

achieve the National Educational Goals for all citizens, and for other purposes; to the Committee on Labor and Human Resources.

EC-929. A communication from the Secretary of Health and Human Services, transmitting, pursuant to law, the fiscal years 1991 and 1992 report relative to the effectiveness of programs under the Lead Contamination Control Act; to the Committee on Labor and Human Resources.

EC-930. A communication from the Secretary of Labor, transmitting, pursuant to law, a fiscal year 1992 report relative to employment and training programs; to the Committee on Labor and Human Resources.

EC-931. A communication from the Secretary of Health and Human Services, transmitting, pursuant to law, the annual report of the Administration on Aging for fiscal year 1994; to the Committee on Labor and Human Resources.

EC-932. A communication from the Administrator of the Small Business Administration, transmitting, pursuant to law, the 1994 report relative to minority small business and capital ownership development; to the Committee on Small Business.

EC-933. A communication from the Secretary of Veterans' Affairs, transmitting, a draft of proposed legislation to amend title 38, United States Code, to clarify the eligibility of certain minors for burial in national cemeteries; to the Committee on Veterans' Affairs.

EC-934. A communication from the Secretary of Veterans' Affairs, transmitting, a draft of proposed legislation to amend title 38, United States Code, to restrict payment of a clothing allowance to incarcerated veterans and to create a presumption of permanent and total disability for pension purposes for certain veterans who are patients in a nursing home; to the Committee on Veterans' Affairs.

EC-935. A communication from the Secretary of Veterans' Affairs, transmitting, a draft of proposed legislation entitled the "Veterans' Insurance Reform Act of 1995"; to the Committee on Veterans' Affairs.

REPORTS OF COMMITTEES

The following reports of committees were submitted:

By Mr. CHAFEE, from the Committee on Environment and Public Works, with an amendment in the nature of a substitute:

S. 440. A bill to amend title 23, United States Code, to provide for the designation of the National Highway System, and for other purposes (Rept. No. 104-86).

INTRODUCTION OF BILLS AND JOINT RESOLUTIONS

The following bills and joint resolutions were introduced, read the first and second time by unanimous consent, and referred as indicated:

By Mr. D'AMATO:

S. 838. A bill to provide for additional radio broadcasting to Iran by the United States; to the Committee on Foreign Relations.

By Mr. CHAFEE (for himself, Mr. GRAHAM, and Mr. CONRAD):

S. 839. A bill to amend title XIX of the Social Security Act to permit greater flexibility for States to enroll medicaid beneficiaries in managed care arrangements, to remove barriers preventing the provision of medical assistance under State medicaid plans through managed care, and for other purposes; to the Committee on Finance.

By Mr. CONRAD:

S. 840. A bill to provide the States greater flexibility in providing jobs for, and assist-

ance to, needy families, to improve child support enforcement, to reduce teenage pregnancy, and for other purposes; to the Committee on Finance.

SUBMISSION OF CONCURRENT AND SENATE RESOLUTIONS

The following concurrent resolutions and Senate resolutions were read, and referred (or acted upon), as indicated:

By Mr. DOLE (for himself and Mr. DASCHLE):

S. Res. 122. A resolution designating James R. Ketchum as Curator Emeritus of the United States Senate; considered and agreed to.

S. Res. 123. A resolution relating to the retirement of Gerald A. Hackett; considered and agreed to.

S. Res. 124. A resolution relating to the retirement of Frederick R. Broomfield, Sr.; considered and agreed to.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. D'AMATO:

S. 838. A bill to provide for additional radio broadcasting to Iran by the United States; to the Committee on Foreign Relations.

RADIO FREE IRAN ACT

Mr. D'AMATO. Mr. President, I rise today to introduce the Radio Free Iran Act.

This legislation is intended to create a Farsi-language service to be broadcast to Iran that will supplement, not supplant the current programming already beamed to Iran by the Voice of America. This service is intended to be made political in nature and as such, will bring to the Iranian people the real news that they are denied access to be the dictatorial regime in Tehran.

It is vital to the people of Iran that they be exposed to the truth of what is happening inside Iran. More must be done to detail what the regime is doing to this proud people. The Iranian people must understand how the regime has created impossible living conditions through massive inflation and shortages, persecuted minorities, denied human rights, and forced international isolation upon this proud nation because of its abhorrent practices.

The regime has robbed the Iranian people of its glorious history, replacing it with the status of a pariah state. The regime in Tehran is known as the chief sponsor of international terrorism, it is known as one of the worst abusers of human rights, and it is known for its unceasing determination to obtain weapons of mass destruction. This in itself is lowering the Iranian people's living standards with each passing day.

This legislation is intended to expose the people of Iran to a more balanced approach to the conditions in Iran so that they can hopefully have a greater impact on their own future.

If anything is clear it is that the Iranian people deserve better. They deserve a chance to live free of the abusive and dictatorial nature of their corrupt government. They deserve to shed the status that this regime has cast

upon them, and they deserve the chance to regain their proper role in the world.

Radio Free Iran will not be the panacea, but it will be the beginning. I want Radio Free Iran to be for the Iranian people what Radio Free Europe did for the people of Eastern Europe. The only goal for the Iranian people is freedom from oppression.

I urge my colleagues to support this worthwhile project.

Mr. President, I ask unanimous consent that the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 838

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Radio Free Iran Act".

SEC. 2. FINDINGS.

Congress makes the following findings:

(1) It is the policy of the United States to support the right of the People of Iran to seek, receive, and impart information and ideas through any media, regardless of frontiers, in accordance with article 19 of the Universal Declaration of Human Rights.

(2) Consonant with this policy, radio broadcasting to Iran may be effective in furthering the open communication of accurate information and ideas about Iran to the people of Iran.

(3) Such broadcasting to Iran, operated in a manner not inconsistent with the broad foreign policy of the United States and in accordance with high professional standards, would be in the national interest.

SEC. 3. RADIO BROADCASTING TO IRAN.

(a) IN GENERAL.—In order to carry out the objectives set forth in section 2, the United States Information Agency shall provide for the open communication of information and ideas on Iran through the use of radio broadcasting to Iran. Radio broadcasting to Iran under this section shall serve as a consistently reliable and authoritative source of accurate, objective, and comprehensive news on Iran.

(b) REQUIREMENTS RELATING TO BROADCASTING.—(1) Radio broadcasting under subsection (a) shall be provided in accordance with standards that ensure the broadcast of programs which are objective, accurate, and balanced, and which present a variety of views. Such standards shall be established by the board established under section 4.

(2) Radio broadcasting under subsection (a) shall be provided in the Farsi language.

(c) DESIGNATION OF BROADCASTS.—Any program of United States Government radio broadcasts in the Farsi language under this section shall be designated "Radio Free Iran".

(d) RELATIONSHIP WITH OTHER RADIO SERVICE TO IRAN.—It is the sense of Congress that radio broadcasting under this section supplement and not supplant other radio broadcasting and radio broadcasting services to Iran in the Farsi language that are provided by the United States Government.

(e) AUTHORITY TO CONTRACT.—The Director of the United States Information Agency may carry out this section by means of grants, contracts, and leases and by such other means as the Director determines appropriate. Any grant, contract, or lease under this subsection shall specify that payment thereunder by the Director is subject to the availability of appropriations thereof.

(f) ASSISTANCE FROM OTHER GOVERNMENT AGENCIES.—The Director may secure on a reimbursable basis from any department or agency of the Federal Government, with the concurrence of the head of the department or agency, any technical or administrative support or services (including personnel and property) that the Director may require in order to provide radio broadcasting to Iran under this section. Any reimbursement under this subsection shall be credited to the appropriation from which the support or services was derived.

SEC. 4. ADVISORY BOARD.

(a) IN GENERAL.—There is hereby established an advisory board to be known as the Advisory Board for Radio Free Iran (in this section referred to as the "Board").

(b) MEMBERSHIP MATTERS.—(1) The Board shall be composed of eight members of whom—

(A) four shall be appointed by the President;

(B) two shall be appointed by the President pro tempore of the Senate, upon the recommendation of the majority and minority leaders of the Senate; and

(C) two shall be appointed by the Speaker of the House of Representatives, in consultation with the minority leader of the House of Representatives.

(2) Members shall be appointed for terms of 4 years. Any vacancy in the Board shall not affect its powers but shall be filled in the same manner as the original appointment.

(3) The President shall designate one member of the Board to be the Chairman.

(c) DUTIES.—The Board shall have the following duties:

(1) To establish standards for the broadcast of programs under section 3, which standards shall ensure that such programs are objective, accurate, and balanced, and present a variety of views.

(2) To monitor the broadcast of programs under that section in order to ensure that the programs meet the standards so established.

(d) COMPENSATION.—(1) Each member of the Board who is not an officer or employee of the Federal Government shall be compensated at a rate equal to the daily equivalent of the annual rate of basic pay prescribed for level IV of the Executive Schedule under section 5315 of title 5, United States Code, for each day (including travel time) during which such member is engaged in the performance of the duties of the Board. All members of the Board who are officers or employees of the United States shall serve without compensation in addition to that received for their services as officers or employees of the United States.

(2) The members of the Board shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Board.

(e) PROCUREMENT OF SUPPLIES AND SERVICES.—The Board may, to the extent it considers necessary to carry out its duties under this section, procure supplies, services, and other personal property, including specialized electronic equipment.

SEC. 5. AUTHORIZATION OF APPROPRIATIONS.

(a) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated for the United States Information Agency for fiscal year 1996 such sums as may be necessary for purposes of carrying out this Act, including the activities of the board established under section 4.

(b) AVAILABILITY OF FUNDS.—Amounts appropriated under this section shall remain available until expended.

By Mr. CHAFEE (for himself, Mr. GRAHAM, and Mr. CONRAD):

S. 839. A bill to amend title XIX of the Social Security Act to permit greater flexibility for States to enroll Medicaid beneficiaries in managed care arrangements, to remove barriers preventing the provision of medical assistance under State Medicaid plans through managed care, and for other purposes; to the Committee on Finance.

MEDICAID MANAGED CARE ACT

Mr. CHAFEE. Mr. President, we face many difficult decisions in the next few months. Due to the increasing national deficit and our efforts to control it, we must carefully review all Federal programs. Of particular concern are Federal entitlement programs such as Medicare and Medicaid. Today we are debating a budget resolution that will reduce the growth rate in Medicaid spending by \$175 billion over the next 7 years. I am supportive of efforts to bring Federal spending under control, including Federal spending on the Medicaid Program. However, I am deeply concerned about the future of this program which provides critical health care services to low-income children, pregnant women, persons with disabilities and the elderly.

Clearly, as we move forward we can expect to see some dramatic changes in the Medicaid Program. And as a former Governor, I understand the need to provide States with additional flexibility to administer the program, and to control costs. Many may question whether it is possible to meet these objectives without jeopardizing health care services to millions of low-income Americans. Some have suggested converting the Medicaid Program into a block grant and capping the general rate of growth in Federal expenditures. While I agree that we should give States more flexibility, I do not believe that it is reasonable to expect the Federal Government to hand over more than \$100 billion per year without expecting accountability. Thus, earlier this year I began to look for alternatives to this approach.

Mr. President, today I am joining with my colleagues Senators BOB GRAHAM and KENT CONRAD in introducing legislation that we believe will serve two very important objectives in the Medicaid Program. First, this legislation will give States the additional flexibility that they need to administer the Medicaid Program by allowing them to enroll Medicaid patients in managed care. Second, this bill will set Federal standards for managed care to ensure that Medicaid patients receive the same quality of care afforded private managed care patients.

Specifically, this legislation would allow States to require Medicaid patients to enroll in managed care plans. States would be required to offer patients a choice of a least two plans. States would no longer have to go through the lengthy and cumbersome process of applying to the Secretary of

Health and Human Services for a waiver of Medicaid regulations.

This legislation sets Federal standards for managed care plans that wish to enroll Medicaid patients. Plans would be required to meet certain standards for quality, access to care, and solvency. These standards are especially important given recent problems in States that have set up Medicaid managed care programs under the waiver process. Plans have failed to contract with enough providers to serve the Medicaid population; plans have been permitted to operate under standards that are lower than commercial insurers are required to meet; and plans have used fraudulent marketing practices to entice Medicaid patients to sign up with their plans. These actions have resulted in patients being denied medically necessary services, and have resulted in States and the Federal Government paying for care that was never given.

Considering these abuses, why should we allow Medicaid managed care at all? Because managed care, if done correctly, can vastly improve the quality of health care provided to low-income families. In today's fee-for-service program, patients face myriad problems. Some are forced to get care in hospital emergency rooms because they cannot find a private physician willing or able to accept Medicaid's low payment rates. Those who do have access to providers often face waiting for hours in clinics which are overcrowded and understaffed. And, sadly, they often do not have access to primary and preventive care services which would have prevented them from becoming ill to begin with.

Medicaid managed care, if done well, provides regular prenatal care to assure that children are born healthy. These plans provide coverage for check-ups and immunizations to prevent serious illnesses. And they give patients a medical home—a provider they know can go to if they are sick, or a number to call if they have questions.

Medicaid managed care also has the potential of benefiting our overall health care system by providing access to primary care providers rather than forcing patients to make costly and unnecessary visits to hospital emergency rooms. It gives providers the opportunity to catch and treat, or prevent, costly health problems.

Mr. President, I hope as we move forward in this budget debate that we will be successful in funding a means of giving Governors the additional flexibility they need to administer their Medicaid programs. I am also hopeful that we will be successful in dramatically decreasing the rate of growth in this program. The legislation that I introduce today will give States the flexibility they have sought without going through the costly and complicated waiver process, and I look forward to working with the Governors to identify

additional areas of flexibility in the Medicaid Program.

We must bear in mind, however, that the Medicaid Program is the sole source of health insurance for millions of low-income Americans. I believe that it would be a mistake for Congress, in its efforts to control Federal spending, to take any action that would result in a dramatic increase in our Nation's uninsured population. I hope my colleagues will join with me in cosponsoring this legislation.

Mr. President, I ask unanimous consent that the text of the bill be included in the RECORD.

There being no objection, the bill was ordered, to be printed in the RECORD, as follows:

S. 839

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Medicaid Managed Care Act of 1995".

SEC. 2. PERMITTING GREATER FLEXIBILITY FOR STATES TO ENROLL BENEFICIARIES IN MANAGED CARE ARRANGEMENTS.

(a) IN GENERAL.—Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) is amended—

(1) by redesignating section 1931 as section 1932; and

(2) by inserting after section 1930 the following new section:

"STATE OPTIONS FOR ENROLLMENT OF BENEFICIARIES IN MANAGED CARE ARRANGEMENTS

"SEC. 1931. (a) MANDATORY ENROLLMENT.—

"(1) IN GENERAL.—Subject to the succeeding provisions of this section, a State may require an individual eligible for medical assistance under the State plan under this title to enroll with an eligible managed care provider as a condition of receiving such assistance and, with respect to assistance furnished by or under arrangements with such provider, to receive such assistance through the provider, if the following provisions are met:

"(A) The provider meets the requirements of section 1932.

"(B) The provider enters into a contract with the State to provide services for the benefit of individuals eligible for benefits under this title under which prepaid payments to such provider are made on an actuarially sound basis.

"(C) There is sufficient capacity among all providers meeting such requirements to enroll and serve the individuals required to enroll with such providers.

"(D) The individual is not a special needs individual (as defined in subsection (c)).

"(E) The State—

"(i) permits an individual to choose an eligible managed care provider—

"(I) from among not less than 2 Medicaid managed care plans; or

"(II) between a Medicaid managed care plan and a primary care case management provider;

"(ii) provides the individual with the opportunity to change enrollment among eligible managed care providers not less than once annually and notifies the individual of such opportunity not later than 60 days prior to the first date on which the individual may change enrollment;

"(iii) establishes a method for establishing enrollment priorities in the case of an eligible managed care provider that does not have sufficient capacity to enroll all such individuals seeking enrollment under which in-

dividuals already enrolled with the provider are given priority in continuing enrollment with the provider;

"(iv) establishes a default enrollment process which meets the requirements described in paragraph (2) and under which any such individual who does not enroll with an eligible managed care provider during the enrollment period specified by the State shall be enrolled by the State with such a provider in accordance with such process; and

"(v) establishes the sanctions provided for in section 1933.

"(2) DEFAULT ENROLLMENT PROCESS REQUIREMENTS.—The default enrollment process established by a State under paragraph (1)(E)(iv) shall—

"(A) provide that the State may not enroll individuals with an eligible managed care provider which is not in compliance with the requirements of section 1932; and

"(B) provide for an equitable distribution of individuals among all eligible managed care providers available to enroll individuals through such default enrollment process, consistent with the enrollment capacities of such providers.

"(3) EXCEPTION FOR CERTAIN SERVICES.—A State may not require an individual eligible for medical assistance under the State plan under this title to enroll with an eligible managed care provider as a condition of receiving medical assistance consisting of payment for Medicare cost-sharing under section 1905(p)(3).

"(b) REENROLLMENT OF INDIVIDUALS WHO REGAIN ELIGIBILITY.—

"(1) IN GENERAL.—If an individual eligible for medical assistance under a State plan under this title and enrolled with an eligible managed care provider with a contract under subsection (a)(1)(B) ceases to be eligible for such assistance for a period of not greater than 2 months, the State may provide for the automatic reenrollment of the individual with the provider as of the first day of the month in which the individual is again eligible for such assistance.

"(2) CONDITIONS.—Paragraph (1) shall only apply if—

"(A) the month for which the individual is to be reenrolled occurs during the enrollment period covered by the individual's original enrollment with the eligible managed care provider;

"(B) the eligible managed care provider continues to have a contract with the State agency under subsection (a)(1)(B) as of the first day of such month; and

"(C) the eligible managed care provider complies with the requirements of section 1932.

"(3) NOTICE OF REENROLLMENT.—The State shall provide timely notice to an eligible managed care provider of any reenrollment of an individual under this subsection.

"(c) SPECIAL NEEDS INDIVIDUALS DESCRIBED.—In this section, a 'special needs individual' means any of the following:

"(1) SPECIAL NEEDS CHILD.—An individual who is under 19 years of age who—

"(A) is eligible for supplemental security income under title XVI;

"(B) is described under section 501(a)(1)(D);

"(C) is a child described in section 1902(e)(3); or

"(D) is in foster care or is otherwise in an out-of-home placement.

"(2) HOMELESS INDIVIDUALS.—An individual who is homeless (without regard to whether the individual is a member of a family), including—

"(A) an individual whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations; or

"(B) an individual who is a resident in transitional housing.

"(3) MIGRANT AGRICULTURAL WORKERS.—A migratory agricultural worker or a seasonal agricultural worker (as such terms are defined in section 329 of the Public Health Service Act), or the spouse or dependent of such a worker."

(b) CONFORMING AMENDMENT.—Section 1902(a)(23) of such Act (42 U.S.C. 1396a(a)(23)) is amended—

(1) in the matter preceding subparagraph (A), by striking "subsection (g) and in section 1915" and inserting "subsection (g), section 1915, and section 1931,"; and

(2) in subparagraph (B)—

(A) by striking "a health maintenance organization, or a" and inserting "or with an eligible managed care provider, as defined in section 1932(g)(1), or";

SEC. 3. REMOVAL OF BARRIERS TO PROVISION OF MEDICAID SERVICES THROUGH MANAGED CARE.

(a) REPEAL OF CURRENT BARRIERS.—Except as provided in subsection (b), section 1903(m) of the Social Security Act (42 U.S.C. 1396b(m)) is repealed on the date of the enactment of this Act.

(b) EXISTING CONTRACTS.—In the case of any contract under section 1903(m) of such Act which is in effect on the day before the date of the enactment of this Act, the provisions of such section shall apply to such contract until the earlier of—

(1) the day after the date of the expiration of the contract; or

(2) the date which is 1 year after the date of the enactment of this Act.

(c) ELIGIBLE MANAGED CARE PROVIDERS DESCRIBED.—Title XIX of such Act (42 U.S.C. 1396 et seq.), as amended by section 2(a), is amended—

(1) by redesignating section 1932 as section 1933; and

(2) by inserting after section 1931 the following new section:

"ELIGIBLE MANAGED CARE PROVIDERS

"SEC. 1932. (a) DEFINITIONS.—In this section, the following definitions shall apply:

"(1) ELIGIBLE MANAGED CARE PROVIDER.—The term 'eligible managed care provider' means—

"(A) a Medicaid managed care plan; or

"(B) a primary care case management provider.

"(2) MEDICAID MANAGED CARE PLAN.—The term 'Medicaid managed care plan' means a health maintenance organization or any other plan which provides or arranges for the provision of one or more items and services to individuals eligible for medical assistance under the State plan under this title in accordance with a contract with the State under section 1931(a)(1)(B).

"(3) PRIMARY CARE CASE MANAGEMENT PROVIDER.—

"(A) IN GENERAL.—The term 'primary care case management provider' means a health care provider that—

"(i) is a physician, group of physicians, a Federally-qualified health center, a rural health clinic, or an entity employing or having other arrangements with physicians that provides or arranges for the provision of one or more items and services to individuals eligible for medical assistance under the State plan under this title in accordance with a contract with the State under section 1931(a)(1)(B);

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

"(iii) receives an additional fixed fee per enrollee for a period specified in such contract for providing case management services (including approving and arranging for

the provision of health care items and services specified in such contract on a referral basis) to enrolled individuals; and

“(iv) is not an entity that is at risk.

“(B) AT RISK.—In subparagraph (A)(iv), the term ‘at risk’ means an entity that—

“(i) has a contract with the State under which such entity is paid a fixed amount for providing or arranging for the provision of health care items or services specified in such contract to an individual eligible for medical assistance under the State plan and enrolled with such entity, regardless of whether such items or services are furnished to such individual; and

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

(b) ENROLLMENT.—

“(I) NONDISCRIMINATION.—An eligible managed care provider may not discriminate on the basis of health status or anticipated need for services in the enrollment, reenrollment, or disenrollment of individuals eligible to receive medical assistance under a State plan under this title.

“(2) TERMINATION OF ENROLLMENT.—

“(A) IN GENERAL.—An eligible managed care provider shall permit an individual eligible for medical assistance under the State plan under this title who is enrolled with the provider to terminate such enrollment for cause at any time, and without cause during the 60-day period beginning on the date the individual receives notice of enrollment, and shall notify each such individual of the opportunity to terminate enrollment under these conditions.

“(B) FRAUDULENT INDUCEMENT OR COERCION AS GROUNDS FOR CAUSE.—For purposes of subparagraph (A), an individual terminating enrollment with an eligible managed care provider on the grounds that the enrollment was based on fraudulent inducement or was obtained through coercion shall be considered to terminate such enrollment for cause.

“(C) NOTICE OF TERMINATION.—

“(i) NOTICE TO STATE.—

“(I) BY INDIVIDUALS.—Each individual terminating enrollment with an eligible managed care provider under subparagraph (A) shall do so by providing notice of the termination to an office of the State agency administering the State plan under this title, the State or local welfare agency, or an office of an eligible managed care provider.

“(II) BY PLANS.—Any eligible managed care provider which receives notice of an individual’s termination of enrollment with such provider through receipt of such notice at an office of an eligible managed care provider shall provide timely notice of the termination to the State agency administering the State plan under this title.

“(ii) NOTICE TO PLAN.—The State agency administering the State plan under this title or the State or local welfare agency which receives notice of an individual’s termination of enrollment with an eligible managed care provider under clause (i) shall provide timely notice of the termination to such provider.

“(D) REENROLLMENT.—Each State shall establish a process under which an individual terminating enrollment under this paragraph shall be promptly enrolled with another eligible managed care provider and notified of such enrollment.

“(3) PROVISION OF ENROLLMENT MATERIALS IN UNDERSTANDABLE FORM.—Each eligible managed care provider shall provide all enrollment materials in a manner and form which may be easily understood by a typical adult enrollee of the provider who is eligible for medical assistance under the State plan under this title.

“(c) QUALITY ASSURANCE.—

“(I) ACCESS TO SERVICES.—Each eligible managed care provider shall provide or arrange for the provision of all medically necessary medical assistance under this title which is specified in the contract entered into between such provider and the State under section 1931(a)(1)(B) for enrollees who are eligible for medical assistance under the State plan under this title.

“(2) TIMELY DELIVERY OF SERVICES.—Each eligible managed care provider shall respond to requests from enrollees for the delivery of medical assistance in a manner which—

“(A) makes such assistance—

“(i) available and accessible to each such individual, within the area served by the provider, with reasonable promptness and in a manner which assures continuity; and

“(ii) when medically necessary, available and accessible 24 hours a day and 7 days a week; and

“(B) with respect to assistance provided to such an individual other than through the provider, or without prior authorization, in the case of a primary care case management provider, provides for reimbursement to the individual (if applicable under the contract between the State and the provider) if—

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

“(ii) it was not reasonable given the circumstances to obtain the services through the provider, or, in the case of a primary care case management provider, with prior authorization.

“(3) EXTERNAL INDEPENDENT REVIEW OF ELIGIBLE MANAGED CARE PROVIDER ACTIVITIES.—

“(A) REVIEW OF MEDICAID MANAGED CARE PLAN CONTRACT.—

“(i) IN GENERAL.—Except as provided in subparagraph (B), each medicaid managed care plan shall be subject to an annual external independent review of the quality and timeliness of, and access to, the items and services specified in such plan’s contract with the State under section 1931(a)(1)(B). Such review shall specifically evaluate the extent to which the medicaid managed care plan provides such services in a timely manner.

“(ii) AVAILABILITY OF RESULTS.—The results of each external independent review conducted under this subparagraph shall be available to participating health care providers, enrollees, and potential enrollees of the medicaid managed care plan, except that the results may not be made available in a manner that discloses the identity of any individual patient.

“(B) DEEMED COMPLIANCE.—

“(i) MEDICARE PLANS.—The requirements of subparagraph (A) shall not apply with respect to a medicaid managed care plan if the plan is an eligible organization with a contract in effect under section 1876.

“(ii) PRIVATE ACCREDITATION.—

“(I) IN GENERAL.—The requirements of subparagraph (A) shall not apply with respect to a medicaid managed care plan if—

“(aa) the plan is accredited by an organization meeting the requirements described in clause (iii); and

“(bb) the standards and process under which the plan is accredited meet such requirements as are established under subclause (II), without regard to whether or not the time requirement of such subclause is satisfied.

“(II) STANDARDS AND PROCESS.—Not later than 180 days after the date of the enactment of this Act, the Secretary shall specify requirements for the standards and process under which a medicaid managed care plan is accredited by an organization meeting the requirements of clause (iii).

“(iii) ACCREDITING ORGANIZATION.—An accrediting organization meets the requirements of this clause if the organization—

“(I) is a private, nonprofit organization;

“(II) exists for the primary purpose of accrediting managed care plans or health care providers; and

“(III) is independent of health care providers or associations of health care providers.

“(C) REVIEW OF PRIMARY CARE CASE MANAGEMENT PROVIDER CONTRACT.—Each primary care case management provider shall be subject to an annual external independent review of the quality and timeliness of, and access to, the items and services specified in the contract entered into between the State and the primary care case management provider under section 1931(a)(1)(B).

“(4) PROVIDING INFORMATION ON SERVICES.—

“(A) REQUIREMENTS FOR MEDICAID MANAGED CARE PLANS.—

“(i) INFORMATION TO THE STATE.—Each medicaid managed care plan shall provide to the State (at such frequency as the Secretary may require), complete and timely information concerning the following:

“(I) The services that the plan provides to (or arranges to be provided to) individuals eligible for medical assistance under the State plan under this title.

“(II) The identity, locations, qualifications, and availability of participating health care providers.

“(III) The rights and responsibilities of enrollees.

“(IV) The services provided by the plan which are subject to prior authorization by the plan as a condition of coverage (in accordance with paragraph (6)(A)).

“(V) The procedures available to an enrollee and a health care provider to appeal the failure of the plan to cover a service.

“(VI) The performance of the plan in serving individuals eligible for medical assistance under the State plan under this title.

“(ii) INFORMATION TO HEALTH CARE PROVIDERS, ENROLLEES, AND POTENTIAL ENROLLEES.—Each medicaid managed care plan shall—

“(I) upon request, make the information described in clause (i) available to participating health care providers, enrollees, and potential enrollees in the plan’s service area; and

“(II) provide to enrollees and potential enrollees information regarding all items and services that are available to enrollees under the contract between the State and the plan that are covered either directly or through a method of referral and prior authorization.

“(B) REQUIREMENTS FOR PRIMARY CARE CASE MANAGEMENT PROVIDERS.—Each primary care case management provider shall—

“(i) provide to the State (at such frequency as the Secretary may require), complete and timely information concerning the services that the primary care case management provider provides to (or arranges to be provided to) individuals eligible for medical assistance under the State plan under this title;

“(ii) make available to enrollees and potential enrollees information concerning services available to the enrollee for which prior authorization by the primary care case management provider is required; and

“(iii) provide enrollees and potential enrollees information regarding all items and services that are available to enrollees under the contract between the State and the primary care case management provider that are covered either directly or through a method of referral and prior authorization.

“(C) REQUIREMENTS FOR BOTH MEDICAID MANAGED CARE PLANS AND PRIMARY CARE CASE MANAGEMENT PROVIDERS.—Each eligible managed care provider shall provide the State with aggregate encounter data for early and periodic screening, diagnostic, and treatment services under section 1905(r) furnished

to individuals under 21 years of age. Any such data provided may be audited by the State and the Secretary.

“(5) **TIMELINESS OF PAYMENT.**—An eligible managed care provider shall make payment to health care providers for items and services which are subject to the contract under section 1931(a)(1)(B) and which are furnished to individuals eligible for medical assistance under the State plan under this title who are enrolled with the provider on a timely basis and under the claims payment procedures described in section 1902(a)(37)(A), unless the health care provider and the eligible managed care provider agree to an alternate payment schedule.

“(6) **ADDITIONAL QUALITY ASSURANCE REQUIREMENTS FOR MEDICAID MANAGED CARE PLANS.**—

“(A) **CONDITIONS FOR PRIOR AUTHORIZATION.**—A Medicaid managed care plan may require the approval of medical assistance for nonemergency services before the assistance is furnished to an enrollee only if the system providing for such approval—

“(i) provides that such decisions are made in a timely manner, depending upon the urgency of the situation; and

“(ii) permits coverage of medically necessary medical assistance provided to an enrollee without prior authorization in the event of an emergency.

“(B) **INTERNAL GRIEVANCE PROCEDURE.**—Each Medicaid managed care plan shall establish an internal grievance procedure under which a plan enrollee or a provider on behalf of such an enrollee who is eligible for medical assistance under the State plan under this title may challenge the denial of coverage of or payment for such assistance.

“(C) **USE OF UNIQUE PHYSICIAN IDENTIFIER FOR PARTICIPATING PHYSICIANS.**—Each Medicaid managed care plan shall require each physician providing services to enrollees eligible for medical assistance under the State plan under this title to have a unique identifier in accordance with the system established under section 1902(x).

“(D) **PATIENT ENCOUNTER DATA.**—

“(i) **IN GENERAL.**—Each Medicaid managed care plan shall maintain sufficient patient encounter data to identify the health care provider who delivers services to patients and to otherwise enable the State plan to meet the requirements of section 1902(a)(27). The plan shall incorporate such information in the maintenance of patient encounter data with respect to such health care provider.

“(ii) **COMPLIANCE.**—A Medicaid managed care plan shall—

“(I) submit the data maintained under clause (i) to the State; or

“(II) demonstrate to the State that the data complies with managed care quality assurance guidelines established by the Secretary in accordance with clause (iii).

“(iii) **STANDARDS.**—In establishing managed care quality assurance guidelines under clause (ii)(II), the Secretary shall consider—

“(I) managed care industry standards for—

“(aa) internal quality assurance; and

“(bb) performance measures; and

“(II) any managed care quality standards established by the National Association of Insurance Commissioners.

“(d) **DUE PROCESS REQUIREMENTS FOR ELIGIBLE MANAGED CARE PROVIDERS.**—

“(1) **DENIAL OF OR UNREASONABLE DELAY IN DETERMINING COVERAGE AS GROUNDS FOR HEARING.**—If an eligible managed care provider—

“(A) denies coverage of or payment for medical assistance with respect to an enrollee who is eligible for such assistance under the State plan under this title; or

“(B) fails to make any eligibility or coverage determination sought by an enrollee

or, in the case of a Medicaid managed care plan, by a participating health care provider or enrollee, in a timely manner, depending upon the urgency of the situation,

the enrollee or the health care provider furnishing such assistance to the enrollee (as applicable) may obtain a hearing before the State agency administering the State plan under this title in accordance with section 1902(a)(3), but only, with respect to a Medicaid managed care plan, after completion of the internal grievance procedure established by the plan under subsection (c)(6)(B).

“(2) **COMPLETION OF INTERNAL GRIEVANCE PROCEDURE.**—Nothing in this subsection shall require completion of an internal grievance procedure if such procedure does not exist or if the procedure does not provide for timely review of health needs considered by the enrollee's health care provider to be of an urgent nature.

“(e) **MISCELLANEOUS.**—

“(1) **PROTECTING ENROLLEES AGAINST THE INSOLVENCY OF ELIGIBLE MANAGED CARE PROVIDERS AND AGAINST THE FAILURE OF THE STATE TO PAY SUCH PROVIDERS.**—Each eligible managed care provider shall provide that an individual eligible for medical assistance under the State plan under this title who is enrolled with the provider may not be held liable—

“(A) for the debts of the eligible managed care provider, in the event of the provider's insolvency;

“(B) for services provided to the individual—

“(i) in the event of the provider failing to receive payment from the State for such services; or

“(ii) in the event of a health care provider with a contractual or other arrangement with the eligible managed care provider failing to receive payment from the State or the eligible managed care provider for such services; or

“(C) for the debts of any health care provider with a contractual or other arrangement with the provider to provide services to the individual, in the event of the insolvency of the health care provider.

“(2) **TREATMENT OF CHILDREN WITH SPECIAL HEALTH CARE NEEDS.**—

“(A) **IN GENERAL.**—In the case of an enrollee of an eligible managed care provider who is a child with special health care needs—

“(i) if any medical assistance specified in the contract with the State is identified in a treatment plan prepared for the enrollee by a program described in subparagraph (C), the eligible managed care provider shall provide (or arrange to be provided) such assistance in accordance with the treatment plan either—

“(I) by referring the enrollee to a pediatric health care provider who is trained and experienced in the provision of such assistance and who has a contract with the eligible managed care provider to provide such assistance; or

“(II) if appropriate services are not available through the eligible managed care provider, permitting such enrollee to seek appropriate specialty services from pediatric health care providers outside of or apart from the eligible managed care provider; and

“(ii) the eligible managed care provider shall require each health care provider with whom the eligible managed care provider has entered into an agreement to provide medical assistance to enrollees to furnish the medical assistance specified in such enrollee's treatment plan to the extent the health care provider is able to carry out such treatment plan.

“(B) **PRIOR AUTHORIZATION.**—An enrollee referred for treatment under subparagraph (A)(i)(I), or permitted to seek treatment out-

side of or apart from the eligible managed care provider under subparagraph (A)(i)(II) shall be deemed to have obtained any prior authorization required by the provider.

“(C) **CHILD WITH SPECIAL HEALTH CARE NEEDS.**—For purposes of subparagraph (A), a child with special health care needs is a child who is receiving services under—

“(i) a program administered under part B or part H of the Individuals with Disabilities Education Act;

“(ii) a program for children with special health care needs under title V;

“(iii) a program under part B or part D of title IV; or

“(iv) any other program for children with special health care needs identified by the Secretary.

“(3) **PHYSICIAN INCENTIVE PLANS.**—Each Medicaid managed care plan shall require that any physician incentive plan covering physicians who are participating in the Medicaid managed care plan shall meet the requirements of section 1876(i)(8).

“(4) **INCENTIVES FOR HIGH QUALITY ELIGIBLE MANAGED CARE PROVIDERS.**—The Secretary and the State may establish a program to reward, through public recognition, incentive payments, or enrollment of additional individuals (or combinations of such rewards), eligible managed care providers that provide the highest quality care to individuals eligible for medical assistance under the State plan under this title who are enrolled with such providers. For purposes of section 1903(a)(7), proper expenses incurred by a State in carrying out such a program shall be considered to be expenses necessary for the proper and efficient administration of the State plan under this title.”

(d) **CLARIFICATION OF APPLICATION OF FFP DENIAL RULES TO PAYMENTS MADE PURSUANT TO MEDICAID MANAGED CARE PLANS.**—Section 1903(i) of such Act (42 U.S.C. 1396b(i)) is amended by adding at the end the following sentence: “Paragraphs (1)(A), (1)(B), (2), (5), and (12) shall apply with respect to items or services furnished and amounts expended by or through an eligible managed care provider (as defined in section 1932(a)(1)) in the same manner as such paragraphs apply to items or services furnished and amounts expended directly by the State.”

(e) **CLARIFICATION OF CERTIFICATION REQUIREMENTS FOR PHYSICIANS PROVIDING SERVICES TO CHILDREN AND PREGNANT WOMEN.**—Section 1903(i)(12) of such Act (42 U.S.C. 1396b(i)(12)) is amended—

(1) in subparagraph (A)(i), to read as follows:

“(i) is certified in family practice or pediatrics by the medical specialty board recognized by the American Board of Medical Specialties for family practice or pediatrics or is certified in general practice or pediatrics by the medical specialty board recognized by the American Osteopathic Association;”

(2) in subparagraph (B)(i), to read as follows:

“(i) is certified in family practice or obstetrics by the medical specialty board recognized by the American Board of Medical Specialties for family practice or obstetrics or is certified in family practice or obstetrics by the medical specialty board recognized by the American Osteopathic Association;” and

(3) in both subparagraphs (A) and (B)—

(A) by striking “or” at the end of clause (v);

(B) by redesignating clause (vi) as clause (vii); and

(C) by inserting after clause (v) the following new clause:

“(vi) delivers such services in the emergency department of a hospital participating in the State plan approved under this title, or”.

SEC. 4. ADDITIONAL REQUIREMENTS FOR MEDICAID MANAGED CARE PLANS.

Section 1932 of the Social Security Act, as added by section 3(c)(2), is amended—

(1) by redesignating subsections (d) and (e) as subsections (e) and (f), respectively; and

(2) by inserting after subsection (c) the following new subsection:

“(d) ADDITIONAL REQUIREMENTS FOR MEDICAID MANAGED CARE PLANS.—

“(1) DEMONSTRATION OF ADEQUATE CAPACITY AND SERVICES.—

“(A) IN GENERAL.—Subject to subparagraph (C), each medicaid managed care plan shall provide the State and the Secretary with adequate assurances (as determined by the Secretary) that the plan, with respect to a service area—

“(i) has the capacity to serve the expected enrollment in such service area;

“(ii) offers an appropriate range of services for the population expected to be enrolled in such service area, including transportation services and translation services consisting of the principal languages spoken in the service area;

“(iii) maintains sufficient numbers of providers of services included in the contract with the State to ensure that services are available to individuals receiving medical assistance and enrolled in the plan to the same extent that such services are available to individuals enrolled in the plan who are not recipients of medical assistance under the State plan under this title;

“(iv) maintains extended hours of operation with respect to primary care services that are beyond those maintained during a normal business day;

“(v) provides preventive and primary care services in locations that are readily accessible to members of the community; and

“(vi) provides information concerning educational, social, health, and nutritional services offered by other programs for which enrollees may be eligible.

“(B) PROOF OF ADEQUATE PRIMARY CARE CAPACITY AND SERVICES.—Subject to subparagraph (C), a medicaid managed care plan that contracts with a reasonable number of primary care providers (as determined by the Secretary) and whose primary care membership includes a reasonable number (as so determined) of the following providers will be deemed to have satisfied the requirements of subparagraph (A):

“(i) Rural health clinics, as defined in section 1905(l)(1).

“(ii) Federally-qualified health centers, as defined in section 1905(l)(2)(B).

“(iii) Clinics which are eligible to receive payment for services provided under title X of the Public Health Service Act.

“(C) SUFFICIENT PROVIDERS OF SPECIALIZED SERVICES.—Notwithstanding subparagraphs (A) and (B), a medicaid managed care plan may not be considered to have satisfied the requirements of subparagraph (A) if the plan does not have a sufficient number (as determined by the Secretary) of providers of specialized services, including perinatal and pediatric specialty care, to ensure that such services are available and accessible.

“(2) WRITTEN PROVIDER PARTICIPATION AGREEMENTS FOR CERTAIN PROVIDERS.—Each medicaid managed care plan that enters into a written provider participation agreement with a provider described in paragraph (l)(B) shall—

“(A) include terms and conditions that are no more restrictive than the terms and conditions that the medicaid managed care plan includes in its agreements with other participating providers with respect to—

“(i) the scope of covered services for which payment is made to the provider;

“(ii) the assignment of enrollees by the plan to the provider;

“(iii) the limitation on financial risk or availability of financial incentives to the provider;

“(iv) accessibility of care;

“(v) professional credentialing and recertification;

“(vi) licensure;

“(vii) quality and utilization management;

“(viii) confidentiality of patient records;

“(ix) grievance procedures; and

“(x) indemnification arrangements between the plans and providers; and

“(B) provide for payment to the provider on a basis that is comparable to the basis on which other providers are paid.”.

SEC. 5. PREVENTING FRAUD IN MEDICAID MANAGED CARE.

(a) IN GENERAL.—Section 1932 of the Social Security Act, as added by section 3(c)(2) and amended by section 4, is amended—

(1) by redesignating subsection (f) as subsection (g); and

(2) by inserting after subsection (e) the following new subsection:

“(f) ANTI-FRAUD PROVISIONS.—

“(1) PROVISIONS APPLICABLE TO ELIGIBLE MANAGED CARE PROVIDERS.—

“(A) PROHIBITING AFFILIATIONS WITH INDIVIDUALS DEBARRED BY FEDERAL AGENCIES.—

“(i) IN GENERAL.—An eligible managed care provider may not knowingly—

“(I) have a person described in clause (iii) as a director, officer, partner, or person with beneficial ownership of more than 5 percent of the plan's equity; or

“(II) have an employment, consulting, or other agreement with a person described in clause (iii) for the provision of items and services that are significant and material to the organization's obligations under its contract with the State.

“(ii) EFFECT OF NONCOMPLIANCE.—If a State finds that an eligible managed care provider is not in compliance with subclause (I) or (II) of clause (i), the State—

“(I) shall notify the Secretary of such non-compliance;

“(II) may continue an existing agreement with the provider unless the Secretary (in consultation with the Inspector General of the Department of Health and Human Services) directs otherwise; and

“(III) may not renew or otherwise extend the duration of an existing agreement with the provider unless the Secretary (in consultation with the Inspector General of the Department of Health and Human Services) provides to the State and to the Congress a written statement describing compelling reasons that exist for renewing or extending the agreement.

“(iii) PERSONS DESCRIBED.—A person is described in this clause if such person—

“(I) is debarred or suspended by the Federal Government, pursuant to the Federal acquisition regulation, from Government contracting and subcontracting;

“(II) is an affiliate (within the meaning of the Federal acquisition regulation) of a person described in clause (i); or

“(III) is excluded from participation in any program under title XVIII or any State health care program, as defined in section 1128(h).

“(B) RESTRICTIONS ON MARKETING.—

“(i) DISTRIBUTION OF MATERIALS.—

“(I) IN GENERAL.—An eligible managed care provider may not distribute marketing materials within any State—

“(aa) without the prior approval of the State; and

“(bb) that contain false or materially misleading information.

“(II) PROHIBITION.—The State may not enter into or renew a contract with an eligible managed care provider for the provision of services to individuals enrolled under the State plan under this title if the State deter-

mines that the provider intentionally distributed false or materially misleading information in violation of subclause (I)(bb).

“(ii) SERVICE MARKET.—An eligible managed care provider shall distribute marketing materials to the entire service area of such provider.

“(iii) PROHIBITION OF TIE-INS.—An eligible managed care provider, or any agency of such provider, may not seek to influence an individual's enrollment with the provider in conjunction with the sale of any other insurance.

“(iv) PROHIBITING MARKETING FRAUD.—Each eligible managed care provider shall comply with such procedures and conditions as the Secretary prescribes in order to ensure that, before an individual is enrolled with the provider, the individual is provided accurate and sufficient information to make an informed decision whether or not to enroll.

“(2) PROVISIONS APPLICABLE ONLY TO MEDICAID MANAGED CARE PLANS.—

“(A) STATE CONFLICT-OF-INTEREST SAFEGUARDS IN MEDICAID RISK CONTRACTING.—A medicaid managed care plan may not enter into a contract with any State under section 1931(a)(1)(B) unless the State has in effect conflict-of-interest safeguards with respect to officers and employees of the State with responsibilities relating to contracts with such plans or to the default enrollment process described in section 1931(a)(1)(D)(iv) that are at least as effective as the Federal safeguards provided under section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423), against conflicts of interest that apply with respect to Federal procurement officials with comparable responsibilities with respect to such contracts.

“(B) REQUIRING DISCLOSURE OF FINANCIAL INFORMATION.—In addition to any requirements applicable under section 1902(a)(27) or 1902(a)(35), a medicaid managed care plan shall—

“(i) report to the State (and to the Secretary upon the Secretary's request) such financial information as the State or the Secretary may require to demonstrate that—

“(I) the plan has the ability to bear the risk of potential financial losses and otherwise has a fiscally sound operation;

“(II) the plan uses the funds paid to it by the State and the Secretary for activities consistent with the requirements of this title and the contract between the State and plan; and

“(III) the plan does not place an individual physician, physician group, or other health care provider at substantial risk (as determined by the Secretary) for services not provided by such physician, group, or health care provider, by providing adequate protection (as determined by the Secretary) to limit the liability of such physician, group, or health care provider, through measures such as stop loss insurance or appropriate risk corridors;

“(ii) agree that the Secretary and the State (or any person or organization designated by either) shall have the right to audit and inspect any books and records of the plan (and of any subcontractor) relating to the information reported pursuant to clause (i) and any information required to be furnished under section paragraphs (27) or (35) of section 1902(a);

“(iii) make available to the Secretary and the State a description of each transaction described in subparagraphs (A) through (C) of section 1318(a)(3) of the Public Health Service Act between the plan and a party in interest (as defined in section 1318(b) of such Act); and

“(iv) agree to make available to its enrollees upon reasonable request—

“(I) the information reported pursuant to clause (i); and

“(II) the information required to be disclosed under sections 1124 and 1126.

“(C) ADEQUATE PROVISION AGAINST RISK OF INSOLVENCY.—

“(i) ESTABLISHMENT OF STANDARDS.—The Secretary shall establish standards, including appropriate equity standards, under which each medicaid managed care plan shall make adequate provision against the risk of insolvency.

“(ii) CONSIDERATION OF OTHER STANDARDS.—In establishing the standards described in clause (i), the Secretary shall consider—

“(I) such solvency standards as the National Association of Insurance Commissioners may prescribe; and

“(II) solvency standards applicable to eligible organizations with a risk-sharing contract under section 1876.

“(D) REQUIRING REPORT ON NET EARNINGS AND ADDITIONAL BENEFITS.—Each medicaid managed care plan shall submit a report to the State and the Secretary not later than 12 months after the close of a contract year containing—

“(i) the most recent audited financial statement of the plan's net earnings, in accordance with guidelines established by the Secretary in consultation with the States, and consistent with generally accepted accounting principles; and

“(ii) a description of any benefits that are in addition to the benefits required to be provided under the contract that were provided during the contract year to members enrolled with the plan and entitled to medical assistance under the State plan under this title.”.

SEC. 6. SANCTIONS FOR NONCOMPLIANCE BY ELIGIBLE MANAGED CARE PROVIDERS.

(a) SANCTIONS DESCRIBED.—Title XIX of such Act (42 U.S.C. 1396 et seq.), as amended by section 3(c), is amended—

(1) by redesignating section 1933 as section 1934; and

(2) by inserting after section 1932 the following new section:

“SANCTIONS FOR NONCOMPLIANCE BY ELIGIBLE MANAGED CARE PROVIDERS

“SEC. 1933. (a) USE OF INTERMEDIATE SANCTIONS BY THE STATE TO ENFORCE REQUIREMENTS.—Each State shall establish intermediate sanctions, which may include any of the types described in subsection (b) other than the termination of a contract with an eligible managed care provider, which the State may impose against an eligible managed care provider with a contract under section 1931(a)(1)(B) if the provider—

“(1) fails substantially to provide medically necessary items and services that are required (under law or under such provider's contract with the State) to be provided to an enrollee covered under the contract, if the failure has adversely affected (or has a substantial likelihood of adversely affecting) the enrollee;

“(2) imposes premiums on enrollees in excess of the premiums permitted under this title;

“(3) acts to discriminate among enrollees on the basis of their health status or requirements for health care services, including expulsion or refusal to reenroll an individual, except as permitted by sections 1931 and 1932, or engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment with the provider by eligible individuals whose medical condition or history indicates a need for substantial future medical services;

“(4) misrepresents or falsifies information that is furnished—

“(A) to the Secretary or the State under section 1931 or 1932; or

“(B) to an enrollee, potential enrollee, or a health care provider under such sections; or

“(5) fails to comply with the requirements of section 1876(i)(8).

“(b) INTERMEDIATE SANCTIONS.—The sanctions described in this subsection are as follows:

“(1) Civil money penalties as follows:

“(A) Except as provided in subparagraph (B), (C), or (D), not more than \$25,000 for each determination under subsection (a).

“(B) With respect to a determination under paragraph (3) or (4)(A) of subsection (a), not more than \$100,000 for each such determination.

“(C) With respect to a determination under subsection (a)(2), double the excess amount charged in violation of such subsection (and the excess amount charged shall be deducted from the penalty and returned to the individual concerned).

“(D) Subject to subparagraph (B), with respect to a determination under subsection (a)(3), \$15,000 for each individual not enrolled as a result of a practice described in such subsection.

“(2) The appointment of temporary management to oversee the operation of the eligible managed care provider and to assure the health of the provider's enrollees, if there is a need for temporary management while—

“(A) there is an orderly termination or reorganization of the eligible managed care provider; or

“(B) improvements are made to remedy the violations found under subsection (a), except that temporary management under this paragraph may not be terminated until the State has determined that the eligible managed care provider has the capability to ensure that the violations shall not recur.

“(3) Permitting individuals enrolled with the eligible managed care provider to terminate enrollment without cause, and notifying such individuals of such right to terminate enrollment.

“(c) TREATMENT OF CHRONIC SUBSTANDARD PROVIDERS.—In the case of an eligible managed care provider which has repeatedly failed to meet the requirements of section 1931 or 1932, the State shall (regardless of what other sanctions are provided) impose the sanctions described in paragraphs (2) and (3) of subsection (b).

“(d) AUTHORITY TO TERMINATE CONTRACT.—In the case of an eligible managed care provider which has failed to meet the requirements of section 1931 or 1932, the State shall have the authority to terminate its contract with such provider under section 1931(a)(1)(B) and to enroll such provider's enrollees with other eligible managed care providers (or to permit such enrollees to receive medical assistance under the State plan under this title other than through an eligible managed care provider).

“(e) AVAILABILITY OF SANCTIONS TO THE SECRETARY.—

“(1) INTERMEDIATE SANCTIONS.—In addition to the sanctions described in paragraph (2) and any other sanctions available under law, the Secretary may provide for any of the sanctions described in subsection (b) if the Secretary determines that—

“(A) an eligible managed care provider with a contract under section 1931(a)(1)(B) fails to meet any of the requirements of section 1931 or 1932; and

“(B) the State has failed to act appropriately to address such failure.

“(2) DENIAL OF PAYMENTS TO THE STATE.—The Secretary may deny payments to the State for medical assistance furnished under the contract under section 1931(a)(1)(B) for individuals enrolled after the date the Secretary notifies an eligible managed care provider of a determination under subsection (a) and until the Secretary is satisfied that the

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

“(f) DUE PROCESS FOR ELIGIBLE MANAGED CARE PROVIDERS.—

“(1) AVAILABILITY OF HEARING PRIOR TO TERMINATION OF CONTRACT.—A State may not terminate a contract with an eligible managed care provider under section 1931(a)(1)(B) unless the provider is provided with a hearing prior to the termination.

“(2) NOTICE TO ENROLLEES OF TERMINATION HEARING.—A State shall notify all individuals enrolled with an eligible managed care provider which is the subject of a hearing to terminate the provider's contract with the State of the hearing and that the enrollees may immediately disenroll with the provider for cause.

“(3) OTHER PROTECTIONS FOR ELIGIBLE MANAGED CARE PROVIDERS AGAINST SANCTIONS IMPOSED BY STATE.—Before imposing any sanction against an eligible managed care provider other than termination of the provider's contract, the State shall provide the provider with notice and such other due process protections as the State may provide, except that a State may not provide an eligible managed care provider with a pretermination hearing before imposing the sanction described in subsection (b)(2).

“(4) IMPOSITION OF CIVIL MONETARY PENALTIES BY SECRETARY.—The provisions of section 1128A (other than subsections (a) and (b)) shall apply with respect to a civil money penalty imposed by the Secretary under subsection (b)(1) in the same manner as such provisions apply to a penalty or proceeding under section 1128A.”.

(b) CONFORMING AMENDMENT RELATING TO TERMINATION OF ENROLLMENT FOR CAUSE.—Section 1932(b)(2)(B) of the Social Security Act, as added by section 3(c)(2), is amended by inserting after “coercion” the following: “, or pursuant to the imposition against the eligible managed care provider of the sanction described in section 1933(b)(3).”.

SEC. 7. CONFORMING AMENDMENTS.

(a) EXCLUSION OF CERTAIN INDIVIDUALS AND ENTITIES FROM PARTICIPATION IN PROGRAM.—Section 1128(b)(6)(C) of the Social Security Act (42 U.S.C. 1320a-7(b)(6)(C)) is amended—

(1) in clause (i), by striking “a health maintenance organization (as defined in section 1903(m))” and inserting “an eligible managed care provider, as defined in section 1932(a)(1).”; and

(2) in clause (ii), by inserting “section 1115 or” after “approved under”.

(b) STATE PLAN REQUIREMENTS.—Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended—

(1) in subsection (a)(30)(C), by striking “section 1903(m)” and inserting “section 1931(a)(1)(B)”; and

(2) in subsection (a)(57), by striking “hospice program, or health maintenance organization (as defined in section 1903(m)(1)(A))” and inserting “or hospice program”;

(3) in subsection (e)(2)(A), by striking “or with an entity described in paragraph (2)(B)(iii), (2)(E), (2)(G), or (6) of section 1903(m) under a contract described in section 1903(m)(2)(A)”;

(4) in subsection (p)(2)—

(A) by striking “a health maintenance organization (as defined in section 1903(m))” and inserting “an eligible managed care provider, as defined in section 1932(a)(1).”; and

(B) by striking “an organization” and inserting “a provider”; and

(C) by striking “any organization” and inserting “any provider”; and

(5) in subsection (w)(1), by striking “sections 1903(m)(1)(A) and” and inserting “section”.

(c) PAYMENT TO STATES.—Section 1903(w)(7)(A)(viii) of the Social Security Act

(42 U.S.C. 1396b(w)(7)(A)(viii)) is amended to read as follows:

“(viii) Services of an eligible managed care provider with a contract under section 1931(a)(1)(B).”

(d) USE OF ENROLLMENT FEES AND OTHER CHARGES.—Section 1916 of the Social Security Act (42 U.S.C. 1396e) is amended in subsections (a)(2)(D) and (b)(2)(D) by striking “a health maintenance organization (as defined in section 1903(m))” and inserting “an eligible managed care provider, as defined in section 1932(a)(1),” each place it appears.

(e) EXTENSION OF ELIGIBILITY FOR MEDICAL ASSISTANCE.—Section 1925(b)(4)(D)(iv) of the Social Security Act (42 U.S.C. 1396r-6(b)(4)(D)(iv)) is amended to read as follows:

“(iv) ENROLLMENT WITH ELIGIBLE MANAGED CARE PROVIDER.—Enrollment of the caretaker relative and dependent children with an eligible managed care provider, as defined in section 1932(a)(1), less than 50 percent of the membership (enrolled on a prepaid basis) of which consists of individuals who are eligible to receive benefits under this title (other than because of the option offered under this clause). The option of enrollment under this clause is in addition to, and not in lieu of, any enrollment option that the State might offer under subparagraph (A)(i) with respect to receiving services through an eligible managed care provider in accordance with sections 1931, 1932, and 1933.”

(f) ASSURING ADEQUATE PAYMENT LEVELS FOR OBSTETRICAL AND PEDIATRIC SERVICES.—Section 1926(a) of the Social Security Act (42 U.S.C. 1396r-7(a)) is amended in paragraphs (1) and (2) by striking “health maintenance organizations under section 1903(m)” and inserting “eligible managed care providers under contracts entered into under section 1931(a)(1)(B)” each place it appears.

(g) PAYMENT FOR COVERED OUTPATIENT DRUGS.—Section 1927(j)(1) of the Social Security Act (42 U.S.C. 1396r-8(j)(1)) is amended by striking “****Health Maintenance Organizations, including those organizations that contract under section 1903(m),” and inserting “health maintenance organizations and medicaid managed care plans, as defined in section 1932(a)(2).”

(h) DEMONSTRATION PROJECTS TO STUDY EFFECT OF ALLOWING STATES TO EXTEND MEDICAID COVERAGE FOR CERTAIN FAMILIES.—Section 4745(a)(5)(A) of the Omnibus Budget Reconciliation Act of 1990 (42 U.S.C. 1396a note) is amended by striking “(except section 1903(m))” and inserting “(except sections 1931, 1932, and 1933)”.

SEC. 8. EFFECTIVE DATE; STATUS OF WAIVERS.

(a) EFFECTIVE DATE.—Except as provided in subsection (b), the amendments made by this Act shall apply to medical assistance furnished—

(1) during quarters beginning on or after October 1, 1995; or

(2) in the case of assistance furnished under a contract described in section 3(b), during quarters beginning after the earlier of—

(A) the date of the expiration of the contract; or

(B) the expiration of the 1-year period which begins on the date of the enactment of this Act.

(b) APPLICATION TO WAIVERS.—

(1) EXISTING WAIVERS.—If any waiver granted to a State under section 1115 or 1915 of the Social Security Act (42 U.S.C. 1315, 1396n) or otherwise which relates to the provision of medical assistance under a State plan under title XIX of the such Act (42 U.S.C. 1396 et seq.), is in effect or approved by the Secretary of Health and Human Services (in this subsection referred to as the “Secretary”) as of the applicable effective date described in subsection (a), the amendments made by this

Act shall not apply with respect to the State before the expiration (determined without regard to any extensions) of the waiver to the extent such amendments are inconsistent with the terms of the waiver.

(2) SECRETARIAL EVALUATION AND REPORT FOR EXISTING WAIVERS AND EXTENSIONS.—

(A) PRIOR TO APPROVAL.—On and after the applicable effective date described in subsection (a), the Secretary, prior to extending any waiver granted under section 1115 or 1915 of the Social Security Act (42 U.S.C. 1315, 1396n) or otherwise which relates to the provision of medical assistance under a State plan under title XIX of the such Act (42 U.S.C. 1396 et seq.), shall—

(i) conduct an evaluation of—

(I) the waivers existing under such sections or other provision of law as of the date of the enactment of this Act; and

(II) any applications pending, as of the date of the enactment of this Act, for extensions of waivers under such sections or other provision of law; and

(ii) submit a report to the Congress recommending whether the extension of a waiver under such sections or provision of law should be conditioned on the State submitting the request for an extension complying with the provisions of sections 1931, 1932, and 1933 of the Social Security Act (as added by this Act).

(B) DEEMED APPROVAL.—If the Congress has not enacted legislation based on a report submitted under subparagraph (A)(ii) within 120 days after the date such report is submitted to the Congress, the recommendations contained in such report shall be deemed to be approved by the Congress.

(3) FUTURE WAIVERS.—

(A) IN GENERAL.—Except as provided in paragraphs (1) and (2), and subparagraph (B), the Secretary may not waive the application of section 1931, 1932, or 1933 of such Act (as added by this Act) with respect to any State.

(B) SPECIAL RULE REGARDING A WAIVER OF THE REQUIREMENTS APPLICABLE TO ELIGIBLE MANAGED CARE PROVIDERS FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS.—Notwithstanding the provisions of subparagraph (A), the Secretary may waive, pursuant to section 1115 or 1915 of the Social Security Act (42 U.S.C. 1315, 1396n), or otherwise, the application of section 1932(g)(2) of such Act (as added by this Act) if the State applying for the waiver demonstrates that, with respect to each eligible managed care provider having an enrollee who is a child with special health care needs (as defined in section 1932(g)(2)(B) of such Act), such provider shall—

(i) provide (or arrange to be provided) any medical assistance specified in the provider’s contract with the State that is identified in a treatment plan for the enrollee prepared by a program described in section 1932(g)(2)(B) of such Act in accordance with such treatment plan—

(I) without regard to any prior authorization requirement which would otherwise apply to the provision of such assistance; and

(II) unless the eligible managed care provider demonstrates to the satisfaction of the Secretary that the provider is or has an arrangement with a health care provider with the specialized pediatric expertise required to provide the medical assistance specified in the treatment plan, without regard to whether or not the health care provider specified in the treatment plan has otherwise entered into an agreement with the eligible managed care provider to provide medical assistance to plan enrollees;

(ii) require each health care provider with whom the eligible managed care provider has entered into an agreement to provide medical assistance to enrollees to furnish medical

assistance specified in such treatment plan to the extent necessary to carry out such treatment plan; and

(iii) demonstrate that it has adequate written agreements with pediatric specialists as determined by the Secretary to ensure appropriate specialist care and referrals.

By Mr. CONRAD:

S. 840. A bill to provide the States greater flexibility in providing jobs for, and assistance to, needy families, to improve child support enforcement, to reduce teenage pregnancy, and for other purposes; to the Committee on Finance.

WORK AND GAINFUL EMPLOYMENT ACT

Mr. CONRAD. Mr. President, I thank the Chair and I thank my distinguished colleague from Nebraska for securing this time and I thank the distinguished Republican manager of the bill, the Senator from New Mexico, for his graciousness in allowing me at this time to introduce a bill which I will send to the desk.

This bill is a major welfare reform piece of legislation and I ask that it be printed, but not in the RECORD. I want to make that clear: I am not asking it to be printed in the RECORD, so we can save the taxpayers some money. But I am introducing a bill to dramatically revamp the welfare system in this country. I call it the Work and Gainful Employment Act.

The WAGE Act significantly reforms our welfare system while protecting the children of America against an abdication of Federal responsibility. I offer an innovative approach to reforming welfare that is based on four principles: work, protecting children, State flexibility, and family. The WAGE Act is designed foremost to put welfare recipients to work and to make welfare recipients self-sufficient. Under my plan, States receive unprecedented flexibility to experiment in developing new methods for moving welfare recipients into work. The WAGE Act retains a safety net for children and an automatic stabilizer for States.

Mr. President, Americans overwhelmingly agree that the current welfare system does not work; it does not move recipients from dependency to work and self-sufficiency. Welfare undermines the basic values of our country—work, family, self-sufficiency, and personal responsibility—and sends a detrimental message to children that welfare can be a permanent way of life.

The WAGE Act is a departure from the status quo. The current system focuses on writing checks and does little to promote work and self-sufficiency. States are overburdened by extensive Federal regulations that impede their ability to enact innovative and creative approaches to moving individuals off of welfare. The worst part of welfare is the message sent to children—that if their parents do nothing, the government will send them a check. We have no choice but to revamp and reengineer welfare from the ground up.

The WAGE Act ends welfare as we know it. In its place, States are given

the flexibility to design work programs that do one thing—move parents into the work force. But the WAGE Act does not just let States take the money and run.

It is based on the principle that those who raise the money should have some say in how it is spent. But it discards the micromanagement of the past.

The WAGE Act has four themes:

First, work. From the day that a parent sets foot in a welfare office, we will expect that person to work or to demonstrate progress toward self-sufficiency.

Second, State flexibility. States will have a wide latitude to design effective work programs under a new work and gainful employment block grant. The WAGE block grant will also provide incentives for moving parents into the work force.

Third, profamily. Families that stay together and play by the rules will be supported in their efforts to be self-sufficient. For children in divorced and never-married families, both parents will be expected to provide financial support through extensive and tough new child support enforcement measures.

Fourth, protects children. A transitional aid program will replace AFDC and provide cash assistance to families with children. States will have broad flexibility to determine eligibility and to set benefit levels and time limits. Teen parents will be required to stay in school and to live with their parents or in adult-supervised living arrangements.

Under my proposal, the transitional aid program will be a cooperative Federal-State effort, with the Federal Government providing matching funds to States. However, unlike AFDC, it will emphasize the need for participants to work or prepare themselves for work. The WAGE block grant will provide States with the means to move welfare recipients into work. The WAGE Act will save money and reform the welfare system without resorting to the free-for-all of AFDC block grants that does little to hold States accountable and that puts America's children at great risk.

While there are savings to be realized in ending welfare inefficiencies, I hope the Senate's deliberations will emphasize first and foremost that welfare reform is not an experiment to be tested on America's poor children. The House bill allows States to count people as working who are kicked off the rolls. Mr. President, what could be more absurd than to say that people are working who have just been eliminated from the welfare rolls? You can be eliminated from the welfare rolls and not working, and we should not count people as working who are not. Real welfare reform is about solving the problem of transitioning parents into the work force, not the streets.

The person most affected by our deliberations are America's children. I hope that our efforts will focus on sup-

porting and enabling their parents to be self-sufficient. That is the only approach that will ensure that we are responsible to the next generation.

Mr. President, let me end as I began. This new welfare reform proposal emphasizes four principles: work, State flexibility, families, and protecting children.

I think those ought to be the principles that underlie any reform of our welfare system.

ADDITIONAL COSPONSORS

S. 364

At the request of Mr. BROWN, the name of the Senator from Colorado [Mr. CAMPBELL] was added as a cosponsor of S. 364, a bill to authorize the Secretary of the Interior to participate in the operation of certain visitor facilities associated with, but outside the boundaries of, Rocky Mountain National Park in the State of Colorado.

S. 412

At the request of Ms. SNOWE, the name of the Senator from Connecticut [Mr. LIEBERMAN] was added as a cosponsor of S. 412, a bill to amend the Federal Food, Drug, and Cosmetic Act to modify the bottled drinking water standards provisions, and for other purposes.

S. 495

At the request of Mrs. KASSEBAUM, the name of the Senator from Mississippi [Mr. LOTT] was added as a cosponsor of S. 495, a bill to amend the Higher Education Act of 1965 to stabilize the student loan programs, improve congressional oversight, and for other purposes.

S. 529

At the request of Mr. GRAHAM, the name of the Senator from Arizona [Mr. MCCAIN] was added as a cosponsor of S. 529, a bill to provide, temporarily, tariff and quota treatment equivalent to that accorded to members of the North American Free Trade Agreement (NAFTA) to Caribbean Basin beneficiary countries.

S. 729

At the request of Mr. BAUCUS, the names of the Senator from Mississippi [Mr. COCHRAN] and the Senator from Oklahoma [Mr. INHOFE] were added as cosponsors of S. 729, a bill to provide off-budget treatment for the Highway Trust Fund, the Airport and Airway Trust Fund, the Inland Waterways Trust Fund, and the Harbor Maintenance Trust Fund, and for other purposes.

S. 770

At the request of Mr. DOLE, the name of the Senator from Minnesota [Mr. GRAMS] was added as a cosponsor of S. 770, a bill to provide for the relocation of the United States Embassy in Israel to Jerusalem, and for other purposes.

S. 834

At the request of Mr. BROWN, his name was withdrawn as a cosponsor of S. 834, a bill to restore the American

family, reduce illegitimacy, and reduce welfare dependence.

SENATE CONCURRENT RESOLUTION 11

At the request of Ms. SNOWE, the name of the Senator from New Jersey [Mr. BRADLEY] was added as a cosponsor of Senate Concurrent Resolution 11, a concurrent resolution supporting a resolution to the long-standing dispute regarding Cyprus.

AMENDMENT NO. 1112

At the request of Mr. BRADLEY his name was added as a cosponsor of Amendment No. 1112 proposed to S. Con. Res. 13, an original concurrent resolution setting forth the congressional budget for the United States Government for the fiscal years 1996, 1997, 1998, 1999, 2000, 2001, and 2002.

SENATE RESOLUTION 122—DESIGNATING JAMES R. KETCHUM AS CURATOR EMERITUS OF THE U.S. SENATE

Mr. DOLE (for himself and Mr. DASCHLE) submitted the following resolution; which was considered and agreed to:

S. RES. 122

Whereas James R. Ketchum will retire from the United States Senate after 25 years as Senator Curator, and 35 years of Government service;

Whereas he has dedicated his Senate service to preserving the works of art, history, and traditions of the Senate;

Whereas he has contributed immeasurably to the restoration of the Old Senate Chamber, the Old Supreme Court Chamber, the President's Room, and other historic rooms in the Capitol;

Whereas he has developed exhibitions and educational programs detailing the rich heritage of the Senate for all to enjoy;

Whereas he has upheld the high standards and traditions of the Senate with abiding devotion; and

Whereas he has earned the respect, affection, and esteem of the United States Senate; Now, therefore, be it

Resolved, That, effective July 1, 1995, as a token of the appreciation of the Senate for his long and faithful service, James R. Ketchum is hereby designated as Curator Emeritus of the United States Senate.

SENATE RESOLUTION 123—RELATING TO THE RETIREMENT OF GERALD A. HACKETT

Mr. DOLE (for himself and Mr. DASCHLE) submitted the following resolution; which was considered and agreed to:

S. RES. 123

Whereas Gerald A. Hackett will retire from the United States Senate after 33 years of service, the last 29 years as Executive Clerk;

Whereas his dedication to the United States resulted in the computerization of the nomination and treaty processes, and the online publishing of the Executive Journal;

Whereas he has performed the duties of his office with remarkable diligence, perseverance, efficiency, and intelligence;

Whereas he has faithfully performed his duties serving all Members of the Senate with great professional integrity and dedication; and

Whereas Gerald A. Hackett has earned the respect, admiration and esteem of the United States Senate: Now, therefore, be it