(4) the application is accompanied by the assurances described in section 4011(c); and

(5) the application is accompanied by such additional assurances, agreements, and other information as the Secretary may reasonably require.

(c) OPERATION GRANTS.—

(1) PREFERENCE.—In making a grant or entering into a contract under subsection (a), the Secretary shall give a greater degree of preference to applicants in accordance with subparagraphs (A) and (B) of section 4011(d)(1).

(2) USE OF FINANCIAL ASSISTANCE.—A community health group receiving financial assistance for the operation of the group under a grant or contract pursuant to subsection (a) may use such assistance to address geographic, financial, and other barriers to access health care services including—

(A) transportation, including rural and frontier emergency transportation systems;

(B) patient outreach;

(C) patient education;

(D) translation services;

(E) consumer information that would improve access to care; and

(F) other services related to the provision of health care services.

(d) REPORTS AND AUDITS.—A community health group that receives a grant or contract under subsection (a) shall—

(1) provide such reports and information on activities carried out under this section in a manner and form required by the Secretary; and

(2) provide an annual organization-wide audit that meets applicable standards of the Secretary.

(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to make payments under subsection (a), such sums as may be necessary for each of the fiscal years 1995 through 2004.

## Subpart B—Capital Assistance

### SEC. 4013. LOANS, LOAN GUARANTEES, AND GRANTS FOR CAPITAL INVESTMENT.

(a) IN GENERAL.—In the case of a community health group or isolated rural facility that submits an application in accordance with subsection (b), the Secretary may make the financial assistance described in subsection (c) available to such group or facility for the provision of capital assistance.

(b) APPLICATION.—For purposes of subsection (a), an application is in accordance with this subsection if—

(1) the applicant submits an application to the Secretary at such time and in such manner as the Secretary may reasonably require;

(2) in the case of an isolated rural facility, such facility submits its application prior to January 1, 1999;

(3) in the case of a project for construction, conversion, expansion or modernization of a facility, the applicant submits to the Secretary—

(A) a description of the site;

(B) plans and specifications which meet requirements prescribed by the Secretary;

(C) information reasonably demonstrating that title to such site is vested in one or more of the entities filing the application (unless the agreement described in paragraph (4)(A) is made); and

(D) a specification of the type of financial assistance being requested under subsection (a);

(4) in the case of a project for construction, conversion, expansion or modernization of a facility, the application is accompanied by an agreement that—

(A) title to such site will be vested in one or more of the entities filing the application

(unless the assurance described in paragraph (3)(C) has been submitted under such paragraph);

(B) adequate financial support will be available for completion of the project and for its maintenance and operation when completed;

(C) the facility will be made available to all persons seeking service regardless of their ability to pay;

(5) the application is accompanied by the assurances described in paragraphs section 4011(c) to the same extent and in the same manner as such provisions apply to awards of grants and contracts under such paragraphs, except that if the applicant is an isolated rural facility described in section 4002(d)(9) only the assurances described in paragraph (1) and subparagraphs (A), (B), (C), and (D) (if translation services are appropriate) of paragraph (2) of section 4011(c) shall apply; and

(6) the application is accompanied by such additional assurances, agreements and other information as the Secretary may reasonably require.

(c) FINANCIAL ASSISTANCE DESCRIBED.—The financial assistance that the Secretary may provide under subsection (a) consists of—

(1) loans;

(2) guarantees on the payment of principal and interest to Federal and non-Federal lenders on behalf of community health groups and isolated rural facilities; and

(3) grants for urgent capital needs (in accordance with criteria for determining such needs to be developed by the Secretary).

(d) PRIORITIES REGARDING AVAILABILITY OF FINANCIAL ASSISTANCE.—

(1) AMOUNTS RESERVED FOR FACILITIES IN RURAL DESIGNATED AREAS.—At least 10 percent of the dollar value of financial assistance made under subsection (a) during any given year shall be allocated to entities described in subsection (a) that serve rural underserved areas designated by the State and approved by the Secretary under section 4001(a) or designated by the Secretary under subsection (b) of such section, to the extent the Secretary receives a sufficient number of qualified applications made by such entities.

(2) PREFERENCES.—In making financial assistance available under subsection (a), the Secretary shall give a greater degree of preference to applicants proposing to use such assistance—

(A) for projects for the renovation and modernization of medical facilities necessary to prevent or eliminate safety hazards;

(B) to avoid noncompliance with licensure or accreditation standards; or

(C) to provide essential services.

(3) LIMITATION.—The Secretary may authorize the use of amounts under subsection (a) for the construction of new buildings only if—

(A) the Secretary determines that appropriate facilities are not available through acquiring, modernizing, expanding or converting existing buildings, or that construction of new buildings will cost less; and

(B) the applicant demonstrates that it has secured assurances of State, local, or other non-Federal support of the project.

(e) AMOUNT OF ASSISTANCE.—The principal amount of loans or loan guarantees under subsection (a) may, when added to any other assistance under this section, cover up to 100 percent of the costs involved.

(f) USE OF ASSISTANCE.—

(1) IN GENERAL.—An entity described in subsection (a) shall use the financial assistance described in such subsection for—

(A) the acquisition, modernization, conversion, and expansion of facilities that will enhance the provision and accessibility of health care; and

(B) except as provided in paragraph (2), for the purchase of major equipment, including hardware for information systems.

(2) ISOLATED RURAL FACILITIES.—In the case of an isolated rural facility that receives financial assistance to purchase major equipment for the furnishing of telemedicine services, such facility may not use such assistance to purchase high-cost telemedicine technologies that—

(A) incur high cost per minute of usage charges; or

(B) require consultants to be available at the same time as the patient and the referring physician.

(g) TERMS AND CONDITIONS.—

(1) LOANS.—Any loan made under subsection (a) shall, subject to the Federal Credit Reform Act of 1990, meet such terms and conditions (including provisions for recovery in case of default) as the Secretary, in consultation with the Secretary of the Treasury, determines to be necessary to carry out

the purposes of such section while protecting the financial interests of the United States. Terms and conditions for such loans shall include provisions regarding the following:

(A) Security.

(B) Maturity date.

(C) Amount and frequency of installments.

(D) Rate of interest, which shall be at a rate comparable to the rate of interest prevailing on the date the loan is made.

Notwithstanding the provisions of subparagraph (D), the Secretary shall have the discretion to provide for a rate of interest that is lesser than the rate of interest described in such subparagraph.

(2) LOAN GUARANTEES.—The Secretary may not approve a loan guarantee under this section unless the Secretary determines that the terms, conditions, security (if any), and schedule and amount of repayments with respect to the loan are sufficient to protect the financial interests of the United States and are otherwise reasonable. Such loan guarantees shall be subject to such further terms and conditions as the Secretary determines, in consultation with the Secretary of the Treasury, and subject to the Federal Credit Reform Act of 1990, to be necessary to

ensure that the purposes of this section will be achieved.

(h) DEFAULTS; RIGHT OF RECOVERY.—

(1) DEFAULTS.—

(A) IN GENERAL.—The Secretary may take such action as may be necessary to prevent a default on loans or loan guarantees under this section including the waiver of regulatory conditions, deferral of loan payments, renegotiation of loans, and the expenditure of funds for technical and consultative assistance, for the temporary payment of the interest and principal on such a loan, and for other purposes.

(B) FORECLOSURE.—The Secretary may take such action, consistent with State law respecting foreclosure procedures, as the Secretary deems appropriate to protect the interest of the United States in the event of a default on a loan made pursuant to this section, including selling real property pledged as security for such a loan or loan guarantee and for a reasonable period of time taking possession of, holding, and using real property pledged as security for such a loan or loan guarantee.

(C) WAIVERS.—The Secretary may, for good cause, but with due regard to the financial interests of the United States, waive any right of recovery which the Secretary has by reason of the failure of a borrower to make payments of principal of and interest on a loan made pursuant to this section except that if such loan is sold and guaranteed, any such waiver shall have no effect upon the Secretary's guarantee of timely payment of principal and interest.

(2) TWENTY-YEAR OBLIGATION; RIGHT OF RECOVERY.—

(A) IN GENERAL.—

(i) LOANS AND LOAN GUARANTEES.—With respect to a facility for which a loan, or loan guarantee is to be made pursuant to this section, the Secretary may provide the loan or loan guarantee only if the applicant involved agrees that the applicant will be liable to the United States for the amount of the loan or loan guarantee, together with an amount representing interest, if at any time during the 20-year period beginning on the date of completion of the activities involved, the facility—

(I) ceases to be a facility utilized by a community health group, or by another public or nonprofit private entity that provides health services in one or more areas that are rural or urban underserved areas designated by the State and approved by the Secretary under section 4001(a), or designated by the Secretary under subsection (b) of such section; or

(II) is sold or transferred to any entity other than an entity that is—

(aa) a community health group or other entity described in subclause (I); and

(bb) approved by the Secretary as a purchaser or transferee regarding the facility.

(ii) DIRECT GRANTS.—With respect to a facility for which substantial capital costs are to be paid from a grant made pursuant to this section, an assurance that the applicant will be liable to the United States for the amount of the award expended for such costs, together with an

amount representing interest, if at any time during the 20-year period beginning on the date of completion of the activities involved, the facility—

(I) ceases to be a facility utilized by a community health group, isolated rural facility, or by another public or nonprofit private entity that provides health services in one or more rural or urban underserved areas designated by the State and approved by the Secretary under section 4001(a) or designated by the Secretary under subsection (b) of such section; or

(II) is sold or transferred to any entity other than an entity that is—

(aa) a community health group or other entity described in clause (i); and

(bb) approved by the Secretary as a purchaser or transferee regarding the facility.

(B) SUBORDINATION; WAIVERS.—The Secretary may subordinate or waive the right of recovery under clause (i) or (ii) of subparagraph

(A), and any other Federal interest that may be derived by virtue of a loan, loan guarantee, or grant under subsection (a), if the Secretary determines that subordination or waiver will further the objectives of this section.

(i) REPORTS AND AUDITS.—A community health group or isolated rural facility that receives a loan, loan guarantee, or grant under subsection (a) shall—

(1) provide such reports and information on activities carried out under this section in a manner and form required by the Secretary; and

(2) provide an annual organization-wide audit that meets applicable standards of the Secretary.

(j) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to make payments under subsection (a), such sums as may be necessary for each of the fiscal years 1995 through 2004.

(k) ADMINISTRATION OF PROGRAMS.—This subpart, and any other program of the Secretary that provides loans or loan guarantees, shall be carried out by a centralized loan unit established within the Department of Health and Human Services.

## PART II—DEVELOPMENT OF TELEMEDICINE IN RURAL UNDERSERVED AREAS

### SEC. 4021. GRANTS FOR DEVELOPMENT OF RURAL TELEMEDICINE.

(a) IN GENERAL.—

(1) GRANTS AWARDED.—The Secretary, acting through the Office of Rural Health Policy, shall award grants to eligible entities that have applications approved under subsection (b) for the purpose of expanding access to health care services for individuals in rural areas through the use of telemedicine. Grants shall be awarded under this section to encourage the initial development of rural telemedicine networks, expand existing networks, link existing networks together, or link such networks to existing fiber optic telecommunications systems.

(2) ELIGIBLE ENTITY.—For purposes of this section, the term "eligible entity" includes hospitals and other health care providers in a health care network of community-based providers that includes at least three of the following:

(A) Community or migrant health centers.

(B) Local health departments.

(C) Community mental health centers.

(D) Nonprofit hospitals.

(E) Private practice health professionals, including rural health clinics.

(F) Other publicly funded health or social services agencies.

(b) APPLICATION.—To be eligible to receive a grant under this section an entity shall prepare and submit to the Secretary an application at such time, in such manner and containing such information as the Secretary may require, including the anticipated need for the grant, a description of the use to which the eligible entity would apply any amounts received under such grant, the source and amount of non-Federal funds the entity would pledge for the project, a showing of the long-term viability of the project and evidence of the provider commitment to the network. The applicant should demonstrate the manner in which the project will promote the integration of telemedicine in the community so as to avoid redundancy of technology and achieve economies of scale.

(c) PREFERENCE.—The Secretary shall, in awarding grants under this section, give preference to applicants that—

(1) are health care providers in rural health care networks or providers that propose to form such networks, and the majority of the providers in

such a network are located in a medically underserved or health professional shortage areas;

(2) can demonstrate broad geographic coverage in the rural areas of the State, or States in which the applicant is located;

(3) propose to use Federal funds to develop plans for, or to establish, telemedicine systems that will link rural hospitals and rural health care providers to other hospitals and health care providers;

(4) will use the amounts provided under the grant for a range of health care applications and to promote greater efficiency in the use of health care resources;

(5) demonstrate the long term viability of projects through use of local matching funds (cash or in-kind); and

(6) demonstrate financial, institutional, and community support for the long range viability of the network.

(d) USE OF AMOUNTS.—Amounts received under a grant awarded under this section shall be utilized for the development of telemedicine networks. Such amounts may be used to cover the costs associated with the development of telemedicine networks and the acquisition of

telemedicine equipment and modifications or improvements of telecommunications facilities including—

(1) the development and acquisition through lease or purchase of computer hardware and software, audio and visual equipment, computer network equipment, modification or improvements to telecommunications transmission facilities, telecommunications terminal equipments, interactive video equipment, data terminal equipment, and other facilities and equipment that would further the purposes of this section;

(2) the provision of technical assistance and instruction for the development and use of such programming equipment or facilities;

(3) the development and acquisition of instructional programming;

(4) demonstration projects for teaching or training medical students, residents, and other health professions students in rural training sites about the application of telemedicine;

(5) transmission costs, maintenance of equipment, and compensation of specialists and referring practitioners;

(6) development of projects to use telemedicine to facilitate collaboration between health care providers; or

(7) such other uses that are consistent with achieving the purposes of this section as approved by the Secretary.

(e) PROHIBITED USES.—Amounts received under a grant awarded under this section may not be used for any of the following:

(1) Expenditures to purchase or lease equipment to the extent the expenditures would exceed more than 60 percent of the total grant funds.

(2) Expenditures for indirect costs (as determined by the Secretary) to the extent the expenditures would exceed more than 10 percent of the total grant funds.

**SEC. 4022. REPORT AND EVALUATION OF TELEMEDICINE.**

Not later than October 1, 1995, the White House Information Infrastructure Task Force shall prepare and submit to Congress a report that evaluates telemedicine. Such report shall evaluate—

(1) whether telemedicine expands access to health care services;

(2) the effectiveness and cost effectiveness of telemedicine services;

(3) the quality of telemedicine services delivered; and

(4) all Federal activity regarding telemedicine and recommendations for a coordinated Federal strategy to increase access to health care through telemedicine.

**SEC. 4023. REGULATIONS ON REIMBURSEMENT OF TELEMEDICINE.**

Not later than July 1, 1996, the Secretary, in consultation with the Director of the Office of Rural Health and the Administrator of the Health Care Financing Administration, shall issue regulations concerning reimbursement for telemedicine services provided under title XVIII of the Social Security Act.

**SEC. 4024. AUTHORIZATION OF APPROPRIATIONS.**

There are authorized to be appropriated such sums as may be necessary to carry out this part.

## PART III—ESSENTIAL PUBLIC HEALTH ACTIVITIES

**SEC. 4031. GRANTS TO STATES FOR ESSENTIAL PUBLIC HEALTH ACTIVITIES.**

(a) IN GENERAL.—To enable a State to carry out the activities described in subsection (b), the Secretary shall make a grant to a State that submits an application under section 4034 in an amount that bears the same

ratio to the amount appropriated for the fiscal year involved as the amounts provided by the Secretary to the State for fiscal year 1981 under the provisions of law referred to in section 1902(a)(2) of the Public Health Service Act (42 U.S.C. 300w-1(a)(2)) bear to the total amount appropriated with respect to such provisions for fiscal year 1981.

(b) ESSENTIAL PUBLIC HEALTH ACTIVITIES.—For purposes of subsection (a), the activities described in this subsection are, subject to subsection (c), as follows:

(1) Data collection and activities related to population health measurement and outcomes monitoring (including gender differences, ethnic identifiers, and health differences between racial and ethnic groups), and analysis for planning and needs assessment.

(2) Activities to protect the environment and to assure the safety of housing, workplaces, food and water, and the public health of communities (including support for poison control centers and preventive health services programs to reduce the prevalence of chronic diseases and to prevent intentional and unintentional injuries).

(3) Investigation and control of adverse health conditions.

(4) Public information and education programs to reduce risks to health.

(5) Accountability and quality assurance activities, including quality of personal health services and any communities' overall access to health services.

(6) Provision of public health laboratory services.

(7) Training and education with special emphasis placed on the training of public health professions and occupational health professionals.

(8) Leadership, policy development and administration activities.

(c) RESTRICTIONS ON USE OF GRANT.—

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

(A) to provide inpatient services;

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

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

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

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

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

(d) MAINTENANCE OF EFFORT.—A funding agreement for a grant under subsection (a) is that the State involved will maintain expenditures of non-Federal amounts for essential public health activities at a level that is not less than the level of such expenditures maintained by the State for the fiscal year preceding the first fiscal year for which the State receives such a grant.

**SEC. 4032. SUBMISSION OF INFORMATION.**

The Secretary may make a grant under section 4031 only if the State involved submits to the Secretary the following information:

(1) A description of existing deficiencies in the State's public health system (at the State level and

the local level), using standards of sufficiency developed by the Secretary.

(2) A description of health status measures to be improved within the State (at the State level and the local level) through expanded public health functions.

(3) Measurable outcomes and process objectives for improving health status and essential public health activities for which the grant is to be expended.

(4) Information regarding each such activity, which—

(A) identifies the amount of State and local funding expended on each such activity for the fiscal year preceding the fiscal year for which the grant is sought; and

(B) provides a detailed description of how additional Federal funding will improve each such activity by both the State and local public health agencies.

(5) A description of the essential public health activities to be carried out at the local level, and a specification for each such activity of—

(A) the communities in which the activity will be carried out; and

(B) the amount of the grant to be expended for the activity in each community so specified.

**SEC. 4033. REPORTS.**

A funding agreement for a grant under section 4031 is that the States involved will, not later than the date specified by the Secretary, submit to the Secretary a report describing—

(1) the purposes for which the grant was expended; and

(2) describing the extent of progress made by the State in achieving measurable outcomes and process objectives described in section 4032(3).

**SEC. 4034. APPLICATION FOR GRANT.**

The Secretary may make a grant under section 4031 only if an application for the grant is submitted to the Secretary, the application contains each agreement described in this part, the application contains the information required in section 4032, and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this part.

**SEC. 4035. ALLOCATIONS FOR CERTAIN ACTIVITIES.**

Of the amounts made available under section 4037 for a fiscal year for carrying out this part, the Secretary

may reserve not more than 5 percent for carrying out the following activities:

(1) Technical assistance with respect to planning, development, and operation of essential public health activities carried out under section 4031, including provision of biostatistical and epidemiological expertise and provision of laboratory expertise.

(2) Development and operation of a national information network among State and local health agencies.

(3) Program monitoring and evaluation of essential public health activities carried out under section 4031.

(4) Development of a unified electronic reporting mechanism to improve the efficiency of administrative management requirements regarding the provision of Federal grants to State public health agencies.

**SEC. 4036. DEFINITIONS.**

For purposes of this part:

(1) The term "funding agreement", with respect to a grant under section 4031 to a State, means that the Secretary may make the grant only if the State makes the agreement involved.

(2) The term "essential public health activities", with respect to a State, means the activities described in section 4031(b).

**SEC. 4037. AUTHORIZATION OF APPROPRIATIONS.**

There are authorized to be appropriated to carry out this part, such sums as may be necessary for each of the fiscal years 1995 through 2004.

**SEC. 4038. SINGLE APPLICATION AND UNIFORM REPORTING SYSTEMS FOR ESSENTIAL PUBLIC HEALTH ACTIVITIES OF PUBLIC HEALTH AND PUBLIC HEALTH CATEGORICAL GRANT PROGRAMS ADMINISTERED BY THE CENTERS FOR DISEASE CONTROL AND PREVENTION.**

(a) SINGLE APPLICATION.—

(1) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall establish a single consolidated application to enable States to apply for the Essential Public Health Activities Grants Program and any or all of the Public Health Service Act categorical programs described in subsection (b).

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

(A) be designed so that information collected will be consistent with the requirements of this part including subsection (b);

(B) be designed and implemented not later than 1 year after the date of enactment of this Act; and

(C) be developed with resources made available under section 4035 (not resources made available for the programs described in subsection (b)).

(3) STATE PUBLIC HEALTH OFFICERS.—In developing the single consolidated application form to be used under this subsection the Secretary shall consult with Federal, State and local public health agencies.

(4) ELIGIBILITY.—States and local governments that have grants, contracts or cooperative agreements in effect with the Centers for Disease Control and Prevention on the date of enactment of this Act shall be eligible to use a single application under this section to apply for any or all of the Public Health Service Act categorical programs described in subsection (b)

(b) ELIGIBLE PUBLIC HEALTH SERVICE ACT PROGRAMS.—Eligible Public Health Service Act categorical programs described in this subsection are the following:

(1) The Preventive Health and Health Services Block Grant under section 1903 of the Public Health Service Act.

(2) The Childhood Lead Poisoning Prevention Program under section 317A of the Public Health Service Act.

(3) The Sexually Transmitted Diseases Program under section 318 of the Public Health Service Act.

(4) The Prevention of Sexually Transmitted Diseases-Related Infertility Program under section 318A of the Public Health Service Act.

(5) The Breast and Cervical Cancer Early Detection Program under sections 1501 through 1509 of the Public Health Service Act.

(6) The National Program of Cancer Registries under section 399H of the Public Health Service Act.

(7) The Injury Control and Prevention Program under sections 391 through 394 of the Public Health Service Act.

(8) The preventive health for prostate cancer program under section 317D of the Public Health Service Act.

(9) The birth defects data program under section 317C of the Public Health Service Act.

(10) Programs under this part.

(11) Other relevant programs as determined appropriate by the Secretary.

(c) ALLOCATION OF FUNDS.—In awarding grants to States and local governments under a single application under this section, the Secretary shall delineate to each grantee the amounts to be dedicated to each of the programs described in subsection (b) and ensure that funding allotments for each of such programs are consistent with the requirements of Federal law.

(d) UNIFORM ESSENTIAL PUBLIC HEALTH ACTIVITIES REPORTING SYSTEM.—

(1) DEVELOPMENT.—The Secretary, acting through the Director of the Office of Disease Prevention and Health Promotion and the Director of the Centers for Disease Control and Prevention, in consultation with other relevant Federal and State health agencies with data collection responsibilities, shall develop and implement a Uniform Essential Public Health Activities Reporting System to collect

program and fiscal data concerning the programs described in subsection (b).

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

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

(B) be designed so that information collected will be consistent with the requirements of this part including subsection (b);

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

(D) be developed with resources made available under section 4035 of this Act (not resources made available for the programs described in subsection (b)).

(e) STUDY.—

(1) IN GENERAL.—Within a reasonable period of time after the date of enactment of this Act, the Secretary shall request that the Institute of Medicine conduct a study concerning—

(A) the effects of consolidating any or all of the grant programs administered by the Centers for Disease Control and Prevention and de-

scribed in subsection (b) into a Essential Public Health Activities Block Grant Program;

(B) the development of alternative methods for implementing a block grant program or categorical grant program; and

(C) alternative formulas for allocating State grants that incorporate measures of health status, population and degree of poverty.

If the Institute of Medicine declines to conduct the study under this paragraph, the Secretary shall make grants to or enter into contracts with a public or nonprofit private entity with relevant expertise for the conduct of such study.

(2) REPORT.—Not later than 1 year after the date of the submission of a request under paragraph (1) (or the receipt of a grant or contract under such paragraph), the Institute of Medicine (or the grant or contract recipient) shall prepare and submit to the Secretary and the appropriate committees of Congress a report that contains the results of the study conducted under paragraph (1).

(3) ISSUANCE OF PLAN.—Not later than 1 year after the date on which the report under paragraph (2) is received by the Secretary and the committees referred to in such paragraph, the Secretary shall

issue a plan in response to the report. Such plan shall include recommendations for relevant amendments to the grant programs referred to in paragraph (1)

## PART IV—RURAL HEALTH PLAN DEMONSTRATION PROJECTS

### SEC. 4041. RURAL HEALTH PLAN DEMONSTRATION PROJECTS.

(a) IN GENERAL.—The Secretary, in consultation with the Secretary of Labor, may establish and implement not more than 3 demonstration projects for the designation of rural health plan areas. To be designated as a rural health plan area under this section, an area must be a rural area (as defined in section 1866(d)(2)(D) of the Social Security Act) or an underserved nonurban area in accordance with other criteria specified by the Secretary.

(b) APPLICATION.—To be eligible to conduct a demonstration project under this section, an entity shall prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require to ensure that project participants meet the goals described in subsection (d). An application submitted under this section shall—

(1) identify the area in which the demonstration project will be conducted; and

(2) provide assurances that the area described in paragraph (1) meets the requirements of subsection (a).

(c) REQUIREMENTS.—An entity offering a health plan through a demonstration project under this section shall—

(1) have a recognized, long-standing relationship with the rural community in which the project is being conducted;

(2) ensure that the health plan is operated as a certified health plan;

(3) ensure that the plan meets the requirements for certified health plans under title I;

(4) ensure that the plan offers enrollment—

(A) on an experience-rated basis to experience-rated employees of the plan sponsor; and

(B) on a community-rated basis to community-rated individuals in the community rating area in which such plan operates; and

(5) meet the requirements of subtitle A of title I.

(d) GOALS.—The goals referred to in this subsection are as follows:

(1) To develop a reliable supply of health care providers and rural health service delivery infrastructures with a sound financial footing.

(2) To develop a mechanism to begin to provide the benefits of networking found in urban health systems to rural Americans living in rural health plan areas.

(e) DURATION.—The Secretary may revoke the designation of a rural health plan area if the Secretary determines that the entity conducting the project in such area has failed to comply with the requirements of this section. The Secretary may not designate a rural health plan area under this section after December 31, 1999.

(f) EVALUATIONS AND REPORTS.—

(1) EVALUATIONS.—Each entity offering a health plan through a demonstration project under this section shall submit to the Secretary such interim evaluations as the Secretary may require.

(2) REPORT.—Not later than 360 days after the date on which the first demonstration project is implemented under this section, and annually thereafter for each year in which a project is being conducted, the Secretary shall submit to Congress a report that evaluates the effectiveness of such projects. Such reports shall include any legislative rec-

ommendations determined appropriate by the Secretary.

## PART V—MENTAL HEALTH AND SUBSTANCE ABUSE SYSTEM INTEGRATION

### SEC. 4051. INTEGRATION OF MENTAL HEALTH AND SUBSTANCE ABUSE SYSTEMS.

(a) MENTAL HEALTH SERVICES.—Section 1912(b) of the Public Health Service Act (42 U.S.C. 300x-1(b)) is amended by adding at the end thereof the following:

"(13) The plan describes—

"(A) the impact of changes (including gaps in coverage and access) resulting from the enactment of the Health Reform Act concerning the provision of mental illness services to individuals in both the public and private sectors and, if appropriate to ensure the provision of mental illness services, the measures to be implemented by the State to achieve the integration of the mental illness services of the State and its political subdivisions with the mental illness services provided by health plans; and

"(B) the method of financing mental illness services by source, including medicaid (title XIX of the Social Security Act), Federal block grant funds under this title, Federal cat-

egorical funds, State and local revenues, and health plan payments.

The measures described in paragraph (1) may include the development and operation of comprehensive managed mental health programs. To the maximum extent practicable, such measures shall be the same as and coordinated with those to integrate the substance abuse services under section 1921.".

(b) SUBSTANCE ABUSE SERVICES.—Section 1932(b)(1) of such Act (42 U.S.C. 300x-32(b)(1)) is amended by strike "if the plan" and all that follows and inserting "if the plan—

"(A) contains detailed provisions for complying with each funding agreement for a grant under section 1921 that is applicable to the State, including a description of the manner in which the State intends to expend the grant;

"(B) the impact of changes (including gaps in coverage and access) resulting from the enactment of the Health Reform Act concerning the provision of substance abuse services to individuals in both the public and private sectors and, if appropriate to ensure the provision of substance abuse services, the measures to be implemented by the State to achieve the inte-

gration of the substance abuse services of the State and its political subdivisions with the substance abuse services provided by health plans; and

"(B) the method of financing substance abuse services by source, including medicaid (title XIX of the Social Security Act), Federal block grant funds under this title, Federal categorical funds, State and local revenues, and health plan payments.

The measures described in paragraph (1) may include the development and operation of comprehensive managed substance abuse treatment programs. To the maximum extent practicable, such measures shall be the same as and coordinated with those to integrate the mental illness services under section 1911.".

## PART VI—SCHOOL-RELATED HEALTH SERVICES

### SEC. 4061. AUTHORIZATION OF APPROPRIATIONS.

(a) FUNDING FOR SCHOOL-RELATED HEALTH SERVICES.—For the purpose of carrying out this part, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 1996 through 2004.

(b) FUNDING FOR PLANNING AND DEVELOPMENT GRANTS.—Of amounts made available under this section,

not to exceed $10,000,000 for each of fiscal years 1996 and 1997 may be utilized to carry out section 4064.

**SEC. 4062. ELIGIBILITY FOR GRANTS.**

(a) IN GENERAL.—

(1) PLANNING AND DEVELOPMENT GRANTS.—Entities eligible to apply for and receive grants under section 4064 are—

(A) State health agencies or State educational agencies that apply on behalf of local community partnerships; or

(B) local community partnerships in States in which health or education agencies have not successfully applied.

(2) OPERATIONAL GRANTS.—Entities eligible to apply for and receive grants under section 4065 are—

(A) a qualified State as designated under subsection (c) that apply on behalf of local community partnerships; or

(B) local community partnerships in States that are not designated under subparagraph (A).

(b) LOCAL COMMUNITY PARTNERSHIPS.—

(1) IN GENERAL.—A local community partnership under subsection (a)(1)(B) and (a)(2)(B) is an entity that, at a minimum includes—

(A) a local health care provider, which may be a local public health department, with experience in delivering services to children and youth or medically underserved populations;

(B) local educational agency on behalf of one or more public schools; and

(C) one community based organization located in the community to be served that has a history of providing services to at-risk children and youth.

(2) RURAL COMMUNITIES.—In rural communities, local partnerships should seek to include, to the fullest extent practicable, providers and community based organizations with experience in serving the target population.

(3) PARENT AND COMMUNITY PARTICIPATION.—An applicant described in subsection (a) shall, to the maximum extent feasible, involve broad-based community participation (including parents of the youth to be served).

(c) QUALIFIED STATE.—A qualified State under subsection (a)(2)(A) is a State that, at a minimum—

(1) demonstrates an organizational commitment (including a strategic plan) to providing a broad range of health, health education and support services to at-risk youth; and

(2) has a memorandum of understanding or cooperative agreement jointly entered into by the State agencies responsible for health and education regarding the planned delivery of health and support services in school-based or school-linked centers.

**SEC. 4063. PREFERENCES.**

In making grants under sections 4064 and 4065, the Secretary shall give priority to applicants whose-communities to be served show the most substantial level of need for health services among children and youth.

**SEC. 4064. PLANNING AND DEVELOPMENT GRANTS.**

(a) IN GENERAL.—The Secretary may make grants during fiscal years 1996 and 1997 to entities eligible under section 4062 to develop school-based or school-linked health service sites.

(b) USE OF FUNDS.—Amounts provided under a grant under this section may be used for the following:

(1) Planning for the provision of school health services, including—

(A) an assessment of the need for health services among youth in the communities to be served;

(B) the health services to be provided and how new services will be integrated with existing services;

(C) assessing and planning for the modernization and expansion of existing facilities and equipment to accommodate such services; and

(D) an affiliation with relevant health plans.

(2) recruitment and training of staff for the administration and delivery of school health services;

(3) the establishment of local community partnerships as described in section 4062(b);

(4) in the case of States, the development of memorandums of understanding or cooperative agreements for the coordinated delivery of health and support services through school health service sites; and

(5) other activities necessary to assume operational status.

(c) APPLICATION FOR GRANTS.—To be eligible to receive a grant under this section an entity described in sec-

tion 4062 (a) shall submit an application in a form and manner prescribed by the Secretary.

(d) NUMBER OF GRANTS.—Not more than one planning grant may be made to a single applicant. A planning grant may not exceed 2 years in duration.

(e) AMOUNT AVAILABLE FOR DEVELOPMENT GRANT.—The Secretary may award not to exceed—

(1) $150,000 to entities under section 4062(a)(1)(A) and to localities planning for a city-wide or countywide school health services delivery system; and

(2) $50,000 to entities under section 4062(a)(1)(B).

**SEC. 4065. GRANTS FOR OPERATION OF SCHOOL HEALTH SERVICES.**

(a) IN GENERAL.—The Secretary may make grants to eligible entities described in section 4062(a)(2) that submit applications consistent with the requirements of this section, to pay the cost of operating school-based or school-linked health service sites.

(b) USE OF GRANT.—Amounts provided under a grant under this section may be used for the following—

(1) health services, including diagnosis and treatment of simple illnesses and minor injuries;

(2) preventive health services, including health screenings follow-up health care, mental health, and preventive health education;

(3) enabling services, as defined in subsection (l), and other necessary support services;

(4) training, recruitment, and compensation of health professionals and other staff necessary for the administration and delivery of school health services; and

(5) referral services, including the linkage of individuals to health plans, and community-based health and social service providers.

(c) APPLICATION FOR GRANT.—To be eligible to receive a grant under this section an entity described in section 4062(a)(2) shall submit an application in a form and manner prescribed by the Secretary. In order to receive a grant under this section, an applicant must include in the application the following information—

(1) a description of the services to be furnished by the applicant;

(2) the amounts and sources of funding that the applicant will expend, including estimates of the amount of payments the applicant will receive from health plans and other sources;

(3) a description of local community partnerships, including parent and community participation;

(4) a description of the linkages with other health and social service providers; and

(5) such other information as the Secretary determines to be appropriate.

(d) ASSURANCES.—In order to receive a grant under this section, an applicant must meet the following conditions—

(1) school health service sites will, directly or indirectly, provide a broad range of health services, in accordance with the determinations of the local community partnership, that may include—

(A) diagnosis and treatment of simple illnesses and minor injuries;

(B) preventive health services, including health screenings and follow-up health care, mental health and preventive health education;

(C) enabling services, as defined in subsection (l);

(D) referrals (including referrals regarding mental health and substance abuse) with follow-up to ensure that needed services are received;

(2) the applicant provides services recommended by the health provider, in consultation

with the local community partnership, and with the approval of the local education agency;

(3) the applicant provides the services under this subsection to adolescents, and other school age children and their families as deemed appropriate by the local partnership;

(4) the applicant establishes an affiliation with relevant health plans and will establish reimbursement procedures and will make every reasonable effort to collect appropriate reimbursement for services provided; and

(5) the applicant agrees to supplement and not supplant the level of State or local funds under the direct control of the applying State or participating local education or health authority expended for school health services as defined by this Act; and

(6) services funded under this Act will be coordinated with existing school health services provided at a participating school.

(e) STATE LAWS.—Notwithstanding any other provision in this part, no school based health clinic may provide services, to any minor, when to do so is a violation of State laws or regulations pertaining to informed consent for medical services to minors.

(f) LIMITATION ON ADMINISTRATIVE FUNDS.—In the case of a State applying on behalf of local educational partnerships, the applicant may retain not more than 5 percent of grants awarded under this subpart for administrative costs.

(g) DURATION OF GRANT.—A grant under this section shall be for a period determined appropriate by the Secretary.

(h) AMOUNT OF GRANT.—The annual amount of a grant awarded under this section shall not be more than $200,000 per school-based or school-linked health service site.

(i) FEDERAL SHARE.—

(1) IN GENERAL.—Subject to paragraph (3), a grant for services awarded under this section may not exceed—

(A) 90 percent of the non-reimbursed cost of the activities to be funded under the program for the first 2 fiscal years for which the program receives assistance under this section; and

(B) 75 percent of the non-reimbursed cost of such activities for subsequent years for which the program receives assistance under this section.

The remainder of such costs shall be made available as provided in paragraph (2).

(2) FORM OF NON-FEDERAL SHARE.—The non-Federal share required by paragraph (1) may be in cash or in-kind, fairly evaluated, including facilities, equipment, personnel, or services, but may not include amounts provided by the Federal Government. In-kind contributions may include space within a school facilities, school personnel, program use of school transportation systems, outposted health personnel, and extension of health provider medical liability insurance.

(3) WAIVER.—The Secretary may waive the requirements of paragraph (1) for any year in accordance with criteria established by regulation. Such criteria shall include a documented need for the services provided under this section and an inability of the grantee to meet the requirements of paragraph (1) despite a good faith effort.

(j) TRAINING AND TECHNICAL ASSISTANCE.—Entities that receive assistance under this section may use not to exceed 10 percent of the amount of such assistance to provide staff training and to secure necessary technical assistance. To the maximum extent feasible, technical assistance should be sought through local community-based en-

tities. The limitation contained in this subsection shall apply to individuals employed to assist in obtaining funds under this part. Staff training should include the training of teachers and other school personnel necessary to ensure appropriate referral and utilization of services, and appropriate linkages between class-room activities and services offered.

(k) REPORT AND MONITORING.—The Secretary will submit to the Committee on Labor and Human Resources in the Senate and the Committee on Energy and Commerce in the House of Representatives a biennial report on the activities funded under this Act, consistent with the ongoing monitoring activities of the Department. Such reports are intended to advise the relevant Committees of the availability and utilization of services, and other relevant information about program activities.

(l) ENABLING SERVICES.—Enabling services shall include transportation, community and patient outreach, patient and family education, translation services, case management, home visiting, and such other services as the Secretary determines to be appropriate in carrying out the purpose described in such subsection.

## PART VII—ADDITIONAL PROVISIONS REGARDING PUBLIC HEALTH

**SEC. 4071. COMMUNITY SCHOLARSHIP PROGRAM.**

Section 338L of the Public Health Service Act (42 U.S.C. 245t) is amended—

(1) in the section heading, by striking "**DEMONSTRATION**";

(2) in subsection (a)—

(A) by striking "for the purpose of carrying out demonstration programs"; and

(B) by striking "health manpower shortage areas" and inserting "Federally-designated health professional shortage areas";

(3) in subsection (c)—

(A) by striking "health manpower shortage areas" and inserting "Federally-designated health professional shortage areas" in the matter preceding paragraph (1); and

(B) by striking "in the health manpower shortage areas in which the community organizations are located," and inserting "in a Federally-designated health professional shortage area that is served by the community organization awarding the scholarship," in paragraph (2);

(4) in subsection (e)(1), by striking "health manpower shortage area" and inserting "a Federally-designated health professional shortage area";

(5) in subsection (k)(2), by striking "internal medicine" and all that follows through the end thereof and inserting "general internal medicine, general pediatrics, obstetrics and gynecology, dentistry, or mental health, that are provided by physicians or other health professionals."; and

(6) in subsection (l)(1)—

(A) by striking "1991" and inserting "1995"; and

(B) by striking fiscal year 1993" and inserting "for each fiscal year thereafter".

**SEC. 4072. WOMEN'S AND PEDIATRIC HEALTH SERVICES RESEARCH.**

(a) GRANT PROGRAM.—

(1) ESTABLISHMENT.—The Secretary, acting through the Administrator for Health Care Policy and Research, shall make grants to institutions that provide women's and pediatric health services to a significant population of high-risk obstetrical patients and neo-natal intensive care patients for the purpose of conducting a program described in paragraph (2).

(2) PROGRAM DESCRIBED.—A program described under this paragraph is a program to—

(A) research, design, and implement model accountability and outcome standards through a partnership initiative between management and a health care union to ensure participatory decision-making, and to minimize workforce dislocation; and

(B) conform delivery systems to the reformed health care marketplace.

(3) USE OF FUNDS.—Grant funds received under this section may be used by an institution described in paragraph (1) for the costs of establishing or operating a program described in paragraph (2), including costs related to acquiring or maintaining for the institution—

(A) appropriate staff;

(B) information systems;

(C) physical space;

(D) materials to conduct the program; and

(E) a mechanism or procedures for the dissemination of the results of the program.

(b) SUBMISSION OF APPLICATIONS.—To be eligible for a grant under this section, an institution shall submit

an application to the Secretary under such terms and conditions as are determined appropriate by the Secretary.

(c) COLLECTION OF INFORMATION.—An institution receiving a grant under this section shall collect and submit information on the results of the research conducted with such grant funds to the Secretary under such terms and conditions as are determined appropriate by the Secretary.

(d) COMPLIANCE.—If the Secretary determines that an institution receiving grant funds under this section has failed to operate a program in accordance with the terms of its approved application, the Secretary may withhold payment of such funds until the institution remedies such noncompliance.

(e) REPORT.—Not later than December 31, 1997, the Secretary shall submit a report to the Congress based on the information required to be collected under subsection (c) which describes the results of the research conducted with grants funds received under this section, together with any recommendations for legislation, if necessary.

(f) AUTHORIZATION.—There are authorized to be appropriated to carry out the purposes of this section such sums as may be necessary for each of the fiscal years 1995 through 1997.

**SEC. 4073. PARITY FOR FEDERAL FACILITIES SUPPORTING RESEARCH.**

Subpart 1 of part E of title IV of the Public Health Service Act is amended by inserting after section 479 (42 U.S.C. 287 et seq.) the following new section:

**"SEC. 479A. COLLECTIONS.**

"The Secretary may collect health plan payments for patient care costs pursuant to a qualified investigational treatment (as defined in section 1107(5) of the Health Reform Act) that are incurred in Public Health Service Research facilities, for deposit in the General Treasury.".

## PART VIII—NATIONAL HEALTH SERVICE CORPS

**SEC. 4081. NATIONAL HEALTH SERVICE CORPS.**

Section 338 of the Public Health Service Act (42 U.S.C. 254k) is amended by adding at the end thereof the following new subsection:

"(c) Of the amounts appropriated under this section, the Secretary shall reserve such amounts as may be necessary to ensure that, 20 percent of the aggregate number of individuals who are participants in the Scholarship Program under section 338A, or in the Loan Repayment Program under section 338B, are being educated or are serving as nurse practitioners, nurse midwives, nurse anesthetists or physician assistants.

"(d) Of the amounts appropriate under this section, the Secretary shall reserve such amounts as may be nec-

essary to ensure that 15 percent of the aggregate number of individuals who are participants in the scholarship program under section 338A, or in the Loan Repayment Program under section 338B, are being educated or are serving as dentists, psychiatrists, psychologists, or clinical social workers.".

# Subtitle B—Graduate Medical Education

## PART I—WORKFORCE PRIORITIES FOR DIRECT GRADUATE MEDICAL EDUCATION

### SEC. 4101. NATIONAL COMMISSION ON GRADUATE MEDICAL EDUCATION.

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

(b) MEMBERSHIP.—

(1) APPOINTMENT.—The Commission shall consist of 13 members appointed by the Director of the Congressional Office of Technology Assessment (referred to in this section as the "Director") without regard to the provisions of title 5, United States Code, governing appointments in the competitive service. Members of the Commission shall first be appointed no later than May 1, 1995, for a term of 3 years, except that the Director may provide initially for such shorter terms as will ensure that the terms of no more than 4 members expire in any one year.

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

national physician workforce. The membership of the Commission shall include, but is not limited to, the following:

(A) Consumers of health care services, at least one of whom resides in a rural area.

(B) Primary health care physicians who are faculty members of medical schools (including officials of medical schools and executive officers of teaching hospitals) and primary health care physicians who are practicing and are not faculty members of medical schools, at least one of whom resides in a rural area.

(C) Non-primary health care specialty physicians who are faculty members of medical schools, non-primary health care specialty physicians who are not faculty members of medical schools, officials of medical schools, and executive officers of teaching hospitals.

(D) Officers and employees of health plans, at least one of whom represents a managed care entity.

(c) ACTIVITIES OF THE COMMISSION.—

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

(A) IN GENERAL.—Not later than May 1, 1996, the Commission shall develop a legislative proposal containing the Commission's legislative recommendations on the national health care workforce (as developed under subparagraph (B)).

(B) NATIONAL HEALTH CARE WORKFORCE.—

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

(I) the composition of residency training positions after considering how such composition and the composition of the physician health care workforce addresses the needs of the health care market for access to health care services, including access in underserved rural and urban areas, economic efficiency, and quality; and

(II) a system for distributing funds to the residency positions that are supported by the Graduate Medical Education Trust Fund established

under section 9511 of the Internal Revenue Code of 1986 beginning in academic year 1998 that is as decentralized and nonregulatory as possible and that is administered by the Secretary of Health and Human Services (referred to in this section as the "Secretary").

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

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

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

(III) take into account developments in the health care market and



50e

the supply of nonphysician health care providers that affect the need for physicians, the physician specialty mix, and physician distribution;

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

(V) take into account the historical allocation of residency positions funded, the impact on the health care delivery systems that have relied on such positions, the quality of the programs, and the unique missions or special services provided by the programs;

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

(aa) consider the direct distribution of all funds through

residency programs, through health care training consortia, through teaching hospitals, or through methods that adjust per resident payments by various weighting factors; and

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

(C) ONGOING REPORTS AND RECOMMENDATIONS TO THE CONGRESS AND THE SECRETARY.—After a legislative proposal developed by the Commission under subparagraph (A) is submitted under section 4102, the Commission shall submit to the Congress and the Secretary annual reports or legislative recommendations on issues which include—

(i) assessments and recommendations, as appropriate, in the following areas:

(I) the composition of the physician and non-physician national health care workforce and how such composi-

tion addresses the needs of the health care market;

(II) sources and uses of funds related to direct and indirect graduate medical education and options for future payment policy;

(III) payment distribution methods related to graduate medical education and options for future distribution policy;

(IV) per-speciality national average direct graduate medical education payments and direct medical education payment amounts provided by this Act;

(V) incentives to encourage health care practitioners to enter primary health care specialty areas and to provide services in underserved areas and options for future policies;

(VI) role, composition, distribution, and costs related to international medical graduates in the national health care workforce and options for future policies; and

(VII) the funding of academic health centers and teaching hospitals considering changes in the medical market and the unique educational and research missions of such entities;

(ii) recommendations for a coordinated policy for the future direction and distribution of grants, demonstration projects, and other funding affecting the health care workforce; and

(iii) recommendations and a schedule for topics to be addressed in subsequent reports, based on the findings and recommendations of the Commission described in the previous clauses.

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

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

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

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

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

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

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

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

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

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

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

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

(g) FUNDING FOR COMMISSION.—There are authorized to be appropriated such sums as may be necessary to carry out the provisions of this section.

(h) CONFORMING AMENDMENT REPEALING THE COUNCIL ON GRADUATE MEDICAL EDUCATION.—Effective October 1, 1995, section 30 of the Health Professions Extension Amendments of 1992 (Public Law 102-408) is repealed.

**SEC. 4102. FAST TRACK PROCEDURE FOR CONSIDERATION OF LEGISLATIVE PROPOSAL ON NATIONAL HEALTH CARE WORKFORCE.**

(a) IN GENERAL.—The legislative proposal of the National Commission on Graduate Medical Education (referred to in this section as the "Commission") described in section 4101(c)(1)(A) shall be submitted to Congress

in the form of an implementing bill which contains the statutory provisions necessary or appropriate to implement the proposal. Such an implementing bill shall be considered by Congress as described in section 1108.

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

## PART II—PAYMENTS FOR OPERATION OF APPROVED PHYSICIAN TRAINING PROGRAMS

### Subpart A—Payments for Operation of Approved Physician Training Programs

#### SEC. 4111. FEDERAL FORMULA PAYMENTS FOR THE DIRECT COSTS OF THE OPERATION OF APPROVED PHYSICIAN TRAINING PROGRAMS.

(a) REQUIREMENT ON SECRETARY TO MAKE PAYMENTS.—In the case of a qualified entity (as defined in subsection (c)) that in accordance with section 4112 submits to the Secretary an application for calendar year 1997 or any subsequent calendar year, the Secretary shall

make payments for such year to the qualified entity for the purpose specified in subsection (b). The Secretary shall make the payments in an amount determined in accordance with section 4113, and may administer the payments as a contract, grant, or cooperative agreement.

(b) PAYMENTS FOR OPERATION OF APPROVED PHYSICIAN TRAINING PROGRAMS.—The purpose of payments under subsection (a) is to assist a qualified entity with the direct costs of operation of an approved physician training program.

(c) DEFINITIONS.—For purposes of this subpart:

(1) APPROVED PHYSICIAN TRAINING PROGRAM.—The term "approved physician training program", with respect to the medical specialty involved, means a residency or other postgraduate program that trains physicians and meets the following conditions:

(A) Participation in the program may be counted toward certification in the medical specialty as determined under the applicable standards of the American Board of Medical Specialties or the Council on Postdoctoral Training of the American Osteopathic Association.

(B) The program is accredited by the Accreditation Council on Graduate Medical Edu-

cation, or approved by the Council on Postdoctoral Training of the American Osteopathic Association.

(2) QUALIFIED ENTITY.—The term "qualified entity" means—

(A) a qualified health care training consortium (as defined in paragraph (3)); or

(B) any other entity which incurs the cost of operating an approved physician training program.

(3) QUALIFIED HEALTH CARE TRAINING CONSORTIUM.—The term "qualified health care training consortium" means a health care training consortium (as defined in section 1886(j)(5) of the Social Security Act (as added by section 4115)) that meets the requirements of section 1886(j)(2) of such Act.

**SEC. 4112. APPLICATION FOR PAYMENTS.**

For purposes of section 4111(a), an application for payments under such section for a calendar year is in accordance with this section if—

(1) the qualified entity submits the application not later than the date specified by the Secretary; and

(2) the application is in such form, is made in such manner, and contains such agreements, assur-

ances, and information as the Secretary determines to be necessary to carry out this subpart.

**SEC. 4113. AVAILABILITY OF FUNDS FOR PAYMENTS; ANNUAL AMOUNT OF PAYMENTS.**

(a) GRADUATE MEDICAL EDUCATION TRUST FUND.—The following amounts shall be available for a calendar year for making payments under section 4111 from the Graduate Medical Education Trust Fund established under section 9551 of the Internal Revenue Code of 1986:

(1) In the case of calendar year 1997, $4,300,000,000.

(2) In the case of calendar year 1998, $4,820,000,000.

(3) In the case of calendar year 1999, $5,440,000,000.

(4) In the case of each of calendar years 2000 and 2001, $5,910,000,000.

(5) In the case of each subsequent calendar year, the amount specified in paragraph (4) increased by the product of such amount and the percentage increase in the consumer price index (as defined in subsection (e)(1)) for such year.

(b) AMOUNT OF PAYMENTS FOR INDIVIDUAL ELIGIBLE ENTITIES.—

(1) IN GENERAL.—Payment amounts with respect to any physician training program made on such program's behalf to the qualified entity with which the physician training program participates under this section shall be equal to the product of the number of full time equivalent training participants in the program, and the per resident amount for the training program.

(2) PER RESIDENT AMOUNT.—

(A) IN GENERAL.—Except as provided under subparagraph (B), the per resident amount for a training program shall be equal to—

(i) with respect to—

(I) the first calendar year during which the program receives payment under subsection (a), 90 percent;

(II) the second calendar year during which the program receives payment under subsection (a), 80 percent;

(III) the third calendar year during which the program receives payment under subsection (a), 70 percent;

(IV) the fourth calendar year during which the program receives payment under subsection (a), 60 percent; and

(V) the fifth and subsequent calendar year during which the program receives payment under subsection (a), 50 percent;

of the approved FTE resident amount that would have been determined under section 1886(h)(2)(D) of the Social Security Act (42 U.S.C. 1395ww(h)(2)(D)) for the hospital operating such approved physician training program for a cost reporting period beginning in such calendar year if the amendments made by section 4114 of the Health Reform Act had not been made; and

(ii) with respect to—

(I) the first calendar year during which the program receives payment under subsection (a), 10 percent;

(II) the second calendar year during which the program receives

payment under subsection (a), 20 percent;

(III) the third calendar year during which the program receives payment under subsection (a), 30 percent;

(IV) the fourth calendar year during which the program receives payment under subsection (a), 40 percent; and

(V) the fifth and subsequent calendar years during which the program receives payment under subsection (a), 50 percent;

of the geographically adjusted national average per resident amount.

(B) MINIMUM PER RESIDENT AMOUNT.—Notwithstanding the provisions of subparagraph (A), the per resident amount for a training program shall not be less than 75 percent of the geographically adjusted national average per resident amount determined in accordance with subparagraph (A)(ii).

(C) NO HISTORIC PAYMENT BASIS.—For purposes of subparagraph (A)(i), the Secretary

shall determine the appropriate per resident amount applicable to a qualified entity that—

(i) has an approved physician training program that sponsored or is affiliated with more than one hospital that had a per resident amount determined under section 1886(h) of the Social Security Act which reflects the average per resident amounts under such section for such hospitals; or

(ii) is an institution that did not have a per resident amount determined under such section for cost reporting periods beginning before 1996 which reflects the national average per resident amount.

(3) ADJUSTMENT FACTOR.—Payments under this section shall be subject to an adjustment factor, as determined by the Secretary, so that total payments in any year will not exceed the amounts specified in subsection (a) and as provided in subsection (d).

(4) ADDITIONAL PROVISIONS REGARDING NATIONAL AVERAGE COST.—

(A) DETERMINATION OF NATIONAL AVERAGE COST.—The Secretary shall in accordance with clause (ii) of paragraph (2)(A) determine,

for academic year 1992–1993, an amount equal to the geographically adjusted national average per resident amount described in such clause with respect to training a participant in an approved physician training program. The national average applicable under such clause for a calendar year for such programs is, subject to subparagraph (B), the amount determined under the preceding sentence increased by the amount necessary to offset the effects of inflation occurring since academic year 1992–1993, as determined through use of the consumer price index.

(B) GEOGRAPHIC ADJUSTMENT.—The national average determined under subparagraph (A) and applicable to a calendar year shall, in the case of the qualified entity involved, be adjusted by a factor to reflect regional differences in the applicable wage and wage-related costs.

(c) DETERMINATION OF FULL-TIME-EQUIVALENT TRAINING PARTICIPANTS.—

(1) IN GENERAL.—Except as otherwise provided in this subsection, in determining the number of full-time equivalent training participants in approved physician training programs under subsection

(b)(1), paragraphs (4) and (5) of section 1886(h) of the Social Security Act (as in effect on the day before the date of the enactment of this Act) shall apply.

(2) SUBSTITUTION OF CERTAIN DEFINITIONS.—For purposes of paragraph (1), in applying paragraph (5) of section 1886(h) of the Social Security Act, the Secretary shall—

(A) substitute the definition of the term "consumer price index" under subsection (e)(1) for the definition of such term under section 1886(h)(5)(B) of such Act; and

(B) substitute the definition of the term "initial training period" under subsection (e)(2) for the definition of "initial residency period" under section 1886(h)(5)(F) of such Act.

(3) RULES.—The Secretary shall establish rules for the computation of the number of full-time-equivalent training participants in approved physician training programs in accordance with paragraph (1).

(4) COUNTING TIME SPENT IN OUTPATIENT SETTINGS.—The rules established by the Secretary shall provide that only time spent in activities relating to patient care shall be counted and that all the

time so spent by a training participant under an approved physician training program shall be counted towards the determination of full-time equivalency, without regard to the setting in which the activities are performed.

(d) LIMITATION.—Subject to subsection (a), if the amount available from the Graduate Medical Education Trust Fund established under section 9551 of the Internal Revenue Code of 1986 for a calendar year is insufficient for providing each qualified entity with the amount of payments determined under subsection (b) for the entity for such year, the Secretary shall make such pro rata reductions in the amounts so determined as may be necessary to ensure that the total of payments made under section 4111 for such year equals the amount specified under subsection (a).

(e) DEFINITIONS.—For purposes of this subpart:

(1) CONSUMER PRICE INDEX.—The term "consumer price index" means the Consumer Price Index for All Urban Consumers (U.S. city average).

(2) INITIAL TRAINING PERIOD.—The term "initial training period" means the period of time required for board eligibility, except that—

(A) except as provided in subparagraph (B), in no case shall the initial period of partici-

pation exceed an aggregate period of formal training of more than 5 years for any individual, and

(B) a period, of not more than 2 years, during which an individual is in a—

(i) residency or fellowship program in geriatric medicine, preventive medicine, or adolescent medicine, or

(ii) a fellowship program in family medicine, general internal medicine or general pediatrics, which provides training for a faculty position in family medicine, general internal medicine or general pediatrics,

shall be treated as part of the initial training participation period, but shall not be counted against any limitation on the initial training period.

The initial training period shall be determined, with respect to a training participant, as of the time the training participant enters any approved physician training program.

**SEC. 4114. TERMINATION OF MEDICAL EDUCATION PAYMENTS.**

(a) IN GENERAL.—Section 1886(h) (42 U.S.C. 1395ww(h)) is amended by adding at the end the following new paragraph:

"(6) TERMINATION OF PAYMENTS ATTRIBUTABLE TO COSTS OF TRAINING PHYSICIANS.—Notwithstanding any other provision of this section or section 1861(v), no payment may be made under this title for direct graduate medical education costs attributable to an approved medical residency training program for any cost reporting period (or portion thereof) beginning on or after January 1, 1997.".

(b) PROHIBITION AGAINST RECOGNITION OF COSTS OF TRAINING PHYSICIANS.—Section 1861(v)(1) (42 U.S.C. 1395x(v)(1)), as amended by section 3212(b), is amended by adding at the end the following new subparagraph:

"(U) Such regulations shall not include any provision for specific recognition of the costs of graduate medical education for hospitals for any cost reporting period (or portion thereof) beginning on or after January 1, 1997. Nothing in the previous sentence shall be construed to affect in any way payments to hospitals for the costs of any

approved educational activities that are not described in such sentence.".

**Subpart B—Interim Graduate Medical Education Consortium Program**

**SEC. 4115. GRADUATE MEDICAL EDUCATION CONSORTIUM PROGRAM.**

Section 1886 of the Social Security Act (42 U.S.C. 1395ww) is amended by adding at the end the following new subsection:

"(j) CONSORTIUM PROGRAM.—

"(1) IN GENERAL.—The Secretary shall provide for the establishment and operation of health care training consortia (as defined in paragraph (5)(B)) which are located in a State (or a region of a State) or are multi-State consortia (which may be regions of various States) for the purpose of receiving funds otherwise available for direct graduate medical education costs under subsection (h).

"(2) REQUIREMENTS ON CONSORTIA.—

"(A) IN GENERAL.—A health care training consortium shall meet the following requirements:

"(i) ADMINISTRATION.—A health care training consortium shall establish an administrative structure that reflects the

membership of the consortium. The Secretary shall monitor the administrative structure of each consortium receiving payments under this subsection to ensure that each member has adequate representation within such structure.

"(ii) USE OF FUNDS.—

"(I) IN GENERAL.—The members of a health care training consortium shall collectively determine a plan for how funds received by the consortium under this subsection will be used to better satisfy local and regional workforce needs and the educational quality of the approved physician training programs.

"(II) RESIDENT SITE OF TRAINING.—With respect to payments made by a health care training consortium to support the training of residents, the consortium shall provide that the funds received by the consortium under this subsection are provided to the entity incurring the costs for the

operation of an approved physician training program.

(iii) FISCAL AGENT.—A health care training consortium shall designate a fiscal agent to be responsible and accountable for—

(I) the consortium's performance;

(II) coordinating the consortium's activities;

(III) distributing all funds received by the consortium under this subsection based on the plan approved by the consortium under clause (ii); and

(IV) submitting all documentation required by the Secretary regarding the requirements of this subpart.

"(B) PRIMARY CARE TRAINING REQUIREMENT.—For an academic year, the Secretary shall ensure that each health care training consortium is operated with the intent of increasing the consortium's percentage of residents in primary care (as defined in paragraph (5)(C)).

"(3) APPLICATIONS.—

"(A) IN GENERAL.—Each health care training consortium desiring to receive funds under this subsection shall prepare and submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require.

"(B) APPROVAL OF APPLICATIONS.—A consortium that submits an application under subparagraph (A) may begin an operation under this subsection—

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

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

"(4) FUNDING.—

"(A) ALLOCATION OF GME FUNDS.—For each year a consortium operates under this subsection the Secretary shall pay to such consortium an amount equal to the total amount available to hospitals that are members of the consortium under subsection (h). The consortium shall designate a teaching hospital for each resident assigned to the consortium which

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

"(B) USE OF FUNDS.—Each consortium that receives a payment under subparagraph (A) may use such funds for the establishment and operation of the consortium.

"(5) DEFINITIONS.—For purposes of this subsection:

"(A) AMBULATORY TRAINING SITES.—The term 'ambulatory training sites' includes health maintenance organizations, federally qualified health centers, community health centers, migrant health centers, rural health clinics, nursing homes, hospice, and other community-based providers, including private practices.

"(B) HEALTH CARE TRAINING CONSORTIUM.—The term 'health care training consortium' means an entity which includes partnerships of academic health centers, teaching hospitals, ambulatory training sites, or one or more schools of allopathic or osteopathic medicine.

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

## PART III—INDIRECT GRADUATE MEDICAL EDUCATION

### SEC. 4121. FUNDING UNDER MEDICARE FOR TRAINING IN NONHOSPITAL-OWNED FACILITIES.

(a) IN GENERAL.—Section 1886(d)(5)(B)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)(iv)) is amended to read as follows:

"(iv) In determining such adjustment, the Secretary shall—

"(I) count interns and residents assigned to any patient service environment which is part of the hospital's approved medical residency training program (as defined in subsection (h)(5)(A)); and

"(II) count interns and residents providing services at any entity receiving a grant under section 330 of the Public Health Service Act that is under the ownership or control of a hospital (if the hospital incurs all, or

substantially all, of the costs of the services furnished by such interns and residents),

as part of the calculation of the full-time-equivalent number of interns and residents.".

(b) ADJUSTMENT OF INDIRECT TEACHING ADJUSTMENT FACTOR TO ACHIEVE BUDGET NEUTRALITY.—Section 1886(d)(5)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)) is amended by adding at the end the following new clause:

"(v) The Secretary shall reduce all payments under this subparagraph by such percentage as the Secretary determines necessary so that, beginning on the date of the enactment of the Health Reform Act, the amendments made by section 4121(a) of such Act would not result in expenditures under this subparagraph that exceed the amount of such expenditures that would have been made if such amendments had not been made.".

## PART IV—STUDY ON HEALTH PROFESSIONS SCHOOLS PAYMENTS

### SEC. 4131. STUDY ON HEALTH PROFESSIONS SCHOOLS PAYMENTS.

(a) STUDY.—Not later than January 1, 1997, the Secretary shall arrange for an independent study and report to be completed, by the Institute of Medicine or other similar entity, concerning the need for, purpose of, amount of, and allocation method for, medical school funding, public health school funding, graduate nurse education funding, physician assistant school funding, and dental school funding. In conducting the study, the entity conducting the study shall consider the impact of changes in the medical market and the impact of health reform on undergraduate medical education, undergraduate and graduate public health education, physician assistant education, graduate nurse education, and undergraduate dental education.

(b) AUTHORIZATION OF APPROPRIATIONS.—For fiscal years 1996 and 1997, there is authorized to be appropriated from the Graduate Medical Education Trust Fund established under section 9551 of the Internal Revenue Code of 1986 such sums as may be necessary to carry out the purposes of this section.

## PART V—MISCELLANEOUS PROVISION

### SEC. 4141. WAIVER OF FOREIGN COUNTRY RESIDENCE REQUIREMENT WITH RESPECT TO INTERNATIONAL MEDICAL GRADUATES.

(a) WAIVER.—Section 212(e) of the Immigration and Nationality Act (8 U.S.C. 1182(e)) is amended—

(1) in the first proviso by inserting "(or, in the case of an alien described in clause (iii), pursuant to the request of an interested State agency)" after "interested United States Government agency"; and

(2) by inserting after "public interest" the following: "except that in the case of a waiver requested by an interested State agency the waiver shall be subject to the requirements of section 214(k)".

(b) RESTRICTIONS ON WAIVER.—Section 214 of such Act (8 U.S.C. 1184) is amended by adding at the end the following:

"(k)(1) In the case of a request by an interested State agency for a waiver of the two-year foreign residence requirement under section 212(e) with respect to an alien described in clause (iii) of that section, the Attorney General shall not grant such waiver unless—

"(A) in the case of an alien who is otherwise contractually obligated to return to a for-

eign country the Director of such country furnishes a statement in writing that it has no objection to such waiver;

"(B) the alien demonstrates a bona fide offer of full-time employment at a health facility and agrees to begin employment at such facility within 90 days of receiving such waiver and agrees to continue to work in accordance with paragraph (2) at the health care facility in which the alien is employed for a total of not less than 3 years (unless the Attorney General determines that extenuating circumstances such as the closure of the facility or hardship to the alien would justify a lesser period of time);

"(C) the alien agrees to practice medicine in accordance with paragraph (2) for a total of not less than 3 years only in the geographic area or areas which are designated by the Secretary of Health and Human Services as having a shortage of health care professionals; and

"(D) the grant of such waiver would not cause the number of waivers allotted for that State for that fiscal year to exceed twenty.

"(2) Whenever an interested State agency requests the waiver of the two-year residence require-

ment under section 212(e) with respect to an alien described in clause (iii) of that section, the Attorney General shall change the status of the alien to that of an alien described in section 101(a)(15)(H)(b).

"(3) If an alien whose status was changed under paragraph (2) demonstrates that the alien has worked for a period of 5 years in a health professional shortage area, then the Attorney General may approve a petition filed on the alien's behalf by the health care facility in which the alien is employed seeking change of the alien's status to that of a special immigrant described in section 101(a)(27)(L).

"(4) Notwithstanding any other provision of this subsection, the two-year foreign residence requirement under section 212(e) shall apply with respect to an alien described in clause (iii) of that section, who has not otherwise been accorded status under section 101(a)(27)(L), if at any time the alien practices medicine in an area other than an area described in paragraph (1)(C).".

(c) SPECIAL IMMIGRANT STATUS.—Section 101(a)(27) of such Act is amended by adding at the end the following new subparagraph:

"(L) immigrants whose status have been changed from that of an alien described in

paragraph (15)(H)(b) pursuant to section 214(k)(2), except that not more than 500 immigrants may be admitted in any fiscal year under this subparagraph.".

(d) GROUNDS FOR DEPORTATION.—Section 241(a) of such Act (8 U.S.C. 1251(a)) is amended by adding at the end the following new subparagraph:

"(I) FAILURE TO MAINTAIN EMPLOYMENT AS A HEALTH CARE PROFESSIONAL.—Any alien described in section 212(e)(iii) who fails to maintain employment in accordance with subparagraphs (B) and (C) of section 212(k)(1).".

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to aliens admitted to the United States under section 101(a)(15)(J) of the Immigration and Nationality Act, or acquiring such status after admission to the United States, before, on, or after the date of enactment of this Act and before June 1, 2005.

# TITLE V—QUALITY AND CONSUMER PROTECTION

## Subtitle A—Quality Management and Improvement

### SEC. 5001. NATIONAL QUALITY COUNCIL.

(a) ESTABLISHMENT.—Not later than 1 year after the date of enactment of this Act, the Secretary of Health and Human Services shall establish a council to be known as the National Quality Council to oversee a national program of quality management and improvement designed to enhance the quality, appropriateness, and effectiveness of health care services and access to such services in the United States.

(b) APPOINTMENT.—The National Quality Council shall consist of 15 members appointed by the President, with the advice and consent of the Senate, who are broadly representative of the population of the United States and shall include the following:

(1) Individuals and health care providers distinguished in the fields of medicine, public health, health care quality, and related fields of health services research. Such members shall constitute at least one-third of the Council's membership.

(2) Individuals representing consumers of health care services. Such members shall constitute at least one-third of the Council's membership.

(3) Other individuals representing purchasers of health care, health plans, States, and nationally recognized health care accreditation organizations.

(c) DUTIES.—The National Quality Council shall—

(1) develop national goals and performance measures of quality for plans and providers;

(2) oversee the development of survey methodology, sampling and audit methods;

(3) oversee the design and production of Consumer Report Cards;

(4) oversee the quality improvement foundation demonstration project under section 5006;

(5) oversee the evaluation of the impact of the implementation of this Act on the quality of health care services in the United States and the access of consumers to such services; and

(6) report on quality with respect to the medicare program as described in subsection (d).

(d) REPORT ON QUALITY IN MEDICARE.—

(1) IN GENERAL.—Not later than January 1, 1999, the National Quality Council shall prepare and submit to Congress a report containing the rec-

ommendations of the Council on methods to coordinate and integrate quality oversight with respect to the medicare populations remaining in the programs under parts A and B of title XVIII of the Social Security Act.

(2) CONTENTS.—The report under paragraph (1) shall contain—

(A) a status report, prepared by the Prospective Payment Assessment Commission and the Physician Payment Review Commission, concerning the Peer Review Organizations and any other related medicare quality-related activities; and

(B) an evaluation of the quality improvement foundation demonstration project established under section 5006 and the feasibility of expanding the demonstration project and merging the Peer Review Organization program to serve as a national quality improvement program.

(e) CONSULTATION.—In carrying out the duties under this section, the National Quality Council shall establish a process of consultation with appropriate interested parties.

(f) TERMS.—

(1) IN GENERAL.—Except as provided in paragraph (2), members of the Council shall serve for a term of 4 years.

(2) STAGGERED ROTATION.—Of the members first appointed to the Council under subsection (b), the President shall appoint members to serve for a term of between 1 and 4 years so that no more than one third of the Council seats are vacated each year.

(3) SERVICE BEYOND TERM.—A member of the Council may continue to serve after the expiration of the term of the member until a successor is appointed.

(g) VACANCIES.—If a member of the Council does not serve the full term applicable under subsection (f), the individual appointed to fill the resulting vacancy shall be appointed for the remainder of the term of the predecessor of the individual.

(h) CHAIR.—The President shall designate an individual to serve as the chair of the Council.

(i) MEETINGS.—The Council shall meet not less than once during each 4-month period and shall otherwise meet at the call of the President or the chair.

(j) COMPENSATION AND REIMBURSEMENT OF EXPENSES.—Members of the Council shall receive compensation for each day (including travel time) engaged in carry-

ing out the duties of the Council. Such compensation may not be in an amount in excess of the maximum rate of basic pay payable for level IV of the Executive Schedule under section 5315 of title 5, United States Code.

(k) CONFLICTS OF INTEREST.—Members of the Council shall disclose upon appointment to the Council or at any subsequent time that it may occur, conflicts of interest.

(l) EXECUTIVE DIRECTOR; STAFF.—

(1) EXECUTIVE DIRECTOR.—

(A) IN GENERAL.—The Council shall, without regard to section 5311(b) of title 5, United States Code, appoint an Executive Director.

(B) PAY.—The Executive Director shall be paid at a rate equivalent to a rate for the Senior Executive Service.

(2) STAFF.—

(A) IN GENERAL.—Subject to subparagraphs (B) and (C), the Executive Director, with the approval of the Council, may appoint and fix the pay of additional personnel.

(B) PAY.—The Executive Director may make such appointments without regard to the provisions of title 5, United States Code, gov-

erming appointments in the competitive service, and any personnel so appointed may be paid without regard to the provisions of chapter 51 and subchapter III of chapter 53 of such title, relating to classification and General Schedule pay rates, except that an individual so appointed may not receive pay in excess of 120 percent of the annual rate of basic pay payable for GS–15 of the General Schedule.

(C) DETAILED PERSONNEL.—Upon request of the Executive Director, the head of any Federal department or agency may detail any of the personnel of that department or agency to the Council to assist the Council in carrying out its duties under this Act.

(m) CONTRACT AUTHORITY.—To the extent provided in advance in appropriations Acts, the Council may contract with any person (including an agency of the Federal Government) for studies and analysis as required to execute its functions. Any employee of the Executive Branch may be detailed to the Council to assist the Council in carrying out its duties.

(n) CONSULTATIONS WITH EXPERTS.—The Council may consult with any outside expert individuals or groups that the Council determines appropriate in performing its

duties under this section. The Council may establish advisory committees.

(o) ACCESS TO INFORMATION.—The Council may secure directly from any department or agency of the United States information necessary to enable it to carry out its functions, to the extent such information is otherwise available to a department or agency of the United States. Upon request of the chair, the head of that department or agency shall furnish that information to the Council.

(p) DELEGATION OF AUTHORITY.—Except as otherwise provided, the Council may delegate any function to such officers and employees as the Council may designate and may authorize such successive redelegations of such functions with the Council as the Council deems to be necessary or appropriate. No delegation of functions by the Council shall relieve the Council of responsibility for the administration of such functions.

(q) RULEMAKING.—The Council is authorized to establish such rules as may be necessary to carry out this section.

(r) HEALTH CARE PROVIDER.—For purposes of this subtitle, the term "health care provider" means an individual who, or entity that, provides an item or service to an individual that is covered under the health plan (as defined in section 3) in which the individual is enrolled.

**SEC. 5002. NATIONAL QUALITY GOALS.**

The National Quality Council shall develop a set of national quality goals that will address the needs of the general population as well as population subgroups. The goals shall incorporate, among others, goals identified by the Secretary of Health and Human Services for meeting public health objectives delineated in Healthy People 2000, and goals related to improving or maintaining the quality of health care; population health status; health promotion; prevention of diseases, disorders, disabilities, and injuries; and consumer satisfaction.

**SEC. 5003. STANDARDS AND PERFORMANCE MEASURES OF QUALITY FOR HEALTH PLANS.**

(a) DEVELOPMENT.—

(1) IN GENERAL.—The National Quality Council shall establish national standards and performance measures for health plans and providers that will enable the Secretary to assess progress made towards achieving the national quality goals.

(2) MEASURES AND STANDARDS.—

(A) MEASURES.—Quality measures under this section shall assess, at a minimum, the provision of health care services; access to health care services and providers; outcomes of care for specified medical conditions; population health status; health promotion; prevention of

diseases, disorders, disabilities, injuries, and other health conditions; appropriateness of care; and consumer satisfaction, both for the general population and population subgroups, defined by demographic characteristics and health status.

(B) STANDARDS.—Quality standards under this section at a minimum shall relate to:

(i) Health plan compliance with members' rights under this Act.

(ii) Quality improvement and accountability.

(iii) Documentation and review of provider credentialing and competency.

(iv) Management of clinical, and administrative and financial information.

(b) CERTIFICATION OF PLANS.—The National Quality Council shall provide information and technical assistance to the Secretary and the States concerning the use of national standards and performance measures developed under this section for State certification of health plans. The standards and measures shall ensure that health plans are accountable for the overall health and satisfaction of enrolled populations and for the health out-

comes attained by patients treated for specified medical conditions.

(c) ACCURACY OF MEASURES.—A State shall periodically audit the national measures of quality performance to assure accuracy.

**SEC. 5004. PLAN DATA ANALYSIS AND CONSUMER SURVEYS.**

(a) IN GENERAL.—The National Quality Council shall be responsible for surveys, methodology, sampling and audit methods to collect the information necessary to carry out its functions under this subtitle.

(b) SURVEY AND DATA ANALYSIS.—The National Quality Council shall approve a standard design for the consumer surveys and sampling of relevant plan data described in subsection (a).

(c) SURVEY INTEGRATION.—To the extent feasible, surveys developed under this section shall be integrated with existing Federal surveys.

**SEC. 5005. EVALUATION AND REPORTING OF QUALITY PERFORMANCE.**

(a) HEALTH PLAN REPORTS.—Each State annually shall publish and make available to the public a performance report, in a standard format designated by the National Quality Council, outlining the performance of each health plan offered in the State with respect to the set

of national measures of quality performance developed under section and 5003. The report shall include—

(1) the results of a smaller number of such measures for health care providers if the available information is statistically meaningful; and

(2) the results of consumer surveys and an analysis of the plan data collected in section 5004.

(b) CONSUMER REPORT CARDS.—The health plan reports under subsection (a) shall be summarized in a consumer report card as specified by the National Quality Council and made available by the State to all individuals in the State.

(c) QUALITY REPORTS.—The National Quality Council annually shall provide recommendations to the Congress, the National Health Benefits and Coverage Commission, and the Secretary in the form of a summary report that—

(1) outlines in a standard format the performance of each State;

(2) discusses State-level and national trends relating to health care quality; and

(3) presents data for each State from health plan reports and consumer surveys that were conducted during the year.

**SEC. 5006. QUALITY IMPROVEMENT FOUNDATIONS.**

(a) ESTABLISHMENT.—The National Quality Council shall oversee the operation of quality improvement foundations in performing the duties specified in subsection (c).

(b) STRUCTURE AND MEMBERSHIP.—

(1) GRANT PROCESS.—The Secretary, in consultation with the Council, shall, through a competitive grant making process, award demonstration grants for the establishment and operation of quality improvement foundations. In awarding such grants, the Secretary shall consider geographic diversity, regional economies of scale, population density, regional needs and other regional differences.

(2) ELIGIBLE APPLICANTS.—To be eligible to receive a grant for the establishment of a quality improvement foundation under paragraph (1), an applicant entity shall—

(A) be a not-for-profit entity; and

(B) have a board that includes health care providers, representatives from relevant institutions of higher education in the region, consumers, purchasers of health care, and other interested parties.

(c) DUTIES.—

(1) IN GENERAL.—Each quality improvement foundation shall carry out the duties described in

paragraph (2). The foundation shall establish a program of activities incorporating such duties and shall be able to demonstrate the involvement of a broad cross-section of the providers and health care institutions throughout the State or region.

(2) DUTIES DESCRIBED.—The duties described in this paragraph include the following:

(A) Collaboration with and technical assistance to providers and health plans in ongoing efforts to improve the quality of health care provided to individuals in the State.

(B) Population-based monitoring of practice patterns and patient outcomes,on an other than a case-by-case basis.

(C) Developing programs in lifetime learning for health professionals to improve the quality of health care by ensuring that health professionals remain informed about new knowledge, acquire new skills, and adopt new roles as technology and societal demands change.

(D) Disseminating information about successful quality improvement programs, practice guidelines, and research findings, including information on innovative staffing of health professionals.

(E) Assist in developing innovative patient education systems that enhance patient involvement in decisions relating to their health care, including an emphasis on shared decisionmaking between patients and health care providers.

(F) Issuing a report to the public regarding the foundation's activities for the previous year including areas of success during the previous year and areas for opportunities in improving health outcomes for the community, and the adoption of guidelines.

(d) RESTRICTIONS ON DISCLOSURE.—The restrictions on disclosure of information under section 1160 of the Social Security Act shall apply to quality improvement foundations under this section, except that—

(1) such foundations shall make data available to qualified organizations and individuals for research for public benefit under the terms set forth in section 5218;

(2) individuals and qualified organizations shall meet standards consistent with the Public Health Service Act and policies regarding the conduct of scientific research, including provisions related to confidentiality, privacy, protection of humans and shall pay reasonable costs for data; and

(3) such foundations may exchange information with other quality improvement foundations.

**SEC. 5007. AUTHORIZATION OF APPROPRIATIONS.**

(a) NATIONAL QUALITY COUNCIL.—For the purpose of carrying out this subtitle with respect to the establishment and activities of the National Quality Council, there are authorized to be appropriated $4,000,000 for each of the fiscal years 1995 through 2000.

(b) QUALITY IMPROVEMENT FOUNDATIONS.—For the purpose of carrying out section 5006, the are authorized to be appropriated $50,000,000 for each of the fiscal years 1996 through 2000.

**SEC. 5008. ROLE OF HEALTH PLANS IN QUALITY MANAGEMENT.**

Each health plan shall—

(1) measure and disclose performance on quality measures as designated by this Act;

(2) furnish information required under subtitles B and of this title and provide such other reports and information on the quality of care delivered by health care providers who are members of a provider network of the plan as may be required under this Act; and

(3) maintain quality management systems that—

(A) use the national measures of quality performance developed by the National Quality Council under section 5003; and

(B) measure the quality of health care furnished to enrollees under the plan by all health care providers of the plan where practical.

**SEC. 5009. CONFORMING AMENDMENTS TO PUBLIC HEALTH SERVICE ACT.**

Title IX of the Public Health Service Act is amended—

(1) in section 903(a)(4) (42 U.S.C. 299a–1(a)(4)), by inserting "and Quality Improvement Foundations" after "health agencies";

(2) in section 904(c)(1) (42 U.S.C. 299a–2(c)(1)), by inserting "the National Quality Council and" after "in consultation with";

(3) in section 912(b)(4) (42 U.S.C. 299b–1(b)(4))—

(A) by inserting "outcomes," before "risks"; and

(B) by inserting before the semicolon "to the extent feasible given the availability of unbiased, reliable, and valid data";

(4) in section 914 (42 U.S.C. 299b–3)—

(A) in subsection (a)(2)(B)—

(i) by inserting "the National Quality Council," after "shall consult with"; and

(ii) by inserting before the period "and relevant sections of the Health Reform Act";

(B) in subsection (c), by inserting "Quality Improvement Foundations and other" after "carried out through"; and

(C) in subsection (f)—

(i) by striking "TO ADMINISTRATOR" in the subsection heading;

(ii) by striking "Administrator" and inserting "National Quality Council and the"; and

(5) in section 927 (42 U.S.C. 299c–6), by adding at the end thereof the following new paragraphs:

"(5) The term 'National Quality Council' means the Council established under section 5001 of the Health Reform Act.

"(6) The term "Quality Improvement Foundations" means the Foundations established under section 5006 of the Health Reform Act.".

# Subtitle B—Administrative Simplification

## PART 1—PURPOSE AND DEFINITIONS

**SEC. 5101. PURPOSE.**

It is the purpose of this subtitle to improve the efficiency and effectiveness of the health care system, including the medicare program under title XVIII of the Social Security Act and the medicaid program under title XIX of the Social Security Act, by encouraging the development of a health information network through the establishment of standards and requirements for the electronic transmission of certain health information.

**SEC. 5102. DEFINITIONS.**

For purposes of this subtitle:

(1) CODE SET.—The term "code set" means any set of codes used for encoding data elements, such as tables of terms, medical concepts, medical diagnostic codes, or medical procedure codes.

(2) COORDINATION OF BENEFITS.—The term "coordination of benefits" means determining and coordinating the financial obligations of health plans when health care benefits are payable under 2 or more health plans.

(3) HEALTH CARE PROVIDER.—The term "health care provider" includes a provider of services



No page 549/550

(as defined in section 1861(u) of the Social Security Act), a provider of medical or other health services (as defined in section 1861(s) of the Social Security Act), and any other person furnishing health care services or supplies.

(4) HEALTH INFORMATION.—The term "health information" means any information, whether oral or recorded in any form or medium that—

(A) is created or received by a health care provider, health plan, health oversight agency (as defined in section 5202), health researcher, public health authority (as defined in section 5202), employer, life insurer, school or university, or health information network service certified under section 5141; and

(B) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual.

(5) HEALTH INFORMATION NETWORK.—The term "health information network" means the health information system that is formed through the application of the requirements and standards established under this subtitle.

(6) HEALTH INFORMATION PROTECTION ORGANIZATION.—The term "health information protection organization" means a private entity or an entity operated by a State that accesses standard data elements of health information through the health information network and—

(A) processes such information into nonidentifiable health information and discloses such information;

(B) if such information is protected health information (as defined in section 5202), discloses such information in only accordance with subtitle C; and

(C) may store such information

(7) HEALTH INFORMATION NETWORK SERVICE.—The term "health information network service"—

(A) means a private entity or an entity operated by a State that enters into contracts to—

(i) process or facilitate the processing of nonstandard data elements of health information into standard data elements;

(ii) provide the means by which persons are connected to the health informa-

tion network for purposes of meeting the requirements of this subtitle, including the holding of standard data elements of health information;

(iii) provide authorized access to health information through the health information network; or

(iv) provide specific information processing services, such as automated coordination of benefits and claims transaction routing; and

(B) includes a health information protection organization.

(8) HEALTH PLAN.—The term "health plan" has the meaning given such term in section 3(a)(1)(A) except that such term shall include clauses (iii), (iv), (v), (vi), (vii), and (xiii) of such section.

(9) NON-IDENTIFIABLE HEALTH INFORMATION.—The term "non-identifiable health information" means health information that is not protected health information as defined in section 5202.

(10) HEALTH RESEARCHER.—The term "health researcher" shall have the meaning given such term under section 5202.

(11) PATIENT MEDICAL RECORD INFORMATION.—The term "patient medical record information" means health information derived from a clinical encounter that relates to the physical or mental condition of an individual.

(12) STANDARD.—The term "standard" when referring to an information transaction or to data elements of health information means the transaction or data elements meet any standard adopted by the Secretary under part 2 that applies to such information transaction or data elements.

## PART 2—STANDARDS FOR DATA ELEMENTS AND INFORMATION TRANSACTIONS

### SEC. 5111. GENERAL REQUIREMENTS ON SECRETARY.

(a) IN GENERAL.—The Secretary shall adopt standards and modifications to standards under this subtitle that are—

(1) consistent with the objective of reducing the costs of providing and paying for health care;

(2) in use and generally accepted or developed or modified by the standards setting organizations accredited by the American National Standard Institute (ANSI); and

(3) consistent with the objective of protecting the privacy of protected health information (as defined in section 5202).

(b) INITIAL STANDARDS.—The Secretary may develop an expedited process for the adoption of initial standards under this subtitle.

**SEC. 5112. STANDARDS FOR DATA ELEMENTS OF HEALTH INFORMATION.**

(a) IN GENERAL.—The Secretary shall adopt standards necessary to make data elements of the following health information uniform and compatible for electronic transmission through the health information network:

(1) the health information that is appropriate for transmission in connection with transactions described in subsections (a) and (b) of section 5121;

(2) the information required to be submitted by a health plan to a State under section 1020; and

(3) patient medical record information.

(b) ADDITIONS.—The Secretary may make additions to the sets of data elements adopted under subsection (a) as the Secretary determines appropriate in a manner that minimizes the disruption and cost of compliance with such additions.

(c) CERTAIN DATA ELEMENTS.—

(1) UNIQUE HEALTH IDENTIFIERS.—The Secretary shall adopt standards providing for a standard unique health identifier for each individual, employer, health plan, and health care provider for use in the health care system.

(2) CODE SETS.—

(A) IN GENERAL.—The Secretary, in consultation with experts from the private sector and Federal agencies, shall—

(i) select code sets for appropriate data elements from among the code sets that have been developed by private and public entities; or

(ii) establish code sets for such data elements if no code sets for the data elements have been developed.

(B) DISTRIBUTION.—The Secretary shall establish efficient and low-cost procedures for distribution of code sets and modifications to such code sets under section 5115(c).

**SEC. 5113. INFORMATION TRANSACTION STANDARDS.**

(a) IN GENERAL.—The Secretary shall adopt technical standards relating to the method by which data elements of health information that have been standardized under section 5112 may be transmitted electronically, in-

cluding standards with respect to the format in which such data elements shall be transmitted.

(b) SPECIAL RULE FOR COORDINATION OF BENEFITS.—Any standards adopted by the Secretary under paragraph (1) that relate to coordination of benefits shall provide that a claim for reimbursement for medical services furnished is tested by an algorithm specified by the Secretary against all records of enrollment and eligibility for the individual who received such services to determine any primary and secondary obligors for payment.

(c) ELECTRONIC SIGNATURE.—The Secretary, in coordination with the Secretary of Commerce, shall promulgate regulations specifying procedures for the electronic transmission and authentication of signatures, compliance with which will be deemed to satisfy State and Federal statutory requirements for written signatures with respect to information transactions required by this Act and written signatures on medical records and prescriptions.

**SEC. 5114. STANDARDS RELATING TO WRITTEN EXPLANATIONS OF BENEFITS.**

The Secretary shall adopt standard methods and formats which shall be used by health plans to submit a written explanation of benefits to an enrollee.

**SEC. 5115. TIMETABLES FOR ADOPTION OF STANDARDS.**

(a) INITIAL STANDARDS FOR DATA ELEMENTS.—The Secretary shall adopt standards relating to—

(1) the data elements for the information described in section 5112(a)(1) not later than 9 months after the date of the enactment of this subtitle (except in the case of standards with respect to data elements for claims attachments which shall be adopted not later than 24 months after the date of the enactment of this subtitle);

(2) the data elements for the information described in section 5112(a)(2) not later than 9 months after the date of the enactment of this subtitle;

(3) data elements for patient medical record information not earlier than 5 years and not later than 10 years after the date of the enactment of this subtitle; and

(4) any addition to a set of data elements, in conjunction with making such an addition.

(b) INITIAL STANDARDS FOR INFORMATION TRANSACTIONS.—The Secretary shall adopt standards relating to information transactions under section 5113 not later than 9 months after the date of the enactment of this subtitle (except in the case of standards for claims attach-

ments which shall be adopted not later than 24 months after the date of the enactment of this subtitle).

(c) MODIFICATIONS TO STANDARDS.—

(1) IN GENERAL.—Except as provided in paragraph (2), the Secretary shall review the standards adopted under this subtitle and shall adopt modified standards as determined appropriate, but no more frequently than once every 6 months. Any modification to standards shall be completed in a manner which minimizes the disruption and cost of compliance.

(2) SPECIAL RULES.—

(A) MODIFICATIONS DURING FIRST 12-MONTH PERIOD.—Except with respect to additions and modifications to code sets under subparagraph (B), the Secretary shall not adopt any modifications to standards adopted under this subtitle during the 12-month period beginning on the date such standards are adopted unless the Secretary determines that a modification is necessary in order to permit compliance with requirements relating to the standards.

(B) ADDITIONS AND MODIFICATIONS TO CODE SETS.—