

105TH CONGRESS  
1ST SESSION

# S. 146

To permit medicare beneficiaries to enroll with qualified provider-sponsored organizations under title XVIII of the Social Security Act, and for other purposes.

---

## IN THE SENATE OF THE UNITED STATES

JANUARY 21, 1997

Mr. FRIST for Mr. ROCKEFELLER (for himself and Mr. FRIST) introduced the following bill; which was read twice and referred to the Committee on Finance

---

## A BILL

To permit medicare beneficiaries to enroll with qualified provider-sponsored organizations under title XVIII of the Social Security Act, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*  
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE; REFERENCES.**

4 (a) SHORT TITLE.—This Act may be cited as the  
5 “Provider-Sponsored Organization Act of 1997”.

6 (b) REFERENCES TO SOCIAL SECURITY ACT.—Ex-  
7 cept as otherwise specifically provided, whenever in this  
8 Act an amendment is expressed in terms of an amendment  
9 to or repeal of a section or other provision, the reference

1 shall be considered to be made to that section or other  
 2 provision of the Social Security Act.

3 **SEC. 2. QUALIFIED PROVIDER-SPONSORED ORGANIZA-**  
 4 **TIONS AS MEDICARE HEALTH PLAN OPTION.**

5 Section 1876(b) (42 U.S.C. 1395mm(b)) is amended  
 6 to read as follows:

7 “(b)(1) For purposes of this section, the term ‘eligible  
 8 organization’ means a public or private entity (which may  
 9 be a health maintenance organization, a competitive medi-  
 10 cal plan, or a qualified provider-sponsored organization)  
 11 that—

12 “(A) is organized and licensed under State law  
 13 to offer prepaid health services or health benefits  
 14 coverage in each State in which the entity seeks to  
 15 enroll individuals who are entitled to benefits under  
 16 this title; and

17 “(B) is described in paragraph (2), (3), or (4).

18 “(2) An entity is described in this paragraph if the  
 19 entity is a qualified health maintenance organization (as  
 20 defined in section 1310(d) of the Public Health Service  
 21 Act).

22 “(3)(A) An entity is described in this paragraph if  
 23 the entity—

24 “(i) provides to enrolled members health care  
 25 services that include at least—

1           “(I) physicians’ services performed by phy-  
2           sicians (as defined in section 1861(r)(1));

3           “(II) inpatient hospital services;

4           “(III) laboratory, X-ray, emergency, and  
5           preventive services; and

6           “(IV) out-of-area coverage;

7           “(ii) is compensated (except for deductibles, co-  
8           insurance, and copayments) for the provision of  
9           health care services to enrolled members by a pay-  
10          ment which is paid on a periodic basis without re-  
11          gard to the date the health care services are pro-  
12          vided and which is fixed without regard to the fre-  
13          quency, extent, or kind of health care service actu-  
14          ally provided to a member;

15          “(iii) provides physicians’ services primarily—

16               “(I) directly through physicians who are ei-  
17               ther employees or partners of such organiza-  
18               tion; or

19               “(II) through contracts with individual  
20               physicians or 1 or more groups of physicians  
21               (organized on a group practice or individual  
22               practice basis);

23          “(iv) except as provided in subsection (i), as-  
24          sumes full financial risk on a prospective basis for

1 the provision of health care services listed in clause  
2 (i), except that such entity may—

3 “(I) obtain insurance or make other ar-  
4 rangements for the cost of providing to any en-  
5 rolled member health care services listed in  
6 clause (i), the aggregate value of which exceeds  
7 \$5,000 in any year;

8 “(II) obtain insurance or make other ar-  
9 rangements for the cost of health care services  
10 listed in clause (i) provided to its enrolled mem-  
11 bers other than through the entity because  
12 medical necessity required their provision before  
13 they could be secured through the entity;

14 “(III) obtain insurance or make other ar-  
15 rangements for not more than 90 percent of the  
16 amount by which its costs for any of its fiscal  
17 years exceed 115 percent of its income for such  
18 fiscal year; and

19 “(IV) make arrangements with physicians  
20 or other health professionals, health care insti-  
21 tutions, or any combination of such individuals  
22 or institutions to assume all or part of the fi-  
23 nancial risk on a prospective basis for the provi-  
24 sion of basic health services by the physicians

1 or other health professionals or through the in-  
 2 stitutions; and

3 “(v) has made adequate provision against the  
 4 risk of insolvency, which provision is satisfactory to  
 5 the Secretary.

6 “(B) Subparagraph (A)(i)(II) shall not apply to an  
 7 entity that has contracted with a single State agency ad-  
 8 ministering a State plan approved under title XIX for the  
 9 provision of services (other than inpatient hospital serv-  
 10 ices) to individuals eligible for such services under such  
 11 State plan on a prepaid risk basis prior to 1970.

12 “(4) An entity is described in this paragraph if the  
 13 entity is a qualified provider-sponsored organization (as  
 14 defined in subsection (l)(1)(A)).”.

15 **SEC. 3. PARTIAL RISK ARRANGEMENTS.**

16 Section 1876 (42 U.S.C. 1395mm) is amended—

17 (1) by redesignating subsections (i) and (j) as  
 18 subsections (j) and (k), respectively; and

19 (2) by inserting after subsection (h) the follow-  
 20 ing:

21 “(i) The Secretary may enter into a partial risk con-  
 22 tract with an eligible organization under which—

23 “(1) notwithstanding subsection (b)(3)(A)(iv),  
 24 the organization and the program established under  
 25 this title share the financial risk associated with the

1 services the organization provides to individuals enti-  
2 tled to benefits under part A and enrolled under  
3 part B or enrolled under part B only;

4 “(2) notwithstanding subsections (a)(1) and  
5 (h)(2), payment is based on—

6 “(A) a blend of—

7 “(i) the payments that would other-  
8 wise be made to such organization under a  
9 risk-sharing contract under subsection (g);  
10 and

11 “(ii) the payments that would be  
12 made to such organization under a reason-  
13 able cost reimbursement contract under  
14 subsection (h); or

15 “(B) any other methodology agreed upon  
16 by the Secretary and the organization; and

17 “(3) adjustments, if appropriate, are made to  
18 payments to the organization under this section to  
19 reflect any risk assumed by such program.”.

20 **SEC. 4. STANDARDS AND REQUIREMENTS FOR QUALIFIED**  
21 **PROVIDER-SPONSORED ORGANIZATIONS.**

22 Section 1876 (42 U.S.C. 1395mm), as amended by  
23 section 3 of this Act, is amended by adding at the end  
24 the following:

1 “(l)(1)(A) For purposes of this section, the term  
2 ‘qualified provider-sponsored organization’ means a pro-  
3 vider-sponsored organization that—

4 “(i) provides a substantial proportion (as de-  
5 fined by the Secretary, in accordance with subpara-  
6 graph (C) and the regulations established under sec-  
7 tion 1889) of the health care items and services  
8 under the contract under this section directly  
9 through the provider or through an affiliated group  
10 of providers that comprise the organization; and

11 “(ii) is certified under section 1890 as meeting  
12 the regulations established under section 1889,  
13 which, except as provided in the succeeding para-  
14 graphs of this subsection, shall be based on the re-  
15 quirements that apply to an organization described  
16 in subsection (b)(3) with a risk contract under sub-  
17 section (g).

18 “(B) For purposes of this section, the term ‘provider-  
19 sponsored organization’ means a public or private entity  
20 that is a provider or a group of affiliated providers orga-  
21 nized to deliver a spectrum of health care services (includ-  
22 ing basic hospital and physicians’ services) under contract  
23 to purchasers of such services.

24 “(C) In defining a ‘substantial proportion’ for pur-  
25 poses of subparagraph (A)(i), the Secretary—

1           “(i) shall take into account the need for such  
2           an organization to assume responsibility for provid-  
3           ing—

4                   “(I) significantly more than the majority  
5                   of the items and services under the contract  
6                   under this section through its own affiliated  
7                   providers; and

8                   “(II) most of the remainder of the items  
9                   and services under the contract through provid-  
10                  ers with which the organization has an agree-  
11                  ment to provide such items and services,  
12                  in order to assure financial stability and to address  
13                  the practical considerations involved in integrating  
14                  the delivery of a wide range of service providers;

15                  “(ii) shall take into account the need for such  
16                  an organization to provide a limited proportion of  
17                  the items and services under the contract through  
18                  providers that are neither affiliated with nor have an  
19                  agreement with the organization; and

20                  “(iii) may allow for variation in the definition  
21                  of substantial proportion among such organizations  
22                  based on relevant differences among the organiza-  
23                  tions, such as their location in an urban or rural  
24                  area.

1 “(D) For purposes of this paragraph, a provider is  
2 ‘affiliated’ with another provider if, through contract, own-  
3 ership, or otherwise—

4 “(i) one provider, directly or indirectly, controls,  
5 is controlled by, or is under the control of the other;

6 “(ii) each provider is a participant in a lawful  
7 combination under which each provider shares, di-  
8 rectly or indirectly, substantial financial risk in con-  
9 nection with their operations;

10 “(iii) both providers are part of a controlled  
11 group of corporations under section 1563 of the In-  
12 ternal Revenue Code of 1986; or

13 “(iv) both providers are part of an affiliated  
14 service group under section 414 of such Code.

15 “(E) For purposes of subparagraph (D), control is  
16 presumed to exist if one party, directly or indirectly, owns,  
17 controls, or holds the power to vote, or proxies for, not  
18 less than 51 percent of the voting rights or governance  
19 rights of another.

20 “(2)(A) Subject to subparagraph (B), subsection  
21 (b)(1)(A) (relating to State licensure) shall not apply to  
22 a qualified provider-sponsored organization.

23 “(B) Beginning on January 1, 2002, subsection  
24 (b)(1)(A) shall only apply (and subparagraph (A) of this

1 paragraph shall no longer apply) to a qualified provider-  
2 sponsored organization in a State if—

3 “(i) the financial solvency and capital adequacy  
4 standards for licensure of the organization under the  
5 laws of the State are identical to the regulations es-  
6 tablished under section 1889; and

7 “(ii) the standards for licensure of the organi-  
8 zation under the laws of the State (other than the  
9 standards referred to in clause (i)) are substantially  
10 equivalent to the standards established by regula-  
11 tions under section 1889.

12 “(C)(i) A provider-sponsored organization, to which  
13 subsection (b)(1)(A) applies by reason of subparagraph  
14 (B), that seeks to operate in a State under a full risk con-  
15 tract under subsection (g) or a partial risk contract under  
16 subsection (i) may apply for a waiver of the requirement  
17 of subsection (b)(1)(A) for that organization operating in  
18 that State.

19 “(ii) The Secretary shall act on such a waiver applica-  
20 tion within 60 days after the date it is filed and shall grant  
21 a waiver for an organization with respect to a State if the  
22 Secretary determines that—

23 “(I) the State did not act upon a licensure ap-  
24 plication within 90 days after the date it was filed;  
25 or

1           “(II)(aa) the State denied a licensure applica-  
2           tion; and

3           “(bb) the State’s licensing standards or review  
4           process are determined by the Secretary to impose  
5           unreasonable barriers to market entry, including  
6           through the imposition of any requirements, proce-  
7           dures, or other standards on such organization that  
8           are not generally applicable to any other entities en-  
9           gaged in substantially similar activities.

10          “(iii) In the case of a waiver granted under this para-  
11          graph for an organization—

12               “(I) the waiver shall be effective for a 24-month  
13               period, except that it may be renewed based on a  
14               subsequent application filed during the last 6  
15               months of such period;

16               “(II) if the State failed to meet the requirement  
17               of clause (ii)(I)—

18                       “(aa) any application for a renewal may be  
19                       made on the basis described in clause (ii)(I)  
20                       only if the State does not act on a pending li-  
21                       censure application during the 24-month period  
22                       specified in subclause (I);

23                       “(bb) any application for renewal (other  
24                       than one made on the basis described in clause

1 (ii)(I) may be made only on the basis described  
2 in clause (ii)(II); and

3 “(cc) the waiver shall cease to be effective  
4 on approval of the licensure application by the  
5 State during such 24-month period; and

6 “(III) any provisions of State law that relate to  
7 the licensing of the organization and prohibit the or-  
8 ganization from providing coverage pursuant to a  
9 contract under this title shall be superseded during  
10 the period for which such waiver is effective.

11 “(D) Nothing in this paragraph shall be construed  
12 as—

13 “(i) limiting the number of times such a waiver  
14 may be renewed under subparagraph (C)(iii)(I); or

15 “(ii) affecting the operation of section 514 of  
16 the Employee Retirement Income Security Act of  
17 1974 (29 U.S.C. 1144).

18 “(3) The requirement of subsection (b)(3)(A)(i) (re-  
19 lating to benefit package for commercial enrollees) shall  
20 not apply to a qualified provider-sponsored organization.

21 “(4) The requirement of subsection (b)(3)(A)(iii) (re-  
22 lating to delivery of physicians’ services) shall apply to a  
23 qualified provider-sponsored organization, except that the  
24 Secretary shall by regulation specify alternative delivery

1 models or arrangements that may be used by such organi-  
2 zations in lieu of the models or arrangements specified in  
3 such subsection.

4 “(5) The requirement of subsection (b)(3)(A)(iv) (re-  
5 lating to risk assumption) shall apply to a qualified pro-  
6 vider-sponsored organization, except that any such organi-  
7 zation with a full risk contract under subsection (g) may  
8 (with the approval of the Secretary) obtain insurance or  
9 make other arrangements for covering costs in excess of  
10 those permitted to be covered by such insurance and any  
11 arrangements under subsection (b)(3)(A)(iv)(III).

12 “(6)(A) A qualified provider-sponsored organization  
13 shall be treated as meeting the requirement of subsection  
14 (b)(3)(A)(v) (relating to adequate provision against risk  
15 of insolvency) if the organization is fiscally sound.

16 “(B) A qualified provider-sponsored organization  
17 shall be treated as fiscally sound for purposes of subpara-  
18 graph (A) if the organization—

19 “(i) has a net worth that is not less than the  
20 required net worth (as defined in subparagraph (C));  
21 and

22 “(ii) has established adequate claims reserves  
23 (as defined in subparagraph (D)).

24 “(C) For purposes of subparagraph (B)(i), the term  
25 ‘required net worth’ means—

1           “(i) in the case of an organization with a full  
2 risk contract under subsection (g), a net worth (de-  
3 termined in accordance with statutory accounting  
4 principles for insurance companies and health main-  
5 tenance organizations), not less than the greatest  
6 of—

7           “(I) \$1,500,000 at the time of application  
8 and \$1,000,000 thereafter,

9           “(II) the sum of—

10           “(aa) 8 percent of the cost of health  
11 services that are not provided directly by  
12 the organization or its affiliated providers  
13 to enrollees; and

14           “(bb) 4 percent of the estimated an-  
15 nual costs of health services provided di-  
16 rectly by the organization or its affiliated  
17 providers to enrollees; or

18           “(III) 3 months of uncovered expenditures;

19           and

20           “(ii) in the case of an organization with a par-  
21 tial risk contract under subsection (i), an amount  
22 determined in accordance with clause (i), except that  
23 in applying subclause (II) of such clause, the Sec-  
24 retary shall substitute for the percentages specified

1 in such subclause such lower percentages as are ap-  
2 propriate to reflect the risk-sharing arrangements  
3 under the contract.

4 “(D) For purposes of subparagraph (B)(ii), the term  
5 ‘adequate claims reserves’ means, with respect to an orga-  
6 nization, reserves for claims that are—

7 “(i) incurred but not reported; or

8 “(ii) reported but unpaid,

9 that are determined in accordance with statutory account-  
10 ing principles for insurance companies and health mainte-  
11 nance organizations and with professional standards of ac-  
12 tuarial practice and are certified by an independent actu-  
13 ary as adequate in light of the operations and contracts  
14 of the organization.

15 “(E) In applying statutory accounting principles for  
16 purposes of determining the net worth of an organization  
17 under subparagraph (B)(i), the Secretary shall—

18 “(i) treat as ‘admitted assets’—

19 “(I) land, buildings, and equipment of the  
20 organization used for the direct provision of  
21 health care services;

22 “(II) any receivables from governmental  
23 programs due for more than 90 days; and

24 “(III) any other assets designated by the  
25 Secretary; and

1           “(ii) recognize, as a contribution to surplus,  
2           amounts received under subordinated debt (meeting  
3           such requirements as the Secretary may specify).

4           “(F) The Secretary shall recognize ways of complying  
5           with the requirement of subparagraph (A) other than by  
6           means of subparagraph (B), including (alone or in com-  
7           bination)—

8           “(i) letters of credit from a bank;

9           “(ii) financial guarantees from financially  
10           strong parties including affiliates;

11           “(iii) unrestricted fund balances;

12           “(iv) diversity of lines of business and presence  
13           of nonrisk related revenue;

14           “(v) certification of fiscal soundness by an inde-  
15           pendent actuary;

16           “(vi) reinsurance ceded to, or stop loss insur-  
17           ance purchased through, a recognized commercial in-  
18           surance company; and

19           “(vii) any other methods that the Secretary de-  
20           termines are acceptable for such purpose.

21           “(7)(A) A qualified provider-sponsored organization  
22           shall not be treated as meeting the requirements of sub-  
23           section (c)(6) (relating to an ongoing quality assurance

1 program) unless the quality assurance program of the or-  
2 ganization meets the requirements of subparagraphs (B)  
3 and (C).

4 “(B) A quality assurance program meets the require-  
5 ments of this subparagraph if the program—

6 “(i) stresses health outcomes;

7 “(ii) provides opportunities for input by physi-  
8 cians and other health care professionals;

9 “(iii) monitors and evaluates high volume and  
10 high risk services and the care of acute and chronic  
11 conditions;

12 “(iv) evaluates the continuity and coordination  
13 of care that enrollees receive;

14 “(v) establishes mechanisms to detect both un-  
15 derutilization and overutilization of services;

16 “(vi) after identifying areas for improvement,  
17 establishes or alters practice parameters;

18 “(vii) takes action to improve quality and assess  
19 the effectiveness of such action through systematic  
20 followup;

21 “(viii) makes available information on quality  
22 and outcomes measures to facilitate beneficiary com-  
23 parison and choice of health coverage options (in

1 such form and on such quality and outcomes meas-  
2 ures as the Secretary determines to be appropriate);  
3 and

4 “(ix) is evaluated on an ongoing basis as to its  
5 effectiveness.

6 “(C) If a qualified provider-sponsored organization  
7 utilizes case-by-case utilization review, the organization  
8 shall—

9 “(i) base such review on written protocols devel-  
10 oped on the basis of current standards of medical  
11 practice; and

12 “(ii) implement a plan under which—

13 “(I) such review is coordinated with the  
14 quality assurance program of the organization;  
15 and

16 “(II) a transition is made from relying pre-  
17 dominantly on case-by-case review to review fo-  
18 cusing on patterns of care.

19 “(D) A qualified provider-sponsored organization  
20 shall be treated as meeting the requirements of subpara-  
21 graphs (A) and (B) and the requirements of subsection  
22 (c)(6) if the organization is accredited (and periodically  
23 reaccredited) by a private organization under a process  
24 that the Secretary has determined assures that the organi-  
25 zation meets standards that are no less stringent than the

1 standards established under section 1889 to carry out this  
 2 paragraph and subsection (c).”.

3 **SEC. 5. EXEMPTION FROM CERTAIN ENROLLMENT RE-**  
 4 **QUIREMENTS FOR ELIGIBLE ORGANIZATIONS**  
 5 **MEETING ENHANCED QUALITY ASSURANCE**  
 6 **REQUIREMENTS.**

7 (a) IN GENERAL.—Section 1876 of the Social Secu-  
 8 rity Act (42 U.S.C. 1395mm), as amended by section 4  
 9 of this Act, is amended by adding at the end the following:

10 “(m)(1) An eligible organization shall be deemed to  
 11 meet the requirements of subsection (f) (relating to enroll-  
 12 ment composition) if the organization demonstrates that  
 13 it—

14 “(A) is capable of providing coordinated care in  
 15 accordance with the quality assurance standards es-  
 16 tablished under subsections (c)(6) and (l)(7)(B); and

17 “(B) has experience, under a past or present  
 18 arrangement, providing coordinated care to individ-  
 19 uals (other than individuals who are entitled to bene-  
 20 fits under this title) who are enrollees, participants,  
 21 or beneficiaries of a health plan or a State plan ap-  
 22 proved under title XIX.

1       “(2) An eligible organization shall be treated as meet-  
2 ing the quality assurance standards referred to in para-  
3 graph (1)(A) if the organization is accredited (and periodi-  
4 cally reaccredited) by a private organization under a proc-  
5 ess that the Secretary has determined assures that the or-  
6 ganization meets standards that are no less stringent than  
7 the requirements of that subparagraph.

8       “(3) For purposes of paragraph (1), the term ‘health  
9 plan’ means—

10           “(A) any contract of insurance, including any  
11 hospital or medical service policy or certificate, hos-  
12 pital or medical service plan contract, or health  
13 maintenance organization contract, that is provided  
14 by a carrier; and

15           “(B) an employee welfare benefit plan insofar  
16 as the plan provides health benefits and is funded in  
17 a manner other than through the purchase of one or  
18 more policies or contracts described in subparagraph  
19 (A).

20       “(4) For purposes of paragraph (3), the term ‘car-  
21 rier’ means a licensed insurance company, a hospital or  
22 medical service corporation (including an existing Blue  
23 Cross or Blue Shield organization), or any other entity  
24 licensed or certified by a State to provide health insurance  
25 or health benefits.”.

1 (b) SIZE REQUIREMENT FOR ELIGIBLE ORGANIZA-  
2 TIONS.—Section 1876(g)(1) (42 U.S.C. 1395mm(g)(1)) is  
3 amended—

4 (1) by striking “5000” and inserting “1500”;  
5 and

6 (2) by striking “fewer” and inserting “500 or  
7 more”.

8 (c) CONFORMING AMENDMENT.—Section 1876(f)(1)  
9 (42 U.S.C. 1395mm(f)(1)) is amended by striking “Each  
10 eligible” and inserting “Except as provided in subsection  
11 (m), each eligible”.

12 **SEC. 6. ADJUSTED COMMUNITY RATE FOR A QUALIFIED**  
13 **PROVIDER-SPONSORED ORGANIZATION.**

14 Section 1876(g) (42 U.S.C. 1395mm(g)) is amended  
15 by adding at the end the following:

16 “(7) In the case of a qualified provider-sponsored or-  
17 ganization, the adjusted community rate under subsection  
18 (e)(3) and paragraph (2) may be computed (in a manner  
19 specified by the Secretary) using data in the general com-  
20 mercial marketplace or (during a transition period) based  
21 on the costs incurred by the organization in providing such  
22 a product.”.

1 **SEC. 7. PROCEDURES RELATING TO PARTICIPATION OF A**  
2 **PHYSICIAN IN A QUALIFIED PROVIDER-SPON-**  
3 **SORED ORGANIZATION.**

4 Section 1876 (42 U.S.C. 1395mm), as amended by  
5 section 5 of this Act, is amended by adding at the end  
6 the following:

7 “(n) A qualified provider-sponsored organization  
8 shall not be treated as meeting the requirements of this  
9 section unless the organization—

10 “(1) establishes reasonable procedures, as de-  
11 termined by the Secretary, relating to the participa-  
12 tion (under an agreement between a physician or  
13 group of physicians and the organization) of physi-  
14 cians under contracts under this section, including  
15 procedures to provide—

16 “(A) notice of the rules regarding partici-  
17 pation;

18 “(B) written notice of a participation deci-  
19 sion that is adverse to a physician; and

20 “(C) a process within the organization for  
21 appealing an adverse decision, including the  
22 presentation of information and views of the  
23 physician regarding such decision; and

24 “(2) consults with physicians who have entered  
25 into participation agreements with the organization

1 regarding the organization’s medical policy, quality,  
2 and medical management procedures.

3 Paragraph (1)(C) shall not be construed to require a live  
4 evidentiary hearing, a verbatim record, or representation  
5 of the appealing party by legal counsel.”.

6 **SEC. 8. ESTABLISHMENT OF REGULATIONS; CERTIFI-**  
7 **CATION PROCEDURES.**

8 Part C of title XVIII (42 U.S.C. 1395x et seq.) is  
9 amended by inserting after section 1888 (42 U.S.C.  
10 1395yy) the following:

11 “ESTABLISHMENT OF REGULATIONS FOR QUALIFIED  
12 PROVIDER-SPONSORED ORGANIZATIONS

13 “SEC. 1889. (a) INTERIM REGULATIONS.—

14 “(1) IN GENERAL.—Not later than 180 days  
15 after the date of enactment of this section, the Sec-  
16 retary shall promulgate regulations to implement the  
17 requirements for qualified provider-sponsored orga-  
18 nizations under section 1876). Such regulations shall  
19 be issued on an interim basis, but shall become ef-  
20 fective upon publication and shall remain in effect  
21 until the end of December 31, 2001.

22 “(2) CONSULTATION.—In developing regula-  
23 tions under this subsection, the Secretary shall con-  
24 sult with the National Association of Insurance  
25 Commissioners, the American Academy of Actuaries,  
26 State health departments, associations representing

1 provider-sponsored organizations, quality experts  
 2 (including private accreditation organizations), and  
 3 medicare beneficiaries.

4 “(3) CONTRACTS WITH STATE AGENCIES.—The  
 5 Secretary shall enter into contracts with appropriate  
 6 State agencies to monitor performance and bene-  
 7 ficiary access to services provided under this title  
 8 during the period in which interim regulations are in  
 9 effect under this subsection.

10 “(b) PERMANENT REGULATIONS.—

11 “(1) IN GENERAL.—Not later than July 1,  
 12 2001, the Secretary shall issue permanent regula-  
 13 tions to implement the requirements for qualified  
 14 provider-sponsored organizations under section  
 15 1876.

16 “(2) CONSULTATION.—In developing regula-  
 17 tions under this subsection, the Secretary shall con-  
 18 sult with the organizations and individuals listed in  
 19 subsection (a)(2).

20 “(3) EFFECTIVE DATE.—The permanent regu-  
 21 lations developed under this subsection shall be ef-  
 22 fective on and after January 1, 2002.

23 “CERTIFICATION OF PROVIDER-SPONSORED  
 24 ORGANIZATIONS

25 “SEC. 1890. (a) IN GENERAL.—

1           “(1) PROCESS FOR CERTIFICATION.—The Sec-  
 2           retary shall establish a process for the certification  
 3           of provider-sponsored organizations as qualified pro-  
 4           vider-sponsored organizations under section 1876.  
 5           Such process shall provide that an application for  
 6           certification shall be approved or denied not later  
 7           than 90 days after receipt of a complete application.

8           “(2) FEES.—The Secretary may impose user  
 9           fees on entities seeking certification under this sub-  
 10          section in such amounts as the Secretary deems suf-  
 11          ficient to pay the costs to the Secretary resulting  
 12          from the certification process.

13          “(b) DECERTIFICATION.—If a qualified provider-  
 14          sponsored organization is decertified under this section,  
 15          the organization shall notify each enrollee with the organi-  
 16          zation under section 1876 of such decertification.”.

17 **SEC. 9. DEMONSTRATION OF COORDINATED ACUTE AND**  
 18                                   **LONG-TERM CARE BENEFITS; QUALIFIED**  
 19                                   **PROVIDER-SPONSORED ORGANIZATIONS**  
 20                                   **UNDER MEDICAID PROGRAMS.**

21          (a) DEMONSTRATION OF COORDINATED ACUTE AND  
 22          LONG-TERM CARE BENEFITS.—The Secretary of Health  
 23          and Human Services shall provide, in not less than 10  
 24          States, for demonstration projects that permit State med-  
 25          icaid programs under title XIX of the Social Security Act

1 (42 U.S.C. 1396 et seq.) to be treated as eligible organiza-  
2 tions under section 1876 of that Act (42 U.S.C. 1395mm)  
3 for the purpose of demonstrating the delivery of primary,  
4 acute, and long-term care through an integrated delivery  
5 network that emphasizes noninstitutional care to individ-  
6 uals who are—

7 (1) eligible to enroll with an organization under  
8 such section; and

9 (2) eligible to receive medical assistance under  
10 a State program approved under title XIX of the So-  
11 cial Security Act (42 U.S.C. 1396 et seq.).

12 (b) PROVIDER-SPONSORED ORGANIZATIONS UNDER  
13 MEDICAID PROGRAMS.—Section 1903(m)(1)(A) (42  
14 U.S.C. 1396b(m)(1)(A)) is amended, in the matter pre-  
15 ceding clause (i), by inserting “(which may be a provider-  
16 sponsored organization, as defined in section  
17 1876(l)(1)(B))” after “public or private organization”.

18 (c) CONFORMING AMENDMENTS.—

19 (1) Section 1866(a)(1)(O) is amended by strik-  
20 ing “1876(i)(2)(A)” and inserting “1876(j)(2)(A)”.

21 (2) Section 1877(e)(3)(B)(i)(II) is amended by  
22 striking “1876(i)(8)(A)(ii)” and inserting  
23 “1876(j)(8)(A)(ii)”.

1 **SEC. 10. REPORT ON MEDICARE CONTRACTS INVOLVING**  
2 **PARTIAL RISK.**

3 (a) REPORT.—Not later than 4 years after the date  
4 of enactment of this Act, the Secretary of Health and  
5 Human Services (in this section referred to as the “Sec-  
6 retary”) shall submit a report to the Committee on Ways  
7 and Means and the Committee on Commerce of the House  
8 of Representatives and the Committee on Finance of the  
9 Senate.

10 (b) CONTENTS OF REPORT.—The report described in  
11 subsection (a) shall include—

12 (1) the number and type of partial-risk con-  
13 tracts entered into by the Secretary under section  
14 1876(i) of the Social Security Act (42 U.S.C.  
15 1395mm(i));

16 (2) the type of eligible organizations operating  
17 such contracts;

18 (3) the impact such contracts have had on in-  
19 creasing beneficiary access and choice under the  
20 medicare program under title XVIII of that Act (42  
21 U.S.C. 1395 et seq.); and

22 (4) a recommendation as to whether the Sec-  
23 retary should continue to enter into partial-risk con-  
24 tracts under section 1876(i) of that Act (42 U.S.C.  
25 1395mm(i)).

1 **SEC. 11. EFFECTIVE DATES; INTERIM FINAL REGULATIONS.**

2 (a) EFFECTIVE DATES.—

3 (1) IN GENERAL.—Except as provided in para-  
4 graph (2), this Act and the amendments made by  
5 this Act shall take effect on the date of enactment  
6 of this Act.

7 (2) ELIGIBLE ORGANIZATION AMENDMENTS.—

8 The amendments made by sections 2 through 8 shall  
9 take effect on the date of enactment of this Act and  
10 shall apply to contract years beginning on or after  
11 January 1, 1998.

12 (b) USE OF INTERIM FINAL REGULATIONS.—In  
13 order to carry out the amendments made by this Act in  
14 a timely manner for eligible organizations under section  
15 1876 of the Social Security Act (42 U.S.C. 1395mm), ex-  
16 cluding organizations described in subsection (b)(4) of  
17 that section, the Secretary of Health and Human Services  
18 may promulgate regulations that take effect on an interim  
19 basis, after notice and opportunity for public comment.

○