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

(C) RISE AND REPORT.—At the conclusion of the consideration of the implementing bill for amendment, the Committee of the Whole on the State of the Union shall rise and report the bill to the House with such amendments as may have been adopted, and the previous question shall be considered as ordered on the bill and the amendments thereto, and the House shall proceed to vote on final passage without intervening motion except one motion to recommit.

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

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

(B) any Saturday and Sunday not excluded under subparagraph (A) when either House is not in session.

TITLE III—ENTITLEMENT REFORMS

SEC. 3000. REFERENCES IN TITLE.

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

Subtitle A—Medicaid

PART 1—REFORMS

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

SEC. 3001. STATE PLAN REQUIREMENT REGARDING ELIGIBILITY FOR MEDICAL ASSISTANCE.

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

(1) by striking "and" at the end of paragraph (61);

(2) by striking the period at the end of paragraph (62) and inserting "; and"; and

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

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

gible for medical assistance under such section as of the date of the enactment of the Health Reform Act.".

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

SEC. 3002. INTEGRATION OF CERTAIN MEDICAID ELIGIBLES INTO REFORMED HEALTH CARE SYSTEM THROUGH STATE PREMIUM AND COST-SHARING ASSISTANCE PROGRAM.

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

"INTEGRATION OF CERTAIN MEDICAID ELIGIBLES INTO REFORMED HEALTH CARE SYSTEM

"SEC. 1931. (a) IN GENERAL.—

"(1) REQUIREMENT ON STATES.—

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

"(i) shall not furnish medical assistance consisting of acute medical services

described in paragraph (3) to any individuals not described in subsection (b) who are otherwise eligible for medical assistance under the plan; and

"(ii) shall integrate such individuals into the State's premium and cost-sharing assistance program under subtitle B of title II of the Health Reform Act.

"(B) SPECIAL RULE.—Subparagraph (A) shall not apply if—

"(i) the eligibility percentage (as described in section 2102(a)(2)(A)(ii) of the Health Reform Act) for premium assistance for individuals with incomes below certain income thresholds (described in section 2102(a)(2)(A) of such Act) does not equal or exceed 110 percent, and

"(ii) the eligibility percentage (as described in section 2102(a)(2)(B)(ii) of the Health Reform Act) for premium assistance for children and pregnant women (described in section 2102(a)(2)(B) of such Act) does not equal or exceed 240 percent.

"(2) STATE OPTION.—

"(A) IN GENERAL.—For 1997, 1998, and for any succeeding year during which paragraph (1)(B) applies, a State may elect to integrate individuals into the State's premium and cost-sharing assistance program as described in paragraph (1)(A) if the State notifies the Secretary of such election not later than October 1 of the year preceding the year the State intends to begin such integration.

"(B) STATES FURNISHING SERVICES UNDER A WAIVER.—If a State making an election under subparagraph (A) is furnishing medical assistance consisting of acute medical services described in paragraph (3) under a waiver legally in effect under section 1115 and granted pursuant to an application submitted on or before the date of the enactment of the Health Reform Act to individuals who would otherwise be integrated into the State's premium and cost-sharing assistance program, such State may continue to furnish such services to such individuals until the earliest of—

"(i) the termination of the waiver by the State or the Secretary;

"(ii) a determination that the waiver is not legally in effect; or

"(iii) January 1, 1999.

"(3) ACUTE MEDICAL SERVICES.—The term 'acute medical services' means items and services described in section 1905(a) other than the following:

"(A) Nursing facility services (as defined in section 1905(f)).

"(B) Intermediate care facility for the mentally retarded services (as defined in section 1905(d)).

"(C) Personal care services (as described in section 1905(a)(24)).

"(D) Private duty nursing services (as referred to in section 1905(a)(8)).

"(E) Home or community-based services furnished under a waiver granted under subsection (c), (d), or (e) of section 1915.

"(F) Home and community care furnished to functionally disabled elderly individuals under section 1929.

"(G) Community supported living arrangements services under section 1930.

"(H) Case-management services (as described in section 1915(g)(2)).

"(I) Home health care services (as referred to in section 1905(a)(7)), clinic services, and rehabilitation services that are furnished to an individual who has a condition or disability that qualifies the individual to receive any of the services described in a previous subparagraph.

"(J) Services furnished in an institution for mental diseases (as defined in section 1905(i)).

"(b) INDIVIDUALS DESCRIBED.—

"(1) IN GENERAL.—The individuals described in this subsection are—

"(A) SSI-eligible individuals (as defined in paragraph (2));

"(B) individuals who are eligible for benefits under part A of title XVIII; and

"(C) certain aliens with respect to whom emergency services are furnished under section 1903(v)(2).

"(2) SSI-ELIGIBLE INDIVIDUAL.—The term 'SSI-eligible individual' means an individual who is eligible for medical assistance under the State plan and—

"(A) with respect to whom supplemental security income benefits are being paid under title XVI,

"(B) who is receiving a supplementary payment under section 1616 or under section 212 of Public Law 93–66, or

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

"(c) STATE MAINTENANCE OF EFFORT.—

"(1) IN GENERAL.—

"(A) REDUCTION IN QUARTERLY PAYMENTS.—For any calendar quarter in an integration year (as defined in subparagraph (B)), the amount otherwise payable to a State under section 1903 for the quarter shall be reduced by the State maintenance of effort amount for the quarter determined under paragraph (2).

"(B) INTEGRATION YEAR.—For purposes of this paragraph, the term 'integration year' means the first year that the State integrates individuals into the State's premium and cost-sharing assistance program and any succeeding year.

"(2) MAINTENANCE OF EFFORT AMOUNT.—

"(A) IN GENERAL.—The maintenance of effort amount for a State for a calendar quarter in an integration year shall be equal to 25 percent of the State's base payment amount (determined under subparagraph (B)), updated by the percentage change in the State inflation index (described in subparagraph (C)(i)) and the State population index (described in subparagraph (C)(ii)) during the period beginning on January 1, 1995, and ending on December 31 of the applicable integration year (as determined by the Secretary).

"(B) STATE BASE PAYMENT AMOUNT.—The base payment amount for a State for an integration year shall be an amount, as determined by the Secretary, equal to the total expenditures from State funds made under the State plan during fiscal year 1994 with respect to medical assistance consisting of items and services of the type included in the standard benefits package (as defined in section 1101(1)(A) of the Health Reform Act) of the Health Reform Act) for individuals who would not have received such medical assistance if the provisions of this section and the State's pre-

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

"(C) INDEXES.—

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

"(ii) STATE POPULATION INDEX.—The Secretary shall establish a State population index which measures the change in the number of individuals residing in a State from year to year.".

(b) NO FEDERAL FINANCIAL PARTICIPATION.—Section 1903(i) (42 U.S.C. 1396b(i)) is amended—

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

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

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

"(16) with respect any medical assistance consisting of acute medical services described in section

1931(a)(3) furnished to individuals who are not described in section 1931(b).".

(c) EFFECTIVE DATE.—The amendments made by this section shall be effective with respect calendar quarters beginning on or after January 1, 1997.

SEC. 3003. STATE PROGRAMS FOR PROVIDING SUPPLEMENTAL BENEFITS.

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

(1) by striking "and" at the end of paragraph (62);

(2) by striking the period at the end of paragraph (63) and inserting "; and"; and

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

"(64) provide for a State program furnishing supplemental benefits in accordance with part B.".

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

"PART B—STATE PROGRAMS FOR SUPPLEMENTAL BENEFITS

"SEC. 1961. REQUIREMENT TO OPERATE STATE PROGRAM.

"(a) IN GENERAL.—A State with a State plan approved under part A shall have in effect a program for furnishing supplemental benefits (as defined in section 1962(c)) in accordance with this part in calendar years beginning after 1996.

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

"SEC. 1962. PROGRAM DESCRIBED.

"(a) IN GENERAL.—A State program under this part shall furnish supplemental benefits to such classes and categories of the individuals eligible for premium assistance under the State's program for premium and cost-sharing assistance under subtitle B of title II of the Health Reform Act, as determined appropriate by the State.

"(b) PRIORITIES.—

"(1) IN GENERAL.—A State must give priority to children and pregnant women and may give priority to individuals residing in medically underserved areas in furnishing services under this part.

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

"(c) SUPPLEMENTAL BENEFITS DEFINED.—The term 'supplemental benefits' means the acute medical services described in section 1931(a)(3) that are not included in the items and services provided under the standard benefits package (as defined in section 1101(1)(A) of the Health Reform Act).

"SEC. 1963. PAYMENTS TO STATES.

"From its allotment under section 1964(b), the Secretary shall pay to each State for each quarter beginning with the quarter commencing January 1, 1997, an amount equal to—

"(1) an amount equal to the State's Federal medical assistance percentage (as defined in section 1905(b)) of the amount demonstrated by State claims to have been expended during the quarter for furnishing services to eligible individuals under this part; plus

"(2) an amount equal to 50 percent of the remainder of the amounts expended during the quarter as found necessary by the Secretary for the proper and efficient administration of the State program.

"SEC. 1964. FUNDING.

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

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

"(2) for succeeding fiscal years, the amount determined under this subsection for the preceding fiscal year updated by the estimated percentage change in the State inflation index described in section 1931(c)(2)(C)(i) and the State population index described in section 1931(c)(2)(C)(ii).

"(b) ALLOTMENTS TO STATES.—

"(1) IN GENERAL.—The Secretary shall allot the amounts available under subsection (a) for the fiscal year to the States in accordance with an allocation formula developed by the Secretary which takes into account—

"(A) the number of individuals who are eligible for premium assistance under a State's program for premium and cost-sharing assistance compared to the number of such individuals in all States; and

"(B) a State's matching percentage (as defined in paragraph (3)).

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

not expended in such year shall remain available for State programs under this part and may be reallocated to States as the Secretary determines appropriate.

"(3) STATE MATCHING PERCENTAGE.—The term 'State matching percentage' means, with respect to a State, the amount (expressed as a percentage) equal to 1 minus the State's Federal medical assistance percentage.

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

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

"TITLE XIX—MEDICAL ASSISTANCE PROGRAMS AND STATE PROGRAMS FOR SUPPLEMENTAL BENEFITS".

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

SEC. 3004. DEMONSTRATION PROJECTS PERMITTING COVERAGE UNDER CERTIFIED HEALTH PLANS OF SSI-ELIGIBLE INDIVIDUALS.

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

(b) APPLICATION.—A State desiring to participate in a demonstration project under this section shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary determines appropriate.

(c) REQUIREMENTS.—A State participating in a demonstration project under this section shall, in addition to any requirements imposed by the Secretary, meet the following requirements with respect to SSI-eligible individuals:

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

strued to waive any limits on the capacity of a certified health plan applicable under title II of this Act.

(2) INFORMED CHOICE.—The State shall ensure that each SSI-eligible individual is provided sufficient information to make an informed choice about enrolling in a certified health plan and selecting such a plan.

(3) COORDINATION OF BENEFITS.—The State shall ensure that benefits covered under the standard benefits package and provided by a certified health plan are coordinated with any supplemental benefits provided by the State to an SSI-eligible individual.

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

(d) LIMITATION ON NUMBER OF INDIVIDUALS PERMITTED TO MAKE ELECTION.—

(1) IN GENERAL.—

(A) LIMITATION.—The number of SSI-eligible individuals electing to enroll in a certified

health plan under a demonstration project conducted in a State during a year may not exceed the applicable percentage determined under subparagraph (B) of the Secretary's estimate of the total number of such individuals in the State who are eligible to enroll in certified health plans under the project during the year.

(B) APPLICABLE PERCENTAGE DESCRIBED.—The 'applicable percentage' determined under this subparagraph with respect to a State for a year—

(i) for each of the first 3 years for which the State participates in a demonstration project, 15 percent; and

(ii) for each succeeding year in which the State participates in a such a project, the applicable percentage under this subparagraph for the preceding year, increased by 10 percent.

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

(e) DEFINITIONS.—

(1) CERTIFIED HEALTH PLAN.—The term "certified health plan" means a certified health plan (as defined in section 3(a)(2) of the Health Reform Act) that provides a standard benefits package (as described in section 1101(1)(A) of such Act).

(2) SSI-ELIGIBLE INDIVIDUAL.—The term "SSI-eligible individual" means an individual who is eligible for medical assistance under the State plan and—

(A) with respect to whom supplemental security income benefits are being paid under title XVI of the Social Security Act,

(B) who is receiving a supplementary payment under section 1616 of such Act or under section 212 of Public Law 93–66, or

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

Subpart B—State Eligibility to Contract for Coordinated Care Services

SEC. 3011. MODIFICATION OF FEDERAL REQUIREMENTS TO ALLOW STATES MORE FLEXIBILITY IN CONTRACTING FOR COORDINATED CARE SERVICES UNDER MEDICAID.

(a) IN GENERAL.—

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

"(m)(1) No payment shall be made under this title to a State with respect to expenditures incurred by such State for payment to an entity which is at risk (as defined in section 1932(a)(4)) for services provided by such entity to individuals eligible for medical assistance under the State plan under this title, unless the entity is a risk contracting entity (as defined in section 1932(a)(3)) and the State and such entity comply with the applicable provisions of section 1932.

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

ment is a primary care case management entity (as defined in section 1932(a)(2)) and the State and such entity comply with the applicable provisions of section 1932.".

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

"REQUIREMENTS FOR COORDINATED CARE SERVICES

"SEC. 1932. (a) DEFINITIONS.—For purposes of this title—

"(1) PRIMARY CARE CASE MANAGEMENT PROGRAM.—The term 'primary care case management program' means a program operated by a State agency under which such State agency enters into contracts with primary care case management entities for the provision of health care items and services which are specified in such contracts and the provision of case management services to individuals who are—

"(A) eligible for medical assistance under the State plan,

"(B) enrolled with such primary care case management entities, and

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

agement services only as approved and arranged for, or provided, by such entities.

"(2) PRIMARY CARE CASE MANAGEMENT ENTITY.—The term 'primary care case management entity' means a health care provider which—

"(A) must be a physician, group of physicians, a Federally qualified health center, a rural health clinic, or an entity employing or having other arrangements with physicians operating under a contract with a State to provide services under a primary care case management program,

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

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

"(D) is not an entity that is at risk (as defined in paragraph (4)) for such case management services.

"(3) RISK CONTRACTING ENTITY.—The term 'risk contracting entity' means an entity which has a contract with the State agency (or a health insuring organization described in subsection (n)(2)) under which the entity—

"(A) provides or arranges for the provision of health care items or services which are specified in such contract to individuals eligible for medical assistance under the State plan, and

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

"(4) AT RISK.—The term 'at risk' means an entity which—

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

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

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

"(5) FEDERALLY QUALIFIED HEALTH CENTER.—The term 'Federally qualified health center' means a Federally qualified health center as defined in section 1905(l)(2)(B).

"(6) RURAL HEALTH CLINIC.—The term 'rural health clinic' means a rural health clinic as defined in section 1905(l)(1).

"(b) GENERAL REQUIREMENTS FOR RISK CONTRACTING ENTITIES.—

"(1) ORGANIZATION.—A risk contracting entity meets the requirements of this section only if such entity—

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

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

"(B) is a Federally qualified health center or a rural health clinic which has made adequate provision against the risk of insolvency (pursuant to the guidelines and regulations issued by the Secretary under this section), and ensures that individuals eligible for medical assistance under the State plan are not held liable for such entity's debts in case of such entity's insolvency; or

"(C) is an entity which meets all applicable State licensing requirements and has made adequate provision against the risk of insolvency (pursuant to the guidelines and regulations issued by the Secretary under this section), and ensures that individuals eligible for medical assistance under the State plan are not held liable for such entity's debts in case of such entity's insolvency.

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

"(A) the geographic locations, hours of operation, patient to staff ratios, and other relevant characteristics of such entity are sufficient to afford individuals eligible for medical

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

"(B) such entity has reasonable and adequate hours of operation, including 24-hour availability of—

"(i)(I) treatment for an unforeseen illness, injury, or condition of an individual eligible for medical assistance under the State plan and enrolled with such entity; or

"(II) referral to other health care providers for such treatment; and

"(ii) other information, as determined by the Secretary or the State; and

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

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

"(A) that the entity will comply with all applicable provisions of this section, that the State has the right to penalize the entity for failure to comply with such requirements and to terminate the contract in accordance with subsection (j), and that the entity will be subject to penalties imposed by the Secretary under subsection (i) for failure to comply with such requirements;

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

"(i) payments to the entity under the contract shall not exceed an amount equal to 100 percent of the costs (which shall include administrative costs and which may include costs for inpatient hospital services that would have been incurred in the absence of such contract) that would have been incurred by the State agency in the absence of the contract; and

"(ii) the financial risk for inpatient hospital services is limited to an extent established by the State;

"(C) that the Secretary and the State (or any person or organization designated by either) shall have the right to audit and inspect any books and records of the entity (and of any subcontractor) that pertain—

"(i) to the ability of the entity (or a subcontractor) to bear the risk of potential financial losses; or

"(ii) to services performed or determinations of amounts payable under the contract;

"(D) that in the entity's enrollment, reenrollment, or disenrollment of individuals eligible for medical assistance under the State plan and eligible to enroll, reenroll, or disenroll with the entity pursuant to the contract, the entity will not discriminate among such individuals on the basis of such individuals' health status or requirements for health care services;

"(E)(i) individuals eligible for medical assistance under the State plan who have enrolled with the entity are permitted to terminate such

enrollment without cause as of the beginning of the first calendar month (or in the case of an entity described in subsection (e)(4), as of the beginning of the first enrollment period) following a full calendar month after a request is made for such termination;

"(ii) that when an individual has relocated outside the entity's service area, and the entity has been notified of the relocation, services (within reasonable limits) furnished by a health care provider outside the service area will be reimbursed either by the entity or by the State agency; and

"(iii) for written notification of each such individual's right to terminate enrollment, which shall be provided at the time of such individual's enrollment, and, in the case of a child with special health care needs as defined in subsection (e)(1)(B)(ii), at the time the entity identifies such a child;

"(F) in the case of services immediately required to treat an unforeseen illness, injury, or condition, of an individual eligible for medical assistance under the State plan and enrolled with the entity—

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

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

"(G) for disclosure of information in accordance with subsection (h) and section 1124;

"(H) that any physician incentive plan operated by the entity meets the requirements of section 1876(i)(8);

"(I) for maintenance of sufficient patient encounter data to identify the physician who delivers services to patients;

"(J) that the entity will comply with the requirement of section 1902(w) with respect to each enrollee;

"(K) that the entity will implement a grievance system, inform enrollees in writing about how to use such grievance system, ensure that grievances are addressed in a timely manner, and report grievances to the State at intervals to be determined by the State;

"(L) that contracts between the entity and each subcontractor of such entity will require each subcontractor—

"(i) to cooperate with the entity in the implementation of its internal quality assurance program under paragraph (4) and adhere to the standards set forth in the quality assurance program, including standards with respect to access to care, facilities in which patients receive care, and availability, maintenance, and review of medical records;

"(ii) to cooperate with the Secretary, the State agency and any contractor to the State in monitoring and evaluating the quality and appropriateness of care provided to enrollees as required by Federal or State laws and regulations; and

"(iii) where applicable, to adhere to regulations and program guidance with respect to reporting requirements under section 1905(r);

"(M) that, where the State deems it necessary to ensure the timely provision to enrollees of the services listed in subsection

(f)(2)(C)(ii), the State may arrange for the provision of such services by health care providers other than the entity and may adjust its payments to the entity accordingly;

"(N) that the entity and the State will comply with guidelines and regulations issued by the Secretary with respect to procedures for marketing and information that must be provided to individuals eligible for medical assistance under the State plan;

"(O) that the entity must provide payments to hospitals for inpatient hospital services furnished to infants who have not attained the age of 1 year, and to children who have not attained the age of 6 years and who receive such services in a disproportionate share hospital, in accordance with paragraphs (2) and (3) of section 1902(s);

"(P) that the entity shall report to the State, at such time and in such manner as the State shall require, on the rates paid for hospital services (by type of hospital and type of service) furnished to individuals enrolled with the entity;

"(Q) detailed information regarding the relative responsibilities of the entity and the State, for providing (or arranging for the provision of), and making payment for, the following items and services:

"(i) immunizations;

"(ii) the purchase of vaccines;

"(iii) lead screening and treatment services;

"(iv) screening and treatment for tuberculosis;

"(v) screening and treatment for, and preventive services related to, sexually transmitted diseases, including HIV infection;

"(vi) screening, diagnostic, and treatment services required under section 1905(r);

"(vii) family planning services;

"(viii) services prescribed under—

"(I) an Individual Education Plan or Individualized Family Service Plan under part B or part H of the Individuals with Disabilities Education Act; and

"(II) any other individual plan of care or treatment developed under this title or title V;

"(ix) transportation needed to obtain services to which the enrollee is entitled under the State plan or pursuant to an individual plan of care or treatment described in subclauses (I) and (II) of clause (viii); and

"(x) such other services as the Secretary may specify;

"(R) detailed information regarding the procedures for coordinating the relative responsibilities of the entity and the State to ensure prompt delivery of, compliance with any applicable reporting requirements related to, and appropriate record keeping with respect to, the items and services described in subparagraph (Q); and

"(S) such other provisions as the Secretary may require.

"(4) INTERNAL QUALITY ASSURANCE.—A risk contracting entity meets the requirements of this section only if such entity has in effect a written internal quality assurance program which includes a

systematic process to achieve specified and measurable goals and objectives for access to, and quality of, care, which—

"(A) identifies the organizational units responsible for performing specific quality assurance functions, and ensures that such units are accountable to the governing body of the entity and that such units have adequate supervision, staff, and other necessary resources to perform these functions effectively,

"(B) if any quality assurance functions are delegated to other entities, ensures that the risk contracting entity remains accountable for all quality assurance functions and has mechanisms to ensure that all quality assurance activities are carried out,

"(C) includes methods to ensure that physicians and other health care professionals under contract with the entity are licensed or certified as required by State law, or are otherwise qualified to perform the services such physicians and other professionals provide, and that these qualifications are ensured through appropriate credentialing and recredentialing procedures,

"(D) provides for continuous monitoring of the delivery of health care, through—

"(i) identification of clinical areas to be monitored, including immunizations, prenatal care, services required under section 1905(r), and other appropriate clinical areas, to reflect care provided to enrollees eligible for medical assistance under the State plan,

"(ii) use of quality indicators and standards for assessing the quality and appropriateness of care delivered, and the availability and accessibility of all services for which the entity is responsible under such entity's contract with the State,

"(iii) use of epidemiological data or chart review, as appropriate, and patterns of care overall,

"(iv) patient surveys, spot checks, or other appropriate methods to determine whether—

"(I) enrollees are able to obtain timely appointments with primary care providers and specialists, and

"(II) enrollees are otherwise guaranteed access and care as provided under paragraph (2),

"(v) provision of written information to health care providers and other personnel on the outcomes, quality, availability, accessibility, and appropriateness of care, and

"(vi) implementation of corrective actions,

"(E) includes standards for timely enrollee access to information and care which at a minimum shall incorporate standards used by the State or professional or accreditation bodies for facilities furnishing perinatal and neonatology care and other forms of specialized medical and surgical care,

"(F) includes standards for the facilities in which patients receive care,

"(G) includes standards for managing and treating medical conditions prevalent among such entity's enrollees eligible for medical assistance under the State plan,

"(H) includes mechanisms to ensure that enrollees eligible for medical assistance under

the State plan receive services for which the entity is responsible under the contract which are consistent with standards established by the applicable professional societies or government agencies,

"(I) includes standards for the availability, maintenance, and review of medical records consistent with generally accepted medical practice,

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

"(K) meets any other requirements prescribed by the Secretary or the State.

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

"(1) provide that each primary care case management entity participating in such program has a written contract with the State agency,

"(2) include methods for selection and monitoring of participating primary care case management entities to ensure—

"(A) that the geographic locations, hours of operation, patient to staff ratio, and other relevant characteristics of such entities are sufficient to afford individuals eligible for medical assistance under the State plan access to such entities that is at least equivalent to the access to health care providers that would be available to such individuals if such individuals were not enrolled with such entity,

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

"(C) that such entities—

"(i) provide timely and appropriate primary care to such enrollees consistent with standards established by applicable professional societies or governmental agencies, or such other standards prescribed by the Secretary or the State, and

"(ii) where other items and services are determined to be medically necessary,

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

"(3) provide that no preapproval shall be required for emergency health care items or services, and

"(4) permit individuals eligible for medical assistance under the State plan who have enrolled with a primary care case management entity to terminate such enrollment without cause not later than the beginning of the first calendar month following a full calendar month after the request is made for such termination.

"(d) EXEMPTIONS FROM STATE PLAN REQUIREMENTS.—A State plan may permit or require an individual eligible for medical assistance under such plan to enroll with a risk contracting entity or a primary care case management entity without regard to the requirements set forth in the following paragraphs of section 1902(a):

"(1) Paragraph (1) (concerning statewideness).

"(2) Paragraph (10)(B) (concerning comparability of benefits), to the extent benefits not included in the State plan are provided.

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

described in section 1905(a)(4)(C) and except as required under subsection (e).

"(e) STATE OPTIONS WITH RESPECT TO ENROLLMENT AND DISENROLLMENT.—

"(1) MANDATORY ENROLLMENT.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), a State plan may require an individual eligible for medical assistance under such plan to enroll with a risk contracting entity or a primary care case management entity only if the individual is permitted a choice within a reasonable service area (as defined by the State)—

"(i) between or among 2 or more risk contracting entities,

"(ii) among a risk contracting entity and a primary care case management program, or

"(iii) among primary care case management entities.

"(B) SPECIAL NEEDS CHILDREN.—

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

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

"(ii) DEFINITION.—For purposes of this subparagraph, the term 'child with special health care needs' refers to an individual eligible for supplemental security income under title XVI, a child described under section 501(a)(1)(D), or a child described in section 1902(e)(3).

"(2) REENROLLMENT OF INDIVIDUALS WHO REGAIN ELIGIBILITY.—In the case of an individual who—

"(A) in a month is eligible for medical assistance under the State plan and enrolled with a risk contracting entity with a contract under this section,

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

"(C) in the succeeding month is again eligible for such benefits,

the State agency (subject to subsection (b)(3)(E)) may enroll the individual for that succeeding month with such entity, if the entity continues to have a contract with the State agency under this subsection.

"(3) DISENROLLMENT.—

"(A) RESTRICTIONS ON DISENROLLMENT WITHOUT CAUSE.—Except as provided in subparagraph (C), a State plan may restrict the period in which individuals enrolled with risk contracting entities described in paragraph (4) may terminate such enrollment without cause to the first month of each period of enrollment (as defined in subparagraph (B)), but only if the State provides notification, at least once during each such enrollment period, to individuals enrolled with such entity of the right to terminate such enrollment and the restriction on the exercise of this right. Such restriction shall not apply to requests for termination of enrollment for cause.

"(B) PERIOD OF ENROLLMENT.—For purposes of this paragraph, the term 'period of enrollment' means—

"(i) a period not to exceed 6 months in duration, or

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

quirements under this title under which the State could establish a 1-year minimum period of enrollment with risk contracting entities.

"(C) SPECIAL NEEDS CHILDREN.—A State may not restrict disenrollment of a child with special health care needs (as defined in paragraph (1)(B)(ii)).

"(4) ENTITIES ELIGIBLE FOR DISENROLLMENT RESTRICTIONS.—A risk contracting entity described in this paragraph is—

"(A) a qualified health maintenance organization as defined in section 1310(d) of the Public Health Service Act,

"(B) an eligible organization with a contract under section 1876,

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

"(D) an entity that—

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

30, 1976, and has been a grantee under either such section for all periods after that date, and

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

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

"(F) a nonprofit primary health care entity located in a rural area (as defined by the Appalachian Regional Commission)—

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

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

grant, subgrant, or subcontract under such Act or has provided services on a prepaid capitation or other risk basis under a contract with the State agency initially entered into during a year in which the entity was the recipient of such a grant, subgrant, or subcontract,

"(G) an entity that had contracted with the State agency prior to 1970 for the provision, on a prepaid risk basis, of services (which did not include inpatient hospital services) to individuals eligible for medical assistance under the State plan,

"(H) a program pursuant to an undertaking described in subsection (n)(3) in which at least 25 percent of the membership enrolled on a prepaid basis are individuals who—

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

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

health care costs that would have been paid in whole or in part by any governmental entity,

"(I) an entity that, on the date of enactment of this provision, had a contract with the State agency under a waiver under section 1115 or 1915(b) and was not subject to a requirement under this title to permit disenrollment without cause, or

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

"(f) STATE MONITORING AND EXTERNAL REVIEW.—

"(1) STATE GRIEVANCE PROCEDURE.—A State contracting with a risk contracting entity or a primary care case management entity under this section shall provide for a grievance procedure for enrollees of such entity with at least the following elements:

"(A) A toll-free telephone number for enrollee questions and grievances.

"(B) Periodic notification of enrollees of their rights with respect to such entity or program.

"(C) Periodic sample reviews of grievances registered with such entity or program or with the State.

"(D) Periodic survey and analysis of enrollee satisfaction with such entity or program, including interviews with individuals who disenroll from the entity or program.

"(2) STATE MONITORING OF QUALITY AND ACCESS.—

"(A) RISK CONTRACTING ENTITIES.—A State contracting with a risk contracting entity under this section shall provide for ongoing monitoring of such entity's compliance with the requirements of subsection (b), including compliance with the requirements of such entity's contract under subsection (b)(3), and shall undertake appropriate followup activities to ensure that any problems identified are rectified and that compliance with the requirements of subsection (b) and the requirements of the contract under subsection (b)(3) is maintained.

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

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

"(C) SERVICES.—

"(i) IN GENERAL.—The State shall establish procedures (in addition to those required under subparagraphs (A) and (B)) to ensure that the services listed in clause (ii) are available in a timely manner to an individual enrolled with a risk contracting entity or a primary care case management entity. Where necessary to ensure the timely provision of such services, the State shall arrange for the provision of such services by health care providers other than the risk contracting entity or the primary care case management entity in which an individual is enrolled.

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

"(I) prenatal care;

"(II) immunizations;

"(III) lead screening and treatment;

"(IV) prevention, diagnosis and treatment of tuberculosis, sexually transmitted diseases (including HIV infection), and other communicable diseases; and

"(V) such other services as the Secretary may specify.

"(iii) REPORT.—The procedures referred to in clause (i) shall be described in an annual report to the Secretary provided by the State.

"(3) EXTERNAL INDEPENDENT REVIEW.—

"(A) IN GENERAL.—Except as provided in paragraph (4), a State contracting with a risk contracting entity under this section shall provide for an annual external independent review of the quality and timeliness of, and access to, the items and services specified in such entity's contract with the State agency. Such review shall be conducted by a utilization control and peer review organization with a contract under section 1153 or another organization unaffiliated with the State government or with any

risk contracting entity and approved by the Secretary.

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

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

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

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

"(iv) Other activities as prescribed by the Secretary or the State.

"(C) AVAILABILITY.—The results of each external independent review conducted under

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

"(4) DEEMED COMPLIANCE WITH EXTERNAL INDEPENDENT QUALITY OF CARE REVIEW REQUIREMENTS.—

"(A) IN GENERAL.—The Secretary may deem the State to have fulfilled the requirement for independent external review of quality of care with respect to an entity which has been accredited by an organization described in subparagraph (B) and approved by the Secretary.

"(B) ACCREDITING ORGANIZATION.—An accrediting organization described in this subparagraph must—

"(i) exist for the primary purpose of accrediting coordinated care organizations;

"(ii) be governed by a group of individuals representing health care providers, purchasers, regulators, and consumers (a minority of which shall be representatives of health care providers);

"(iii) have substantial experience in accrediting coordinated care organizations,

including an organization's internal quality assurance program;

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

"(v) be a nonprofit organization; and

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

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

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

"(1) IN GENERAL.—Each risk contracting entity shall, with respect to each electing essential

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

"(A) enter into a written provider participation agreement (described in paragraph (2)) with the provider, or

"(B) enter into a written agreement under which the plan shall make payment to the provider in accordance with paragraph (3).

"(2) PARTICIPATION AGREEMENT.—A participation agreement between a risk contracting entity and an electing essential community provider under this subsection shall provide that the entity agrees to treat the provider in accordance with terms and conditions at least as favorable as those that are applicable to other participating providers with the risk contracting entity with respect to each of the following:

"(A) The scope of services for which payment is made by the entity to the provider.

"(B) The rate of payment for covered care and services.

"(C) The availability of financial incentives to participating providers.

"(D) Limitations on financial risk provided to other participating providers.

"(E) Assignment of enrollees to participating providers.

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

"(3) PAYMENTS FOR PROVIDERS WITHOUT PARTICIPATION AGREEMENTS.—Payment in accordance with this paragraph is payment based on payment methodologies and rates used under the applicable Medicare payment methodology and rates (or the most closely applicable methodology under such program as the Secretary of Health and Human Services specifies in regulations).

"(4) ELECTION.—

"(A) IN GENERAL.—In this subsection, the term 'electing essential community provider' means, with respect to a risk contracting entity, an essential community provider that elects this subpart to apply to the entity.

"(B) FORM OF ELECTION.—An election under this paragraph shall be made in a form and manner specified by the Secretary, and shall include notice to the risk contracting entity involved. Such an election may be made annually with respect to an entity, except that the

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

"(5) PROVIDERS DESCRIBED.—The categories of providers and organizations described in this subsection are as follows:

"(A) MIGRANT HEALTH CENTERS.—A recipient or subrecipient of a grant under section 329 of the Public Health Service Act.

"(B) COMMUNITY HEALTH CENTERS.—A recipient or subrecipient of a grant under section 330 of the Public Health Service Act.

"(C) HOMELESS PROGRAM PROVIDERS.—A recipient or subrecipient of a grant under section 340 of the Public Health Service Act.

"(D) PUBLIC HOUSING PROVIDERS.—A recipient or subrecipient of a grant under section 340A of the Public Health Service Act.

"(E) FAMILY PLANNING CLINICS.—A recipient or subrecipient of a grant under title X of the Public Health Service Act.

"(F) INDIAN HEALTH PROGRAMS.—A service unit of the Indian Health Service, a tribal organization, or an urban Indian program, as defined in the Indian Health Care Improvement Act.

"(G) AIDS PROVIDERS UNDER RYAN WHITE ACT.—A public or private nonprofit health care provider that is a recipient or subrecipient of a grant under title XXIII of the Public Health Service Act.

"(H) MATERNAL AND CHILD HEALTH PROVIDERS.—A public or private nonprofit entity that provides prenatal care, pediatric care, or ambulatory services to children, including children with special health care needs, and that receives funding for such care or services under title V of the Social Security Act.

"(I) FEDERALLY QUALIFIED HEALTH CENTER; RURAL HEALTH CLINIC.—A Federally-qualified health center or a rural health clinic (as such terms are defined in section 1861(aa)).

"(6) SUBRECIPIENT DEFINED.—In this subsection, the term 'subrecipient' means, with respect to a recipient of a grant under a particular authority, an entity that—

"(A) is receiving funding from such a grant under a contract with the principal recipient of such a grant, and

"(B) meets the requirements established to be a recipient of such a grant.

"(7) SUNSET OF REQUIREMENT.—The requirements of this subsection shall only apply to risk contracting entities during calendar years 1995 through 2000.

"(h) TRANSACTIONS WITH PARTIES IN INTEREST.—

"(1) IN GENERAL.—Each risk contracting entity which is not a qualified health maintenance organization (as defined in section 1310(d) of the Public Health Service Act) must report to the State and, upon request, to the Secretary, the Inspector General of the Department of Health and Human Services, and the Comptroller General of the United States a description of transactions between the entity and a party in interest (as defined in section 1318(b) of such Act), including the following transactions:

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

"(B) Any furnishing for consideration of goods, services (including management services), or facilities between the entity and such a party, but not including salaries paid to employees for services provided in the normal course of their employment.

"(C) Any lending of money or other extension of credit between the entity and such a party.

The State or the Secretary may require that information reported with respect to a risk contracting entity which controls, or is controlled by, or is under common control with, another entity be in the form of a consolidated financial statement for the risk contracting entity and such entity.

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

"(i) REMEDIES FOR FAILURE TO COMPLY.—

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

"(A) fails substantially to provide services required under section 1905(r), when such an entity is required to do so, or provide medically necessary items and services that are required to be provided to an individual enrolled with such an entity, if the failure has adversely affected (or has substantial likelihood of adversely affecting) the individual;

"(B) imposes premiums on individuals enrolled with such an entity in excess of the premiums permitted under this title;

"(C) acts to discriminate among individuals in violation of the provision of subsection (b)(3)(D), including expulsion or refusal to reenroll an individual or engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment (except as permitted by this section) by eligible individuals with the entity whose medical condition or history indicates a need for substantial future medical services;

"(D) misrepresents or falsifies information that is furnished—

"(i) to the Secretary or the State under this section; or

"(ii) to an individual or to any other entity under this section; or

"(E) fails to comply with the requirements of section 1876(i)(8),

the Secretary may provide, in addition to any other remedies available under law, for any of the remedies described in paragraph (2).

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

"(A) civil money penalties of not more than $25,000 for each determination under paragraph (1), or, with respect to a determination under subparagraph (C) or (D)(i) of such paragraph, of not more than $100,000 for each such determination, plus, with respect to a determination under paragraph (1)(B), double the excess amount charged in violation of such paragraph (and the excess amount charged shall be deducted from the penalty and returned to the individual concerned), and plus, with respect to a determination under paragraph (1)(C), $15,000 for each individual not enrolled as a result of a practice described in such paragraph, or

"(B) denial of payment to the State for medical assistance furnished by a risk contracting entity or a primary care case management entity under this section for individuals enrolled after the date the Secretary notifies the entity of a determination under paragraph (1) and until the Secretary is satisfied that the basis for

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

The provisions of section 1128A (other than subsections (a) and(b)) shall apply to a civil money penalty under subparagraph (A) in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

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

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

"(l) DISPROPORTIONATE SHARE HOSPITALS.—Nothing in this section shall affect any requirement on a State to comply with section 1923.

"(m) REFERRAL PAYMENTS.—For 1 year following the date on which individuals eligible for medical assistance under the State plan in a service area are required to enroll with a risk contracting entity or a primary care case management entity, Federally qualified health centers and rural health centers located in such service area

or providing care to such enrollees, shall receive a fee for educating such enrollees about the availability of services from the risk contracting entity or primary care case management entity with which such enrollees are enrolled.

"(n) SPECIAL RULES.—

"(1) NONAPPLICABILITY OF CERTAIN PROVISIONS TO CERTAIN RISK CONTRACTING ENTITIES.—In the case of any risk contracting entity which—

"(A)(i) is an individual physician or a physician group practice of less than 50 physicians, and

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

"(B) is at risk only for the health care items and services directly provided by such entity,

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

"(2) EXCEPTION FROM DEFINITION OF RISK CONTRACTING ENTITY.—For purposes of this section, the term 'risk contracting entity' shall not include a health insuring organization which was used by a State before April 1, 1986, to administer a por-

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

"(3) NEW JERSEY.—The rules under section 1903(m)(6) as in effect on the day before the effective date of this section shall apply in the case of an undertaking by the State of New Jersey (as described in such section 1903(m)(6)).

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

"(p) GUIDELINES, REGULATIONS, AND MODEL CONTRACT.—

"(1) GUIDELINES AND REGULATIONS ON SOLVENCY.—At the earliest practicable time after the date of enactment of this section, the Secretary shall issue guidelines and regulations concerning solvency standards for risk contracting entities and subcontractors of such risk contracting entities. Such

guidelines and regulations shall take into account characteristics that may differ among risk contracting entities including whether such an entity is at risk for inpatient hospital services.

"(2) GUIDELINES AND REGULATIONS ON MARKETING.—At the earliest practicable time after the date of enactment of this section, the Secretary shall issue guidelines and regulations concerning—

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

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

"(i) the options and rights of such individuals to enroll with, and disenroll from, any such entity, as provided in this section, and

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

obtain services for which such entity is not responsible).

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

"(3) MODEL CONTRACT.—The Secretary shall develop a model contract to reflect the requirements of subsection (b)(3) and such other requirements as the Secretary determines appropriate.".

(b) WAIVERS FROM REQUIREMENTS ON COORDINATED CARE PROGRAMS.—Section 1915(b) (42 U.S.C. 1396n) is amended—

(1) in the matter preceding paragraph (1), by striking "as may be necessary" and inserting ", and section 1932 as may be necessary";

(2) in paragraph (1), by striking "a primary care case-management system or";

(3) by striking "and" at the end of paragraph (3);

(4) by striking the period at the end of paragraph (4) and inserting ", and"; and

(5) by inserting after paragraph (4) the following new paragraph:

"(5) to permit a risk contracting entity (as defined in section 1932(a)(3)) to restrict the period in which individuals enrolled with such entity may terminate such enrollment without cause in accordance with section 1932(e)(3)(A).".

(c) STATE OPTION TO GUARANTEE MEDICAID ELIGIBILITY.—Section 1902(e)(2) (42 U.S.C. 1396a(e)(2)) is amended—

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

"(i) with a qualified health maintenance organization (as defined in title XIII of the Public Health Service Act) or with a risk contracting entity (as defined in section 1932(a)(3)), or

"(ii) with any risk contracting entity (as defined in section 1932(a)(3)) in a State that, on the effective date of this provision, had in effect a waiver under section 1115 of requirements under this title under which the State could extend eligibility for medical assistance for enrollees of such entity, or

"(iii) with an eligible organization with a contract under section 1876,

and who would",

(2) in subparagraph (B), by striking "organization or" each place it appears, and

(3) by adding at the end the following new subparagraph:

"(C) The State plan may provide, notwithstanding any other provision of this title, that an individual shall be deemed to continue to be eligible for benefits under this title until the end of the month following the month in which such individual would (but for this paragraph) lose such eligibility because of excess income and resources, if the individual is enrolled with a risk contracting entity or primary care case management entity (as those terms are defined in section 1932(a)).".

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

(1) by striking "organization or by" and inserting "organization, by"; and

(2) by striking "section 1152, as determined by the Secretary," and inserting "section 1152, as determined by the Secretary, or by another organization approved by the Secretary which is unaffiliated

with the State government or with any risk contracting entity (as defined in section 1932(a)(3)),".

(e) ACCUMULATION OF RESERVES BY CERTAIN ENTITIES.—Any organization referred to in section 329, 330, or 340, of the Public Health Service Act which has contracted with a State agency as a risk contracting entity under section 1932(g)(3)(A) of the Social Security Act may accumulate reserves with respect to payments made to such organization under section 1932(g)(3)(C) of such Act.

(f) CONFORMING AMENDMENTS.—

(1) Section 1128(b)(6)(C)(i) (42 U.S.C. 1320a–7(b)(6)(C)(i)) is amended by striking "health maintenance organization" and inserting "risk contracting entity".

(2) Section 1902(a)(23) (42 U.S.C. 1396a(a)(23)) is amended by striking "primary care case-management system (described in section 1915(b)(1)), a health maintenance organization," and inserting "primary care case management program (as defined in section 1932(a)(1)), a risk contracting entity (as defined in section 1932(a)(3)),".

(3) Section 1902(a)(30)(C) (42 U.S.C. 1396a(a)(30)(C)) is amended by striking "use a utilization" and all that follows through "with the re-

sults" and inserting "provide for independent review and quality assurance of entities with contracts under section 1932, in accordance with subsection (f) of such section 1932, with the results".

(4) Section 1902(a)(57) (42 U.S.C. 1396a(a)(57)) is amended by striking "or health maintenance organization (as defined in section 1903(m)(1)(A))" and inserting "risk contracting entity, or primary care case management entity (as defined in section 1932(a))".

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

(A) by striking "and" at the end of paragraph (63);

(B) by striking the period at the end of paragraph (64) and inserting "; and"; and

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

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

"(66) at State option, provide for a program under which the State contracts with risk contracting entities in accordance with section 1932.".

(6) Section 1902(p)(2) (42 U.S.C. 1396a(p)(2)) is amended by striking "health maintenance organization (as defined in section 1903(m))" and inserting "risk contracting entity (as defined in section 1932(a)(3))".

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

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

(B) in paragraph (2)(E)—

(i) by striking "health maintenance organization" and inserting "risk contracting entity", and

(ii) by striking "organization" and inserting "entity".

(8) Section 1903(k) (42 U.S.C. 1396b(k)) is amended by striking "health maintenance organization which meets the requirements of subsection (m) of this section" and inserting "risk contracting entity which meets the requirements of section 1932".

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

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

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

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

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

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

(B) by striking "health maintenance organization (as defined in section 1903(m)(1)(A))" and inserting "risk contracting entity (as defined in section 1932(a)(3)", and

(C) by striking "health maintenance organization in accordance with section 1903(m)" and inserting "risk contracting entity in accordance with section 1932".

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

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

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

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

PART 2—FINANCING PROVISIONS

SEC. 3101. REPLACEMENT OF DSH PAYMENT PROVISIONS WITH PROVISIONS RELATING TO PAYMENTS TO HOSPITALS SERVING VULNERABLE POPULATIONS.

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

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

"(B) NATIONAL DSH PAYMENT LIMIT.—

"(i) IN GENERAL.—Except as provided in clause (ii), the national DSH payment limit for a fiscal year is equal to 12

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

"(ii) REDUCTION IN LIMIT.—For fiscal years during which the eligibility percentage for premium assistance under section 2102(a)(2)(A)(ii) of the Health Reform Act—

"(I) equals or exceeds 125 percent but is less than 150 percent, '10 percent' shall be substituted for '12 percent' in clause (i);

"(II) equals or exceeds 150 percent but is less than 175 percent, '8 percent' shall be substituted for '12 percent' in clause (i);

"(III) equals or exceeds 175 percent but is less than 200 percent, '6 percent' shall be substituted for '12 percent' in clause (i); and

"(IV) equals 200 percent, '4 percent' shall be substituted for '12 percent' in clause (i).

(2) ADJUSTMENTS TO STATE ALLOTMENT LIMITS.—Section 1923(f)(2)(B) (42 U.S.C. 1396r–4(f)(2)(B)) is amended to read as follows:

"(B) EXCEPTIONS.—

"(i) IN GENERAL.—Except as provided in clause (ii), a State DSH allotment under subparagraph (A) for a fiscal year shall not exceed 12 percent of the total amount of expenditures under the State plan for medical assistance during the fiscal year.

"(ii) REDUCTION IN LIMIT.—For fiscal years during which the eligibility percentage for premium assistance under section 2102(a)(2)(A)(ii) of the Health Reform Act—

"(I) equals or exceeds 125 percent but is less than 150 percent, '10 percent' shall be substituted for '12 percent' in clause (i);

"(II) equals or exceeds 150 percent but is less than 175 percent, '8 percent' shall be substituted for '12 percent' in clause (i);

"(III) equals or exceeds 175 percent but is less than 200 percent, '6 percent' shall be substituted for '12 percent' in clause (i); and

"(IV) equals 200 percent, '4 percent' shall be substituted for '12 percent' in clause (i).

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

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

"(A) IN GENERAL.—Subject to subparagraph (B), the State DSH allotment for a fiscal year is equal to the State DSH allotment for the previous fiscal year increased by the State growth factor (as defined in paragraph (3)(B)) for the fiscal year.".

(B) CONFORMING AMENDMENTS.—(i) Section 1923(f) (42 U.S.C. 1396r–4(f)) is amended by striking paragraph (3) and redesignating paragraph (4) as paragraph (3).

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

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

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

"(B) STATE GROWTH AMOUNT.—The term 'State growth amount' means, with respect to a State for a fiscal year, the product of the State growth factor and the State DSH payment limit for the previous fiscal year.".

(iv) Section 1923(f)(1)(A) (42 U.S.C. 1396r–4(f)(1)(A) is amended by striking "(as defined in paragraph (4)(B))" and inserting "(as defined in paragraph (3)(A))".

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

"(h) TERMINATION OF REQUIREMENT TO MAKE PAYMENT ADJUSTMENTS.—

"(1) IN GENERAL.—Any requirement imposed by this section on a State to increase the rate or amount of payment for inpatient hospital services provided by a hospital which serves a disproportionate number of low income patients with special

needs shall terminate in the year described in paragraph (2).

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

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

(1) by striking "or" at the end of paragraph (15),

(2) by striking the period at the end of paragraph (16) and inserting "; or", and

(3) by inserting after paragraph (16) the following new paragraph:

"(17) during or after the year described in section 1923(h)(2) with respect to any payment made by a State to a hospital which serves a disproportionate number of low income patients with special needs that is in excess of the payment otherwise required under this part.".

(5) EFFECTIVE DATE.—The amendments made by this section shall be effective for calendar quarters beginning on or after October 1, 1997.

(b) PAYMENTS TO HOSPITALS SERVING VULNERABLE POPULATIONS.—Title XIX, as amended by section 3003, is amended by adding at the end the following new part:

"PART C—PAYMENTS TO HOSPITALS SERVING VULNERABLE POPULATIONS

"SEC. 1991. PAYMENTS TO HOSPITALS.

"(a) ENTITLEMENT STATUS.—The Secretary shall make payments in accordance with this part to eligible hospitals described in section 1992. The preceding sentence constitutes budget authority in advance of appropriations Acts and represents the obligation of the Federal Government to provide funding for such payments in the amounts, and for the fiscal years, specified in subsection (b).

"(b) AMOUNT OF ENTITLEMENT.—For purposes of subsection (a), the amounts and fiscal years specified in this subsection are (in the aggregate for all eligible hospitals) $2,500,000,000 for the first applicable fiscal year (as defined in section 1994) and for each subsequent fiscal year.

"(c) PAYMENTS MADE ON QUARTERLY BASIS.—Payments to an eligible hospital under this section for a fiscal year shall be made on a quarterly basis during the year.

"SEC. 1992. IDENTIFICATION OF ELIGIBLE HOSPITALS.

"(a) HOSPITALS IN PARTICIPATING STATES.—In order to be an eligible hospital under this part for a fiscal year, a hospital must be located in a State that is a participating State under title I of the Health Reform Act.

"(b) STATE IDENTIFICATION.—In accordance with the criteria described in subsection (c) and such procedures as the Secretary may require, each State shall identify the hospitals in the State that meet such criteria for a fiscal year and provide the Secretary with a list of such hospitals.

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

"SEC. 1993. AMOUNT OF PAYMENTS.

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

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

amount available for payments under this part for the year.

"(c) LOW-INCOME PERCENTAGE DEFINED.—

"(1) IN GENERAL.—For purposes of this section, an eligible hospital's 'low-income percentage' for a year is equal to the amount (expressed as a percentage) of the total low-income days for all eligible hospitals for the year that are attributable to the hospital.

"(2) LOW-INCOME DAYS DESCRIBED.—For purposes of paragraph (1), an eligible hospital's low-income days for a year shall be equal to the product of—

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

"(B) the hospital's low-income utilization rate for the previous year under section 1923(b)(3) (as such section is in effect on the day before the date of the enactment of this part).

"SEC. 1994. DEFINITION.

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

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

"TITLE XIX—MEDICAL ASSISTANCE PROGRAMS, STATE PROGRAMS FOR SUPPLEMENTAL BENEFITS, AND PAYMENTS TO HOSPITALS SERVING VULNERABLE POPULATIONS".

Subtitle B—Medicare

PART 1—REFORMS

SEC. 3201. IMPROVEMENTS TO RISK CONTRACTS.

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

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

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

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

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

develop comparative materials with respect to all eligible organizations in an area (and with respect to the program established under this title for individuals not enrolled with such an organization) for distribution by such organizations or the Secretary to individuals eligible to enroll under this section.".

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

(1) by amending paragraph (2) to read as follows:

"(2) The Secretary may modify or waive the requirement imposed by paragraph (1) if an eligible organization demonstrates that it provides for adequate quality of care for individuals enrolled under this section by—

"(A) meeting the quality standards for organizations with contracts under this section;

"(B) meeting the fiscal soundness requirements under this section;

"(C) demonstrating successful operational experience as an eligible organization under this section for at least the 3 years immediately preceding an application for a waiver under this paragraph; and

"(D) demonstrating that the number of individuals enrolled in the plan or its parent organization is at least 50,000 at the time of application for a waiver under this paragraph.

In making a determination under subparagraph (A) with respect to an eligible organization, the Secretary may accept quality performance standards as measured by private organizations acceptable to the Secretary or organizations designated by the Secretary, including peer review organizations."; and

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

"(4) The Secretary may terminate the requirement under paragraph (1) when the Secretary determines that health plans have established alternative quality assurance mechanisms that effectively provide sufficient quality safeguards.".

(e) REBATES.—Section 1876(g)(2) (42 U.S.C. 1395mm(g)(2)) is amended in the matter following subparagraph (B) by striking "community rate (as so reduced); except" and inserting "community rate (as so reduced) or, at the election of the plan, a cash rebate equal to such difference; except".

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

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

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

SEC. 3202. ADDITIONAL IMPROVEMENTS TO RISK CONTRACTS AND INCORPORATION OF INSURANCE REFORMS.

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

"MEDICARE CHOICE

"SEC. 1876. (a) IN GENERAL.—

"(1) GENERAL PERMISSION TO CONTRACT.—

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

"(i) the plan has at least 5,000 enrollees (except that the Secretary may enter into such a contract with a certified standard health plan that has fewer enrollees if the plan primarily serves members residing outside of urbanized areas); and

"(ii) the plan—

"(I) meets the requirements of this section with respect to individuals enrolled under this section; and

"(II) meets the requirements necessary to maintain its status as a certified standard health plan with respect to individuals enrolled under this section that do not conflict with any of the requirements under this section.

"(B) REASONABLE COST REIMBURSEMENT CONTRACTS.—The Secretary may enter into a reasonable cost reimbursement contract (as defined in paragraph (4)(C)) with any certified standard health plan in a community rating area if—

"(i)(I) the plan so elects;

"(II) the Secretary is not satisfied that the plan has the capacity to bear the risk of potential losses under a risk contract under this section, or

"(III) the plan has an insufficient number of individuals enrolled to be eligible to enter into a risk contract; and

"(ii) the Secretary is otherwise satisfied that the plan is able to perform its contractual obligations effectively and efficiently.

"(2) AVAILABILITY OF PLANS.—

"(A) IN GENERAL.—Subject to the provisions of subsection (e), every individual entitled to benefits under part A and enrolled under part B or enrolled under part B only shall be eligible to enroll under this section with any certified standard health plan with a contract under this section which serves the community rating area in which the individual resides.

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

"(i) during an annual period as prescribed by the Secretary,

"(ii) as specified by the Secretary if the plan is financially insolvent, if the individual moves from the community rating

area served by the plan, if other special circumstances exist, or if the plan offers additional open enrollment periods, as prescribed by the Secretary, and

"(iii) for cause as defined by the Secretary in regulations.

"(C) MARKETING MATERIALS.—

"(i) DISTRIBUTION BY PLANS.—The Secretary may prescribe the procedures and conditions under which a certified standard health plan with a contract under this section may provide individuals eligible to enroll under this section with information about the plan. No brochures, application forms, or other promotional or informational material may be distributed by a plan to (or for the use of) individuals eligible to enroll with the plan under this section unless—

"(I) at least 45 days before its distribution, the plan has submitted the material to the Secretary for review, and

"(II) the Secretary has not disapproved the distribution of the material.

The Secretary shall review all such material submitted and shall disapprove such material if the Secretary determines, in the Secretary's discretion, that the material is materially inaccurate or misleading or otherwise makes a material misrepresentation.

"(ii) DISTRIBUTION BY THE SECRETARY.—The Secretary shall develop and distribute comparative materials to individuals eligible to enroll under this section regarding all certified standard health plans with contracts under this section and the program established under this title for individuals not enrolled with such a plan.

"(3) PAYMENTS.—

"(A) PAYMENTS IN LIEU OF NORMAL PAYMENTS.—Subject to subsection (i)(3), payments under a contract to a certified standard health plan under this section shall be instead of the amounts which (in the absence of the contract) would be otherwise payable, pursuant to sections 1814(b) and 1833(a), for services fur-

nished by or through the plan to individuals enrolled with the plan under this section.

"(B) SOURCE OF PAYMENT.—The payment to a certified standard health plan under this section for individuals enrolled under this section with the plan and entitled to benefits under part A and enrolled under part B shall be made from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund. The portion of that payment to the plan for a month to be paid by each trust fund shall be determined as follows:

"(i) With respect to expenditures by certified standard health plans with risk contracts under this section, the allocation shall be determined each year by the Secretary based on the ratio of expenditures from each trust fund for the preceding year to the expenditures from both trust funds for the preceding year.

"(ii) With respect to expenditures by a certified standard health plan with a reasonable cost reimbursement contract under this section, the initial allocation shall be based on the plan's most recent budget,

such allocation to be adjusted, as needed, after cost settlement to reflect the distribution of actual expenditures.

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

"(A) CERTIFIED STANDARD HEALTH PLAN.—The term 'certified standard health plan' shall have the meaning given such term in section 3(a)(2)(A) of the Health Reform Act.

"(B) COMMUNITY RATING AREA.—The term 'community rating area' means the community rating areas designated by a State under section 1303 of the Health Reform Act.

"(C) REASONABLE COST REIMBURSEMENT CONTRACT.—The term 'reasonable cost reimbursement contract' means a contract with a certified standard health plan pursuant to which such plan is reimbursed on the basis of its reasonable cost (as defined in section 1861(v)) in the manner prescribed in subsection (c)(2).

"(b) PAYMENT RULES UNDER RISK CONTRACTS.—

"(1) IN GENERAL.—

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

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

"(B) DETERMINATION OF CLASSES OF INDIVIDUALS AND RATE FACTORS FOR SUCH CLASSES.—

"(i) DETERMINATION OF CLASSES.—For purposes of this section, the Secretary shall define appropriate classes of individuals, based on age, disability status, usage or nonusage of Veterans' Administration or military treatment facilities and associated physicians, providers, and suppliers, and such other factors as the Secretary determines to be appropriate.

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

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

"(C) MAXIMUM PER CAPITA RATE.—

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

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

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

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

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

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

"(II) FFSPCC RATIO BETWEEN .8 AND .95.—For community rating areas with a FFSPCC ratio less than .95 but greater than .8, the adjustment factor shall be the sum of .85, plus—

"(aa) .1, multiplied by

"(bb) the ratio of the excess of the FFSPCC ratio over .8, to .15.

"(III) FFSPCC RATIO BETWEEN .95 AND 1.05.—For community rating areas with a FFSPCC ratio of at least .95 but less than 1.05, the adjustment factor shall be the FFSPCC ratio.

"(IV) FFSPCC RATIO BETWEEN 1.05 AND 1.2.—For community rating areas with a FFSPCC ratio of at least 1.05 but less than 1.2, the adjustment factor shall be the sum of 1.05, plus—

"(aa) .1, multiplied by

"(bb) the ratio of the excess of the FFSPCC ratio over 1.05, to .15.

"(V) FFSPCC RATIO BETWEEN 1.2 AND 1.5.—For community rating areas with a FFSPCC ratio of at least 1.2 but less than 1.5, the adjustment factor shall be the sum of 1.2, plus—

"(aa) .1, multiplied, by

"(bb) the ratio of the excess of the FFSPCC ratio over 1.2, to .3.

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

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

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

"(iv) BUDGET NEUTRALITY.—The Secretary shall change the adjustment factors as necessary to ensure that total spending under this title shall not exceed the level of spending that would occur if the average medicare per capita rate in each community rating area were equal to the projected average monthly fee-for-service costs for a community rating area in each such community rating area.

"(v) ALTERNATIVE FORMULA.—The Secretary may substitute an alternative formula for determining the maximum rate in each community rating area. Such an alternative formula shall generally conform to the pattern of adjustment factors specified in clause (ii), except that such formula shall maintain a consistent mathematical relationship between the adjustment factor and the FFSPCC ratio in each such com-

munity rating area in a manner that achieves budget neutrality.

"(2) DETERMINATION OF AVERAGE MEDICARE PER CAPITA RATE.—

"(A) DETERMINATION BY SECRETARY.—The Secretary shall annually determine under subparagraph (B), and shall announce (in a manner intended to provide notice to interested parties) not later than October 1 before the calendar year concerned, the average medicare per capita rate of payment for each community rating area.

"(B) FORMULA FOR AVERAGE MEDICARE PER CAPITA RATE.—

"(i) IN GENERAL.—The monthly average medicare per capita rate of payment for a community rating area served by a certified standard health plan shall be equal to the sum of—

"(I) the plan component determined under clause (ii); and

"(II) the fee-for-service component determined under clause (iii).

"(ii) PLAN COMPONENT.—The amount determined under this clause is the

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

"(I) the amount of the uniform monthly premium submitted by the plan to the Secretary under subparagraph (C), adjusted by a factor determined by the Secretary to normalize the difference in the distribution of individuals projected to be enrolled in the plan among the various classes of individuals defined by the Secretary to the community rating area distribution of all individuals in the program under this title among such classes; multiplied by

"(II) a fraction (expressed as a percentage), the numerator of which is the number of all medicare eligible individuals enrolled in the plan (as projected by the plan using either historical experience or some other methodology developed by the Secretary), and the denominator of which is the

number of all medicare eligible individuals in the community rating area.

"(iii) FEE-FOR-SERVICE COMPONENT.—The amount determined under this clause is—

"(I) the projected average monthly per capita fee-for-service costs (as defined in subparagraph (D)) for the community rating area for medicare eligible individuals not enrolled in certified standard health plans with contracts under this section, adjusted by the factor described in clause (ii)(I); multiplied by

"(II) a fraction (expressed as a percentage), the numerator of which is equal to the number of all medicare eligible individuals in the community rating area minus the number of such individuals who are enrolled in certified standard health plans with risk contracts under this section (as determined in accordance with subclause (I)), and the denominator of which is the number of all medicare eligible in-

dividuals in the community rating area.

"(iv) ALTERNATIVE FORMULA.—The Secretary may substitute an alternative formula for determining the average medicare per capita rate in each community rating area. Such alternative formula shall be based on competitive bids submitted by participating certified standard health plans.

"(C) UNIFORM MONTHLY PREMIUMS; PREMIUM FOR SUPPLEMENTARY COVERAGE PLANS.—

"(i) IN GENERAL.—Each certified standard health plan with a risk contract under this section shall, not later than August 1 of each year, submit to the Secretary a bid for the next calendar year for each community rating area with respect to which the plan has a risk contract. A bid with respect to a community rating area shall include the following:

"(I) UNIFORM MONTHLY PREMIUM.—A statement of the uniform monthly premium amount that the

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

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

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

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

year, the Secretary shall provide for notice to certified standard health plans with risk contracts of proposed changes to be made in the methodology or benefit coverage assumptions from the methodology and assumptions used in the previous calendar year and shall provide such plans an opportunity to comment on such proposed changes.

"(D) PROJECTED AVERAGE MONTHLY PER CAPITA FEE-FOR-SERVICE COSTS.—

"(i) IN GENERAL.—For purposes of subparagraph (B), the term 'projected average monthly per capita fee-for-service costs' means, with respect to a community rating area, the amount, prorated to be expressed as a monthly amount, that the Secretary estimates in advance would be payable in any contract year for services covered under parts A and B or part B only and types of expenses otherwise reimbursable under parts A and B or part B only (including administrative costs incurred by organizations described in sections 1816 and 1842), if the services were

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

"(ii) BASIS FOR ESTIMATES.—

"(I) DIRECT CALCULATIONS.—Except as provided in subclause (II), the estimate made by the Secretary under clause (i) shall be made on the basis of actual experience of the community rating area and shall include experience with actual expenditures under this title (trended forward) for individuals who are entitled to such services under this title and are not enrolled with a plan in such area (including individuals who receive services from a facility operated by the Veterans' Administration or a military treatment facility).

"(II) INADEQUATE DATA.—If the Secretary determines that the data in that community rating area is inadequate to make an accurate estimate, the Secretary may use the actual experience of a similar area, with appro-

priate adjustments to assure actuarial equivalence, including adjustments the Secretary may determine appropriate to adjust for demographics, health status, and the presence of specific medical conditions.

"(3) PAYMENT RULES.—

"(A) AMOUNT OF PREMIUM.—Each certified standard health plan with a contract under this section must provide to individuals enrolled with the plan under this section, for the duration of such enrollment during each contract period, a fixed monthly premium equal to the uniform monthly premium amount determined by the plan with respect to the individual under paragraph (2)(C). An individual enrolled in the plan shall be responsible for paying to the plan the difference between the fixed monthly premium amount described in the preceding sentence and the average medicare per capita rate paid to the plan in accordance with subparagraph (B).

"(B) AVERAGE MEDICARE PER CAPITA RATE.—

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

"(ii) ADJUSTMENTS.—

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

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

a health benefit plan operated, sponsored, or contributed to, by the individual's employer or former employer (or the employer or former employer of the individual's spouse) and ending on the date on which the individual is enrolled in the plan under this section, except that for purposes of making such retroactive adjustments under this clause, such period may not exceed 90 days. No adjustment may be made under the preceding sentence with respect to any individual who does not certify that the plan provided the individual with the explanation described in subsection (e)(6) at the time the individual enrolled with the plan.

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

retary under this title for services furnished to the individual.

"(C) PAYMENT GREATER THAN FIXED MONTHLY PREMIUM.—If, with respect to any individual enrolled in a certified standard health plan with a risk contract under this section, the average medicare per capita rate paid under this section to the plan exceeds the fixed monthly premium amount described in subparagraph (A), the plan shall apply such excess to the individual as a contribution to a premium for any policy for any supplemental plan offered by the plan and described in subsection (d)(1)(B) that the individual may elect.

"(e) PAYMENT RULES FOR REASONABLE COST REIMBURSEMENT CONTRACTS.—

"(1) REIMBURSEMENT.—

"(A) IN GENERAL.—A certified standard health plan with a reasonable cost reimbursement contract under this section may, at the option of such plan, provide that the Secretary—

"(i) will reimburse hospitals and skilled nursing facilities either for the reasonable cost (as determined under section

1861(v)) or for payment amounts determined in accordance with section 1886, as applicable, of services furnished to individuals enrolled with such plan, and

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

"(B) DIRECT PAYMENTS.—If a certified standard health plan with a reasonable cost reimbursement contract under this section pays a hospital or skilled nursing facility directly, the amount paid shall not exceed the reasonable cost of the services (as determined under section 1861(v)) or the amount determined under section 1886, as applicable, unless such plan demonstrates to the satisfaction of the Secretary that such excess payments are justified on the basis of advantages gained by the plan.

"(2) PAYMENTS TO PLANS.—Payments made to a certified standard health plan with a reasonable cost reimbursement contract under this section shall be subject to appropriate retroactive corrective adjustment at the end of each contract year so as to assure that such plan is paid for the reasonable cost actually incurred (excluding any part of incurred

cost found to be unnecessary in the efficient delivery of health services) or the amounts otherwise determined under section 1886 for the types of expenses otherwise reimbursable under this title for providing services covered under this title to individuals enrolled in the plan.

"(3) REPORTS BY PLANS.—A certified standard health plan with a reasonable cost reimbursement contract under this subsection shall provide that the Secretary shall require, at such time following the expiration of each accounting period of the plan (and in such form and in such detail) as the Secretary may prescribe—

"(A) that the plan report to the Secretary in an independently certified financial statement its per capita incurred cost based on the types of components of expenses otherwise reimbursable under this title for providing services under parts A and B, including therein, in accordance with accounting procedures prescribed by the Secretary, its methods of allocating costs between individuals enrolled under this section and other individuals enrolled with such plan;

"(B) that failure to report such information as may be required may be deemed to constitute evidence of likely overpayment on the basis of which appropriate collection action may be taken;

"(C) that in any case in which a plan is related to another plan by common ownership or control, a consolidated financial statement shall be filed and that the allowable costs for such organization may not include costs for the types of expense otherwise reimbursable under this title, in excess of those which would be determined to be reasonable in accordance with regulations (providing for limiting reimbursement to costs rather than charges to the plan by related plans and owners) issued by the Secretary; and

"(D) that in any case in which compensation is paid by a plan substantially in excess of what is normally paid for similar services by similar practitioners (regardless of method of compensation), such compensation may as appropriate be considered to constitute a distribution of profits.

"(d) COVERAGE OF BENEFITS.—

"(1) IN GENERAL.—

"(A) STANDARD PACKAGE OF SERVICES.—A certified standard health plan with a contract under this section must provide to individuals enrolled in the plan under this section, through providers and other persons that meet the applicable requirements of this title and part A of title XI—

"(i) only those services covered under parts A and B of this title for those members entitled to benefits under part A and enrolled under part B, or

"(ii) only those services covered under part B for those members enrolled only under such part.

"(B) SUPPLEMENTARY COVERAGE PLANS.—

"(i) REQUIREMENT TO ENROLL IN MINIMUM SUPPLEMENTARY COVERAGE PLAN.—Each individual enrolled in a certified standard health plan must enroll in a supplementary coverage plan that offers at least the benefits described in subclauses (I) and (II) of clause (iii).

"(ii) REQUIREMENT TO OFFER SUPPLEMENTARY COVERAGE PLANS.—A cer-

tified standard health plan with a contract under this section must offer individuals enrolled with the plan under this section at least the 2 supplemental coverage plans described in clauses (iii) and (iv).

"(iii) MINIMUM SUPPLEMENTARY COVERAGE PLAN.—The minimum supplementary coverage plan described under this clause provides—

"(I) coverage for preventive care services (as defined by the Secretary); and

"(II) the following additions to part A coverage under the standard package of services described in subparagraph (A)(i):

"(aa) Inpatient hospital services shall not be limited to 150 days pursuant to section 1812(a)(1).

"(bb) The requirement that an individual be an inpatient in a hospital for 3 consecutive days prior to the individual's receipt of posthospital extended care serv-

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

"(iv) OUTPATIENT PRESCRIPTION DRUG SUPPLEMENTARY COVERAGE PLAN.—The supplementary coverage plan described in this clause provides coverage for outpatient prescription drugs (as defined by the Secretary).

"(v) ONE SPONSOR.—A sponsor of a certified standard health plan may not offer a supplementary coverage plan to an individual that is enrolled in a certified standard health plan of another sponsor, except that sponsors of supplementary coverage plans may offer such supplementary coverage plans to any individual that is entitled to benefits under part A that does not enroll with a certified standard health plan under this section or pursuant to section 3203 of the Health Reform Act.

"(vi) SUPPLEMENTARY COVERAGE PLAN.—The term 'supplementary coverage plan' means any health insurance coverage offered by a certified standard health plan or medicare supplemental policy (as de-

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

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

"(A) make the services described in paragraph (1)(A) (and such other health care services as enrolled individuals have contracted for under a supplemental plan described in paragraph (1)(B))—

"(i) available and accessible to enrolled individuals within the community rating area with reasonable promptness and in a manner which assures continuity, and

"(ii) when medically necessary, available and accessible twenty-four hours a day and seven days a week, and

"(B) provide for reimbursement with respect to services which are described in subparagraph (A) (and such other health care services as enrolled individuals have contracted for under a supplemental plan described in para-

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

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

"(ii) it was not reasonable given the circumstances to obtain the services through the plan.

"(3) SPECIAL EXCEPTION.—If there is a national coverage determination made in the period beginning on the date for the submission of bids under subsection (b)(2)(C) and ending on the next such date of submission that the Secretary projects will result in a significant change in the costs to a certified standard health plan with a risk contract under this section of providing the benefits that are the subject of such national coverage determination and that was not incorporated in the determination of the bid for such period, and if such coverage determination provides for coverage of additional benefits or under additional circumstances, subsection (a)(3)(A) shall not apply to payment for such additional benefits or benefits provided under such additional circumstances until the first contract year

that begins after the end of such period, unless otherwise required by law.

"(4) COST SHARING.—

"(A) IN GENERAL.—Each certified standard health plan with a contract under this section must provide to individuals enrolled under this section with respect to the services described in paragraph (1)(A), standard cost sharing requirements to be determined by the Secretary consistent with cost sharing requirements imposed under a health maintenance organization delivery system.

"(B) COST SHARING FIXED DURING CONTRACT PERIOD.—Each certified standard plan must provide to individuals enrolled under this section, for the duration of such enrollment during each contract period, cost sharing that is fixed during the duration of the contract period.

"(e) ENROLLMENT PERIODS.—

"(1) IN GENERAL.—Each certified standard health plan with a contract under this section must have an open enrollment period (which may be specified by the Secretary), for the enrollment of individuals under this section, of at least 30 days duration

every year and for the additional periods specified under paragraphs (2) through (4), and must provide that at any time during which enrollments are accepted, the plan will accept up to the limits of its capacity (as determined by the Secretary) and without restrictions, except as may be authorized in regulations, individuals who are eligible to enroll in the plan in the order in which they apply for enrollment, unless to do so would result in failure to meet the requirements of subsection (f) or would result in the enrollment of enrollees substantially nonrepresentative, as determined in accordance with regulations of the Secretary, of the population in the community rating area served by the plan.

"(2) NONRENEWAL OR TERMINATION.—

"(A) IN GENERAL.—If a contract under this section is not renewed or is otherwise terminated, certified standard health plans with contracts under this section and serving the same community rating area as under the terminated contract are required to have an open enrollment period for individuals who were enrolled under the terminated contract as of the date of notice of such termination.

"(B) OPEN ENROLLMENT PERIOD.—The open enrollment periods required under subparagraph (A) shall be for 30 days and shall begin 30 days after the date that the Secretary provides notice of such requirement.

"(C) EFFECTIVENESS OF ENROLLMENT.—Enrollment under this paragraph shall be effective 30 days after the end of the open enrollment period, or, if the Secretary determines that such date is not feasible, such other date as the Secretary specifies.

"(3) SPECIAL RULE.—Each certified standard health plan with a contract under this section shall have an open enrollment period for each individual who enrolls in a plan during any enrollment period specified by section 1837 that applies to that individual. Enrollment under this clause shall be effective as specified by section 1838.

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

the month in which the individual becomes a resident of that community rating area and shall end at the end of the following month. Enrollment under this subparagraph shall be effective as of the first of the month following the month in which the individual enrolls.

"(5) CONTINUED ENROLLMENT PROTECTED.—Each certified standard health plan with a contract under this section must provide assurances to the Secretary that it will not expel or refuse to re-enroll any enrolled individual because of the individual's health status or requirements for health care services, and that it will notify each such individual of such fact at the time of the individual's enrollment.

"(6) NOTICE OF RIGHTS, ETC.—Each certified standard health plan with a contract under this section shall provide each enrollee, at the time of enrollment and not less frequently than annually thereafter, an explanation of the enrollee's rights under this section, including an explanation of—

"(A) the enrollee's rights to benefits from the plan,

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

"(C) out-of-area coverage provided by the plan,

"(D) the plan's coverage of emergency services and urgently needed care, and

"(E) appeal rights of enrollees.

"(7) CONTINUATION OF COVERAGE.—Each certified standard plan that provides items and services pursuant to a contract under this section shall provide assurances to the Secretary that in the event the plan ceases to provide such items and services, the plan shall provide or arrange for supplemental coverage of benefits under this title related to a preexisting condition with respect to any exclusion period, to all individuals enrolled with the plan who receive benefits under this title, for the lesser of 6 months or the duration of such period.

"(8) NOTICE OF RIGHT OF TERMINATION.—

"(A) IN GENERAL.—Each certified standard health plan with a risk contract under this section shall notify individuals eligible to enroll with the plan under this section and individuals enrolled with the plan under this section that—

"(i) the plan is authorized by law to terminate or refuse to renew the contract, and