b), the Secretary shall adjust the State private per capita estimates to correct for such estimation errors.

(3) ADJUSTMENT IN 1998.—In applying section 6001(e)(4) under paragraph (1), the adjustment for each State private per capita estimate shall be the same as the adjustment to the national private per capita estimate under such section.

Subtitle C—Stand-By Federal Cost Containment

SEC. 6201. APPLICATION OF MAXIMUM PAYMENT RATES IN STATES THAT FAIL TO CONTROL COSTS.

(a) DETERMINATION OF STATE PERFORMANCE.—

(1) IN GENERAL.—During each year (beginning with 1997), the Secretary shall determine for each State whether the actual State private per capita health care expenditures (determined in a manner similar to the manner in which the national private per capita expenditures is determined under section 6001(d)(2)) for the previous year exceeded the State private per capita estimate for the State for such year (as determined under subtitle B). Such determination shall be based on information submitted by providers under section 6005 and such other data as the Secretary finds appropriate.

(2) ADJUSTMENT OF ACTUAL PER CAPITA HEALTH EXPENDITURES.—

(A) IN GENERAL.—In accordance with procedures established by the Secretary, a State may apply to the Secretary to exclude from the computation of actual State per capita health expenditures under paragraph (1) in the State for a year expenditures attributable to health care needs of a sudden and temporary nature, such as epidemics or natural disasters, to the extent that health care expenditures for such or similar needs were not reflected in the State private per capita estimate.

(B) LIMITATION.—For purposes of subparagraph (A), expenditures extending over a period of longer than 6 months shall not be considered temporary.

(b) APPLICATION OF STANDBY COST CONTAINMENT UNDER SUBTITLE D.—

(1) IN GENERAL.—If the Secretary determines in a year under subsection (a) beginning after 1999 that the actual State per capita health expenditures in a State for the previous year was greater than the State private per capita estimate for the State for such year, subject to paragraph (2) the provisions of subtitle D shall apply to charges imposed (and payments made) for services furnished in the State on or after January 1 of the following year.

(2) SUBSTITUTION OF STATE APPROVED ALTERNATIVE PAYMENT SYSTEM.—

(A) ALTERNATIVE PAYMENT SYSTEM.—Subtitle D shall not apply in a State for a year to services if the Secretary determines that the State has in effect for the year an alternative payment system that meets the applicable requirements of subtitle A of title III for the services covered.

(B) BENEFITS MANAGEMENT PROGRAM.—Subtitle D shall not apply in a State for a year if the Secretary determines that the State has in effect for the year a benefits management program that meets the applicable requirements of subtitle B of title III.

Subtitle D—Maximum Payment Rates

PART 1—ESTABLISHMENT AND APPLICATION OF MAXIMUM PAYMENT RATES

SEC. 6301. PROCESS.

(a) PUBLICATION OF RATES.—

(1) IN GENERAL.—The Secretary shall cause to have published in the Federal Register—

(A) not later than April 1 of each year (or not later than September 1, 1995, in the case of rates for 1996), proposed maximum payment rates under this subtitle for the following year for public comment, and

(B) not later than October 1 of each year (or not later than December 1, 1995, in the case of rates for 1996), after such consideration of public comment on the proposed rates, the maximum payment rates under this subtitle for the following year.

(2) PAYMENT RATES ONLY ADVISORY FOR 1996 THROUGH 2000.—The maximum payment rates for 1996 through 2000 published under paragraph (1) are only advisory and shall not be applied to payment for services during such years.

(b) ITEMS INCLUDED IN PUBLICATIONS.—The Secretary shall include in the publications referred to in subsection (a)(1)—

(1) a description of the payment methodology used in the establishment of maximum payment rates; and

(2) in the case of a publication under subsection (a)(1)(B), the extent that the rates differ from the applicable Commis-

sion's recommendations under subsection (c), an explanation of the Secretary's grounds for not following such recommendations.

(c) REPORTS OF COMMISSIONS.—With respect to the establishment of maximum payment rates for services under this subtitle, the applicable Commission, not later than June 1 of each year, shall report its recommendations to the Secretary and Congress concerning such rates for the following year. Each such report may include such other recommendations relating to the operation of this subtitle as the Commission considers appropriate.

(d) PAYMENT RATE DEFINED.—In this subtitle, the term "payment rate" means, with respect to health care services for which amounts are payable under a plan or program, the rate of payment provided for under the plan or program and including cost-sharing (including deductibles, coinsurance, and extra billing amounts) applicable under the plan or program with respect to the services.

SEC. 6302. PAYMENT METHODOLOGY; RELATION TO ESTIMATE ALLOCATION.

(a) PAYMENT METHODOLOGY.—

(1) IN GENERAL.—Subject to sections 8002(c) and 8003, the Secretary shall establish maximum payment rates under this subtitle consistent with the payment rate methodology specified under part 2.

(2) TREATMENT OF SERVICES WITHIN A CLASS.—Nothing in this title shall be construed as requiring that maximum payment rates established under this subtitle for different health care services within a class of services be the same or determined under the same methodology.

(b) RELATION TO NATIONAL PRIVATE PER CAPITA ESTIMATE.—

(1) IN GENERAL.—Subject to paragraph (2), the maximum payment rates for a year shall be established under this subtitle in a manner so that, if they were to apply in the year in all the States under this title—

(A) the national average private per capita expenditures for all the services within each class subject to such rates, is equal to

(B) the percent of the national private per capita estimate allocated to the class under section 6003(a)(1) for the year.

(2) RULES FOR CERTAIN STATES.—The rates shall be established under paragraph (1) not taking into account any reductions in such rates effected under section 4004(c)(2)(A). The reductions under such section shall be applied only to the rates (as so established) in that State.

SEC. 6303. GENERAL APPLICATION AND ENFORCEMENT OF MAXIMUM PAYMENT RATES.

(a) LIMITS ON CHARGES.—

(1) IN GENERAL.—In the case of a provider that provides health care services to an individual for which a maximum payment rate is established and applied pursuant to this subtitle and subtitle C—

(A) the provider may not charge (i) an amount in excess of such rate or (ii) on a payment basis other than the payment basis established for such services under part 2;

(B) the provider may not collect for such services an amount in excess of such rate; and

(C) the individual and other entities, including a health benefit plan, are not liable collectively for payment of any amount that exceeds such rate.

(2) RELATION TO MEDICARE PROGRAMS.—This subsection shall not apply to services furnished to an individual who is entitled to benefits with respect to such services under title XVIII of the Social Security Act, medicare part C, or the program established under part B of title XXII of the Social Security Act.

(b) ENFORCEMENT THROUGH CIVIL MONEY PENALTIES.—

(1) IMPROPER CHARGES.—If a provider imposes a charge in violation of subsection (a)(1)(A), the provider is subject to civil money penalty in an amount not to exceed $100 for each such charge.

(2) IMPROPER COLLECTION.—If a provider collects excess amounts in violation of subsection (a)(1)(B) and does not refund such excess amounts within 30 days of date on which the provider is notified (in a form and manner specified by the Secretary) that the provider collected excess amount, the provider is subject to a civil money penalty in an amount equal to three times the amount of such excess which has not been so refunded or, if greater, $500.

(3) PROCESS.—The provisions of section 1128A of the Social Security Act (other subsections (a) and (b)) shall apply to a civil money penalty under this subsection in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a) of such Act.

(4) DEPOSIT OF PENALTIES IN ALL-PAYER HEALTH CARE FRAUD AND ABUSE CONTROL ACCOUNT.—Any civil money penalties collected under this subsection shall be paid into the All-payer Health Care Fraud and Abuse Control Account (established under section 9212).

PART 2—METHODOLOGIES FOR DETERMINING MAXIMUM PAYMENT RATES

SEC. 6311. BASIS FOR MAXIMUM PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES.

(a) PAYMENT RATES.—

(1) IN GENERAL.—Subject to subsection (e), the maximum payment rate established under this subtitle for a service within the class of services consisting of inpatient hospital services that is provided by—

(A) a hospital that is not an exempt hospital (as defined in paragraph (4)) is the payment rate specified in paragraph (2), or

(B) an exempt hospital is the payment rate specified in paragraph (3).

(2) RATE FOR GENERAL HOSPITALS.—The payment rate under this paragraph during a year shall be equal to the sum of the following:

(A) STANDARD DRG-BASED PAYMENT RATE.—The product of—

(i) the standardized amount applicable to the hospital, as established in accordance with subsection (b), adjusted under subsection (d); and

(ii) the weighting factor assigned to the service (as determined in accordance with subsection (c)).

(B) OUTLIERS.—An amount for discharges classified as outliers, in accordance with a methodology similar to the methodology used under section 1886(d)(5)(A) of the Social Security Act.

(C) DIRECT GRADUATE MEDICAL EDUCATION.—An amount for direct graduate medical education costs of the hospital, as determined in accordance with section 7024(e(1)).

(3) RATE FOR EXEMPT HOSPITALS.—The payment rate under this paragraph during a year shall be determined on a per admission basis, based on the allowable operating receipts of the hospital (determined in the manner specified in subparagraphs (A) and (B) of subsection (b)(2)).

(4) EXEMPT HOSPITAL DEFINED.—In this section, the term "exempt hospital" means—

(A) a psychiatric hospital (as defined in section 1861(f) of the Social Security Act), including a psychiatric unit of a hospital which is a distinct part of the hospital (as defined by the Secretary);

(B) a rehabilitation hospital (as defined by the Secretary), including a rehabilitation unit of a hospital which is a distinct part of the hospital (as defined by the Secretary);

(C) a hospital whose inpatients are predominantly individuals under 18 years of age;

(D) a hospital which has an average inpatient length of stay (as determined by the Secretary) of greater than 25 days; or

(E) a hospital that the Secretary has classified, at any time on or before December 31, 1990, for purposes of applying exceptions and adjustments to payment amounts under section 1886(d) of such Act, as a hospital involved extensively in treatment for or research on cancer.

(5) EXCLUSION OF EXEMPT HOSPITALS IN DETERMINATIONS.—For purposes of the succeeding subsections of this section, the term "hospital" does not include an exempt hospital.

(b) ESTABLISHMENT OF STANDARDIZED AMOUNTS.—

(1) IN GENERAL.—The Secretary shall establish a standardized amount under subsection (a) for hospitals located in a large urban area and for other hospitals for a year by standardizing the hospital's average cost per discharge (based on the hospital's allowed operating receipts, as determined under paragraph (2)) in accordance with paragraph (3). For purposes of the preceding sentence, a hospital is located in a "large urban area" if the hospital is treated as being located in a large urban area under section 1886(d) of the Social Security Act for purposes of the medicare program.

(2) ALLOWED OPERATING RECEIPTS PER DISCHARGE DEFINED.—

(A) IN GENERAL.—For purposes of paragraph (1) and except as provided in subparagraph (B), a hospital's "allowed operating receipts" means the total of all receipts of the hospital (without regard to the source) attributable to routine operating costs, ancillary service operating costs, and special care unit operating costs with respect to inpatient hospital services, as determined on an average per admission or per discharge basis (as determined by the Secretary), during 1993, increased by the Secretary's estimate of the percentage increase in such receipts between the midpoint of 1993 and the midpoint of 1995.

(B) EXCLUSIONS.—In determining a hospital's allowed operating receipts per discharge under subparagraph (A), the Secretary shall exclude receipts attributable to services for which payment was made to the hospital under the medicare program and discharges (or admissions) attributable to individuals entitled to benefits under part A of the medicare program.

(C) CERTAIN OUTPATIENT RECEIPTS INCLUDED.—In determining a hospital's allowed operating receipts under subparagraph (A), the Secretary shall include all receipts attributable to services that are provided by the hospital (or by an entity wholly owned or operated by the hospital) to a patient during the 3 days immediately preceding the date of the patient's admission if such services are diagnostic services (including clinical diagnostic laboratory tests) or are other services related to the admission (as defined by the Secretary).

(3) PROCESS FOR STANDARDIZING AMOUNTS.—The Secretary shall standardize the average per discharge amount for each hospital for a year, in a manner similar to the standardization process described in section 1886(d)(2)(C) of the Social Security Act, by providing for the following adjustments and exclusions:

(A) Adjusting for variations among hospitals by area in the average hospital wage level, using the area wage

level applied for hospitals under the medicare program under section 1886(d)(3)(E) of the Social Security Act.

(B) Adjusting for variations in case mix among hospitals.

(C) Excluding an estimate of the additional payments to be made for outliers, using the amounts paid to hospitals for outliers under the medicare program under section 1886(d)(5)(A) of such Act (except that the Secretary may apply different amounts if the Secretary finds that such different amounts more accurately reflect outliers for services furnished to individuals who are not medicare beneficiaries).

(D) Adjusting for variations among hospitals by area in input prices other than wages and wage-related costs.;

(E) Excluding an estimate of indirect medical education costs, using the indirect medical education adjustment applied for hospitals under the medicare program under section 1886(d)(5)(B) of such Act.

(F) Excluding an estimate of the additional payments made for hospitals serving a disproportionate share of low-income individuals, determined in the same manner as payment adjustments made on behalf of such hospitals under section 1886(d)(5)(F) of such Act (as amended by this Act).

(G) Excluding an estimate of direct graduate medical education costs.

(H) Excluding an estimate of capital-related costs.

(c) ESTABLISHMENT OF DIAGNOSIS-RELATED GROUPS AND WEIGHTING FACTORS.—

(1) DIAGNOSIS-RELATED GROUPS.—For purposes of this section, the Secretary shall establish a classification of inpatient hospital discharges by diagnosis-related groups and a methodology for classifying specific hospital discharges within these groups.

(2) WEIGHTING FACTORS.—For each diagnosis-related group established under paragraph (1), the Secretary shall assign an appropriate weighting factor which reflects the relative hospital resources used with respect to discharges classified within that group compared to discharges classified within other groups.

(3) USE OF MEDICARE GROUPS AND FACTORS.—In establishing diagnosis-related groups and assigning weighting factors for such groups under this paragraph, the Secretary shall use the diagnosis-related groups and weighting factors used under the medicare program under section 1886(d)(4) of the Social Security Act, except to the extent that the Secretary must establish diagnosis-related groups in addition to the groups under such program, or adjust such weighting factors, to take into account the application of payment rates under this section to inpatient hospital services furnished to individuals who are not medicare beneficiaries. In carrying out this paragraph, the Secretary shall establish separate diagnosis-related groups and weighting factors applicable to services furnished to children.

(d) ADJUSTMENTS TO STANDARDIZED AMOUNTS.—The adjustments under this subsection are as follows:

(1) WAGE ADJUSTMENT.—Adjusting for variations among hospitals by area in the average hospital wage level, using the area wage level applied for hospitals under the medicare program under section 1886(d)(3)(E) of the Social Security Act.

(2) NON-WAGE ADJUSTMENT.—Adjusting for variations among hospitals by area in input prices other than wages and wage-related costs.

(3) ADDITION OF INDIRECT MEDICAL EDUCATION.—Adding an amount for the indirect medical education costs of the hospital, in accordance with section 7024(e)(2).

(4) ADDITION OF CAPITAL.—Adding an amount for capital and capital-related costs, determined in the same manner as payment for such costs is provided under section 1886(g) of the Social Security Act.

(5) ADDITION OF DSH.—Adding an amount in the case of hospitals serving a disproportionate share of low-income individuals, determined in the same manner as payment adjustments are made on behalf of such hospitals under section 1886(d)(5)(F) of such Act (as amended by this Act).

(e) OTHER ADJUSTMENTS.—

(1) NEEDS OF CERTAIN FACILITIES.—The Secretary may adjust the maximum payment rates otherwise determined under this section for hospitals in such manner and to such extent as the Secretary considers appropriate to take into account the needs of—

(A) regional and national referral centers described in section 1886(d)(5)(C) of the Social Security Act;

(B) sole community hospitals described in section 1886(d)(5)(D) of such Act; and

(C) essential access hospitals designated by the Secretary under section 1820(i)(1) of such Act.

(2) RULES FOR TRANSFERRED PATIENTS.—The Secretary shall provide for rules for applying the maximum payment rates under this section in the case of a hospital for inpatient hospital services provided to patients transferred to (or from) the hospital, in accordance with the rules used with respect to such transfers under the medicare program.

SEC. 6312. BASIS FOR MAXIMUM PAYMENT RATES FOR CLASS OF PHYSICIANS' SERVICES AND OTHER PROFESSIONAL MEDICAL SERVICES.

(a) USE OF RELATIVE VALUE FEE SCHEDULE.—

(1) IN GENERAL.—Subject to subsection (b), the maximum payment rates established under this subtitle for a service within the class of services consisting of physicians' services and other professional medical services during a year shall be equal to the product of—

(A) the relative value for the service applied under section 1848(b) of the Social Security Act;

(B) an applicable conversion factor (determined by the Secretary in an amount consistent with the requirements of section 6302(b)); and

(C) the applicable geographic adjustment factors applied under section 1848(b) of the Social Security Act.

(b) NEW PROCEDURE CODES AND RELATIVE VALUE UNITS.—In applying subsection (a) in the case of services for which relative value units have not been established under section 1848 of the Social Security Act, the Secretary shall establish relative value units in the same manner as if payment for such services were made under the medicare program.

(c) PUBLICATION OF DEFINITIONS, RELATIVE VALUE UNITS, AND PAYMENT POLICIES.—The Secretary shall provide for publication of such definitions, relative value units (established under subsection (b)), and payment policies as may be necessary for payers to apply the maximum payment rates established under this section.

SEC. 6313. BASIS FOR OTHER MAXIMUM PAYMENT RATES FOR SERVICES USING CERTAIN MEDICARE PAYMENT METHODOLOGIES.

The maximum payment rates established under this subtitle for services for any of the following classes of services shall be determined using the applicable payment methodologies under the medicare program as follows:

(1) In the case of facility services described in section 1832(a)(2)(F) of the Social Security Act furnished in connection with a surgical procedure specified pursuant to section 1833(i)(1)(A) of such Act and furnished to an individual in an

ambulatory surgical center described in such section, the methodology described in section 1833(i)(2) of such Act.

(2) For services provided by Federally qualified health centers, the methodology shall be the cost-based methodology used in determining payment amounts under the medicare programs, as amended by section 7022, and the maximum payment rates shall be the amounts determined under such programs.

(3) For the class of diagnostic testing services described in section 6002(a)(2)(C)—

(A) in the case of clinical laboratory services, the methodology described in sections 1833(a)(2)(D) and 1833(h) of such Act (including the requirement of direct billing for such services), and

(B) in the case of other diagnostic services, the applicable methodology under part B of title XVIII of the Social Security Act.

(4) In the case of an item of durable medical equipment (described in section 1834(a)(13) of the Social Security Act), the methodology described in section 1834(a)(1) of such Act.

(5) In the case of prosthetic devices and orthotics and prosthetics, the methodology described in section 1834(h)(1)(A) of the Social Security Act.

(6) In the case of psychologists and clinical social workers, the methodologies described in section 1833(a)(1)(L) and 1833(a)(1)(F) of the Social Security Act, respectively.

(7) For prescription drugs, the methodology used to determine payment limits under section 1834(d)(4) of the Social Security Act, as inserted by section 3102(a), except that—

(A) any reference in such section to "1998" or "1999" shall be deemed to be a reference to "1996" or "1997",

(B) any reference in such section to "4 12-month periods ending with June 1997" shall be deemed a reference to "2 12-month periods ending with June 1995", and

(C) any reference in such section to the uniform percentage increase determined under section 8206(a) shall be deemed a reference to national rate of increase for the class of prescription drugs established under 6003(a)(2)(B).

(8) For renal dialysis services, home dialysis supplies and equipment (as defined in section 1881(b)(8) of the Social Security Act), and self-care home dialysis support services (as defined in section 1881(b)(9) of such Act), the methodology described in section 1881(b) of such Act.

(9) For any other service within a class of services for which the amount of payment made under part B of the medicare program is determined on the basis of reasonable or prevailing charge, the methodology used for payment for such service under such part.

SEC. 6314. SERVICES PROVIDED BY MANAGED CARE ORGANIZATIONS.

(a) IN GENERAL.—The maximum payment rates established under this subtitle for capitation payments made to managed care organizations for the guaranteed national benefit package shall be determined using the applicable payment methodologies established under subsection (b).

(b) PAYMENT METHODOLOGY.—

(1) IN GENERAL.—The Secretary shall establish a system of determining payments to managed care organizations contracting to provide the guaranteed national benefit package on a capitated or risk basis.

(2) USE OF MEDICARE METHODOLOGY.—Such methodology shall be based on the methodology used under section 1876 of the Social Security Act, and the payment rates shall reflect the guaranteed national benefit package and a representative population of individuals in the private sector.

(c) PAYMENT RATES.—The maximum payment rates under this section shall be equal to 95 percent of the actuarially comparable

cost of providing services to individuals not enrolled with managed care organizations, consistent with maximum payment rates established under this part.

SEC. 6315. OTHER SERVICES.

In the case of services within a class of services for which a methodology for establishing maximum payment rates is not otherwise provided pursuant to the preceding provisions of this subtitle, by January 1, 1997, the Secretary shall establish an appropriate methodology for establishing such rates, taking into account the payment methodology or methodologies in use under the medicare program or other health benefit plans, including prospective payment methodologies developed and implemented under section 8002(a).

Subtitle E—Administrative and Judicial Review

SEC. 6401. LIMITATION ON ADMINISTRATIVE AND JUDICIAL REVIEW.

There shall be no administrative or judicial review of any of the following determinations:

(1) The maximum payment rates established under subtitle D, including—

(A) relative values and relative value units and conversion factors;

(B) the establishment of diagnosis-related groups, of the methodology for the classification of discharges within such groups, and of the appropriate weighting factors thereof.

(2) The national private per capita estimate and the State private per capita estimate for each State.

(3) Allocation of the national private per capita estimate or a State private per capita estimate to a class of health services.

SEC. 6402. REFERENCES TO MEDICARE PROVISIONS.

In this title, except as otherwise specifically provided, any references to provisions of title XVIII of the Social Security Act are deemed to be references to such provisions as in effect on the day after the date of the enactment of the Guaranteed Health Insurance Act of 1994, taking into account the amendments made to such title by such Act.

Subtitle F—National Health Cost Commission

SEC. 6501. NATIONAL HEALTH COST COMMISSION.

(a) ESTABLISHMENT.—By not later than January 1, 1997, the President shall establish a National Health Cost Commission (in this subtitle referred to as the "Commission").

(b) COMPOSITION.—The Commission shall consist of 9 members, appointed by the President, who shall serve at the pleasure of the President. The President shall appoint members based on their expertise and national recognition in the fields of health economics, provider reimbursement, health insurance, health benefits design, and related fields. The Commission shall include individuals from diverse geographic areas and, to the greatest extent feasible, the membership of the Commission shall reflect the racial, ethnic, and gender composition of the population of the United States. In appointing members to the Commission, the President shall seek recommendations from the Speaker and majority and minority leaders of the House of Representatives and the majority and minority leaders of the Senate.

(c) DUTIES.—

(1) ANALYSES.—

(A) IN GENERAL.—The Commission shall conduct analyses of the health care cost and revenue data reported to the Secretary under section 6004.

(B) ANALYSIS OF REGIONAL VARIATION IN PER CAPITA EXPENDITURES DUE TO PRACTICE PATTERNS.—The Commission shall conduct analyses of the variations in per capita expenditures and utilization patterns among different geographic areas (that are States or sub-State areas) due to variation in practice patterns, not due to other factors (such as health care input prices and demographic factors).

(2) ANNUAL REPORTS.—Not later than April 1 of each year, beginning in 1998, the Commission shall submit a report to Congress on health care costs in the United States. The report shall include an analysis relating to each of the following:

(A) The rate of growth in health care costs, by type of provider, by type of payer, and by State.

(B) The success or failure of the private sector in maintaining health care expenditures within the national health expenditure estimates established under subtitle A on a State-by-State basis.

(C) The impact of universal coverage on health care costs and on payment for services by private payers.

(D) The future rate of growth in health care costs, based on projections of historical trends, using the same economic assumptions used by the Congressional Budget Office.

(E) The variations in per capita expenditures described in paragraph (1)(B).

(3) RECOMMENDATIONS ON CHANGES IN STATE HEALTH EXPENDITURE ESTIMATES TO ELIMINATE INAPPROPRIATE REGIONAL VARIATION.—The annual report submitted under this subsection in 1999 shall include recommendations relating to such phased-in changes in the State private sector per capita health expenditure estimates under section 6101 as the Commission determines to be appropriate to eliminate the effect of inappropriate variations described in paragraph (1)(B). In making such recommendations, the Commission shall take into account the prior success of cost containment efforts in the States and may take into account regional variations in demographic or health status and in health care input prices.

(d) SPECIAL REPORT IN 2000.—

(1) IN GENERAL.—In the report submitted under subsection (c)(2) in 2000, the Commission shall include a specific finding regarding whether a system of cost containment should be imposed on health care services provided under private health benefit plans. The finding shall be based on the most recent data available at the time of the report's preparation.

(2) RECOMMENDATIONS.—

(A) IN GENERAL.—Such report may recommend that the system of private sector cost containment provided under subtitle C be allowed to go into effect, or may recommend an alternative system.

(B) LEGISLATIVE PROPOSAL.—Any recommendations which require legislation to implement shall include a detailed legislative proposal providing for their implementation.

(C) NO CHANGES IN GUARANTEED NATIONAL BENEFIT PACKAGE.—Such recommendations shall not include any change in the guaranteed national benefit package.

(e) ADMINISTRATION.—The President shall assure such compensation, staff, and support services for the Commission as may be necessary for the Commission to carry out its duties.

SEC. 6502. EXPEDITED CONSIDERATION OF RECOMMENDATIONS AND ALTERNATIVES.

(a) INTRODUCTION AND REFERRAL.—

(1) IN GENERAL.—If—

(A) the report under section 6501(d) contains a detailed legislative proposal, and

(B) such report is accompanied by a statement (provided by the Director of the Congressional Budget Office under subsection (i)) that the system provided in the proposal meets the cost-containment objectives set forth in this Act,

the majority leader (or the leader's designee) in each House shall introduce (by request and not later than 7 days after the date of receipt by Congress of the report) the legislative proposal as a bill. The title of that bill shall be "A bill to achieve the cost containment objectives set forth in the Guaranteed Health Insurance Act of 1994, and for other purposes.".

(2) REFERRAL.—That bill shall be referred on the date of introduction to the appropriate committee (or committees) in accordance with rules of the respective Houses.

(b) DISCHARGE DEADLINE.—If any committee to which the bill is referred does not report the bill by the end of the 45-day period beginning on the date the bill was referred to the committee, the committee shall be automatically discharged from further consideration of the bill as of the end of such period.

(c) FLOOR CONSIDERATION.—

(1) HOUSE OF REPRESENTATIVES.—For the purpose of expediting consideration and passage of a measure reported or discharged under this section, it shall be in order for the Committee on Rules of the House of Representatives to report a privileged resolution providing for the consideration of the bill. Any such resolution, if it makes in order any amendments to the bill, shall make in order an amendment consisting of the text of the Commission's recommendations.

(2) SENATE.—[LANGUAGE TO BE INSERTED LATER.]

(d) NO RECOMMITTAL.—It shall not be in order to move to recommit the bill.

(e) FINAL PASSAGE.—A vote on final passage of the bill shall be taken in a House not later than the end of the 15-day period beginning on the date on which the motion to proceed to its consideration in that House has been approved.

(f) SPECIAL RULES.—If the House of Representatives approves a bill and the Senate approves a bill the text of which is identical to the text of the bill approved by the House of Representatives, the Senate is deemed to have approved the bill approved by the House of Representatives, effective on the later of—

(1) the date of approval of a bill in the Senate, or

(2) the date the Senate receives a message from the House of Representatives announcing that the House has passed the bill.

(g) RULES OF HOUSE OF REPRESENTATIVES AND SENATE.—This section is enacted by the Congress—

(1) as an exercise of the rulemaking power of the House of Representatives and of the Senate, respectively, or of that House to which they specifically apply and such rules supersede other rules only to the extent that they are inconsistent therewith, and

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

(h) NOT INCLUDING CERTAIN DAYS.—Days on which a House of Congress is not in session because of an adjournment of more than 3 days shall be excluded in the computation of any number of days in a period under this section with respect to that House.

(i) CONGRESSIONAL BUDGET OFFICE DETERMINATIONS.—The Director of the Congressional Budget Office, upon request of the Commission or an appropriate committee, shall—

(1) review any bill to be proposed by the Commission or the committee to determine if the system of health care cost

containment reflected in the bill would meet the cost-containment objectives set forth in this Act, and

(2) provide a written statement of such determination.

TITLE VII—PUBLIC HEALTH INITIATIVES

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Subtitle A—Health Workforce Priorities

PART 1—NATIONAL PLAN REGARDING PHYSICIANS AND OTHER HEALTH PROFESSIONALS

Subpart A—National Plan; General Provisions

SEC. 7001. DEVELOPMENT OF PLAN.

(a) IN GENERAL.—

(1) DEVELOPMENT OF PLAN.—The Secretary shall develop and carry out in accordance with this part a plan for the applicable period to be known as the National Health Care Workforce Plan.

(2) PURPOSE.—The purpose of the Plan shall be to establish a national goal for the United States of developing a

health care workforce whose composition reflects the needs of the United States for practitioners in the various health professions, including the need for practitioners in primary health care.

(3) DEFINITIONS.—For purposes of this subtitle:

(A) The term "applicable period" means the academic years designated by the Secretary as the years to which a plan under paragraph (1) is to apply, except that the initial applicable period shall be the academic years 1998 through 2002.

(B) The term "academic year" means the 1-year period beginning on July 1. The academic year beginning July 1, 1998, is academic year 1998.

(C) The term "Plan" means the plan under paragraph (1) for the applicable period involved.

(b) PROVISIONS REGARDING HEALTH PROFESSIONALS OTHER THAN PHYSICIANS.—With respect to health professionals other than physicians, the Secretary shall in carrying out subsection (b) ensure that, for the academic years of the applicable period, the Plan—

(1) establishes recommendations for national goals regarding the number and variety of such professionals that should be trained (including goals regarding nurse practitioners and other advanced practice nurses); and

(2) provides recommendations for encouraging the training of such professionals in accordance with the goals.

(c) PROVISIONS REGARDING PHYSICIANS.—

(1) IN GENERAL.—With respect to physicians, the Secretary shall develop the Plan in accordance with subpart B.

(2) APPLICABILITY OF CERTAIN REQUIREMENTS.—Subsections (e) through (g) apply both to provisions of the Plan that relate to physicians and to provisions of the Plan that relate to other health professionals.

(d) PERIODIC REVIEW AND REVISION OF PLAN.—With respect to the discretion provided in this part to the Secretary for the development and administration of the Plan, the Secretary shall periodically review the Plan, and shall revise the Plan to the extent determined by the Secretary to be appropriate.

(e) CONSIDERATION OF PROJECTED NUMBERS OF PROFESSIONALS.—In developing and revising the Plan, the Secretary shall take into account projections of the health care needs of the United States.

(f) CONSULTATIONS.—In developing and revising the Plan, the Secretary shall consult with the advisory council established under section 7011, consumers, experts in health workforce needs, teaching physicians, physicians in private practice, nurses, representatives of health insurers (including health maintenance organizations and other managed care plans), other organizations representing physicians, organizations involved in the accreditation of residency training programs, and organizations involved in the certification of practitioners.

(g) REPORT TO CONGRESS.—Not later than June 30, 1996, the Secretary shall submit to the Congress a final report describing the contents of the initial Plan. The report shall include an analysis of the impact on teaching hospitals and other training sites of limiting support for training, consistent with the Plan. The Secretary may submit interim reports regarding any component of the Plan (regardless of whether the Secretary has prepared other components).

Subpart B—National Plan; Provisions Regarding Physicians

SEC. 7011. NATIONAL ADVISORY COUNCIL ON GRADUATE MEDICAL EDUCATION.

(a) IN GENERAL.—There is established within the Department of Health and Human Services an advisory council to be known as the National Advisory Council on Graduate Medical Education (in this subtitle referred to as the "Council").

(b) DUTIES.—The Council shall provide advice to the Secretary on carrying out this subpart. In providing such advice, the Council shall develop and submit to the Secretary a proposal for the components of the Plan under section 7001 that relate to physicians (including the provisions of the Plan required in sections 7012 and 7013).

(c) COMPOSITION.—

(1) IN GENERAL.—The Secretary shall appoint to the Council 15 individuals who are not officers or employees of the United States. Such individuals shall include not less than 1 individual from each of the following categories of individuals or entities:

(A) Organizations representing consumers of health care services.

(B) Physicians who are faculty members of medical schools (as defined in section 7012(f)), or who supervise approved physician training programs (as so defined).

(C) Physicians in private practice who are not physicians described in subparagraph (B).

(D) Practitioners in public health.

(E) Medical schools.

(F) Teaching hospitals.

(G) Certified health plans (as defined in section 2).

(H) The Accreditation Council on Graduate Medical Education.

(I) The American Board of Medical Specialities.

(J) The Council on Postdoctoral Training of the American Osteopathic Association.

(K) The Council on Podiatric Medical Education of the American Podiatric Medical Association.

(2) REQUIREMENTS REGARDING REPRESENTATIVE MEMBERSHIP.—To the greatest extent feasible, the membership of the Council shall represent the various geographic regions of the United States, shall reflect the racial, ethnic, and gender composition of the population of the United States, and shall be broadly representative of medical schools and teaching hospitals in the United States.

(3) EX OFFICIO MEMBERS; OTHER FEDERAL OFFICERS OR EMPLOYEES.—The membership of the Council shall include individuals designated by the Secretary to serve as members of the Council from among Federal officers or employees who are appointed by the President, or by the Secretary (or by other Federal officers who are appointed by the President with the advice and consent of the Senate). Individuals designated under the preceding sentence shall include each of the following officials (or a designee of the official):

(A) The Secretary of Health and Human Services.

(B) The Secretary of Veterans Affairs.

(C) The Secretary of Defense.

(d) CHAIR.—The Secretary shall, from among members of the Council appointed under subsection (c)(1), designate an individual to serve as the Chair of the Council.

(e) TERMINATION.—The Council terminates December 31, 1999.

SEC. 7012. ANNUAL DESIGNATION OF AUTHORIZED PER-SPECIALTY NUMBER OF SPECIALTY POSITIONS; REQUIREMENTS REGARDING PRIMARY HEALTH CARE.

(a) ANNUAL AUTHORIZATION OF NUMBER OF POSITIONS PER SPECIALTY.—With respect to physicians, the Secretary shall in carrying out section 7001 ensure that, for each medical specialty, the Plan designates, for each of the academic years of the applicable period, the number of individuals nationwide who are authorized to be enrolled in approved physician training programs in the specialty for the academic year involved, including a designation of the number of individuals who are authorized to enter the programs for such year. The Secretary may, under section 7001(d), change a number designated under the preceding sentence for an academic year to reflect changing needs for physicians in the various medical specialties.

(b) PRIMARY HEALTH CARE.—

(1) REQUIREMENT ACROSS SPECIALTIES.—In designating the per-specialty annual numbers of positions for all medical specialties for academic year 2002 or any subsequent academic year, the Secretary shall ensure that, of the class of training participants entering approved physician training programs for the year, the percentage that enters such programs in primary health care is not less than 55 percent, subject to the following:

(A) The Secretary, in order to provide a period of transition regarding such requirement, shall establish a lesser percentage for each of the academic years 1998 through 2001.

(B) The Secretary may change the percentage specified in the Plan for any academic year to reflect changing needs for physicians in the various medical specialties.

(2) RULES OF CONSTRUCTION.—For purposes of the requirement of paragraph (1) (relating to a percentage):

(A) The requirement applies in the aggregate to all training participants in approved physician training programs for the academic year involved, and not individually to any such program.

(B) In the case of approved physician training programs in a medical specialty participation in which is a prerequisite to participation in approved physician training programs in another medical specialty, the Secretary shall apply the requirement of paragraph (1) as follows:

(i) The Secretary shall periodically make an estimate, by specialty, of the average number of training participants in such prerequisite programs who subsequently enter the other programs.

(ii) In designating the per-specialty annual numbers of positions for such prerequisite programs, the Secretary shall consider such estimates in order to ensure that the numbers designated for the programs reasonably reflect the needs of the United States for practitioners in the medical specialities for which the programs provide training.

(3) EXCLUSION FROM DETERMINATION.—Specialty positions in approved physician training programs in podiatric medicine shall be excluded from determinations under paragraph (1) (both determinations regarding the number of entering positions in specialties in primary health care and the number of entering positions in other specialities).

(c) CERTAIN CONSIDERATIONS IN DESIGNATING ANNUAL NUMBERS.—Factors considered by the Secretary in designating a per-specialty annual number of positions for an academic year shall include the extent to which there is a need for additional practitioners in the medical specialty involved. In carrying out the preceding sentence, the Secretary shall consider, among other factors determined by the Secretary to be relevant, the incidence and prevalence (in the general population and in various other populations)

of the diseases, disorders, or other health conditions with which the specialty is concerned.

(d) DEFINITIONS.—

(1) APPROVED PROGRAM.—For purposes of this subtitle:

(A) The term "approved physician training program", with respect to the medical specialty involved, means (subject to subparagraph (C)) a residency or other postgraduate program that trains physicians and meets the conditions described in clause (i), or the conditions described in clause (ii), as follows:

(i) The conditions described in this clause are that—

(I) participation in the program may be counted toward certification in the medical specialty, as determined under the applicable standards of the American Board of Medical Specialities or the Council on Postdoctoral Training of the American Osteopathic Association; and

(II) the program is accredited by the Accreditation Council on Graduate Medical Education or approved by the Council on Postdoctoral Training of the American Osteopathic Association.

(ii) The conditions described in this clause are that—

(I) the program meets the condition described in subclause (I) of clause (i), or the condition described in subclause (II) of such clause, but not both; and

(II) the Secretary designates the program as an approved physician training program for purposes of this subtitle.

(B) The term "approved physician training program" includes any postgraduate program meeting the conditions described in clause (i) or (ii) in subparagraph (A), including such a program that provides health services in an ambulatory setting (regardless of whether the program provides inpatient hospital services).

(C) The term "approved physician training program" includes (notwithstanding subparagraphs (A) and (B)) each program that receives payments under section 1886(h) of the Social Security Act as an approved medical residency training program.

(2) OTHER DEFINITIONS.—For purposes of this subtitle:

(A) The term "medical school" means a school of medicine (as defined in section 799 of the Public Health Service Act) or a school of osteopathic medicine (as so defined).

(B) The term "medical specialty" includes all medical, surgical, and other physician specialties and subspecialties.

(C) The term "per-specialty annual number of positions", with respect to a medical specialty, means the number designated by the Secretary under subsection (a) for approved physician training programs for the academic year involved.

(D) The term "primary health care" means the following medical specialties: Family medicine, general internal medicine, general pediatrics, geriatrics, preventive medicine, osteopathic general practice, and obstetrics and gynecology.

(E) The term "specialty position" means a position as a training participant.

(F) The term "training participant" means an individual who is enrolled in an approved physician training program.

SEC. 7013. ALLOCATIONS AMONG SPECIALITIES AND PROGRAMS.

(a) PROVISIONS IN NATIONAL PLAN.—

(1) IN GENERAL.—With respect to physicians, the Secretary shall in carrying out section 7001 ensure that the Plan specifies that the per-specialty annual number of positions designated under section 7012 for a medical specialty for an academic year is to be allocated among approved physician training programs in the specialty.

(2) METHODOLOGY FOR PROGRAM BY PROGRAM IMPLEMENTATION OF PLAN.—In developing the Plan, the Secretary shall develop a methodology for annually allocating among the approved physician training programs in a medical specialty the per-specialty annual number of positions that the Secretary has designated for the academic year involved. The Secretary shall include among the factors upon which the methodology is based the following:

(A) The geographic distribution of physicians.

(B) The historical distribution of specialty positions among the various geographic areas of the United States.

(C) The extent to which the approved physician training programs of a hospital directly provide health services to patients of the hospital.

(D) The extent to which a reduction in the allocation of specialty positions for such programs of a hospital will have an adverse effect on the financial capacity of the hospital to maintain a level of health services equivalent to the level the hospital would provide in the absence of the reduction.

(E) The quality of physician training programs.

(F) The need to train physicians in sites other than hospitals, as appropriate to the specialty involved.

(G) The need to encourage the training of minority physicians.

(H) The need for appropriate opportunities for training in osteopathic specialities.

(I) The extent to which graduates of an approved physician training program are practicing in underserved rural and urban areas.

(J) The extent to which an approved physician training program provides training under the program in underserved rural and urban areas, including training provided at health facilities provided for under Public Law 94–437.

(3) DEFINITION.—For purposes of this subtitle, the term "underserved", with respect to a rural or urban area, means a health professional shortage area as defined in section 332(a)(1) of the Public Health Service Act.

(b) ANNUAL ALLOCATIONS BY SECRETARY.—

(1) IN GENERAL.—For academic year 1998 and each subsequent academic year, the Secretary shall for each medical specialty make allocations among approved physician training programs of the per-specialty annual number of positions designated for the academic year involved. The preceding sentence is subject to section 7031 (relating to qualifying physician training consortia).

(2) USE OF PLAN METHODOLOGY.—In making allocations under paragraph (1), the Secretary shall use the methodology developed under subsection (a)(2), with such modifications in the methodology as the Secretary may make under section 7001(d).

(c) ADVANCE NOTICE TO PROGRAMS.—The Secretary shall notify each approved physician training program of the allocation to be made for the program under subsection (b) for an academic year not later than October 1 of the preceding academic year.

(d) EXCLUSIONS FROM ALLOCATION SYSTEM.—

(1) IN GENERAL.—The Secretary shall exclude from the applicability of this section any specialty position filled by a training participant described in paragraph (2). Such positions

in an approved physician training program are in addition to specialty positions allocated to the program under subsection (b).

(2) RELEVANT TRAINING PARTICIPANTS.—For purposes of paragraph (1) and other provisions of this subtitle, a training participant described in this paragraph is such a participant who, through a program carried out jointly by a medical school and another accredited educational entity, has received both—

(A) a doctorate of medicine; and

(B) a doctorate of philosophy, or an equivalent degree.

PART 2—PAYMENTS TO TEACHING HOSPITALS

SEC. 7021. FORMULA PAYMENTS REGARDING PRIVATE-SECTOR SHARE OF COSTS OF GRADUATE MEDICAL EDUCATION.

(a) IN GENERAL.—In the case of each teaching hospital that in accordance with section 7023 submits to the Secretary an application for calendar year 1996 or any subsequent calendar year (referred to in this part as an "eligible hospital" for the year involved), the Secretary shall in accordance with section 7024 make payments for such year to the hospital, and shall in accordance with such section make adjustments in maximum payment rates for the hospital. The preceding sentence is subject to section 7031 (relating to qualifying physician training consortia).

(b) DEFINITIONS.—For purposes of this subtitle, the term "teaching hospital" means any hospital that receives payments under subsection (d)(5)(B) or (h) of section 1886 of the Social Security Act (relating to graduate medical education).

SEC. 7022. AGREEMENT REGARDING COMPLIANCE WITH ALLOCATION SYSTEM.

With respect to the approved physician training programs of a teaching hospital, the Secretary may make payments under section 7021 for the programs only if the hospital agrees to ensure that the numbers of individuals enrolled in the programs is in accordance with allocations made under section 7013 for the programs.

SEC. 7023. APPLICATION FOR PAYMENTS.

(a) IN GENERAL.—For purposes of section 7021(a), an application for payments under such section for a calendar year is in accordance with this section if—

(1) the application is submitted not later than the date specified by the Secretary;

(2) the application contains the agreement required in section 7022; and

(3) the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this part.

(b) CONSOLIDATION WITH APPLICATION UNDER PART 3.—The Secretary may establish procedures through which teaching hospitals simultaneously apply for payments under section 7021 and 7041.

SEC. 7024. ANNUAL AMOUNT OF PAYMENTS.

(a) IN GENERAL.—From amounts in the Health Care Workforce Trust Fund under section 9512 of the Internal Revenue Code of 1986, the Secretary shall, subject to section 7025, make payments under section 7021 to an eligible hospital for a calendar year as follows:

(1) Payments, made on a periodic basis, whose sum is equal to the amount determined under subsection (c) for the hospital for the year (which amount relates to the direct costs for graduate medical education attributable to certain individuals).

(2) Payments (in addition to payments under paragraph (1)), made on a periodic basis, whose sum is equal to the amount determined under subsection (d) for the hospital for

the year (which amount relates to the per discharge indirect costs of the hospital for graduate medical education attributable to certain individuals).

Payments under paragraph (1) are effective for portions of cost reporting periods occurring on or after January 1, 1996. Payments under paragraph (2) are effective for patient discharges occurring on or after such date.

(b) RELATIONSHIP OF PAYMENTS TO ALLOCATION OF SPECIALTY POSITIONS.—On and after July 1, 1998, the Secretary, in making determinations under subsections (c) and (d) for the payments required in paragraphs (1) and (2) of subsection (a) for an eligible hospital, shall count only training participants who are in a specialty position that, under section 7013, has been allocated to an approved physician training program of the hospital. In the case of payments under paragraph (1) of subsection (a), the preceding sentence is effective for portions of cost reporting periods occurring on or after such date; and in the case of payments under paragraph (2) of such subsection, the sentence is effective for patient discharges occurring on or after such date.

(c) AMOUNT OF PAYMENTS; DIRECT COSTS.—

(1) IN GENERAL.—For purposes of paragraph (1) of subsection (a), the amount determined under this subsection for an eligible hospital for a calendar year is the product of—

(A) the aggregate nonmedicare training amount for the hospital, as defined in paragraph (2); and

(B) the direct-cost Fund payout percentage, as defined in paragraph (4).

(2) AGGREGATE NONMEDICARE TRAINING AMOUNT.—For purposes of this subtitle, the term "aggregate nonmedicare training amount", with respect to the eligible hospital involved, means (subject to paragraph (3)(D)) an amount equal to the product of subparagraphs (A) and (B), as follows:

(A) Subject to section 7025(b), the number of full-time-equivalent training participants in the approved physician training programs of the hospital for the academic year in which the calendar year begins (including training participants described in section 7013(d)(2)).

(B) An amount equal to the product of—

(i) the national average FTE training amount, as defined in paragraph (3); and

(ii) a percentage equal to 1 minus the medicare patient load of the hospital (determined under section 1886(h)(3)(C) of the Social Security Act) for the cost reporting period involved, except that the determination of the medicare patient load for purposes of this clause shall include (in addition to the patients included under such section) patients enrolled in the program under title XXI of such Act.

(3) NATIONAL AVERAGE FTE TRAINING AMOUNT.—

(A) IN GENERAL.—For purposes of this subtitle, the term "national average FTE training amount" means the national average of the costs per training participant for all approved physician training programs and all medical specialities, which average shall be derived from the per-resident approved FTE resident amounts in effect for hospitals under section 1886(h) of the Social Security Act for academic year 1992 (as adjusted under subparagraphs (B) and (C)). The weighting factor applied pursuant to paragraph (4)(C) of such section shall be the weighting factor in effect under such paragraph on the day before the date of the enactment of this Act.

(B) ANNUAL ADJUSTMENTS PER CONSUMER PRICE INDEX.—The national average applicable under subparagraph (A) for a calendar year for such programs is, subject to subparagraph (C), the amount determined under subparagraph (A) increased by the amount necessary to offset

the effects of inflation occurring since academic year 1992, as determined through use of the consumer price index.

(C) INDIVIDUAL ADJUSTMENTS PER AREA WAGE INDEX.—The national average determined under subparagraph (A) and adjusted under subparagraph (B) for a calendar year shall, in the case of the approved physician training programs of the eligible hospital involved, be adjusted by a factor to reflect regional differences in wage and wage-related costs, as determined in accordance with the area wage index applicable (as of the beginning of such year) to hospitals in the labor-market area involved, as determined under section 1886(d)(3)(E) of the Social Security Act.

(D) ALTERNATIVE RULE FOR CERTAIN HOSPITALS.—

(i) ELECTION FOR APPLICABILITY OF RULE.—In the case of an eligible hospital for which the election under section 1861(b)(7) of the Social Security Act was in effect on July 1, 1994, and has remained in effect continuously from such date, the following applies:

(I) The hospital may, with respect to the determination under paragraph (2) of the aggregate nonmedicare training amount for the hospital, elect to have the alternative rule described in clause (ii) applied to the hospital.

(II) If the election under such section 1861(b)(7) ceases to be in effect, any election made by the hospital under subclause (I) is terminated.

(III) If the hospital has made the election under subclause (I) and subsequently requests that the election be terminated, the Secretary shall approve the request. Upon the approval of the request, the hospital may not subsequently elect to have the alternative rule applied to the hospital.

(ii) DESCRIPTION OF ALTERNATIVE RULE.—With respect to a determination under paragraph (2) of the aggregate nonmedicare training amount for an eligible hospital that has made the election under clause (i), the alternative rule described in this clause is as follows:

(I) In lieu of the applicability of the national FTE training amount (for purposes of paragraph (2)(B)(i)), the Secretary shall apply an amount equal to the approved FTE resident amount in effect for the hospital under section 1886(h)(2) of the Social Security Act.

(II) Subject to the modification applied under subclause (I), the Secretary shall determine an amount under paragraph (2).

(III) The Secretary shall determine an amount equal to the product of the percentage determined under paragraph (2)(B)(ii) and the amount of the physician costs of services recognized under section 1861(v)(1) of the Social Security Act pursuant to the election of the hospital under section 1861(b)(7) of such Act.

(IV) In lieu of the applicability of the aggregate nonmedicare training amount (for purposes of paragraph (1)(A)), the Secretary shall apply an amount equal to the sum of the amount determined under subclause (II) and the amount determined under subclause (III).

(4) DIRECT-COST FUND PAYOUT PERCENTAGE.—For purposes of this subtitle, the term "direct-cost Fund payout percentage", with respect to the calendar year involved, means a percentage equal to the ratio of—

(A) the amount available in the Health Care Workforce Trust Fund for such year (as estimated by the Secretary); to

(B) an amount equal to the sum of clauses (i) through (iv), as follows:

(i) The total amount of payments under subsection (a)(1) that would be made to eligible hospitals for such year if each hospital received, pursuant to paragraph (1), 100 percent of the aggregate nonmedicare training amount determined for the hospital.

(ii) The total of the amounts determined under subsection (d) of section 7041 for such year for teaching hospitals eligible for payments under such section.

(iii) The total of the amounts determined for such year for grants under section 848 of the Public Health Service Act (relating to graduate nursing education).

(iv) The total of the amounts determined for such year for grants under section 741 of such Act (relating to medical schools).

(d) AMOUNT OF PAYMENTS; INDIRECT COSTS.—

(1) IN GENERAL.—For purposes of paragraph (2) of subsection (a), the amount determined under this subsection for an eligible hospital for a calendar year is the product of—

(A) an amount equal to the sum of the nonmedicare per-discharge supplemental payments, as defined in paragraph (2); and

(B) the indirect-cost Fund payout percentage, as defined in paragraph (3).

(2) NONMEDICARE PER-DISCHARGE SUPPLEMENTAL PAYMENT.—

(A) IN GENERAL.—For purposes of this subtitle, the term "nonmedicare per-discharge supplemental payment", with respect to a calendar year, means a payment made to an eligible hospital for a discharge during the year of a patient described in subparagraph (B), the amount of which payment is determined in accordance with subparagraph (C).

(B) RELEVANT PATIENTS.—For purposes of subparagraph (A), a patient described in this subparagraph is a patient who is not—

(i) entitled to benefits under part A of title XVIII of the Social Security Act;

(ii) enrolled in the health insurance program under title XXI of such Act; or

(iii) eligible for medical assistance under title XIX of such Act.

(C) AMOUNT OF PER-DISCHARGE PAYMENT.—For purposes of subparagraph (A), the amount of the payment under such subparagraph for the discharge of a patient described in subparagraph (B) is the product of—

(i) an amount equal to the maximum payment rate determined for the discharge under subsection (a)(2)(A) of section 6311, except that for purposes of this clause, the determination under such subsection shall be made without the adjustments described in paragraphs (3) through (5) of subsection (d) of such section; and

(ii) the percentage applicable to the hospital under section 1886(d)(5)(B)(ii) of the Social Security Act.

(3) INDIRECT-COST FUND PAYOUT PERCENTAGE.—For purposes of this subtitle, the term "indirect-cost Fund payout percentage", with respect the calendar year involved, means a percentage equal to the ratio of—

(A) the amount available in the Health Care Workforce Trust Fund for such year remaining after payments for the year have been made under subsection

(a)(1), under section 7041, and under sections 848 and 741 of the Public Health Service Act (as such amount is estimated by the Secretary); to

(B) the total amount of payments under subsection (a)(2) that would be made to eligible hospitals for such year if each hospital received, pursuant to paragraph (1), 100 percent of an amount equal to the sum of the nonmedicare per-discharge supplemental payments determined for the hospital.

(e) OFFSET REGARDING SHORTFALL IN FUND PAYMENTS; INCREASE IN MAXIMUM PAYMENT RATES UNDER TITLE VI.—

(1) SHORTFALL IN DIRECT-COST PAYMENTS.—

(A) IN GENERAL.—In the case of an eligible hospital, for any calendar year for which the direct-cost Fund payout percentage is less than 100 percent, the Secretary shall increase, by the amount determined under subparagraph (B), the maximum payment rate otherwise applicable to a discharge under subtitle D of title VI for inpatient services furnished by the hospital. The amount so determined shall be applied uniformly to each discharge from the hospital. This paragraph is subject to paragraph (3).

(B) AMOUNT OF INCREASE.—For purposes of subparagraph (A), the amount of the increase per discharge for a calendar year for an eligible hospital is the product of—

(i) a percentage equal to 1 minus the direct-cost Fund payout percentage; and

(ii) the applicable per discharge training amount for the hospital, as defined in subparagraph (C).

(C) APPLICABLE PER DISCHARGE TRAINING AMOUNT.—For purposes of this subtitle, the term "applicable per discharge training amount", with respect to the eligible hospital involved and the calendar year involved, means an amount equal to the quotient of—

(i) the aggregate nonmedicare training amount for the hospital, as determined under subsection (c)(1)(A); divided by

(ii) the average annual number of discharges of patients described in subsection (d)(2)(B) during the most recent 3-year period (as determined by the Secretary on the basis of the most recent data available to the Secretary).

(2) SHORTFALL IN INDIRECT-COST PAYMENTS.—

(A) IN GENERAL.—In the case of an eligible hospital, for any calendar year for which the indirect-cost Fund payout percentage is less than 100 percent, the Secretary shall increase, by the amount determined under subparagraph (B), the maximum payment rate per discharge otherwise established under section 6311 with respect to the discharge. The preceding sentence is subject to paragraph (3).

(B) AMOUNT OF INCREASE.—For purposes of subparagraph (A), the amount of the per discharge increase for an eligible hospital for a calendar year is the product of—

(i) a percentage equal to 1 minus the indirect-cost Fund payout percentage; and

(ii) an amount equal to the amount applicable under subsection (d)(2)(C)(i) to the discharge multiplied by the percentage applicable to the hospital under section 1886(d)(5)(B)(ii) of the Social Security Act.

(3) RELATIONSHIP OF RATE INCREASES TO ALLOCATIONS OF SPECIALTY POSITIONS.—Effective for patient discharges occurring on or after July 1, 1998, the Secretary, in making determinations under paragraphs (1) and (2) of increases in amounts, shall count only training participants who are in a

specialty position that, under section 7013, has been allocated to an approved physician training program.

(f) PUBLICATION OF FUND PAYOUT PERCENTAGES AND ADJUSTMENTS IN MAXIMUM PAYMENT RATES.—The Secretary shall include in the publication of the final maximum payment rates for a calendar year under section 6301(a)—

(1) the direct-cost Fund payout percentage;

(2) the indirect-cost Fund payout percentage; and

(3) the hospital-specific adjustments in such rates determined under paragraph (1) or (2) of subsection (e).

(g) DEFINITIONS.—For purposes of this subtitle, the term "full-time-equivalent training participant" means a full-time equivalent resident of the hospital as determined under section 1886(h)(4) of the Social Security Act for the cost reporting period involved.

SEC. 7025. TRANSITIONAL PROVISIONS REGARDING DIRECT-COST PAYMENTS.

(a) PAYMENT BLEND.—For each of the calendar years 1996 through 1998, in the case of an eligible hospital (other than an eligible hospital making the election under section 7024(c)(3)(D)), the amount required in section 7024(a)(1) to be paid to the hospital is the sum of paragraphs (1) and (2), as follows (as applicable to the calendar year involved):

(1) An amount determined in accordance with section 7024(c) except that, in lieu of applying the national FTE training amount (for purposes of paragraph (2)(B)(i) of such section), the Secretary shall apply the following:

(A) For calendar year 1996, an amount equal to 75 percent of the approved FTE resident amount in effect for the hospital under section 1886(h)(2) of the Social Security Act.

(B) For calendar year 1997, an amount equal to 50 percent of such resident amount.

(C) For calendar year 1998, an amount equal to 25 percent of such resident amount.

(2) An amount determined in accordance with section 7024(c) except that, in lieu of applying 100 percent of the national FTE training amount (for purposes of paragraph (2)(B)(i) of such section), the Secretary shall apply the following:

(A) For calendar year 1996, an amount equal to 25 percent of such training amount.

(B) For calendar year 1997, an amount equal to 50 percent of such training amount.

(C) For calendar year 1998, an amount equal to 75 percent of such training amount.

(b) TRANSITIONAL LIMIT ON NUMBER OF FTES.—In determining the number of full-time-equivalent training participants under section 7024(c)(2)(A) for a hospital, for the period beginning on January 1, 1996 and ending on June 30, 1998, such number may not exceed the number of full-time equivalent residents determined with respect to the hospital under section 1886(h)(4) of the Social Security Act for portions of cost-reporting periods during the academic year 1994.

SEC. 7026. RULE OF CONSTRUCTION REGARDING MEDICARE AMENDMENTS.

Except as otherwise provided in this subtitle:

(1) A reference in this title to title XVIII of the Social Security Act shall be considered to be a reference to such title as in effect on the day after the date of the enactment of this Act, without regard to any amendment subsequently made to such title XVIII.

(2) For purposes of paragraph (1), an amendment to such title XVIII that is made by this Act as of the day referred to in such paragraph applies to this title upon the amendment taking effect, without regard to whether the date on which the amendment takes effect is after the day referred to in such paragraph.

PART 3—QUALIFYING PHYSICIAN TRAINING CONSORTIA

SEC. 7031. SPECIAL RULES REGARDING ALLOCATION OF SPECIALTY POSITIONS AND RECEIPT OF DIRECT-COST PAYMENTS.

(a) IN GENERAL.—In the case of a qualifying physician training consortium (as defined in subsection (b))—

(1) the Secretary may make allocations under section 7013 to the consortium in the aggregate in lieu of making the allocations individually to the approved physician training programs of the consortium; and

(2) if the Secretary makes allocations to the consortium pursuant to paragraph (1)—

(A) the Secretary shall make payments under sections 7024(a)(1) and 7041 to the consortium in the aggregate in lieu of making the payments individually to the teaching hospitals of the consortium; and

(B) the payments shall be made on the basis of the amount of the payments that otherwise would have been made to the hospitals, adjusted through averaging the criteria that under sections 7024(a)(1) and 7041 do not apply uniformly to teaching hospitals and through weighting such averages according to the extent to which the data that form the basis of such criteria apply to the hospitals of the consortium.

(b) DEFINITION.—For purposes of this subtitle, the term "qualifying physician training consortium" means a group of teaching hospitals meeting the following conditions:

(1) The hospitals of the group have entered into an agreement under which a consortium is established, and the purposes of the consortium include the purposes specified in subsection (c).

(2) The hospitals of the consortium include not less than 2 teaching hospitals, and—

(A) with respect to allocations under section 7013, all of the approved physician training programs of the hospitals participate in the consortium; and

(B) with respect to any entity (other than an entity that is part of any of the hospitals of the consortium) at whose facilities any of the hospitals conducts a significant amount of training under such programs, each of such entities participates in the consortium.

(3) For the academic year preceding the academic year for which the allocations are to be made pursuant to subsection (a), or for academic year 1994, the aggregate number of training participants of the consortium who were entering their first approved physician training program was not less than 50.

(4) The consortium submits to the Secretary an application in accordance with subsection (d) for designation as a qualifying physician training consortium, and the Secretary approves the application.

(c) PURPOSES OF CONSORTIUM.—The purposes referred to in subsection (b)(1) regarding a consortium are as follows:

(1) The approved physician training programs of the consortium collaborate in the provision of training under the programs.

(2) With respect to an aggregate allocation for a medical specialty that is made to the consortium pursuant to subsection (a)(1), the consortium designates the number of specialty positions to be received by each of the approved physician training programs of the consortium in the specialty.

(3) With respect to aggregate payments that are made to the consortium pursuant to subsection (a)(2), the consortium allocates the payments among each of the teaching hospitals of the consortium.

(4) Such other purposes as the Secretary determines to be appropriate.

(d) APPLICATION FOR CONSORTIUM STATUS.—

(1) IN GENERAL.—For purposes of subsection (b)(4), an application under this subsection for designation as a qualifying physician training consortium for a calendar year is in accordance with this subsection if—

(A) the application is submitted not later than the date specified by the Secretary;

(B) the application demonstrates that the teaching hospitals involved meet the conditions described in paragraphs (1) through (3) of subsection (b);

(C) the application contains an agreement described in section 7022 from each of the teaching hospitals; and

(D) the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this part.

(2) RELATION TO REQUIREMENT OF INDIVIDUAL APPLICATIONS.—If a group of teaching hospitals submits to the Secretary an application in accordance with paragraph (1) for a calendar year, and the Secretary approves the application, each of the hospitals shall be considered to have submitted an application in accordance with section 7023 (and accordingly, each of the hospitals is an eligible hospital for the year for purposes of part 2).

PART 4—TRANSITIONAL PAYMENTS FOR TEACHING HOSPITALS LOSING SPECIALTY POSITIONS

SEC. 7041. TRANSITIONAL PAYMENTS TO TEACHING HOSPITALS.

(a) PAYMENTS REGARDING EFFECTS OF ALLOCATION OF SPECIALTY POSITIONS.—In the case of each hospital that in accordance with subsection (c) submits to the Secretary an application for calendar year 1998 or any subsequent calendar year (in this section referred to as an 'eligible hospital' for the year involved), the Secretary shall make payments for the year to the hospital in an amount determined in accordance with subsection (d). Such payments shall be made from amounts in the Health Care Workforce Trust Fund under section 9512 of the Internal Revenue Code of 1986.

(b) HOSPITALS LOSING SPECIALTY POSITIONS; OTHER CONDITIONS.—

(1) HOSPITALS LOSING SPECIALTY POSITIONS.—

(A) IN GENERAL.—The Secretary may make payments under subsection (a) to a teaching hospital for a calendar year only if, as a result of allocations under 7013, the aggregate number of full-time-equivalent specialty positions for the hospital for the academic year in which the calendar year begins (as estimated by the Secretary) is below the aggregate number of such positions for the hospital for academic year 1993.

(B) AGGREGATE NUMBER OF SPECIALTY POSITIONS LOST.—For purposes of this section:

(i) The term "aggregate number of specialty positions lost", with respect to a teaching hospital and an academic year, means the difference between the 2 aggregate numbers determined by the Secretary under subparagraph (A) for the hospital.

(ii) The term "lost position", with respect to an academic year, means a full-time-equivalent specialty position counted in the determination under clause (i) of the aggregate number of specialty positions lost for the year.

(2) COMPLIANCE WITH ALLOCATION SYSTEM.—With respect to the approved physician training programs of a teaching hospital, the Secretary may make payments under subsection (a) only if the hospital agrees to ensure that the numbers of individuals enrolled in the programs is in accordance with allocations made under section 7013 for the programs.

(c) APPLICATION FOR PAYMENTS.—For purposes of subsection (a), an application for payments under such subsection for a teaching hospital is in accordance with this subsection if—

(1) the hospital submits the application not later than the date specified by the Secretary;

(2) the application demonstrates that the hospital meets the condition described in subsection (b)(1)(A);

(3) the application contains each agreement required in this section; and

(4) the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary.

(d) AMOUNT OF PAYMENTS.—The amount of payments required in subsection (a) to be made to an eligible hospital for a calendar year is an amount equal to the product of paragraphs (1) and (2), as follows:

(1) An amount equal to the product of—

(A) the aggregate lost position amount, as defined in subsection (e) for the academic year; and

(B) 1 minus the medicare patient load of the hospital (determined under section 1886(h)(3)(C) of the Social Security Act) for the cost reporting period involved, except that the determination of the medicare patient load for purposes of this subparagraph shall include (in addition to the patients included under such section) patients enrolled in the program under title XXI of such Act.

(2) The direct-cost Fund payout percentage under section 7024(c)(4).

(e) AGGREGATE LOST POSITION AMOUNT.—

(1) FIRST YEAR OF RECEIVING PAYMENTS.—For purposes of subsection (d)(1)(A), the term "aggregate lost position amount", with respect to the first calendar year for which an eligible hospital receives payments under subsection (a), means an amount equal to the product of—

(A) the aggregate number of specialty positions lost (as defined in subsection (b)(1)(B)); and

(B) an amount equal to 100 percent of the national average FTE training amount in effect for the year under section 7024(c)(3) (or, as the case may be, 100 percent of the alternative amount that applies to the hospital under section 7024(c)(3)(D) or section 7025).

(2) SUBSEQUENT YEARS OF PAYMENT.—For purposes of subsection (d)(1)(A), the term "aggregate lost position amount", with respect to the second or subsequent calendar year for which an eligible hospital receives payments under subsection (a), means an amount equal to the sum of subparagraphs (A) through (D), as follows:

(A) An amount equal to the product of—

(i) the aggregate number of specialty positions lost, less an amount equal to the sum of—

(I) the number of lost positions for which payments are being made for the calendar year pursuant to subparagraphs (B) through (D); and

(II) the total number of lost positions for which, in determinations under this subsection for the hospital for prior calendar years, the percentage applicable to the national average or alternative amount referred to in paragraph (1)(B) was 25 percent; and

(ii) 100 percent of such national average or alternative amount applicable for the year involved.

(B) An amount equal to the product of—

(i) the number of lost positions for which, in the determination under this subsection for the hospital for the preceding calendar year, the percentage applicable to the national average or alternative amount was 100 percent, subject to paragraph (3) (relating to decreases in aggregate numbers); and

(ii) 75 percent of the national average or alternative amount applicable for the year involved.

(C) An amount equal to the product of—

(i) the number of lost positions for which, in the determination under this subsection for the hospital for the preceding calendar year, the percentage applicable to the national av rage or alternative amount was 75 percent, subject to paragraph (3); and

(ii) 50 percent of the national average or alternative amount applicable for the year involved.

(D) An amount equal to the product of—

(i) the number of lost positions for which, in the determination under this subsection for the hospital for the preceding calendar year, the percentage applicable to the national average or alternative amount was 50 percent, subject to paragraph (3); and

(ii) 25 percent of the national average or alternative amount applicable for the year involved.

(3) RULE REGARDING DECREASE IN AGGREGATE NUMBER OF SPECIALTY POSITIONS LOST.—With respect to payments under subsection (a) for an eligible hospital for a calendar year, if the aggregate number of specialty positions lost for the academic year involved is less than such number for the preceding academic year (which difference between the 2 aggregate numbers is referred to in this paragraph as the "decrease in the number of lost positions"), the following applies:

(A) The Secretary shall identify the number of lost positions for which, as determined under paragraph (2) without regard to this paragraph, the percentage applicable to payments for the calendar year is 75 percent, the number of such positions for which such percentage is 50 percent, and the number of such positions for which such percentage is 25 percent.

(B) In the case of the lost positions so identified, the Secretary shall apply the decrease in the number of lost positions as follows:

(i) First, as a reduction in the number of positions for which the percentage applicable is 75 percent.

(ii) Second (for any remaining portions of the decrease after compliance with clause (i)), as a reduction in the number of positions for which such percentage is 50 percent.

(iii) Third (for any remaining portions of the decrease after compliance with clause (ii)), as a reduction in the number of positions for which such percentage is 25 percent.

PART 5—OTHER HEALTH PROFESSIONS PROGRAMS

Subpart A—Graduate Nursing Education

SEC. 7051. FEDERAL PAYMENTS FOR GRADUATE NURSING EDUCATION.

(a) IN GENERAL.—Part B of title VIII of the Public Health Service Act (42 U.S.C. 297 et seq.) is amended by adding at the end the following subpart:

"Subpart IV—Grants Under Health Care Workforce Trust Fund

"FORMULA GRANTS FOR GRADUATE NURSE EDUCATION PROGRAMS

"SEC. 848. (a) GRANTS UNDER HEALTH CARE WORKFORCE TRUST FUND.—

"(1) IN GENERAL.—In the case of each graduate nurse education program that in accordance with subsection (c) submits to the Secretary an application for calendar year 1996 or any subsequent calendar year (in this section referred to as an 'eligible program' for the year involved), the Secretary shall make a grant for the year to the program for the purposes specified in subsection (b). The grant shall consist of the allotment determined for the program under subsection (d).

"(2) TRUST FUND.—Grants under paragraph (1) shall be made from amounts in the Health Care Workforce Trust Fund under section 9512 of the Internal Revenue Code of 198[illegible]. Of the amounts in such Fund, the amount available for carrying out this section for a calendar year is the product of—

"(i) $150,000,000; and

"(ii) the direct-cost Fund payout percentage for the year, as determined under section 7024(c)(4) of the Guaranteed Health Insurance Act of 1994.

"(3) RESERVATION OF AMOUNTS.—Of the amount available under paragraph (2) for carrying out this section for a calendar year, the Secretary may reserve not more than 10 percent for carrying out section 849.

"(b) PURPOSE OF PAYMENTS.—

"(1) IN GENERAL.—The Secretary may make a grant under subsection (a) only if the graduate nurse education program involved agrees that the payments will be expended only for the following purposes:

"(A) Increasing nursing education opportunities for individuals from disadvantaged backgrounds (including members of racial or ethnic minority groups) through the activities authorized in section 827(a).

"(B) Expanding enrollment, including individuals who are not described in subparagraph (A).

"(C) Providing scholarships to students in financial need with preference given to those who agree to practice in health professional shortage areas.

"(D) Developing and supporting programs to provide students with experience in providing primary health care services in noninstitutional settings.

"(E) Developing innovative approaches to delivering services in the cultural context and language most appropriate for the individuals to whom the services are provided.

"(F) Developing programs or otherwise providing for education and training in the identification, treatment, and referral of cases of domestic violence.

"(G) Such other purposes as the Secretary determines to be appropriate.

"(2) ALLOCATION.—The Secretary may make a grant under subsection (a) only if the graduate nurse education program involved agrees that the program will expend not less than 20 percent of the grant to carry out the purpose described in paragraph (1)(A).

"(c) APPLICATION FOR PAYMENTS.—For purposes of subsection (a)(1), an application for a grant under such subsection for a calendar year is in accordance with this subsection if—

"(1) the application is submitted not later than the date specified by the Secretary;

"(2) the application contains the agreements required in this section; and

"(3) the application is in such form, is made in such manner, and contains such agreements, assurances, and informa-

tion as the Secretary determines to be necessary to carry out this section.

"(d) AMOUNT OF PAYMENTS.—

"(1) IN GENERAL.—For purposes of subsection (a), the allotment determined under this subsection for an eligible program for a calendar year is the product of—

"(A) the percentage determined for the program under the formula established by the Secretary under paragraph (2); and

"(B) the amount available under subsection (a)(2) for the year, less any amount the Secretary reserves under subsection (a)(3).

"(2) DEVELOPMENT OF FORMULA.—The Secretary shall establish a formula for purposes of paragraph (1)(A). The formula shall be established by the Secretary on the basis of the following factors (which factors shall be given equal weight):

"(A) The percentage constituted by the ratio of—

"(i) the number of individuals enrolled (or accepted for enrollment) in the eligible program involved; to

"(ii) the sum of the respective numbers determined under clause (i) for each eligible program.

"(B) A factor developed by the Secretary to reflect the operational costs of the program relative to the operational costs of other eligible programs.

"(C) A factor developed by the Secretary to reflect the extent of the need for the nursing professionals involved in medically underserved communities.

"(e) DEFINITION OF GRADUATE NURSE EDUCATION PROGRAM.—For purposes of this section, the term 'graduate nurse education programs' means programs for advanced nurse education, including programs for education as nurse practitioners, programs for education as nurse midwives, programs for education as nurse anesthetists, programs for advanced training in occupational health nursing, other programs for training in clinical nurse specialties determined by the Secretary to require advanced education, and programs in nursing administration.

"(f) REPORT TO CONGRESS.—

"(1) IN GENERAL.—The Secretary shall conduct a study for the purpose of determining the cost incurred in the operation of graduate nurse education programs. In conducting the study, the Secretary shall evaluate the program carried out under subsection (a) and may develop recommendations for improving the program.

"(2) DATE CERTAIN FOR COMPLETION.—Not later than February 1, 1998, the Secretary shall complete the study required in paragraph (1) and submit to the Congress the findings made in the study, including any recommendations developed in the study.

"CATEGORICAL GRANTS REGARDING BASIC NURSE EDUCATION

"SEC. 849. (a) IN GENERAL.—The Secretary may make grants to public and nonprofit schools of nursing for the purpose of improving the capacity of such schools to provide for basic nurse education and practice.

"(b) FUNDING.—Grants under subsection (a) shall be made from such amounts as the Secretary may reserve under section 848(a)(3).".

(b) OTHER MODIFICATIONS REGARDING TITLE VIII.—

(1) IN GENERAL.—Section 851 of the Public Health Service Act (42 U.S.C. 298) is amended—

(A) by striking "(a) There is" and all that follows and inserting the following: "(a) IN GENERAL.—There is established within the Department of Health and Human Services an advisory council to be known as the National Advisory Council on Nurse Education (in this section referred to as the "Council").

"(b) DUTIES.—

"(1) IN GENERAL.—The Council shall provide advice to the Secretary on carrying out this title, including advice on—

"(A) the need for educating additional individuals as advanced practice nurses; and

"(B) matters relating to the program under section 848.

"(2) CERTAIN ACTIVITIES.—The Council may collect and analyze data for purposes of carrying out the duties of the Council under paragraph (1), including data on the number of advanced practice nurses and other health professionals in the various geographic areas of the United States.

"(c) COMPOSITION.—

"(1) IN GENERAL.—The membership of the Council shall include individuals who are appointed to the Council from among individuals who are not officers or employees of the United States. Such individuals shall be appointed by the Secretary, and shall include individuals from each of the following categories:

"(A) Nurse practitioners, nurse midwives, nurse anesthetists, and clinical nurse specialists.

"(B) Schools of nursing, teaching hospitals or other entities that provide health services, and other experts in health care financing, in the delivery of health services, and in education in the health professions.

"(2) REPRESENTATIVE MEMBERSHIP.—To the greatest extent feasible, the membership of the Council shall represent the various geographic regions of the United States, and shall reflect the racial, ethnic, and gender composition of the population of the United States.

"(3) EX OFFICIO MEMBERS; OTHER FEDERAL OFFICERS OR EMPLOYEES.—The membership of the Council shall include individuals designated by the Secretary to serve as members of the Council from among Federal officers or employees who are appointed by the President, or by the Secretary (or by other Federal officers who are appointed by the President with the advice and consent of the Senate). Individuals designated under the preceding sentence shall include each of the following officials (or a designee of the official):

"(A) The Secretary of Health and Human Services.

"(B) The Secretary of Veterans Affairs.

"(C) The Secretary of Defense.

"(d) CHAIR.—The Secretary shall, from among members of the National Council appointed under subsection (c)(1), designate an individual to serve as the Chair of the Council."; and

(B) in the heading for the section, by striking "PRACTICE;" and all that follows and inserting "PRACTICE".

(2) RULE OF CONSTRUCTION.—With respect to the advisory council in effect under section 851 of the Public Health Service Act on the day before the date of the enactment of this Act, individuals who were serving as members of the council may serve as members of the Council established under the amendment made by subsection (a), except as inconsistent with the amendment.

Subpart B—Medical Schools

SEC. 7061. FEDERAL PAYMENTS FOR MEDICAL SCHOOLS.

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

"SEC. 741. FORMULA GRANTS FOR MEDICAL SCHOOLS.

"(a) GRANTS UNDER HEALTH CARE WORKFORCE TRUST FUND.—

"(1) IN GENERAL.—In the case of each school of medicine or osteopathic medicine that in accordance with subsection (c) submits to the Secretary an application for calendar year 1996 or any subsequent calendar year (in this section referred to as

an eligible school for the year involved), the Secretary shall make a grant for the year to the school for the purposes specified in subsection (b). The grant shall consist of the allotment determined for the school under subsection (d).

"(2) TRUST FUND.—Grants under paragraph (1) shall be made from amounts in the Health Care Workforce Trust Fund under section 9512 of the Internal Revenue Code of 1986. Of the amounts in such Fund, the amount available for carrying out this section for a calendar year is the product of—

"(i) $50,000,000; and

"(ii) the direct-cost Fund payout percentage for the year, as determined under section 7024(c)(4) of the Guaranteed Health Insurance Act of 1994.

"(b) EXPENDITURES OF GRANT.—

"(1) IN GENERAL.—The Secretary may make a grant under subsection (a) only if the school involved agrees to expend the grant in accordance with the following purposes:

"(A) The school will carry out a program to recruit and retain minority and disadvantaged individuals (including members of racial or ethnic minority groups).

"(B) The school will carry out a program to encourage students of the school to enter a field in primary health care.

"(C) The school will provide for education and training in the identification, treatment, and referral of cases of domestic violence.

"(D) The school will establish goals for the programs described in subparagraphs (A) through (C) and will monitor the programs to determine the extent to which progress is being made toward achieving the goals.

"(2) CERTAIN AUTHORITIES REGARDING MINORITY AND DISADVANTAGED INDIVIDUALS.—With respect to the program for minority and disadvantaged individuals that is carried out by a school of medicine or osteopathic medicine receiving a grant under subsection (a), the Secretary may authorize the school to expend the grant for the following purposes:

"(A) Identifying, recruiting, and selecting minority and disadvantaged individuals for the program.

"(B) Facilitating the entry of such individuals into the school.

"(C) Providing counseling or other services designed to assist such individuals in successfully completing the educational programs involved.

"(D) Providing, for a period prior to the entry of such individuals into the regular course of education of the school, preliminary education designed to assist the individuals in successfully completing such regular course of education at the school, or referring the individuals to hospitals providing such preliminary education.

"(E) Publicizing existing sources of financial aid available to the individuals for attendance at the school.

"(F) Paying such scholarships as the Secretary may determine for such attendance.

"(G) Paying such stipends as the Secretary may approve for such individuals for any period of education in student-enhancement programs (other than regular courses) at the school, except that such a stipend may not be provided to an individual for more than 12 months, and such a stipend shall be in an amount of $40 per day (notwithstanding any other provision of law regarding the amount of stipends).

"(3) ALLOCATION.—The Secretary may make a grant under subsection (a) only if the school involved agrees that the school will expend not less than 20 percent of the grant to carry out the purposes described in paragraph (2).

"(c) APPLICATION FOR PAYMENTS.—For purposes of subsection (a)(1), an application for a grant under such subsection for a calendar year is in accordance with this subsection if—

"(1) the application is submitted not later than the date specified by the Secretary;

"(2) the application contains the agreements required in this section; and

"(3) the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this section.

"(d) AMOUNT OF PAYMENTS.—

"(1) IN GENERAL.—For purposes of subsection (a), the allotment determined under this subsection for an eligible school for a calendar year is the product of—

"(A) the percentage determined for the school under the formula established by the Secretary under paragraph (2); and

"(B) the amount determined under subsection (a)(2) for the year.

"(2) DEVELOPMENT OF FORMULA.—The Secretary shall establish a formula for purposes of paragraph (1)(A). Subject to paragraph (3), the formula shall be established by the Secretary on the basis of the following factors (which factors shall be given equal weight):

"(A) The number of minority and disadvantaged individuals enrolled (or accepted for enrollment) in the entering class of the eligible school involved for the academic year in which the calendar year begins, plus the number of minority and disadvantaged individuals to whom the contingency described in subsection (e) applies (subject to not counting any individual more than once for purposes of this subparagraph).

"(B) Of the individuals graduating from the school for the academic year that is 6 years prior to the academic year involved, the number of individuals who have entered a postgraduate residency training program in a field of primary health care.

"(3) MINIMUM FORMULA AMOUNT FOR CERTAIN SCHOOLS.—If for the year involved an eligible school is a grantee under section 740, the Secretary shall ensure that the amount determined pursuant to paragraph (1)(A) for the school is not less than the amount of the grant made under section 740 to the school for fiscal year 1994, or fiscal year 1995, whichever is greater, subject to the school agreeing to expend the grant under subsection (a) to reach the goals established for the school under section 740 regarding the recruitment and retention of minority and disadvantaged individuals. The Secretary shall waive the requirement of such agreement if the Secretary determines that the goal for the school has been reached.

"(e) PAYMENTS BY MEDICAL SCHOOLS FOR OFF-SCHOOL EDUCATION.—The Secretary may make a grant under subsection (a) for a calendar year only if the school involved agrees that if, for the academic year beginning in such calendar year, 1 or more students is enrolled (or accepted for enrollment) in the school on the contingency of successfully completing for the academic year a substantial number of hours in medical education through an educational institution that does not operate a school of medicine or osteopathic medicine, and if the school provides credit toward a doctorate in medicine for the hours successfully completed at such other institution, then the school will pay to the other institution for such calendar year an amount equal to the product of—

"(1) the amount of the grant under subsection (a) for the calendar year; and

"(2) the percentage constituted by the ratio of—

"(A) the number of such students attending the other institution for the academic year; to

"(B) the total number of individuals enrolled (or accepted for enrollment) in the eligible school involved for the academic year in which the calendar year begins, plus the number of individuals to whom the contingency described in this subsection applies (subject to not counting any individual more than once for purposes of this subparagraph).".

PART 6—MISCELLANEOUS PROVISIONS

SEC. 7071. STUDY OF FUNDING NEEDS OF HEALTH PROFESSIONS SCHOOLS.

(a) IN GENERAL.—The Secretary shall conduct a study for the purpose of determining the funding needs of health professions schools, including schools of medicine and osteopathic medicine, and schools of dentistry.

(b) CONSIDERATION OF CERTAIN COSTS.—In conducting the study under subsection (a), the Secretary shall also consider the following costs regarding the funding needs of health professions schools:

(1) Uncompensated costs incurred in providing health care.

(2) Costs resulting from reduced productivity due to teaching responsibilities.

(3) Increased costs of caring for the health needs of patients with severe medical complications.

(4) Uncompensated costs incurred in conducting clinical research.

(5) The impact of competitive health plans on payments for professional services delivered by faculty.

(6) The costs associated with changes in medical education from hospital inpatient to ambulatory, nonhospital sites.

(c) CONSIDERATIONS REGARDING ADDITIONAL FUNDING.—In conducting the study under subsection (a), the Secretary shall determine the following:

(1) Whether the health professions schools involved have a significant need for an increase in the amount of funds available to the schools.

(2) If there is such a need—

(A) recommendations regarding the sources of funds to provide the increase; and

(B) recommendations for a methodology for determining the amount that should be provided to the schools involved.

(d) REPORT TO CONGRESS.—Not later than 18 months after the date of the enactment of this Act, the Secretary shall submit to the Congress a report describing the findings and recommendations made in the study.

SEC. 7072. ADDITIONAL STUDIES.

(a) PAYMENT AMOUNTS REGARDING GRADUATE MEDICAL EDUCATION.—

(1) IN GENERAL.—The Secretary shall conduct a study to determine whether the program of payments under section 7021 should be modified (relating to payments to approved physician training programs). Factors considered in the study shall include the following factors:

(A) The effect on educational costs of hospital size, faculty salary levels, and geographic region (including location in urban areas and area wage rates).

(B) Variations in costs associated with training in ambulatory settings, including community health centers, managed care organizations, and hospital outpatient clinics.

(C) Variations in costs associated with the operation of approved physician training programs in different medical specialties.

(D) Whether payments to training participants should vary according to which year of training the participant is in.

(E) Whether additional factors should be included under section 7024(c)(3) regarding adjustments in the amount of payments.

(F) Whether, for purposes of section 7024(c), approved physician training programs in podiatric medicine should receive payments on the basis of a national average FTE training amount that is specific to podiatric medicine.

(2) INDEX REGARDING COST VARIATIONS.—The Secretary shall conduct a study for the purpose of developing an index, for use in the program under section 7021, to reflect variations by geographic area in the costs incurred in operating approved physician training programs.

(b) RETRAINING OF PHYSICIANS REGARDING PRACTICING IN PRIMARY HEALTH CARE.—With respect to physicians who do not practice in primary health care, the Secretary shall conduct a study to determine the feasibility of retraining the physicians as practitioners in such care.

(c) DATE CERTAIN FOR COMPLETION.— Not later than February 1, 1997, the Secretary shall complete the studies required in subsections (a) and (b) and submit to the Congress reports describing the findings made in the studies.

PART 7—GENERAL PROVISIONS

SEC. 7081. DEFINITIONS.

For purposes of this subtitle:

(1) The term "academic year" has the meaning given such term in section 7001(a)(3).

(2) The term "aggregate lost position amount" has the meaning given such term in section 7041(e).

(3) The term "aggregate nonmedicare training amount" has the meaning given such term in section 7024(c)(2).

(4) The term "aggregate number of specialty positions lost" has the meaning given such term in section 7041(b)(1)(B).

(5) The term "applicable per discharge training amount" has the meaning given such term in section 7024(e)(1)(C).

(6) The term "applicable period" has the meaning given such term in section 7001(a)(3).

(7) The term "approved physician training program" has the meaning given such term in section 7012(d).

(8) The term "Council" has the meaning given such term in section 7011(a).

(9) The term "direct-cost Fund payout percentage" has the meaning given such term in section 7024(c)(4).

(10) The term "full-time-equivalent training participant" has the meaning given such term in section 7024(g)(2).

(11) The term "indirect-cost Fund payout percentage" has the meaning given such term in section 7024(d)(3).

(12) The term "lost position" has the meaning given such term in section 7041(b)(1)(B).

(13) The term "medical school" has the meaning given such term in section 7012(d).

(14) The term "medical specialty" has the meaning given such term in section 7012(d).

(15) The term "national average FTE training amount" has the meaning given such term in section 7024(c)(3).

(16) The term "nonmedicare per-discharge supplemental payment" has the meaning given such term in section 7024(d)(2).