SUBTITLE D - CORE FUNCTIONS OF PUBLIC HEALTH PROGRAMS; NATIONAL INITIATIVES REGARDING PREVENTIVE HEALTH (H.R. 3600 and S. 1757 p. 564)

PART 1 - FUNDING

Section 3301. Authorization of Public Health Services Funds. (a) The following amounts are authorized for "core" public health functions including surveillance for communicable diseases and occupational hazards. The amount of the authorization is $12,000,000 for fiscal 1995, $325,000,000 for fiscal 1996, $450,000,000 for fiscal 1997, $550,000,000 for fiscal 1998, and $650,000,000 for fiscal year 1999, and $750,000,000 for fiscal year 2000.

(b) Funds are also authorized for national initiatives regarding health promotion and disease prevention. Amounts authorized are $175,000 for fiscal year 1996 and $200,000 in each of fiscal years 1997 through 2000.

(c) Funds authorized under this section are in addition to any other authorized appropriations available for these purposes.

PART 2 - CORE FUNCTIONS OF PUBLIC HEALTH

Section 3311. Purposes. The purposes of activities authorized by the subtitle are to strengthen the capacity of state and local health agencies to perform the following core public health functions:

(1) Monitoring and protecting communities from communicable diseases and exposures to occupational hazards, harmful products and poor quality health care.

(2) Identifying and controlling outbreaks of infectious diseases and patterns of chronic disease and injury.

(3) Providing information for consumers and providers of health care regarding preventive health and the appropriate use of medical care.

(4) The testing and development of new public health control and prevention interventions.

Section 3312. Grants To States For Core Health Functions.(a) Authorizes the Secretary to make grants to states for one or more core public health functions.

(b) The core functions include the following:

(1) Activities to measure population health and monitor (health) outcomes, collection of health data, vital statistics and personal health services data; also analysis for planning and needs assessments, of data supplied by health plans through the information system authorized in title V of the legislation;

(2) Environmental protection activities and activities to assure the safety of

food, housing, workplace and water, including monitoring public health, lead exposure, sewage and solid waste, abatement of lead hazards, recreation and worker safety, and enforcement of public health and sanitary codes;

(3) Investigation and control of adverse health conditions including improvements in emergency treatment preparedness, surveillance and control of environmental health hazards, cooperative activities to reduce violence, outbreaks of disease, and exposure to other health threats;

(4) Public information and education to reduce health risks from use of tobacco, alcohol and other drugs, behavior that increases risk of transmission of HIV and sexually-transmitted diseases, inadequate diet, inactivity and low childhood immunization levels;

(5) Accountability and quality assurance activities including monitoring the quality of personal health services and monitoring community access to health care;

(6) The provision of public health laboratory services such as assessments of blood levels of environmental toxins;

(7) Training and educating public health professionals;

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

(c) States are prohibited from using grant monies to acquire or improve facilities, land, or acquire major medical equipment, to make cash payments to intended recipients of grant-funded health services, to provide inpatient services or to assist entities other than public or private non-profit entities. No more than ten percent of funds may be spent for administrative expenses.

(d) States are required to maintain the same level of state funding for core activities as in the year before the first year in which a core services grant is received.

Section 3313. Submission of Information. The Secretary may make grants only if states submit the following information:

(1) A description of the deficiencies in their current public health systems, using standards of sufficiency developed by the Secretary;

(2) A description of the health-status measures to be improved through expanded public health functions;

(3) Measurable outcomes and process objectives for improving health status and core health functions;

(4) For each public health function to be undertaken, state and local funding for the year prior to the year in which the grant is sought as well as a detailed description of how additional Federal funding will improve the functioning of state and local public health agencies;

(5) A description of the core health functions to be carried out at the local level and the amount of funds to be spent in each community.

Section 3314. Reports. Not later than the date specified by the Secretary, states

must as a condition of funding report to the Secretary on the purposes for which grants were spent and the extent of progress made in achieving measurable outcomes.

Section 3315. Application for Grant. The Secretary may make a grant only if an application includes each agreement described above and the information required in section 3314; also, the application must be in the form and made in the manner required by the Secretary. The application must include any assurances, agreements or information that the Secretary determines are needed.

Section 3316. General Provisions. (a) The Secretary must, in consultation with states, develop uniform data sets for monitoring core health functions.

(b) The duration of a grant is limited to five years, during which annual approval of payments by the Secretary are required. The foregoing may not be interpreted to limit the number of grants a state may receive.

Section 3317. Allocations for Certain Activities. The Secretary may reserve up to five percent of grant funds for carrying out the following activities:

(1) provision of technical assistance with respect to planning, development, and operation of core functions including provision of statistical expertise;

(2) development and operation of a national information network among state and local health agencies;

(3) program monitoring and evaluation of core health functions;

(4) development of a unified electronic reporting mechanism to improve management of Federal grants to state public health agencies.

PART 2 - NATIONAL INITIATIVES REGARDING HEALTH PROMOTION AND DISEASE PREVENTION

Section 3331. Grants for National Prevention Initiatives. (a) The Secretary may make grants to state or local government agencies, private non-profit organizations, and coalitions of such agencies and organizations for developing and implementing community-based health-promotion and disease-prevention activities and strategies.

(b) Eligible entities are units of state and local government, private non-profit organizations (including research institutions) and coalitions that link two or more of these groups.

(c) The Secretary shall assure that projects under this subsection reflect approaches that take into account the special needs of the affected populations, are targeted to needy and vulnerable groups, examine the link between high priority health problems and potential community-based action, and establish and strengthen links between public health agencies

and health plans, alliances, providers and the health care delivery system.

Section 3332. Priorities. (a) The Secretary must establish annual priorities for grants and must allocate funds in accordance with priorities. The Secretary shall publish a statement of priorities in the Federal Register by January 1 and take comments. A final list of priorities for the following fiscal year must then be published.

(b) Grantmaking shall be consistent with the statement of priorities and shall give priority to projects that are potentially replicable.

Section 3333. Submission of Information. Applicants must submit to the Secretary information describing the activities to be conducted and how such activities will contribute to a priority health need, as well as descriptions of the total amount of funding requested, the geographic area and populations to be served, evaluation procedures to be followed and such other information as the Secretary specifies.

Section 3334. Application for a Grant. The Secretary may make grants only if applications are submitted in a form and manner as the Secretary requires.

SUBTITLE E - HEALTH SERVICES FOR MEDICALLY UNDERSERVED POPULATIONS (H.R. 3600 and S. 1757 p. 578)

PART 1 - COMMUNITY AND MIGRANT HEALTH CENTERS

Section 3401. Authorization of Appropriations. (a) Authorizes funds in addition to other authorized funds for community and migrant health centers.

(b) The additional funds authorized are $100,000,000 per year for each of fiscal years 1995 through 2000.

(c) These funds are in addition to other funds available for the centers.

Section 3402. Use of Funds The additional funds authorized may be used for any purposes authorized under sections 329 or 330 of the Public Health Service Act as well as to establish and maintain the financial reserves that are required under Title I for providers of health services.

PART 2 - INITIATIVES FOR ACCESS TO HEALTH CARE

SUBPART A - PURPOSES; FUNDING

Section 3411. Purposes. The purposes of this program are:

(1) to improve access of medically underserved populations to health services through a program of flexible grants, contracts and loans;

(2) to establish transition to a system in which medically underserved populations have adequate choice of community-oriented providers and health plans;

(3) to promote the development of community practice networks and health plans that integrate public and private health providers in underserved areas;

(4) to support linkages between provider of care to underserved populations and regional and corporate alliance health plans; and

(5) to expand system capacity with additional practice sites and improvements in health-care facilities in need of repair.

(6) to link providers in underserved areas with each other, regional health care institutions and academic health centers.

(7) to support activities enabling underserved populations to gain access to and effectively use the health care system.

Section 3412. Authorizations of Appropriations. For the development of community health plans and networks there are authorized to be appropriated $200 million in fiscal 1995, $500 million in fiscal 1996, $600 million for fiscal 1997, $700 million for fiscal year 1998, $500 million for fiscal year 1999, and $200 million for fiscal year 2000. These

funds are in addition to other funds authorized for this program. Funds under this part are also available for use under section 3692 (school health services).

SUBPART B - DEVELOPMENT OF QUALIFIED COMMUNITY HEALTH PLANS AND PRACTICE NETWORKS

Section 3421. Grants and Contracts for the Development of Plans and Networks.

(a) The Secretary may make grants for developing qualified community health plans and community practice networks. These plans and networks may be, in this title, referred to as community health groups.

(b) To be a qualified community health plan, a health plan must be public or non-profit private entity whose principal purpose is to provide the comprehensive benefit package, in areas with shortages of medical personnel or to populations with a significant number of medically underserved persons; the plan must be a member of one or more health alliances; and two or more of the categories of providers specified in subsection (d) must be represented in the plan.

(c) A qualified community practice network means a consortium of health care providers that is a public or private non-profit entity whose principal purpose is to provide services to underserved populations or in health professions shortage areas, which has an agreement with one or more health plans and whose members are governed by a written agreement. Two or more categories of providers in subsection (d) must be included in the consortium.

(d) The relevant categories of providers described in subsections (b) and (c) are the following:

(1) physicians or other health professionals or health care institutions providing care in a shortage area or to an underserved population;

(2) migrant and community health centers;

(3) entities funded under sections 340 and 340A of the Public Health Service Act (homeless health care providers and health care providers in public housing);

(4) entities furnishing health services under Section 1001 or Title XXIII of the Public Health Service Act (family planning clinics and Ryan White program providers);

(5) entities furnishing services under Title V of the Social Security Act (maternal and child health);

(6) entities that are rural health clinics or federally qualified health centers;

(7) entities providing health services to Indians in urban areas under Title V of the Indian Health Care Improvement Act or outpatient services to Indians through the Indian Self Determination Act; and

(8) state or local public health agencies.

The Secretary also may make grants to a health plan that is not a community health

plan but that seeks to develop a community practice network with the entities described in this subsection.

Section 3422. Preferences in Making Grants. In making grants, the Secretary shall give the preference to those applications in which a maximum number of entities described in section 3421(d) are represented and added weight if a large group also includes private physicians, other health professionals or institutions that provide health services in a health professions shortage area, or provide health services to significant numbers of ilndividuals in medically underserved populations.

Section 3423. Certain Uses of Awards. (a) Awards under section 3421 may be spent for the following purposes:

(1) planning the network or health plan, including entering into contracts;
(2) recruitment and compensation of health and administrative staff;
(3) acquisition and expansion of facilities;
(4) acquisition and development of information systems;
(5) other expenditures recognized by the Secretary.

(b) An award that includes funding for capital costs must obligate the recipient to the United States for the amount of the award, plus interest during the 20 year period beginning on the date of completion, if the applicant ceases to be a qualified health plan or network or is sold or transferred to an entity that is not a community health plan or network.

Section 3424. Accessibility of Services. (a) Community health plans and networks must assure that their services are available to persons seeking care, whether or not they are eligible individuals under title I.

(b) A community health group's providers must be approved as Medicare and Medicaid providers. A group must seek reimbursement for the cost of caring for persons entitled to benefits under Title I, Medicare, Medicaid, any other public assistance programs, or private health insurance plans.

(c) The network or plan must prepare a fee schedule that is consistent with local rates and a corresponding schedule of discounts to be determined by a patient's ability to pay.

(d) The plan or network must maximize the accessibility of its services to residents in its area by eliminating barriers resulting from geographical or demographic characteristics, including limited ability of patients to speak English. A plan or network also must periodically determine the accessibility of its services.

Section 3425. Additional Agreements. (a) Networks and plans must provide enabling services (as defined in section 3461(g)) as part of their funding agreement.

(b) Networks and plans must maintain ongoing systems for patient-oriented,

community-responsive quality control, and for collecting and making public information on costs, health-care and financial performance, and other matters.

(c) The plan or network must agree to maximize its use of existing resources.

Section 3426. Submission of Certain Information. (a) The Secretary may make grants only if applicants submit information on the needs (including the need for enabling services) of the medically underserved population to be served by the applicant.

(b) The applicant must also include a description of how the applicant will design the plan or network, a description of efforts to secure financial and technical assistance, and evidence of significant community involvement in the initiation, development and ongoing operation of the project.

Section 3427. Reports; Audits. Funded plans and networks must provide reports and information as required by the Secretary and must submit to annual audits.

Section 3428. Application for Assistance. Applications must include the agreements and information required in other sections of the subtitle and additional agreements and information that the Secretary deems necessary.

Section 3429. General Provisions. (a) The Secretary may not make more than two grant awards under section 3421 for the same project.

(b) The Secretary may determine the amount to be granted for any project.

SUBPART C - CAPITAL COST OF DEVELOPMENT OF QUALIFIED COMMUNITY HEALTH PLANS AND PRACTICE NETWORKS

Section 3441. Loans and Loan Guarantees Regarding Plans and Practice Networks. (a) The Secretary may make loans to public and private entities for capital costs of developing qualified community health groups, and may also guarantee such loans by Federal and non-Federal lenders.

(b) The Secretary shall use the same preferences in making loans that apply to grants under section 3421.

(c) Funds under this section may be used to finance facilities, major equipment, including information systems, to establish financial reserves and other capital costs that are necessary to the purpose of the section (as determined by the Secretary). Priorities shall be placed on loans to modernize facilities, prevent or eliminate safety hazards, and to repair or replace obsolete facilities.

(d) The principal of the loan or loan guarantee, when added to other assistance under

this section, may cover up to 100 percent of the costs involved.

Section 3442. Certain Requirements. (a) The Secretary may approve loans only if reasonably satisfied that the grantee can repay the loan, and only if the grantee provides assurances that additional funds are available to complete the project for which the loan is made. Also, a loan under section 3441 must be on the terms and conditions that are necessary to protect the financial interests of the United States (as determined by the Secretary).

(b) The Secretary may guarantee loans only if the loan conditions, terms and arrangements for repayment are sufficient to protect the financial interests of the United States. Such guarantees are also subject to further terms as determined by the Secretary.

(c) An applicant for a loan or loan guarantee must agree to use existing resources to the maximum extent feasible.

Section 3443. Defaults; Right of Recovery. (a) The Secretary may take necessary action, including waiver of regulatory conditions, deferral of loan repayments or other actions as needed to prevent a default on a loan or loan guarantee. The Secretary may also foreclose a loan in default, or waive, for good cause, any right of recovery from a borrower who fails to make payments on a loan. A waiver of the right of recovery does not modify the Secretary's obligation to make payments for a loan that has been sold and guaranteed.

(b) A loan becomes due and payable immediately if a facility for which loan funds have been used is sold within 20 years after the federally-financed work on it is completed. The loan becomes due if sale is to an entity not eligible for assistance under the section, or not approved by the Secretary, or if the facility ceases to be a public or nonprofit private entity eligible for assistance. The Secretary may also subordinate or waive the right of recovery and any other Federal interest based on a loan or loan guarantee for capital projects, if such waiver(s) would further the purpose of serving medically underserved populations.

Section 3444. Provisions Regarding Construction or Expansion of Facilities. (a) The Secretary may provide loans or loan guarantees for the construction, conversion expansion or modernization of a facility, only if the applicant describes the facility site, provides plans and specifications which meet the Secretary's requirements, and demonstrates that title is vested in one or more of the applicants.

(b) An applicant for a loan must make the following agreements:

(1) Title to the site will be vested in one or more of the applicants;

(2) Adequate financial support is available for completing and maintaining and operating the facility;

(3) The construction contract complies with the Davis Bacon Act (relating to payment of laborers); and

(4) The facility will be available to persons seeking service there, regardless of their ability to pay.

Section 3445. Application for Assistance. The Secretary may provide assistance only if the applicant files the application in the form and manner prescribed by the Secretary.

Section 3446. Administration of Programs. The loans and loan guarantees for capital projects must be administered from a centralized unit in the Department of Health and Human Services.

SUBPART D - ENABLING SERVICES

Section 3461. Grants for Enabling Services. (a)(1) The Secretary may make grants to qualified community health groups (plans and networks) and to other public and private non-profit groups that provide services in one or more health professional shortage areas or to medically underserved populations and are experienced in providing services to increase the capacity of individuals to use health services. The grants are to be used to provide enabling services.

(b) Enabling services are transportation, community and patient outreach, patient education, translation services, and other services that would increase the capacity of individuals to use the comprehensive benefits to which the Act entitles them.

(c) Grants may be made only if the applicant submits information demonstrating the need for the services, a proposed grant budget and evidence of significant community involvement in the project.

(d) Grant applicants must agree not to charge fees for grant-funded enabling services.

(e) Grant applicants must make maximum use of existing resources.

(f) Applications must be filed in a form and manner prescribed by the Secretary, and include agreements and assurances deemed necessary by the Secretary.

(g) Enabling services are services described in subsection (b), when furnished by an entity described in subsection (a).

PART 3 - NATIONAL HEALTH SERVICE CORPS

Section 3471. Authorization of Appropriations. (a) Funds for carrying out subpart II of part D of title III of the Public Health Service Act, and section 3472 of the Health Security Act, are authorized in the following amounts: $50,000,000 for fiscal year 1995, $100,000,000 for fiscal year 1996, and $200,000,000 for each of fiscal years 1997 through 2000.

(b) The authorizations are in addition to funds otherwise authorized.

(c) Funds may be appropriated under this section at any time before the fiscal year for which they are appropriated.

Section 3472. Allocation for Participation of Nurses in Scholarship and Loan Repayment Programs. Of amounts appropriated under section 3471, the Secretary shall reserve such amounts as may be needed to ensure that of the aggregate number of persons participating in the scholarship program or loan repayment program of the National Health Service Corps (section 338A of the Public Health Service Act), the total proportion of individuals being educated as or serving as nurses increases to 20 percent.

PART 4 - PAYMENTS TO HOSPITALS SERVING VULNERABLE POPULATIONS

Section 3481. Payments to Hospitals. (a) The Secretary shall make payments to eligible hospitals from funds made available under this part. The amounts specified in subsection (b) must be made available to the Secretary on behalf of eligible hospitals, but payment is not guaranteed to the state in which an eligible hospital is located or to any individual receiving services from the hospital.

(b)(1) The total amount of the payments is $800,000,000 for the fiscal year in which the general effective date occurs and for each subsequent year.

(2) For any year prior to the general effective date, the amount specified shall equal the aggregate disproportionate share hospitals (DSH) percentage of the amount otherwise available under this section. The aggregate DSH percentage is equal to the percent of total payments to DSH hospitals in all states represented by the payments to DSH hospitals in participating states.

(c) Hospitals qualifying for payments shall receive them for five years, without regard to the first year in which a hospital receives payment.

(d) Payments shall be made on a quarterly basis.

Section 3482. Identification of Eligible Hospitals. (a) In order to qualify for payments, a hospital must be located in a participating state. However, a qualifying hospital may continue to receive payments even if the state in which it is located is no longer a participating state.

(b) States shall identify for the Secretary those hospitals that meet the qualification criteria.

(c) In order to qualify, a hospital must have a low income percentage caseload (as defined in section 1923(b)(3) of the Social Security Act) during the base year of not less

than 25 percent.

Section 3483. Amount of Payments. (a) Of total amounts available for payment, 75 percent shall be allocated based on the hospital's low income percentage of the allocation for the year.

(b) Twenty-five percent of the total shall be allocated to hospitals for services that are not covered services under the Act. The Secretary shall develop an allocation methodology.

(c) An eligible hospital's low income percentage shall equal the amount of all low income days attributable to the hospital. Low income days equal the total amount of inpatient days multiplied by the hospital's low income utilization rate under section 1923(b)(3).

Section 3484. Base Year. The base year is the year prior to the year of the general effective date of this Act.

SUBTITLE F - MENTAL HEALTH; SUBSTANCE ABUSE
(H.R. 3600 and S.1757 p. 615)

PART 1 - FINANCIAL ASSISTANCE

Section 3501. Authorization of Appropriations. (a) Funds are authorized for the purposes of this subtitle in the following amounts: $100,000,000 in fiscal year 1995; $150,000,000 in fiscal year 1996, and $250,000,000 for each of fiscal years 1997 through 2000.

(b) Of amounts made available, the Secretary shall reserve as much as is deemed appropriate for activities under section 3503. Of the remaining amounts, the Secretary shall reserve 50 percent for activities described in subsection (a) of section 3502 and 50 percent for activities under subsection (b) of section 3502.

(c) The amounts authorized above are in addition to any other funds authorized for the same purposes.

Section 3502. Supplemental Formula Grants for States Regarding Activities Under Part B of Title XIX of the Public Health Service Act. (a) The Secretary shall make mental health grants to states that have submitted applications meeting the requirements of subsection (e). The allotment formula shall be the same one used under section 1918(a)(2) of the Public Health Service Act.

(b) The Secretary shall make grants for substance abuse services to states that have submitted applications. The amounts of the grants are determined by using the formula under section 1933(a)(1)(B)(i) and section 1918(a)(2)(A).

(c)(1) The Secretary shall approve grant uses that are consistent with the mental health and substance abuse activities that are described in this section. The state must agree to spend grant funds in accordance with the Secretary's approved uses.

(2) Approved uses are as follows:

(A) transportation and translation, patient and community outreach, patient education, and such other services as the Secretary deems appropriate for the purpose of increasing the access of individuals to services relating to mental health and substance abuse;

(B) improving the capacity of state and local service systems to coordinate and monitor mental health and substance abuse services, improving information systems, and establishing linkages between mental health and substance abuse services and primary care providers and health plans;

(C) providing incentives to integrate public and private systems

for treatment of mental health and substance abuse treatment systems; and

(D) any activity for which a grant may be made under sections 1911 and 1921 of the Public Health Service Act.

(d) As a condition of grant receipt, a state, may not reduce its funding for mental health and substance abuse activities below the level spent in the fiscal year preceding the first year for which the state receives the grant. The Secretary may waive this requirement if the state agrees to spend the funds that would otherwise be subject to the requirement on the developing community based care systems for the eventual integration of the public and private systems for treating mental health or substance abuse (as applicable to the grant).

(e) The state's application must be submitted in a form, time and manner and include agreements and assurances as required by the Secretary.

Section 3503. Capital Costs of Development of Certain Clinics and Centers. (a) The Secretary may make loans and loan guarantees to public and non-profit private entities, for the capital costs of developing non-acute, residential treatment centers and ambulatory clinics.

(b) Priority must be given to loan and loan guarantees for centers and clinics in areas with a health professions shortage or with significant numbers of medically underserved individuals.

(c) Loans and loan guarantees shall be made only in accordance with procedures in subpart C of Part 2 of subtitle E.

PART 2 - AUTHORITIES REGARDING PARTICIPATING STATES

SUBPART A - REPORT

Section 3511. Report on Integration of Mental Health and Substance Abuse Systems.

(a) As a condition of being a participating state, each state must submit, not later than October 1, 1998, a plan to achieve the integration of state and local mental health and substance abuse services with services that are included in the comprehensive benefit plan.

(b) The state's report shall contain the following information:

(1) the number of persons served by state and local mental health and substance abuse systems and the proportion who are eligible persons under title I of the Act;

(2) services furnished to eligible persons, including each type of benefit furnished, the diagnoses for which the benefits are furnished, the amount, duration and scope of coverage of each benefit furnished, applicable limits on benefits, and

cost-sharing rules that apply;

(3) the extent to which mental health and substance abuse providers providing services under a state plan participate in alliance health plans and reasons for any lack of participation by these providers;

(4) the amount of revenues from health plans received by mental health and substance abuse providers that do participate in health plans and that are funded under one or more state program(s);

(5) the amount spent by the state and its political subdivisions in each of the two years before it became a participating state, for items and services covered in the comprehensive benefit package; also, the amount spent on medically necessary care not included in the benefit package, including medical and other health care and related supportive services;

(6) an estimate of the amount the state will need to spend on uncovered benefits and services after mental health and substance abuse services are expanded in the year 2001;

(7) a description of how the state will assure that all eligible individuals served by state-funded mental health and substance abuse programs will be enrolled in a health benefit plan and how mental health and substance abuse services not covered in the benefit package will continue to be furnished;

(8) a description of the conditions under which integration of mental health and substance abuse providers into health plans can be achieved and an identification of changes in provider participation and health plan certification requirements that are needed to achieve integration; and

(9) if integration is not medically appropriate or feasible for one or more groups of individuals treated in state programs, a description of the reasons therefor, and a plan for assuring coordination of care and services covered in the benefit package and the state program for these people.

(c) Reports shall be submitted in a form and manner prescribed by the Secretary.

SUBPART B - PILOT PROGRAM

Section 3521. Pilot Program. (a) The Secretary shall establish a pilot program to demonstrate model methods of integrating mental health and substance abuse services with the mental health and substance abuse services covered in the comprehensive benefit package under title I.

(b) In establishing the pilot program, the Secretary must consider the following factors:

(1) the types of items and services needed by patients in addition to those covered under Title I;

(2) optimal methods of treating persons with long term mental illness and substance abuse conditions;

(3) the capacity of alliance health plans to furnish such treatment;

(4) necessary modifications in coverage and services furnished by health plans; and

(5) the role of publicly funded providers in integrating acute and long-term treatment.

SUBTITLE G - COMPREHENSIVE SCHOOL HEALTH EDUCATION; SCHOOL-RELATED HEALTH SERVICES
(H.R. 3600 and S. 1757 p. 627)

PART 1 - GENERAL PROVISIONS

Section 3601. Purposes. The purposes of activities authorized in this subtitle are to:

(1) support, in kindergarten through grade 12, sequential, age appropriate comprehensive health education programs that address locally relevant priorities;

(2) establish a national framework for comprehensive school health education programs, focused on such health-risk behaviors as drug abuse, sexual behavior resulting in HIV and other sexually-transmitted diseases, unintended pregnancy, injuries and other unhealthy lifestyles; the framework must also allow for integration of the school health plans with state plans for achieving national education and health goals for the year 2000;

(3) support planning and establishing the school health programs;

(4) support research, evaluation, training and technical assistance;

(5) motivate youth to stay in school and strive for success;

(6) improve the knowledge and skills of children by integrating academic, experiential learning with other elements of comprehensive health education; and

(7) further national education and health goals for the year 2000.

Section 3602. Definitions. (a) Comprehensive school health education programs means programs that address locally relevant priorities and that meet the following conditions:

(1) the program is sequential and age and developmentally appropriate;

(2) the program is provided every year for every student from kindergarten through grade 12;

(3) the program provides comprehensive health education that addresses community, environmental, personal health, family life, substance abuse, growth and development, nutritional health, prevention and control of disease, safety and prevention of injuries, consumer health and health education;

(4) the program promotes personal responsibility for a healthy lifestyle;

(5) the program is culturally sensitive in the content of its instructional materials and approaches;

(6) the program includes activities that support instruction;

(7) the program involves families, community organizations and other appropriate entities;

(8) the program is coordinated with other Federal, state and local programs; and

(9) the program focuses on the health concerns of students in the state, school district or school.

(b)(1) The term local education agency has the meaning given under section 1471 (12) of the Elementary and Secondary Education Act;

(2) the term state education agency has the meaning given under section 1471(23) of the Elementary and Secondary Education Act.

PART 2 - SCHOOL HEALTH EDUCATION; GENERAL PROVISIONS

Section 3611. Authorization of Appropriations. (a) For purposes of carrying out parts 3 and 4 (grants to states and local education agencies respectively), the following amounts are authorized: $50,000,000 for each of fiscal years 1995 through 2000.

(b) Of amounts appropriated under subsection (a) the Secretary may allocate up to $13,000,000 of appropriated funds for local education agency grants under part 4, and up to $5,000,000 for such national leadership activities as research and demonstration, evaluation, and training and technical assistance in comprehensive school education. The Secretary may use up to five percent of the funds for administrative expenses of carrying out parts 3 and 4.

(c) Funds authorized under this part are in addition to other authorizations.

Section 3612. Waivers of Statutory and Regulatory Requirements. (a) (1) The Secretaries of Health and Human Services and of Education may waive restrictions on the use of funds under the Federal programs identified below, if the following conditions are met:

(A) the requirement to be waived impedes achievement of the purposes of parts 3 and 4;

(B) the Secretary determines that the requested use (requiring the waiver) would be consistent with parts 3 and 4;

(C) a state education agency making the request has provided for notice to and comment on the waiver request by local education agencies;

(D) a local education agency or other entity making a waiver request has submitted the request to the state education agency for review;

(2) The programs subject to waiver are: (i) Prevention, Treatment and Rehabilitation Model Projects for High Risk Youth under section 517 of the Public Health Service Act; (ii) State and Local Comprehensive School Health Programs to Prevent Important Health Problems and Improve Educational Outcomes under Section 517 of the Public Health Service Act; (iii) Part B programs under the Drug Free Schools and Communities Act of 1986.

(b) A waiver may not exceed 3 years but may be extended if the waiver has been effective in the purpose for which it was granted, and if the extension is in the public interest.

(c) The Secretaries may not waive statutory and regulatory requirements relating to the following:

(1) comparability of services;
(2) maintenance of effort;
(3) equitable participation of students in private schools;
(4) parental involvement;
(5) distribution of funds;
(6) maintenance of records;
(7) civil rights; and
(8) the requirements of sections 438 and 439 of the General Education Provisions Act.

PART 3 - SCHOOL HEALTH EDUCATION; GRANTS TO STATES

SUBPART A - PLANNING GRANTS FOR STATES

Section 3621. Application for Grants. (a) A state education agency shall submit a planning grant application in the form and manner prescribed by the Secretary.

(b) An application must be developed jointly by state health and education agencies and must include:

(1) an assessment of the state's need for comprehensive school health education, as measured by goals established by the departments of Health and Human Services and Education and state goals;
(2) a description of how the state education and health agencies will collaborate in the development of a comprehensive school health education program in the state, including coordination of existing programs and resources;
(3) a plan to build capacity at the local level to provide for staff development and technical assistance for local education agency and health agency staff;
(4) a preliminary evaluation plan;
(5) information demonstrating that the state has established an advisory council with representation from state agencies with principal responsibilities for health, education and mental health;
(6) a timetable and proposed budget; and
(7) such other information and assurances as the Secretary may require.

(c) A state agency may receive one planning grant annually, and no more than two such grants may be awarded to a state.

Section 3622. Approval of the Secretary. The Secretary may approve the applications that meet the statutory requirements of subpart A that are likely to result in a program meeting the requirements of subpart B.

Section 3623. Amount of Grant. A planning grant may not be less than the amount necessary for the state planning process (as determined by the Secretary), nor more than $500,000.

Section 3624. Authorized Activities. States may use grants under this subpart only to:

(1) carry out the planning process;

(2) carry out state and substate collaboration and coordination activities;

(3) conduct activities to build capacity to provide staff development and technical assistance to local education and health agencies;

(4) develop student learning objectives and assessment instruments;

(5) work with state and local health and education agencies to reduce barriers to implementation of school health education;

(6) to prepare applications for implementation grants; and

(7) to adopt, validate and disseminate curriculum models.

SUBPART B - IMPLEMENTATION GRANTS FOR STATES

Section 3631. Application for Grant. (a) A state must submit an application for an implementation grant in the form and manner specified by the Secretary.

(b) The application for an implementation grant must be developed jointly by state education and health agencies and must include descriptions of:

(1) state program goals and objectives;

(2) the state formula for allocating grant funds to local education agencies;

(3) how the state will coordinate programs funded under this subpart with other local, state and Federal health education programs;

(4) how the comprehensive school health education programs will be coordinated with other local, state and Federal programs;

(5) how the state has worked with state and local health and education agencies;

(6) how the state will monitor implementation;

(7) professional capacity development plans;

(8) staff development and technical assistance plans;

(9) the respective roles of state and local education and health agencies;

(10) how programs will be tailored to be responsive to students, including those with disabilities and from disadvantaged backgrounds; and

(11) the state's evaluation and reporting system.

Section 3632. Selection of Grantees. The Secretary shall establish award criteria for competitive award of implementation grants; the Secretary may give additional planning funds (if any are available) to an unsuccessful implementation grant applicant that could benefit from additional planning.

Section 3633. Amount of Grant. The Secretary shall establish grant award criteria that take into account such factors as the numbers of children enrolled in school and of school-age children living in poverty, and also the scope and quality of a state's plan.

Section 3634. Authorized Activities; Limitation on Administrative Activities. (a) State education agencies receiving grants may retain up to 75 percent of funds in the first year, 50 percent in the second year, and 25 percent in the third year. Funds not retained shall be granted to local education agencies.

(b) States must use retained grant funds for specified purposes, including the following:

(1) statewide and regional coordination activities;

(2) adapting, validating or disseminating models for comprehensive school health education;

(3) building capacity for staff development and technical assistance;

(4) promoting involvement of families and coordinating program activities with community groups and agencies;

(5) evaluating program performance and reporting thereon to the Secretary; and

(6) other activities approved by the Secretary.

(c) States may use up to 10 percent of the retained funds for administrative costs.

Section 3635. Sub-grants to Local Educational Agencies. (a) Local educational agencies may apply to states for implementation grants, and must furnish specific information including

(1) goals and objectives;

(2) how the local agency will target schools with a high need for comprehensive health education, monitor program performance, and ensure cultural and linguistic suitability of the education programs;

(3) monitoring activities;

(4) how the agency will assure that programs are appropriate for students, including those with disabilities and from disadvantaged backgrounds; and

(5) how the local educational agency will evaluate and report on attaining the goals and objectives of (1).

(b) States must select grantees on the basis of evidence of need, as shown by high rates of poverty, births, sexually-transmitted disease, drug and alcohol use, violence among adolescents, and other factors.

(c) Grants must be used for comprehensive school health education programs.

SUBPART C - STATE AND LOCAL REPORTS

Section 3641. State and Local Reports. State agency grant recipients must submit information as required by the Secretary; and local grant recipients must submit required information to the state agency.

PART 4 - SCHOOL HEALTH EDUCATION; GRANTS TO LOCAL EDUCATIONAL AGENCIES

SUBPART A - ELIGIBILITY

Section 3651. Substantial Need of Area Served by Agency. A local educational agency is eligible for a grant under this part if the agency enrolls at least 25,000 students and serves an area that shows a high need for the program, compared to other areas in the United States.

SUBPART B - PLANNING GRANTS FOR LOCAL EDUCATION AGENCIES

Section 3661. Application for Grant. (a) A local education agency must submit a planning grant application to the Secretary in the form and manner required by the Secretary.

(b) Before submitting an application to the Secretary, a local education agency must first submit it for comment to state education and health agencies.

(c) Applications must include the following:

(1) a needs assessment, using Federal and state health and education goals;

(2) information showing that the local agency has established or selected a community-level advisory council, with representation from community health, education, child nutrition and mental health agencies;

(3) a description of expected collaboration among state education and health agencies and local health and education agencies;

(4) a plan to build capacity in the local agency for staff development and technical assistance;

(5) a preliminary evaluation plan;

(6) a planning and budget timetable; and

(7) other information and assurances required by the Secretary.

(d) A local education agency may not receive more than two annual planning grants.

Section 3662. Selection of Grantees. (a) The Secretary must establish criteria for competitive selection of grantees.

(b) The Secretary may not approve a local grant application unless the Secretary determines that the local plan is consistent with the state plan, if any.

Section 3663. Amount of Grant. In any fiscal year, the minimum amount for a local agency planning grant is the amount determined by the Secretary to be needed for agency planning. The maximum amount of a grant in any year is $500,000.

Section 3664. Authorized Activities. Local agencies may use grant funds only for the following purposes:

(1) planning;

(2) joint training, staffing, administration and other coordinating activities among local education, health and other appropriate agencies;

(3) building capacity for staff development and technical assistance;

(4) developing student learning objectives;

(5) reducing barriers to implementing comprehensive school health education;

(6) preparing an implementation plan.

SUBPART C - IMPLEMENTATION GRANTS FOR LOCAL EDUCATIONAL AGENCIES

Section 3671. Application for Grant. (a) A local education agency must submit an implementation grant application to the Secretary of Health and Human Services in the form and manner, and including information and assurances as required by the Secretary.

(b) The application must be submitted to state education agency for comment.

(c) The application must include specified information:

(1) local agency goals and objectives for the program;

(2) how the program will be coordinated with other state and Federal health education programs;

(3) how the program will be coordinated with other state and Federal education programs;

(4) how the agency will reduce barriers to school health education;

(5) how the program will be monitored;

(6) how the agency will build professional development capacity;

(7) how the agency will provide staff development and technical assistance;

(8) the respective role of state and local health and education agencies in implementing comprehensive school health education programs;

(9) how programs will be tailored to meet the needs of students, including those with disabilities and from disadvantaged backgrounds;

(10) evaluation and reporting plans.

Section 3672. Selection of Grantees. (a) The Secretary must establish criteria for the competitive selection of grantees.

(b) The Secretary may not approve a local education agency implementation grant that is not consistent with a state plan.

(c) The Secretary must offer planning grants to local education agencies whose implementation grants have been denied, if there are funds available and if the local agency could benefit from planning.

Section 3673. Amount of Grant. (a) The minimum amount of a grant is the amount necessary for implementation of the program, as determined by the Secretary.

(b) In determining the minimum grant, the Secretary must take into account factors such as the number of children in the schools, the numbers of school-age children living in poverty in the area served by the local agency, and the scope and quality of the plan.

Section 3674. Authorized Activities. An implementation grant may be used for the following purposes:

(1) implementing comprehensive school health education programs;
(2) coordinating local or regional activities;
(3) providing staff development and technical assistance to schools;
(4) administering and monitoring the program;
(5) evaluation and reporting;
(6) other activities authorized by the Secretary.

Section 3675. Reports. Local education agencies that receive implementation grants must submit reports required by the Secretary.

PART 5 - SCHOOL-RELATED HEALTH SERVICES

SUBPART A - DEVELOPMENT AND OPERATION OF PROJECTS

Section 3681. Authorization of Appropriations. (a) For developing and operating school-related health services, the following amounts are authorized: $100,000,000 for fiscal year 1996; $275,000,000 for fiscal year 1997; $350,000,000 for fiscal year 1998; and $400,000,000 for each of fiscal years 1999 and 2000.

(b) Funds appropriated under this section are in addition to other funds available for developing and operating school-related health services.

Section 3682. Eligibility for Development and Operation Grants. (a) Entities

eligible to apply are state health agencies that apply on behalf of local community partnerships, and such local partnerships in states where state health agencies have not applied.

(b) Local partnerships are entities that at a minimum include a local health care provider delivering services to adolescents, one or more public schools, and at least one community based organization. Partnerships shall encourage broad participation from parents and youth, health and social service providers, teachers and school personnel, the regional alliance serving the area in which schools participating in the partnership are located, and other organizations and business leaders.

Section 3683. Preferences. (a) In making grants, the Secretary must give priority to communities with highest level of need among 10 to 19-year-olds as measured by poverty, the presence of a medically underserved population, a health professions shortage area, and a high proportion of children with special health care needs such as disability, adolescent pregnancy, sexually transmitted disease, injuries and gang violence, and exposure to drugs and alcohol.

(b) The Secretary shall give preference to applicants demonstrating a link to qualified community health plans and community networks under subtitle E of title III.

Section 3684. Grants for Development of Projects. (a) The Secretary may make development grants to state health agencies or local community partnerships.

(b) Permissible uses of planning funds include planning for the provision of school health services; staff recruitment, compensation and training; developing agreements with alliance health plans; acquiring equipment and information services, establishing local partnerships (in the case of state applications), and other activities necessary to achieve operational status.

(c) Applications shall be submitted in a form and manner specified by the Secretary. A state agency application must include assurances that the agency is applying on behalf of at least one local community partnership and at least one other community in need of services (as identified by the state) but without a local partnership. In the latter case, the application must also describe how the state will aid the community to develop a partnership. No more than 10 percent of grant awards may be used for administrative activities.

(d) The application shall contain the following contents:

(1) a plan for assessing need;

(2) a description of how the proposed services will reach the maximum number of school-aged children and youth at risk for poor health outcomes;

(3) an explanation of how services will be integrated with other community health and social service programs;

(4) an explanation of how services will be linked to health plans;
(5) evidence of program linkages to regional and corporate alliances; and
(6) a description of quality assurance plans.

(e) No more than one planning grants may be made to an applicant.

Section 3685. Grants for Operation of Projects. (a) The Secretary may make grants, for the cost of operating school health service sites, to state health agencies or local partnerships.

(b) The purposes for which an operating grant may be used include:
(1) furnishing health services;
(2) furnishing enabling services (as defined under section 3461(b));
(3) training, recruitment and compensation of staff;
(4) outreach services, to at-risk youth and parents;
(5) prevention and support services;
(6) linkage of individuals to health plans and community and social services;
(7) other activities authorized by the Secretary.

(c) Applications shall be submitted in a form and manner approved by the Secretary and must include information on the services to be furnished, the amount and sources of funds the applicant will spend, and such other information as the Secretary requires.

(d) The applicant must also meet the following conditions:
(1) the applicant will furnish the following:
(A) diagnosis and treatment of minor illness and injury;
(B) preventive services;
(C) enabling services;
(D) referral and follow up for illness and injury;
(E) health and social services, counseling and referrals, including referrals regarding mental health and substance abuse;
(F) other services the Secretary specifies.
(2) the applicant maintains agreements with all regional and corporate alliance health plans offering services in the applicant's service area;
(3) the applicant participates in Medicaid;
(4) the applicant does not charge for services;
(5) the applicant will periodically review the needs of populations served and will remove barriers to the use of services;
(6) the applicant will provide a plan to meet the needs of non-English speaking populations;
(7) the applicant will provide non-Federal contributions; and
(8) the applicant will operate a quality assurance program consistent with section 3684(d)(6).

(e) Grants will be for periods determined by the Secretary. A grant recipient must provide reports and information required by the Secretary.

Section 3686. Federal Administrative Costs. The Secretary may retain up to five percent of funding for development and operation grants for administrative costs.

SUBPART B - CAPITAL COSTS OF DEVELOPING PROJECTS

Section 3691. Loans and Loan Guarantees Regarding Projects. (a) The Secretary may make loans to and guarantee loans to state health agencies and local partnerships for capital costs of developing school-related health services.

(b) The provisions of section 3441 (loans to develop community health plans and networks) shall apply to loans and loan guarantees under this subpart.

Section 3692. Funding. Amounts made available to the Secretary to carry out subparts B and C of part 2 of subtitle E may be used not only for purposes there authorized but also for school-related health services under this part.

SUBTITLE H - PUBLIC HEALTH SERVICE INITIATIVE FUND
(H.R. 3600 and S. 1757 p. 667)

Section 3701. Public Health Service Initiative. The total amount authorized under subtitles C, D, E, F and G this title and for subtitle D of title VIII (subject to the extent of funding made available in appropriations acts and subject to authorizations of appropriations in the foregoing subtitles) are:

(1) $1,125,000,000 for fiscal year 1995;
(2) $2,984,000,000 for fiscal year 1996;
(3) $3,830,000,000 for fiscal year 1997;
(4) $4,205,000,000 for fiscal year 1998;
(5) $4,055,000,000 for fiscal year 1999; and
(5) $3,666,000,000 for fiscal year 2000.

Amounts are available until expended and are available to carry out the specific programs for which the amounts are appropriated.

SUBTITLE I - COORDINATION WITH COBRA CONTINUATION COVERAGE (H.R. 3600 and S. 1757 p. 668)

Section 3801. Public Health Service Act; Coordination with COBRA Continuation Coverage. (a) Amends section 2202 of the Public Health Service Act (relating to continuation of employment benefits) to provide for continuation of coverage until such time as an individual becomes eligible for comprehensive health benefits under the Health Security Act.

(b) Amends section 2208 of the Public Health Service Act to provide that individuals eligible for coverage under the Health Security Act are no longer covered individuals under this section.

(c) Amends Title XXII of the Public Health Service Act by repealing the title upon the effective date of the Health Security Act (the earlier of January 1, 1998, or on January 1 of the first calendar year in which all states have in effect plans under the Health Security Act.

TITLE IV - MEDICARE AND MEDICAID

SUBTITLE A - MEDICARE AND THE ALLIANCE SYSTEM (H.R. 3600 and S. 1757 p. 674)

PART 1 - ENROLLMENT BENEFICIARIES IN REGIONAL ALLIANCE SYSTEMS

Section 4001. Optional State Integration of Medicare Beneficiaries into Regional Alliance Plans. (a) Adds a new section to the Medicare statute that permits participating states to seek and obtain approval from the Secretary of HHS to integrate Medicare beneficiaries and payments into the regional alliance system through enrollment in health plans. States may obtain approval for Medicare integration whether or not they operate single payer systems.

State applications must contain the following assurances:

(1) States must cover all Medicare-eligible individuals.

(2) Each beneficiary within a covered class must be enrolled in a regional alliance for the area in which the individual resides or (in the case of a single payer state) the state's single system. Each individual must have the same choice among applicable plans as other persons eligible under the Health Security Act. Individuals must be offered at least one fee-for-service plan that meets the following requirements:

(i) The plan's premium rate, and the actuarial value of the premium, deductibles and coinsurance may not exceed the actuarial value of Medicare deductibles and coinsurance;

(ii) the plan's payment rates for hospital services, post-hospital extended care services, home health services, home intravenous drug therapy services, comprehensive outpatient rehabilitation facility services, hospice care, dialysis services and ambulatory surgical services must be accepted by providers of these services as payment in full; and

(iii) the plan's payment rates for physicians are no less a percentage of the amounts accepted as payment in full than are payment rates under Part B.

(3) Health plans must offer at least the items and services covered by Medicare (including the secondary payer program) and coverage rules must be no more restrictive than those used under Medicare.

(4) Premium rules that apply to other alliance eligible individuals may not be applied to Medicare beneficiaries. However, states may not vary the premiums charged different Medicare individuals within the same premium class.

(5) Quality assurance mechanisms are in effect.

(6) Beneficiaries have appeal rights at least equal to those afforded other alliance eligible individuals.

(7) The state will furnish data required by the Secretary and provide access to all relevant documents.

(8) The state will use payments made under this section only to carry out the

purposes of this provision.

In the first year of integration, the amounts payable to the state for each covered beneficiary shall be determined at the rate payable to Medicare risk sharing contractors under section 1876, but at 100 percent rather than 95 percent and without regard to reductions in payments otherwise applicable under section 1876(a)(1)(G). For each succeeding year, the amount payable is the base rate adjusted by the alliance inflation factor. Payments shall be made out of the Hospital Insurance Trust Fund and the Supplementary Medical Insurance Trust Fund, as under section 1876.

(b) Payment begins on January 1 of the first calendar year of approval and ends either on December 31 of the year in which the state notifies the Secretary that it no longer wishes to integrate Medicare, or at a time determined by the Secretary in a case involving substantial non-compliance. No termination is effective without notice to Medicare beneficiaries and health plans.

(c) Payments under this section are in lieu of any other benefits for which Medicare payments would be made.

(d) The Secretary must evaluate state compliance on an ongoing basis.

(e) Definitions in this section have such meaning as under the Health Security Act.

Section 4002. Individual Election to Remain in Certain Health Plans. (a) Section 1876 of the Social Security Act is amended by adding a new subsection that provides that each eligible organization under section 1876 with a risk sharing contract (or that is eligible for such a contract) that also is a health plan participating in a health alliance shall offer continued membership (for the same benefits to which alliance eligible persons are entitled) to a plan enrollee who is a Health Security Act eligible employee, or the spouse or dependent of an eligible employee, who becomes eligible for Medicare and therefore loses eligibility under the Health Security Act. Payments shall be made beginning in the first month in which the individual is Medicare eligible and no longer eligible under the Health Security Act. Payments shall end with the earliest of either the month in which the individual notifies the Secretary that he no longer wants to be enrolled in the eligible organization or the month of open enrollment or the month in which the individual ceases to meet the requirements of this section. Payments under this provision shall be the sole Medicare payment to which the beneficiary is entitled.

Section 4003. Payments to Regional Alliances on Behalf of Certain Medicare Eligible Individuals. Amends Medicare by adding a new section which provides that individuals are not entitled to Medicare coverage if they continue to qualify for coverage under the Health Security Act under section 1012, because they are qualified employees or the spouses of qualified employees. The Secretary must transfer to each regional alliance the amount of the reductions in liability owed the regional alliance under section 6115 of the Health Security Act. Unless all family members qualify for Medicare, reductions in liability

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Section 4001. Optional State Integration of Medicare Beneficiaries into Regional Alliance Plans. (a) Adds a new section to the Medicare statute that permits participating states to seek and obtain approval from the Secretary of HHS to integrate Medicare beneficiaries and payments into the regional alliance system through enrollment in health plans. States may obtain approval for Medicare integration whether or not they operate single payer systems.

State applications must contain the following assurances:

(1) States must cover all Medicare-eligible individuals.

(2) Each beneficiary within a covered class must be enrolled in a regional alliance for the area in which the individual resides or (in the case of a single payer state) the state's single system. Each individual must have the same choice among applicable plans as other persons eligible under the Health Security Act. Individuals must be offered at least one fee-for-service plan that meets the following requirements:

(i) The plan's premium rate, and the actuarial value of the premium, deductibles and coinsurance may not exceed the actuarial value of Medicare deductibles and coinsurance;

(ii) the plan's payment rates for hospital services, post-hospital extended care services, home health services, home intravenous drug therapy services, comprehensive outpatient rehabilitation facility services, hospice care, dialysis services and ambulatory surgical services must be accepted by providers of these services as payment in full; and

(iii) the plan's payment rates for physicians are no less a percentage of the amounts accepted as payment in full than are payment rates under Part B.

(3) Health plans must offer at least the items and services covered by Medicare (including the secondary payer program) and coverage rules must be no more restrictive than those used under Medicare.

(4) Premium rules that apply to other alliance eligible individuals may not be applied to Medicare beneficiaries. However, states may not vary the premiums charged different Medicare individuals within the same premium class.

(5) Quality assurance mechanisms are in effect.

(6) Beneficiaries have appeal rights at least equal to those afforded other alliance eligible individuals.

(7) The state will furnish data required by the Secretary and provide access to all relevant documents.

(8) The state will use payments made under this section only to carry out the purposes of this provision.

In the first year of integration, the amounts payable to the state for each covered beneficiary shall be determined at the rate payable to Medicare risk sharing contractors under section 1876, but at 100 percent rather than 95 percent and without regard to reductions in payments otherwise applicable under section 1876(a)(1)(G). For each succeeding year, the amount payable is the base rate adjusted by the alliance inflation factor. Payments shall be made out of the Hospital Insurance Trust Fund and the Supplementary Medical Insurance Trust Fund, as under section 1876.

(b) Payment begins on January 1 of the first calendar year of approval and ends either on December 31 of the year in which the state notifies the Secretary that it no longer wishes to integrate Medicare, or at a time determined by the Secretary in a case involving substantial non-compliance. No termination is effective without notice to Medicare beneficiaries and health plans.

(c) Payments under this section are in lieu of any other benefits for which Medicare payments would be made.

(d) The Secretary must evaluate state compliance on an ongoing basis.

(e) Definitions in this section have such meaning as under the Health Security Act.

Section 4002. Individual Election to Remain in Certain Health Plans. (a) Section 1876 of the Social Security Act is amended by adding a new subsection that provides that each eligible organization under section 1876 with a risk sharing contract (or that is eligible for such a contract) that also is a health plan participating in a health alliance shall offer continued membership (for the same benefits to which alliance eligible persons are entitled) to a plan enrollee who is a Health Security Act eligible employee, or the spouse or dependent of an eligible employee, who becomes eligible for Medicare and therefore loses eligibility under the Health Security Act. Payments shall be made beginning in the first month in which the individual is Medicare eligible and no longer eligible under the Health Security Act. Payments shall end with the earliest of either the month in which the individual notifies the Secretary that he no longer wants to be enrolled in the eligible organization or the month of open enrollment or the month in which the individual ceases to meet the requirements of this section. Payments under this provision shall be the sole Medicare payment to which the beneficiary is entitled.

Section 4003. Payments to Regional Alliances on Behalf of Certain Medicare Eligible Individuals. Amends Medicare by adding a new section which provides that individuals are not entitled to Medicare coverage if they continue to qualify for coverage under the Health Security Act under section 1012, because they are qualified employees or the spouses of qualified employees. The Secretary must transfer to each regional alliance the amount of the reductions in liability owed the regional alliance under section 6115 of the Health Security Act. Unless all family members qualify for Medicare, reductions in liability under section 6115 are based on the alliance premium credit amount for an individual.

Section 4004. Prohibiting Employers From Taking Into Account Status as a Medicare Beneficiary on Any Account. Amends section 1862(b)(1)(A) by striking existing exceptions to the non-discrimination provision (subclauses (ii) and (iii)) in order to extend the prohibition to all health plans.

Section 1862(b)(1)(B) is amended by extending the prohibition to all group health plans. Section 1862(b)(1) is further amended by striking the limited time period of protection against discrimination for persons with end stage renal disease. Section 1862(b) is further amended to prohibit coverage of items and services for which there is primary coverage under an alliance plan, except that payment may be made for cost sharing amounts covered by Medicare. The provisions of this section take effect on January 1 of the first year in which a state is a participating state.

PART 2 - ENCOURAGING MANAGED CARE UNDER MEDICARE PROGRAM; COORDINATION WITH MEDIGAP PLANS

Section 4011. Enrollment and Termination of Enrollment. (a) Amends section 1876 of the Social Security Act to require uniform open enrollment periods under Medicare risk sharing plans. Also amends section 1882(s) to require sellers of Medigap policies to maintain 30-day uniform open enrollment periods annually during which time issuers may not deny or condition the issuance or effectiveness of policies for reasons of age, health status, claims experience, receipt of health care or medical condition. Policies may not contain pre-existing condition limits (except in limited circumstances now provided under section 1882(s)), elimination periods or probationary periods.

(b) Section 1876(c)(3)(A) is amended to require Medicare risk plans to provide open enrollment periods for new residents of their service areas.

(c) Section 1876(c)(3)(B) is amended to permit enrollment through a third party and to require uniform termination of enrollment rules governing terminations during annual enrollment periods, in cases of financial insolvency, and when persons move from an area.

(d) These amendments become effective for enrollments occurring after 1995, as specified in regulations of the Secretary. The Medigap amendments become effective for supplemental policies issued after 1995.

Section 4012. Uniform Informational Materials. (a) Amends section 1876(c)(3)(C) to require the Secretary to develop uniform informational materials comparing all eligible organizations. Risk plans are required to reimburse the Secretary a pro rata share for the cost of preparation of the materials.

(b) Amends section 1882(f) to require the Secretary to prepare informational and comparative materials about Medigap plans. Plans must reimburse the Secretary a pro rata share of the cost of preparation.

(c) These amendments shall take effect in years after 1995.

Section 4013. Outlier Payments (a) Amends section 1876 to require the Secretary to make additional payments to risk plans of not more than 50 percent of the imputed reasonable cost, as determined by the Secretary, (or if requested by the organization, the reasonable cost) above the threshold amount of Part A and Part B services provided or paid for in a year by the organization to enrollees. The threshold amount is five percent or less of total amounts paid to a risk sharing organization under its contract. Payments in future years must be adjusted to take excess payments into account.

(b) Section 1876(a)(1)(C) is also amended to specify that total amounts paid include the base rate plus the additional payment.

(c) These amendments apply to services furnished after 1994.

Section 4014. Point of Service Option. (a) Amends the statute to add a new section authorizing the Secretary to develop a point of service program through which beneficiaries not already enrolled in risk-sharing organizations may obtain services. A point of service network must meet such criteria as the Secretary may establish.

(b) Minimum criteria for networks are as follows:

(1) networks must serve designated appropriate geographic areas to ensure that the network has sufficient participating members to furnish covered Medicare services;

(2) the Secretary must establish requirements for participating members;

(3) the Secretary must establish payment schedules including a schedule of bundled payment arrangements for selected medical and surgical procedures;

(4) the Secretary must delineate permissible financial incentive arrangements to encourage members to join;

(5) the Secretary must establish standards under which carriers administer the program;

(6) the Secretary must establish procedures for the provision of case management services and criteria for determining when case management will be covered;

(7) the Secretary must establish standards for processing and payment of claims and for apportioning payments among parts A and B;

(8) the Secretary may establish other standards as appropriate;

(9) the Secretary must establish standards for physician participation based on practice patterns and demonstrated quality assurance; and

(10) the Secretary must assure that the point-of-service option does not result in a net financial loss to Medicare, taking both medical and administrative costs into account.

(c) Conforming amendments are added to sections 1812(a) (expanding scope of

covered Part A services to include additional items and services furnished through point of service networks), section 1814(b) (conforming provider payment provisions to point of service amendment to permit payment of additional items and services plus bonus payments), section 1832(a)(2) (expanding scope of Part B benefits to include additional items and services furnished by point-of-service networks), section 1833 (to permit payment for point of service services plus bonus payments), section 1862(a)(1) (to permit coverage of additional Part B items and services under a point-of-service network that otherwise would be excluded while excluding items and services not included in the individual's plan of care). Bonus payments may be made by the Secretary if Medicare costs are reduced and if the quality of care is not adversely affected.

PART 3 - MEDICARE COVERAGE EXPANSIONS

Section 4021. Reference to Coverage of Outpatient Prescription Drugs. References subtitle A of title II.

Section 4022. Expanded Coverage for Physician Assistants, Nurse Practitioners and Clinical Nurse Specialists. (a) Amends section 1861(s)(2)(K) to add services for physician assistants, nurse practitioners and clinical nurse specialists.

(b) The effective date for these amendments is for services furnished on or after January 1, 1996.

PART 4- COORDINATION WITH ADMINISTRATIVE SIMPLIFICATION AND QUALITY MANAGEMENT INITIATIVES

Section 4031. Repeal of Separate Medicare Peer Review Program. The peer review program found at title XI of the Social Security Act is amended to provide that, upon the adoption of the National Quality Management Program under title V of the Health Security Act, the peer review program shall terminate.

Section 4032. Mandatory Assignment for All Part B Services. Section 1833 of the Social Security Act is amended to include a new subsection providing that in the case of items and services furnished after January 1, 1996, payment shall be made only on an assignment related basis. The amendment prohibits patient billing except for applicable deductibles, coinsurance or copayment amounts. Knowing and willful violations of this provision may result in exclusion from the program for up to five years and the imposition of civil money penalties. The violator also may be liable for restitution to the beneficiary.

Section 4033. Elimination of Complexities Caused by Dual Funding Sources and Rules for Payment of Claims. (a) Authorizes the Secretary of HHS to take such steps as may be necessary to consolidate the administration of the Medicare program.

(b) The Secretary shall contract with a single entity to combine intermediary and

carrier functions under Parts A and B for each region of the country except in cases in which the Secretary finds that a national contract is appropriate.

(c) The provisions of section 1816 and 1842 (relating to intermediaries and carriers) are superseded to the extent necessary to carry out this function.

Section 4034. Repeal of PRO Precertification Requirement for Certain Surgical Procedures. (a) Section 1164 is repealed effective upon the date of enactment of the Health Security Act.

(b) The statute is further amended to make conforming changes to eliminate PRO approval of the following procedures: section 1833(a)(10)(D) (clinical diagnostic laboratory tests furnished in connection with obtaining a second opinion); section 1833(a)(2)(A) (home health services furnished in connection with obtaining a second opinion); section 1833(a)(2)(D) (payment rates for clinical laboratory services furnished in connection with a second opinion); section 1833(a)(3) (rural health clinic, federally qualified health center and comprehensive outpatient rehabilitation services furnished in connection with obtaining a second opinion); section 1833(b)(3) (payment principles for services furnished in connection with obtaining a second opinion); section 1834(g)(1)(B) (payment for outpatient rural primary care hospital services furnished in connection with obtaining a second opinion); section 1862(a) (exemption of second opinions from exclusion of coverage); section 1866(a)(2)(A) (provider charges for services furnished in connection with obtaining a second opinion).

Section 4035. Requirements for Changes In Billing Procedures. (a) Prohibits the Secretary from implementing changes in billing and processing procedures under Medicare more frequently than once every six months.

(b) Requires carriers and intermediaries to provide 120 days advance notice to providers of major changes in billing procedures.

(c) The provision becomes effective with contracts beginning nine months after the date of enactment.

PART 5 - AMENDMENTS TO ANTI-FRAUD AND ABUSE PROVISIONS

Section 4041. Anti-Kickback Provisions. (a) Amends section 1128A(a) to authorize the Secretary to impose civil money penalties for violations of section 1128(B)(b) (relating to fraudulent or false statements or material misrepresentations). Amends section 1128A(a) to authorize penalties up to $50,000 for false or misleading statements. Amends section 1128B(b) to increase the civil and criminal penalties for remuneration offered or received in exchange for either referring an individual for services or a lease, purchase or order of goods and services or a recommendation for a lease or purchase.

(b) Amends section 1128B(b)(3)(A) to exempt from the anti-kickback provisions

discounts obtained by providers that are not part of tie-in arrangements, are not exclusive to certain providers, and are not remuneration in cash. Further amends section 1128B(b)(3)(B) to exempt from the anti-kickback provisions amounts paid to employees that are consistent with the fair market value of the service and are not tied to the volume or value of services (except that employees may receive productivity bonuses).

Further amends section 1128B(b)(3)(D) to exempt from the definition of kickback waivers or reduction of coinsurance if the waiver is made pursuant to a public schedule of discounts and obligated as a matter of law to apply. Also exempts waivers of coinsurance by persons who do not routinely waive coinsurance or deductibles and who waive the payment after determining that the individual is indigent or who fail to collect amounts owed after making a reasonable effort or who meet other exceptions authorized by the Secretary.

Section 1128B(b)(3) is further amended by providing that the anti-kickback provisions do not apply to certain federally funded providers and to providers that as a matter of law must waive or reduce coinsurance for certain individuals pursuant to a public schedule of discounts. The copayment waiver rules do not apply to these two classes of providers if remuneration is pursuant to a written arrangement for the use or procurement of space, equipment, goods or services or the referral of patients if there is no private inurement to any current employee, officer, agent or member of the Board, and the arrangement does not preclude the referral of patients to other providers or interfere with the ability of health professionals to refer patients to providers they believe are the most appropriate.

Section 1128B(b)(3) is further amended by adding a new provision providing that the anti-kickback provisions any reduction in cost sharing or increased benefits to individuals enrolled under prepaid per capita health plans.

(c) Amends section 1128B(b) to define referrals from employees to employers to cover referrals for which payments may be made under Medicare or a state health care program.

(d) Amends section 1128B(b) to authorize the Secretary to issue regulations to protect patients from abuse under any of the new anti-kickback exceptions added by this provision.

(e) Amends section B(b) to clarify that in addition to an intent to influence, an element of a punishable offense under the anti-kickback statute is an intent to be influenced . Also clarifies that persons who knowingly and willfully engage in remunerative acts violate the statute even if the knowing and willful payment of remuneration is only one of the purposes underlying the individual's actions.

Section 4042. Revisions to Limitations on Physician Self-Referral. (a) Amends section 1877(a)(1)(B) (relating to physician referral ban) to clarify that physicians may not avoid the ban on self referrals by billing themselves for items and services for which a physician-owned entity would not be permitted to bill.

(b) Amends section 1877(a)(2) (defining financial relationship) to clarify that physician ownership is established in cases involving loans, and interest in the entity held by a physician's relatives.

(c) Amends section 1877(b) (relating to general exceptions) to repeal the exception for services provided by another physician in the same group practice as the referring physician. Also amends section 1877(b) to extend the exception to the physician referral ban to clinical laboratory, x-ray and ultra-sound services that are provided at low cost, as defined by the Secretary, but not in instances where the referral is to another physician in the same group practice. Amends section 1877(b)(2) to exempt certain prepaid practices (other than those reimbursed on a cost basis) from the self-referral ban.

(d) Amends section 1877(c)(1) (relating to the exception to ownership in publicly traded funds and securities) to limit the exception to securities and mutual funds that are publicly traded at the time that they are acquired by the physician.

(e) Amends section 1877(d)(2) (relating to exceptions for rural physicians) to specify that at least 85 percent of the provider's services must be furnished in rural areas in order to qualify for the exception.

(f) Amends section 1877(e)(3)(relating to physician incentive plans) to clarify that the exception applies when physicians are placed at risk for services that are not physician services. Also amends section 1877(e)(3) to clarify that physician incentive plans, as the term is used in this section, are arrangements that have the purpose (rather than merely the effect) of limiting services to enrolled individuals.

Section 1877(e) (4) as redesignated (relating to physician recruitment) is amended to limit the exception to entities located in rural areas, health professions shortage areas, or an entity in which 85 percent of patients are members of medically underserved populations. The exception is also limited to the recruitment of physicians practicing in certain specialties for less than one year. Recruitment plans must be in writing, the new practice location must be at least 100 miles from the established primary practice area and at least 85 percent of new physician revenues must be generated by care for new patients. Recruitment benefits must not be more than 3 years in duration. There must be no requirement that the physician make referrals as a condition of receiving recruitment benefits. The physician must not be prevented from establishing staff privileges at other entities in cases in which the recruiting entity is a hospital. The value of the recruitment benefit must not vary on the basis of volume of referrals. The physician must agree to treat Medicaid and Medicare patients.

Amends section 1877(e)(5) as redesignated (related to exceptions for isolated transactions) to clarify that there may be no financing of the sale between the parties.

Amends section 1877 (e)(7) as redesignated (related to exceptions for payments by a physician) to exempt physician payments for clinical laboratory services when payment is at

the fair market price. Also amends the subsection to permit discount exceptions so long as the discounts are properly disclosed and reflected in the physician's charges and are not part of a tie-in arrangement or selectively made available to individuals and entities.

(g) Amends section 1877(g)(4) (relating to civil money penalty sanctions for certain activities) to allow the imposition of penalties for cross referral and multiple lease arrangements that have the principal purpose of inducing other referrals.

(h) Amends section 1877(h) (relating to definitions and special rules) to clarify that the term "remuneration" includes payments, discounts, price reductions, debt forgiveness, or other in kind or cash benefits made overtly or covertly.

(i) Section 1877(h) is further amended to clarify that the Secretary has the authority to require physical grouping of group practices in order to prevent the abuse of any applicable group practice exception. Also clarifies that the members of the group must personally provide both health services and incidental services.

(j) Amends section 1877(h) (relating to the definition of referrals and referring physician) to strike paragraph (C), which exempts from the definition of "referral" requests by pathologists, radiologists, and radiation oncologists for laboratory and diagnostic radiology tests and radiation therapy.

(k) Amends section 1877(h)(6) (relating to the designation of certain health services under this section) to add both diagnostic services and any other item or service not rendered by the physician personally or under the physician's personal supervision.

(l) Amends section 1877 to authorize the Secretary to promulgate self referral regulations.

(m) Incorporates by reference OBRA 1993.

Section 4043. Civil Monetary Penalties. (a) Amends section 1128(A) (relating to civil money penalties for false claims to add as a sanctionable act the offering or payment of remuneration to Medicare beneficiaries to obtain Medicare services from certain providers, practitioners or suppliers.

Amends section 1128A to add as a type of remuneration the waiver of coinsurance and deductibles unless the waiver is not offered as part of an advertisement or solicitation, the provider does not routinely waive deductibles and coinsurance, and the provider waives the deductible or coinsurance after determining that the individual is indigent or after making a good faith attempt to collect amounts owed or is a provider permitted to waive deductibles and coinsurance.

(b) Amends section 1128A(a)(1) to add as a covered form of remuneration the

deliberate and medically unnecessary upcoding of items and services or provision of medically unnecessary items and services.

(c) Amends section 1128A to cover remuneration by excluded persons during a period of exclusion, who retains a direct or indirect ownership interest greater than five percent, or who is an officer, director, managing employee or agent of a Medicare participating entity.

(d) Amends section 1128A to cover practices designed to circumvent payment methodologies that are designed to circumvent bundled payment arrangements, including hospital diagnosis-related groups (DRG) payments.

Amends section 1128A to cover health plan practices by participating providers that have the effect of limiting or discouraging (compared to other plan enrollees) the use of services by Medicare and Medicaid patients, including differential locations and hours of services.

Amends section 1128A to cover substantial failure to cooperate with a quality assurance program.

Amends section 1128A to cover the substantial failure by plans to provide or authorize medically necessary services if the failure has or is likely to adversely affect the individual.

Amends section 1128A to cover plans that employ or contract with excluded individuals for the provision of services.

Amends section 1128A to cover plans that submit false or fraudulent data to the Federal, state or local government.

(e) Amends section 1128A to increase certain civil monetary penalty amounts and fines.

(f) Amends section 1128A(f) to add interest on penalties to the amounts payable and to add to the amount owed the cost of collection and recovery in the case of late payments.

(g) Amends section 1128A authorizing the Secretary to take action unless the Attorney General acts within a year of having a case referred.

(h) Authorizes the payment of penalties into the all payer account established under section 5402 of the Health Security Act.

Section 4044. Exclusions from Program Participation. (a) Amends section 1128(a)(1) (relating to mandatory exclusion of certain individuals from Medicare and state health programs) to clarify that grounds for mandatory program exclusions include individual convictions for of criminal offenses related to the delivery of services under Medicare or state health programs and individual convictions under Federal or state law in connection with the delivery of a health care item or service relating to fraud, theft, embezzlement, breach of fiduciary responsibility or other financial misconduct.

(b) Amends section 1128(c) (relating to permissive exclusions) to establish a minimum exclusion period of up to 3 years for convictions of offenses described in paragraphs (1), (2) or (3) of section 1128(b). In the case of individuals excluded after conviction of offenses under paragraphs (4) and (5) of section 1128(b), the period of exclusion may not be less than the period during which the individual's or entity's license is revoked or the individual is otherwise excluded from a Federal or state health program. In the case of offenses described under section (b)(6), the period of exclusion shall not be for less than one year.

(c) Amends section 1128(b)(14) (relating to exclusion of persons defaulting on health education loan and scholarship obligations to clarify that only reasonable steps must be taken to secure payment before exclusion may occur.

(d) Amends section 1128(b) to permit exclusion of persons with ownership or control interest in a sanctioned entity (civil money penalties, exclusions or convictions) of five percent or more.

(e) Amends section 1128(b) to add as a ground for exclusion under Medicare the following: actions that violate the all payer health care fraud program under the Health Security Act; the failure to disclose information needed by the Inspector General in order to carry out the All Payer Health Care Fraud and Abuse Control Program; the failure to provide financial information required under the Health Care Security Act; the failure to grant immediate access to entities authorized by law to conduct on-site health and patient safety inspections under the Health Care Security Act.

(f) Amends section 1128(f) to provide that appeals of exclusions shall be brought in the United States Courts of Appeal in the circuit in which the excluded individual or entity resides or has its principal place of business (or in the District of Columbia Court of Appeals in cases in which the entity or individual does not have a principal residence or place of business).

Section 4045. Sanctions Against Practitioners and Persons for Failure to Comply with Statutory Obligations Relating to Quality of Care. (a) Amends section 1156 (relating to the general obligation of providers to furnish only care that is medically necessary, of good quality and economical) to require the Secretary to establish a minimum exclusion period of one year for exclusions for violations of the section.

(b) Amends section 1156 (b)(1) to repeal the provision requiring a finding that a practitioner is unwilling to comply with the requirements of section 1156 before excluding persons who fail to furnish q2uality, medically necessary and economical services.

(c) Amends section 1156 (b)(3) to increase the civil money penalties to $50,000 for each instance in the case of violations under this section.

Section 4046. Effective Date. Amendments made under this part become effective

January 1, 1995.

PART 6 - FUNDING OF GRADUATE MEDICAL EDUCATION AND ACADEMIC HEALTH CENTERS

Section 4051. Transfers from Medicare Trust Funds for Graduate Medical Education. (a) For purposes of complying with section 3034 (relating to support for the institutional costs of graduate medical education) there shall be transferred to the Secretary from Parts A and B of Medicare, the following aggregate amount in any fiscal year:

(1) for fiscal years prior to 1998, the proportion of the amounts spent from the trust funds during the most recent calendar year for payments for the direct cost of graduate medical education attributed to hospitals located in states that are participating states;

(2) in fiscal year 1998, the amounts spent from the trust funds for graduate medical education direct costs in 1997;

(3) in the case of subsequent fiscal years, the amounts specified in paragraph (2) increased by the Secretary's estimate of the percentage increase in the urban consumer price index except that for purposes of this subparagraph the increases provided for in subparagraphs (A) and (C) of section 6001 (relating to subsequent year payment reductions) shall not apply.

(b) Funds transferred under subsection (a) shall be allocated equitably, in accordance with standards prescribed by the Secretary..

(c) Section 1886(h) (relating to graduate medical education payments) is amended to prohibit payments for direct medical education costs after January 1, 1998 (or an earlier date for hospitals located in states that are participating states at an earlier date). The Secretary may not recognize direct graduate medical education costs for any cost reporting period after October 1, 1997, (or an earlier date in the case of hospitals located in states that are participating states at an earlier date).

Section 4052. Transfers from Hospital Insurance Trust Fund for Academic Health Centers. (a) For the purpose of complying with section 3104(a) (relating to payment to academic health centers) there shall be transferred to the Secretary from the Part A Trust Fund the following aggregate amount:

(1) For fiscal years 1998, the proportion of funds spent on indirect medical education that is attributable to hospitals located in a state that is a participating state.

(2) For fiscal year 1998, the amount spent on indirect medical education.

(3) In each subsequent fiscal year, the amount spent in fiscal year 1997, updated by the inflation factor in section 6001(a)(3) of the Health Security Act, but without regard to the reductions in increases under subparagraphs (A) through (C) of section 6001.

(b) Section 1886(d) is amended to prohibit indirect graduate medical education

payments under Medicare for discharges occurring on October 1, 1997, or thereafter (or an earlier date in the case of a state which is a participating state at an earlier date).

PART 7 - COVERAGE OF SERVICES PROVIDED BY FACILITIES AND PLANS OF DEPARTMENTS OF DEFENSE AND VETERANS AFFAIRS

Section 4061. Treatment of Uniformed Services Health Plans Eligible Organization Under Medicare. (a) Amends section 1876 (related to payments to certain risk sharing entities) to provide that Uniformed Service Health Plans shall be deemed to be eligible institutions for covered services that are furnished to Medicare beneficiaries. Payment amounts and items and conditions shall be developed through agreements between the Secretary of HHS and the Secretary of Defense.

(b) This provision takes effect on January 1, 1998.

Section 4062. Coverage of Services provided to Medicare Beneficiaries by Plans and Facilities of the Department of Veterans Affairs. (a) Amends Medicare to add a new section authorizing Medicare payments to VA health plans and VA health care facilities as providers of health services. The Secretary is required to make payments to VA plans under the same terms and conditions as payments would be made to entities under section 1876 of the Social security Act (certain risk sharing plans). VA facilities shall be treated as Medicare providers.

(b) The amendments under this section take effect on October 1, 1997.

Section 4063. Conforming Amendments. A series of conforming amendments are added to the Medicare statute to carry out this part. These amendments take effect on January 1,1998.

SUBTITLE B - SAVINGS IN MEDICARE PROGRAM
(H.R. 3600 and S. 1757 p. 752)

PART 1 - SAVINGS RELATED TO PART A

Section 4101. Reduction in Update for Inpatient Hospital Services. Amends section 1886(b)(3)(relating to updates in inpatient hospital payment rates) by establishing that for each of fiscal years 1997 through 2000, payment increases will be at market basket minus 2.0 percentage points.

Section 4102. Reduction in Adjustment for Indirect Medical Education. Amends section 1886(d)(5) (relating to prospective payments for inpatient hospital services) by revising the indirect teaching adjustment factor to read as follows : c* (((1+r) to the nth power) - 1) where r is the ratio of the hospital's full-time interns and residents and n equals .405. For discharges occurring after October 1, 1994 and before October 1, 1995, "c" is 1.395 and after October 1, 1995, "c" is 0.74.

Section 4103. Reduction in Payments for Capital-related Costs for Inpatient Hospital Services. (a) Amends section 1886(g)(1) (relating to capital related costs for hospitals under the prospective payment system) by specifying that for discharges occuring after September 30,1995, in addition to the 7.4 percent reduction in the unadjusted standard Federal capital payment rate, the Secretary shall reduce by 7.31 percent the unadjusted Federal capital rate in effect as of the date of enactment of the Health Security Act and shall reduce by 10.4 percent the unadjusted hospital specific rate in effect on that date.

Further amends section 1886(g)(1) to give the Secretary authority to establish a factor for the amount of capital cost recognized per discharge that reflects an appropriate factor that takes into account amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality. For payments attributable to portions of cost reporting periods occurring during each of fiscal years 1996 through 2003 the Secretary shall reduce the annual update factor to adjust for excessive increases. The reduction shall not result in an annual update factor of less than 0 but may equal either 4.9 percentage points or the sum of 4.9 percent and the difference between the update factor and the update reduction for the previous year in cases in which the factor was less than the reduction.

(b) Amends section 1861 (v) (relating to reasonable cost reimbursement) by providing that in the case of hospitals exempt from PPS, payment for capital-related costs shall be reduced by 15 percent for cost reporting periods occurring during each of fiscal years 1996 through 2003.

Section 4104. Revisions to Payment Adjustments for Disproportionate Share Hospitals in Participating States. (a) Amends section 1886(d)(5) (relating to payments to hospitals) to authorize the Secretary to pay additional amounts to hospitals located in

participating states and that are disproportionate share facilities as defined under this section. Four categories of hospitals may qualify for payments under this section: urban hospitals with more than 100 beds with SSI patient percentage of at least 5.5 percent; urban hospitals of less than 100 beds with SSI patient percentages of at least 17 percent; rural referral hospitals or rural sole community hospitals with SSI patient percentage of at least 23 percent; and other hospitals with SSI patient percentages of less than 23 percent. The SSI patient percentage is the proportion of all Medicare inpatient days attributable to SSI patients.

The payment percentage for hospitals meeting the disproportionate share requirements of this section are as follows:

(1) in the case of urban hospitals of more than 100 beds, e to the nth power, where "e" is the natural antilog of 1 and "n" is equal to (.5642*(the hospital's SSI patient percentage for the cost reporting period - .055));

(2) for urban hospitals of less than 100 beds and other hospitals, 2 percent;

(3) for rural referral centers and sole community hospitals, the sum of 2 percent and .30 percent of the difference between the hospital's SSI patient percentage and 23 percent.

(b) Amends section 1886 (d)(2) (relating to the establishment of national adjusted DRG rates) to clarify that in establishing a national standard rate the Secretary shall adjust the estimate to take to take into account payments to disproportionate share hospitals and shall include additional payments made to hospitals under section 4104 in setting a standard amount.

(c) Clarifies that the change in DSH payments relates only to hospitals located in participating states.

Section 4105. Moratorium on Designation of Additional Long-Term Care Hospitals. Amends section 1886(d) pertaining to payments to hospitals to prohibit the Secretary from treating as a long term care hospital any hospital that did not have such a status as of the enactment of the Health Security Act.

Section 4106. Extension of Freeze on Updates to Routine Service Costs of Skilled Nursing Facilities. (a) Amends section 1888(a) (relating to payment to skilled nursing facilities for routine costs) to limit to 100 percent the upper limit on payment for reasonable routine service costs for services in skilled nursing facilities and authorizes the Secretary to make such further adjustments as are necessary to extend the savings achieved by OBRA 1993.

(b) Amends section 1888(d)(2) (relating to routine payments to skilled nursing facilities) to limit per diem payments for routine services furnished in skilled nursing facilities to no more than 100 percent of the reasonable cost and authorizes the Secretary to make such further adjustments as are necessary to extend the savings achieved by OBRA 1993.