

"1. If any Member raises the question whether a measure is in fact taken directly in connection with a political matter brought before the United Nations in accordance with the provisions of Chapters IV or VI of the United Nations Charter, the responsibility for making a determination on the question shall rest with the Organization. If, however, political issues beyond the competence of the Organization are involved in making such a determination, the question shall be deemed to fall within the scope of the United Nations.

"2. If a Member which has no direct political concern in a matter brought before the United Nations considers that a measure taken directly in connection therewith and falling within the scope of paragraph 3 of Article 86 constitutes a nullification or impairment within the terms of paragraph 1 of Article 93, it shall seek redress only by recourse to the procedures set forth in Chapter VIII of this Charter".

The purpose of these provisions was explained by the Sixth Committee as follows:

"Paragraph 3 of Article [86], which like paragraph 4 is independent in its operation, is designed to deal with any measure which is directly in connection with a political matter brought before the United Nations in a manner which will avoid conflict of responsibility between the United Nations and the Organization with respect to political matters. The Committee agreed that this provision would cover measures maintained by a Member even though another Member had brought the particular matter before the United Nations, so long as the measure was taken directly in connection with the matter. It was also agreed that such a measure, as well as the political matter with which it was directly connected, should remain within the jurisdiction of the United Nations and not within that of the Organization. The Committee was of the opinion that the important thing was to maintain the jurisdiction of the United Nations over political matters and over economic measures of this sort taken directly in connection with such a political matter, and nothing in Article [86] could be held to prejudice the freedom of action of the United Nations to settle such matters and to take steps to deal with such economic measures in accordance with the provisions of the Charter of the United Nations if they see fit to do so.

"It was the view of the Committee that the word 'measure' in paragraph 3 of Article [86] refers only to a measure which is taken directly in connection with a political matter brought before the United Nations in accordance with Chapters IV and VI of the Charter of the United Nations and does not refer to any other measure".⁶⁵

The Charter provisions in Articles 86 and 99 were not taken into the General Agreement. While Article XXIX:1 provides that "The contracting parties undertake to observe . . . the general principles of Chapters I to VI and of Chapter IX of the Havana Charter", the Note Ad Article XXIX:1 provides that "Chapters VII and VIII . . . have been excluded from paragraph 1 because they generally deal with the organization, functions and procedures of the International Trade Organization". In this connection, during the discussion at the Sixth Session of the Contracting Parties of the US suspension of trade relations with Czechoslovakia it was stated with reference to Article 86, paragraph 3 of the Havana Charter that "although Chapter VII of the Charter was not specifically included by reference in Article XXIX of the Agreement, it had surely been the general intention that the principles of the Charter should be guiding ones for the Contracting Parties".⁶⁶

The present text of Article XXI dates from the 30 October 1948 Geneva Final Act. It has

never been amended. Amendment of Article XXI was neither proposed nor discussed in the 1954-55 Review Session.

IV. RELEVANT DOCUMENTS

Geneva:
Discussion: EPCT/WP.1/SR/11, EPCT/A/SR/25, 30, 33, 40(2), EPCT/A/PV/25, 30, 33, 40(2).
Reports: EPCT/103.
Other: EPCT/W/23.
Havana:
Discussion: E/CONF.2/C.5/SR.14, E/CONF.2/C.6/SR.18, 19, 37, and Add. 1.
Reports: E/CONF.2/C.5/14, E/CONF.2/C.6/45, 93, 104.
Other: E/CONF.2/C.6/12/Add.9, E/CONF.2/C.6/W/48.

See also London, New York and Geneva document references concerning Article XX.

FOOTNOTES

- ¹ EPCT/A/PV/33, p. 20-21 and Corr. 1; see also EPCT/A/SR/33, p. 3.
- ² GATT/CP.3/SR.22, Corr. 1.
- ³ SR.19/12, p. 196.
- ⁴ C/M/157, p. 10.
- ⁵ C/M/157, p. 11.
- ⁶ C/M/159, p. 19; see also C/M/157, p. 8.
- ⁷ C/M/157, p. 12; C/M/159, pp. 14-15.
- ⁸ L/5424, adopted on 29 November 1982, 29S/9, 11.
- ⁹ C/M/188, pp. 2-16; C/M/191, pp. 41-46.
- ¹⁰ C/M/196 at p. 7.
- ¹¹ L/6053, dated 13 October 1953 (unadopted), paras. 5.1-5.3.
- ¹² GATT/CP.3/38, p. 9.
- ¹³ L/5426, 29S/23-24, para. 1.
- ¹⁴ EPCT/A/PV/33, p. 29; see also EPCT/A/PV/33/Corr. 3.
- ¹⁵ EPCT/A/PV/36, p. 19; see also proposal referred to at EPCT/W/264.
- ¹⁶ GATT/CP.3/38; GATT/CP.3/SR.22, p. 8.
- ¹⁷ GATT/CP.3/SR.22, p. 4-5.
- ¹⁸ GATT/CP.3/SR.20, p. 3-4.
- ¹⁹ GATT/CP.3/SR.22, p. 9; Decision of 8 June 1949 at II/28.
- ²⁰ L/3362, adopted on 27 February 1970, 17S/33, 39, para. 22.
- ²¹ *Ibid.*, 17S/40, para. 23.
- ²² L/4250, p. 3.
- ²³ C/M/109, p. 8-9.
- ²⁴ L/4250/Add.1; L/4254, p. 17-18.
- ²⁵ L/5319/Rev. 1.
- ²⁶ L/5317, L/5336; C/M/157, C/M/159.
- ²⁷ L/5424, adopted on 29 November 1982, 29S/9, 11.
- ²⁸ L/5803.
- ²⁹ C/M/1881 p. 4.
- ³⁰ C/M/188, p. 16.
- ³¹ L/5802; C/M/191, pp. 41-46.
- ³² C/M/191, pp. 41-46.
- ³³ C/M/240, p. 31; L/6661.
- ³⁴ L/6948.
- ³⁵ DS27/2, dated 10 February 1992.
- ³⁶ C/M/255, p. 18.
- ³⁷ C/M/256, p. 32.
- ³⁸ C/M/257 p. 3 and Corr. 1.
- ³⁹ C/M/264, p. 3.
- ⁴⁰ COM.IND/6/Add.4, p. 53 (notification); MTN/3B/4, p. 559 (response citing binding resolution under Inter-American Treaty of Reciprocal Assistance). See also Council discussion May 1986 concerning US measures authorizing denial of sugar import quota to any failing to certify that it does not import sugar produced in Cuba for re-export to the US, stated by US to be a "procedural safeguard" against trans-shipment of sugar in violation of the embargo; C/M/198 p. 33, L/5980.
- ⁴¹ C/M/159, p. 18.
- ⁴² See L/5414 (Council report); see also C/W/402, W.38/5, L/5426.
- ⁴³ L/5426, 29S/23.
- ⁴⁴ GATT/CP.3/SR.22, p. 9; II/28.
- ⁴⁵ EPCT/A/PV/33, p. 26-27.
- ⁴⁶ EPCT/A/PV/33 p. 27-29 and EPCT/A/PV/33/Corr. 3.
- ⁴⁷ GATT/CP.3/SR.22, p. 9.
- ⁴⁸ C/M/157, p. 9; C/M/159, p. 14; C/M/165, p. 18.
- ⁴⁹ 29S/24.
- ⁵⁰ L/5607, adopted on 13 March 1984, 31S/67, 72, para. 3.10.
- ⁵¹ *Ibid.*, 31S/73, para. 4.1.
- ⁵² *Ibid.*, 31S/74, paras. 4.4-4.5.
- ⁵³ C/M/178, p. 27.
- ⁵⁴ C/M/191, pp. 41-46.
- ⁵⁵ C/M/196, p. 7.
- ⁵⁶ L/6053 (unadopted), dated 13 October 1986, paras. 5.4-5.11.
- ⁵⁷ C/M/204.
- ⁵⁸ C/M/204. See also communication from Nicaragua at C/W/506.
- ⁵⁹ L/6053, unadopted, dated 13 October 1986, prs. 5.2.

⁶⁰ SR.47/3, p. 5.

⁶¹ See proposal at EPCT/W/23, reports on discussions in Commission A (commercial policy) at EPCT/WP.1/SR/11, EPCT/103 p. 3, EPCT/A/PV/25 p. 38-42.

⁶² EPCT/A/PV/25 p. 39-42.

⁶³ See Havana Reports, p. 118, para. 32 and p. 145-147.

⁶⁴ Havana Reports, p. 153, para. (a).

⁶⁵ Havana Reports, p. 153-154, paras. (b)-(c).

⁶⁶ GATT/CP.6/SR.12, p. 4.

NOTE

In the RECORD of October 27, at page S16007, during consideration of the balanced budget reconciliation bill, Mr. LIEBERMAN moved to commit the bill to the Finance Committee with instructions to report the bill back to the Senate with an amendment. The text of the amendment was not printed in the RECORD. The permanent RECORD will be corrected to reflect the following omitted language.

MOTION TO COMMIT WITH INSTRUCTIONS

Mr. President, I move to commit the bill S. 1357 to the Committee on Finance with instructions to report the bill back to the Senate within 3 days (not to include any day the Senate is not in session) with the following amendment, and to make sufficient reductions in the tax cuts to maintain deficit neutrality.

(Purpose: To restore the solvency of the Medicare part A Hospital Insurance Trust Fund for the next 10 years. To reform the Medicare Program and provide real choices to Medicare beneficiaries by increasing the range of health plans available, providing better information so that beneficiaries can act as informed consumers and to require strategic planning for the demographic changes that will come with the retirement of the "babyboom" generation)

On page 442, beginning on line 1, strike all through page 748, line 18, and insert:

Subtitle A—Medicare

SEC. 7001. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This subtitle may be cited as the "Medicare Improvement and Solvency Protection Act of 1995".

(b) TABLE OF CONTENTS.—The table of contents of this subtitle is as follows:

CHAPTER 1—PROVISIONS TO IMPROVE AND EXPAND MEDICARE CHOICES

- Sec. 7002. Increasing choice under medicare.
Sec. 7003. Provisions relating to medicare coordinated care contracting options.
Sec. 7004. Provisions relating to medicare supplemental policies.
Sec. 7005. Special rule for calculation of payment rates for 1996.
Sec. 7006. Graduate medical education and disproportionate share payment adjustments to hospitals providing services to enrollees in eligible organizations.
Sec. 7007. Effective date.

CHAPTER 2—PROVISIONS RELATING TO QUALITY IMPROVEMENT AND DISTRIBUTION OF INFORMATION

Sec. 7011. Quality report cards.

CHAPTER 3—PROVISIONS TO STRENGTHEN RURAL AND UNDER-SERVED AREAS

- Sec. 7021. Rural referral centers.
Sec. 7022. Medicare-dependent, small, rural hospital payment extension.
Sec. 7023. PROPAC recommendations on urban medicare dependent hospitals.

- Sec. 7024. Payments to physician assistants and nurse practitioners for services furnished in outpatient or home settings.
- Sec. 7025. Improving health care access and reducing health care costs through telemedicine.
- Sec. 7026. Establishment of rural health outreach grant program.
- Sec. 7027. Medicare rural hospital flexibility program.
- Sec. 7028. Parity for rural hospitals for disproportionate share payments.
- CHAPTER 4—GENERAL PROGRAM IMPROVEMENTS AND REFORM
- Sec. 7031. Increased flexibility in contracting for medicare claims processing.
- Sec. 7032. Expansion of centers of excellence.
- Sec. 7033. Selective contracting.
- CHAPTER 5—REDUCTION OF WASTE, FRAUD, AND ABUSE
- SUBCHAPTER A—IMPROVING COORDINATION, COMMUNICATION, AND ENFORCEMENT
- PART I—MEDICARE ANTI-FRAUD AND ABUSE PROGRAM
- Sec. 7041. Medicare anti-fraud and abuse program.
- Sec. 7042. Application of certain health anti-fraud and abuse sanctions to fraud and abuse against Federal health programs.
- Sec. 7043. Health care fraud and abuse provider guidance.
- Sec. 7044. Medicare/medicaid beneficiary protection program.
- Sec. 7045. Medicare benefit quality assurance.
- Sec. 7046. Medicare benefit integrity system.
- PART II—REVISIONS TO CURRENT SANCTIONS FOR FRAUD AND ABUSE
- Sec. 7051. Mandatory exclusion from participation in medicare and State health care programs.
- Sec. 7052. Establishment of minimum period of exclusion for certain individuals and entities subject to permissive exclusion from medicare and State health care programs.
- Sec. 7053. Permissive exclusion of individuals with ownership or control interest in sanctioned entities.
- Sec. 7054. Sanctions against practitioners and persons for failure to comply with statutory obligations.
- Sec. 7055. Sanctions against providers for excessive fees or prices.
- Sec. 7056. Applicability of the bankruptcy code to program sanctions.
- Sec. 7057. Agreements with peer review organizations for medicare coordinated care organizations.
- Sec. 7058. Effective date.
- PART III—ADMINISTRATIVE AND MISCELLANEOUS PROVISIONS
- Sec. 7061. Establishment of the health care fraud and abuse data collection program.
- Sec. 7062. Inspector general access to additional practitioner data bank.
- Sec. 7063. Corporate whistleblower program.
- PART IV—CIVIL MONETARY PENALTIES
- Sec. 7071. Social Security Act civil monetary penalties.
- PART V—CHAPTER 5—AMENDMENTS TO CRIMINAL LAW
- Sec. 7081. Health care fraud.
- Sec. 7082. Forfeitures for Federal health care offenses.
- Sec. 7083. Injunctive relief relating to Federal health care offenses.
- Sec. 7084. Grand jury disclosure.
- Sec. 7085. False Statements.
- Sec. 7086. Obstruction of criminal investigations, audits, or inspections of Federal health care offenses.
- Sec. 7087. Theft or embezzlement.
- Sec. 7088. Laundering of monetary instruments.
- Sec. 7089. Authorized investigative demand procedures.
- PART VI—STATE HEALTH CARE FRAUD CONTROL UNITS
- Sec. 7091. State health care fraud control units.
- PART VII—MEDICARE/MEDICAID BILLING ABUSE PREVENTION
- Sec. 7101. Uniform medicare/medicaid application process.
- Sec. 7102. Standards for uniform claims.
- Sec. 7103. Unique provider identification code.
- Sec. 7104. Use of new procedures.
- Sec. 7105. Required billing, payment, and cost limit calculation to be based on site where service is furnished.
- SUBCHAPTER B—ADDITIONAL PROVISIONS TO COMBAT WASTE, FRAUD, AND ABUSE
- PART I—WASTE AND ABUSE REDUCTION
- Sec. 7111. Prohibiting unnecessary and wasteful medicare payments for certain items.
- Sec. 7112. Application of competitive acquisition process for Part B items and services.
- Sec. 7113. Interim reduction in excessive payments.
- Sec. 7114. Reducing excessive billings and utilization for certain items.
- Sec. 7115. Improved carrier authority to reduce excessive medicare payments.
- Sec. 7116. Effective date.
- PART II—MEDICARE BILLING ABUSE PREVENTION
- Sec. 7121. Implementation of General Accounting Office recommendations regarding medicare claims processing.
- Sec. 7122. Minimum software requirements.
- Sec. 7123. Disclosure.
- Sec. 7124. Review and modification of regulations.
- Sec. 7125. Definitions.
- PART III—REFORMING PAYMENTS FOR AMBULANCE SERVICES
- Sec. 7131. Reforming payments for ambulance services.
- PART IV—REWARDS FOR INFORMATION
- Sec. 7141. Rewards for information leading to health care fraud prosecution and conviction.
- CHAPTER 6—ESTABLISHMENT OF COMMISSION TO PREPARE FOR THE 21ST CENTURY
- Sec. 7161. Establishment.
- Sec. 7162. Duties of the Commission.
- Sec. 7163. Powers of the Commission.
- Sec. 7164. Commission personnel matters.
- Sec. 7165. Termination of the Commission.
- Sec. 7166. Funding for the Commission.
- CHAPTER 7—MEASURES TO IMPROVE THE SOLVENCY OF THE TRUST FUNDS
- SUBCHAPTER A—PROVISIONS RELATING TO PART A
- PART I—GENERAL PROVISIONS
- Sec. 7171. PPS hospital payment update.
- Sec. 7172. Modification in payment policies regarding graduate medical education.
- Sec. 7173. Elimination of DSH and IME for outliers.
- Sec. 7174. Capital payments for PPS inpatient hospitals.
- Sec. 7175. Treatment of PPS-exempt hospitals.
- Sec. 7176. PPS-exempt capital payments.
- Sec. 7177. Prohibition of PPS exemption for new long-term hospitals.
- Sec. 7178. Revision of definition of transfers from hospitals to post-acute facilities.
- Sec. 7179. Direction of savings to hospital insurance trust fund.
- PART II—SKILLED NURSING FACILITIES
- Sec. 7181. Prospective payment for skilled nursing facilities.
- Sec. 7182. Maintaining savings resulting from temporary freeze on payment increases for skilled nursing facilities.
- Sec. 7183. Consolidated billing.
- SUBCHAPTER B—PROVISIONS RELATING TO PART B
- Sec. 7184. Physician update for 1996.
- Sec. 7185. Practice expense relative value units.
- Sec. 7186. Correction of MVPS upward bias.
- Sec. 7187. Limitations on payment for physicians' services furnished by high-cost hospital medical staffs.
- Sec. 7188. Elimination of certain anomalies in payments for surgery.
- Sec. 7189. Upgraded durable medical equipment.
- SUBCHAPTER C—PROVISIONS RELATING TO PARTS A AND B
- PART I—SECONDARY PAYOR
- Sec. 7189A. Extension and expansion of existing medicare secondary payor requirements.
- PART II—HOME HEALTH AGENCIES
- Sec. 7189B. Interim payments for home health services.
- Sec. 7189C. Prospective payments.
- Sec. 7189D. Maintaining savings resulting from temporary freeze on payment increases.
- Sec. 7189E. Elimination of periodic interim payments for home health agencies.
- Sec. 7189F. Effective date.
- CHAPTER 1—PROVISIONS TO IMPROVE AND EXPAND MEDICARE CHOICES**
- SEC. 7002. INCREASING CHOICE UNDER MEDICARE.**
- (a) IN GENERAL.—Title XVIII is amended by inserting after section 1804 the following new section:
- “PROVIDING FOR CHOICE OF COVERAGE
- “SEC. 1805. (a) CHOICE OF COVERAGE.—
- “(1) IN GENERAL.—Subject to the provisions of this section, every individual who is entitled to benefits under part A and enrolled under part B shall elect to receive benefits under this title through one of the following:
- “(A) THROUGH TRADITIONAL MEDICARE SYSTEM.—Through the provisions of parts A and B (hereafter in this section, referred to as the ‘traditional medicare option’).
- “(B) THROUGH AN ELIGIBLE ORGANIZATION.—Through an eligible organization with a contract under part C.
- “(b) PROCESS FOR EXERCISING CHOICE.—
- “(1) IN GENERAL.—The Secretary shall establish a process through which elections described in subsection (a) are made and changed, including the form and manner in which such elections are made and changed. Such elections shall be made or changed during enrollment periods specified under part C.
- “(4) DEFAULT.—
- “(A) INITIAL ELECTION.—
- “(i) IN GENERAL.—Subject to clause (ii), an individual who fails to make an election during an open enrollment period described in section 1852(b)(3) is deemed to have chosen the traditional medicare option.

“(i) SEAMLESS CONTINUATION OF COVERAGE.—The Secretary shall establish procedures under which individuals who are enrolled with an eligible organization at the time of an open enrollment period described in section 1852(b)(3) and who fail to elect to receive coverage other than through the organization are deemed to have elected to have enrolled in a plan offered by the organization.

“(B) CONTINUING PERIODS.—An individual who has made (or deemed to have made) an election under this section is considered to have continued to make such election until such time as—

“(i) the individual changes the election under this section, or

“(ii) an eligible organization's plan is discontinued, if the individual had elected such plan at the time of the discontinuation.

“(5) AGREEMENTS WITH COMMISSIONER OF SOCIAL SECURITY TO PROMOTE EFFICIENT ADMINISTRATION.—In order to promote the efficient administration of this section and the program under part C, the Secretary may enter into an agreement with the Commissioner of Social Security under which the Commissioner performs administrative responsibilities relating to enrollment and disenrollment in eligible organizations under this section.”

(b) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to contracts effective on and after January 1, 1997.

SEC. 7003. PROVISIONS RELATING TO MEDICARE COORDINATED CARE CONTRACTING OPTIONS.

(a) IN GENERAL.—Title XVIII is amended by redesignating part C as part D and by inserting after part B the following new part:

“PART C—PROVISIONS RELATING TO MEDICARE COORDINATED CARE CONTRACTING OPTIONS

“DEFINITIONS

“SEC. 1851. For purposes of this part:

“(a) ADJUSTED COMMUNITY RATE.—The term ‘adjusted community rate’ for a service or services means, at the election of an eligible organization, either—

“(A) the rate of payment for that service or services which the Secretary annually determines would apply to a member enrolled under this part with an eligible organization if the rate of payment were determined under a ‘community rating system’ (as defined in section 1302(8) of the Public Health Service Act, other than subparagraph (C)), or

“(B) such portion of the weighted aggregate premium, which the Secretary annually estimates would apply to a member enrolled under this part with the eligible organization, as the Secretary annually estimates is attributable to that service or services,

but adjusted for differences between the utilization characteristics of the members enrolled with the eligible organization under this part and the utilization characteristics of the other members of the organization (or, if the Secretary finds that adequate data are not available to adjust for those differences, the differences between the utilization characteristics of members in other eligible organizations, or individuals in the area, in the State, or in the United States, eligible to enroll under this part with an eligible organization and the utilization characteristics of the rest of the population in the area, in the State, or in the United States, respectively).

“(b) ELIGIBLE ORGANIZATION.—

“(1) IN GENERAL.—The term ‘eligible organization’ shall include any of the public or private entities described in paragraph (2), organized under the laws of any State:

“(2) ENTITIES DESCRIBED.—The entities described in this paragraph are the following:

“(A) COORDINATED CARE PLANS.—

“(i) IN GENERAL.—Private managed or coordinated care plans which provide health care services through an integrated network of providers, including—

“(I) qualified health maintenance organizations as defined in section 1310(d) of the Public Health Service Act; and

“(II) beginning with services provided on or after January 1, 1997, preferred provider organization plans, point of service plans, provider-sponsored network plans, or other integrated health plans (subject to approval by the Secretary).

“(ii) REQUIREMENTS FOR CERTAIN COORDINATED CARE PLANS.—A coordinated care plan described in clause (i)(II) shall meet the following requirements:

“(I) The plan shall be in the business of providing a plan of health insurance or health benefits and be organized under the laws of any State.

“(II) The plan shall provide physician's services directly or through physicians who are either employees or partners of such an organization or through contracts or agreements with individual physicians or one or more groups of physicians.

“(III) The plan has made adequate provision against the risk of insolvency, which provision is satisfactory to the Secretary.

“(IV) The plan has effective procedures, satisfactory to the Secretary, to monitor utilization and to control the costs of services.

“(V) The plan shall offer all services covered under parts A and B (or B only, as applicable) and such preventive health services designated by the Secretary under section 1853(a)(1).

“(VI) The plan shall provide all enrollees under this part with a comprehensive out-of-plan service benefit (point-of-service) that allows enrollees to obtain all services covered under parts A and B (or B only, as applicable) and such preventive health services designated by the Secretary under section 1853(a)(1) from a provider with whom the plan does not have a contract.

“(VII) The plan shall provide that cost-sharing for services described in subclause (VI) may not exceed the deductibles and coinsurance amounts applicable to services under part A or B.

“(VIII) A provider under contract with the plan may not bill an enrollee under this part an amount in excess of the applicable cost-sharing amount of the rate negotiated between the provider and the plan.

“(IX) The plan shall meet quality and access standards under this part.

“(iii) POINT-OF-SERVICE OPTION.—Not later than January 1, 1996, the Secretary shall issue guidelines that would permit a qualified health maintenance organization (as defined in section 1310(d) of the Public Health Service Act) to offer a point-of-service option under a risk-sharing contract under this part.

“(B) COMPETITIVE MEDICAL PLAN.—A competitive medical plan that meets the following requirements:

“(i) The entity provides to enrolled members at least the following health care services:

“(I) Physicians' services performed by physicians (as defined in section 1861(r)(1)).

“(II) Inpatient hospital services (except in the case of an entity that had contracted with a single State agency administering a State plan approved under title XIX for the provision of services (other than inpatient services) to individuals eligible for such services under such State plan on a prepaid risk basis prior to 1970).

“(III) Laboratory, X-ray, emergency, and preventive services.

“(IV) Out-of-area coverage.

“(i) The entity is compensated (except for deductibles, coinsurance, and copayments)

for the provision of health care services to enrolled members by a payment which is paid on a periodic basis without regard to the date the health care services are provided and which is fixed without regard to the frequency, extent, or kind of health care service actually provided to a member.

“(iii) The entity provides physicians' services primarily—

“(I) directly through physicians who are either employees or partners of such organization, or

“(II) through contracts with individual physicians or one or more groups of physicians (organized on a group practice or individual practice basis).

“(iv) The entity assumes full financial risk on a prospective basis for the provision of the health care services listed in clause (i), except that such entity may—

“(I) obtain insurance or make other arrangements for the cost of providing to any enrolled member health care services listed in clause (i) the aggregate value of which exceeds \$5,000 in any year,

“(II) obtain insurance or make other arrangements for the cost of health care services listed in clause (i) provided to its enrolled members other than through the entity because medical necessity required their provision before they could be secured through the entity,

“(III) obtain insurance or make other arrangements for not more than 90 percent of the amount by which its costs for any of its fiscal years exceed 115 percent of its income for such fiscal year, and

“(IV) make arrangements with physicians or other health professionals, health care institutions, or any combination of such individuals or institutions to assume all or part of the financial risk on a prospective basis for the provision of basic health services by the physicians or other health professionals or through the institutions.

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

“(3) PROVIDER SPONSORED NETWORK.—The term ‘provider sponsored network’ has the meaning given such term in section 1858(a).

“(c) CONTRACTS.—The term—

“(1) ‘risk-sharing contract’ means a contract entered into under section 1856(b); and

“(2) ‘reasonable cost reimbursement contract’ means a contract entered into under section 1856(c).

“(d) AREAS.—

“(1) PAYMENT AREA.—

“(A) IN GENERAL.—Subject to subparagraph (B), the term ‘payment area’ means an entire metropolitan statistical area or single statewide area that does not include a metropolitan statistical area.

“(B) EXCEPTION.—The Secretary may modify the geographic area covered by a payment area if the application of paragraph (1) would result in a substantial disruption of services provided to enrollees under this part by eligible organizations in an area.

“(2) SERVICE AREA.—

“(A) IN GENERAL.—Except as provided in subparagraph (B), the term ‘service area’ means, with respect to an eligible organization, the payment area for such organization.

“(B) EXCLUSION.—The Secretary may permit an organization's service area to exclude any portion of a payment area (other than the central county of a metropolitan statistical area) if—

“(i) the organization demonstrates that it lacks the financial or administrative capacity to serve the entire payment area; and

“(ii) the Secretary finds that the composition of the organization's service area does

not reduce the financial risk to the organization of providing services to enrollees because of the health status or other demographic characteristics of individuals residing in the service area (as compared to the health status or demographic characteristics of individuals residing in the portion of the payment area which the organization seeks to exclude from its service area).

“ELIGIBILITY, ENROLLMENT AND
DISENROLLMENT, AND INFORMATION

“SEC. 1852. (a) ELIGIBILITY FOR ENROLLMENT.—Subject to the provisions of subsection (b), every individual entitled to benefits under part A and enrolled under part B or enrolled under part B only (other than an individual medically determined to have end-stage renal disease) shall be eligible to enroll under this part with any eligible organization with which the Secretary has entered into a contract under this part and which serves the geographic area in which the individual resides.

“(b) COORDINATED OPEN ENROLLMENT PERIOD.—

“(1) IN GENERAL.—Each eligible organization must have an open enrollment period (which shall be specified by the Secretary for each payment area), for the enrollment of individuals under this part, of at least 30 days duration every year and including the period or periods specified under paragraphs (2) through (4), and must provide that at any time during which enrollments are accepted, the organization will accept up to the limits of its capacity (as determined by the Secretary) and without restrictions, except as may be authorized in regulations, individuals who are eligible to enroll under subsection (a) in the order in which they apply for enrollment, unless to do so would result in failure to meet the requirements of section 1855(k) or would result in the enrollment of enrollees substantially nonrepresentative, as determined in accordance with regulations of the Secretary, of the population in the service area of the organization.

“(2) OPEN ENROLLMENT PERIODS IF CONTRACT NOT RENEWED OR TERMINATED.—

“(A) IN GENERAL.—If a risk-sharing contract under this part is not renewed or is otherwise terminated, eligible organizations with risk-sharing contracts under this part and serving a part of the same service area as under the terminated contract are required to have an open enrollment period for individuals who were enrolled under the terminated contract as of the date of notice of such termination. If a risk-sharing contract under this part is renewed in a manner that discontinues coverage for individuals residing in part of the service area, eligible organizations with risk-sharing contracts under this part and enrolling individuals residing in that part of the service area are required to have an open enrollment period for individuals residing in the part of the service area who were enrolled under the contract as of the date of notice of such discontinued coverage.

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

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

“(3) ENROLLMENT UPON MEDICARE ELIGIBILITY.—Each eligible organization shall have an open enrollment period for each individual eligible to enroll under subsection (a) during any enrollment period specified by section 1837 that applies to that individual.

Enrollment under this paragraph shall be effective as specified by section 1838.

“(4) MOVED FROM GEOGRAPHIC AREA OR DISENROLLED FROM ANOTHER ORGANIZATION.—Each eligible organization shall have an open enrollment period for each individual eligible to enroll under subsection (a) who has previously resided outside the organization's service area or who has disenrolled from another organization. The enrollment period shall begin with the beginning of the month that precedes the month in which the individual becomes a resident of that service area or disenrolls from another plan and shall end at the end of the following month. Enrollment under this paragraph shall be effective as of the first of the month following the month in which the individual enrolls.

“(5) PROCEDURES FOR ENROLLMENT AND DISENROLLMENT.—An individual may enroll under this part with an eligible organization in such manner as may be prescribed in regulations (including enrollment through a third party) and may terminate the individual's enrollment with the eligible organization as of the beginning of the first calendar month following the date on which the request is made for such termination (or, in the case of financial insolvency of the organization, as may be prescribed by regulations) or, in the case of such an organization with a reasonable cost reimbursement contract, as may be prescribed by regulations. In the case of an individual's termination of enrollment, the organization shall provide the individual with a copy of the written request for termination of enrollment and a written explanation of the period (ending on the effective date of the termination) during which the individual continues to be enrolled with the organization and may not receive benefits under this title other than through the organization.

“(6) ENROLLMENT AND DISENROLLMENT BY MAIL, PHONE, OR LOCAL SOCIAL SECURITY OFFICE.—

“(A) IN GENERAL.—Each eligible organization that provides items and services pursuant to a contract under this part shall permit an individual eligible to enroll under this part—

“(i) to obtain enrollment forms and information by mail, telephone, or from local social security offices, and

“(ii) to enroll or disenroll by mail or at a local social security office.

“(B) NO VISITS BY AGENTS.—No agent of an eligible organization may visit the residence of such an individual for purposes of enrolling the individual under this part or providing enrollment information to the individual.

“(c) INFORMATION.—

“(1) INFORMATION DISTRIBUTED BY ORGANIZATION.—The Secretary shall prescribe the procedures and conditions under which an eligible organization that has entered into a contract with the Secretary under this part may inform individuals eligible to enroll under this part with the organization about the organization, or may enroll such individuals with the organization. No brochures, application forms, or other promotional or informational material may be distributed by an organization to (or for the use of) individuals eligible to enroll with the organization under this part unless—

“(A) at least 45 days before its distribution, the organization has submitted the material to the Secretary for review; and

“(B) the Secretary has not disapproved the distribution of the material.

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

“(2) DISTRIBUTION OF COMPARATIVE MATERIALS BY SECRETARY.—

“(A) IN GENERAL.—The Secretary shall develop and distribute comparative materials during the enrollment periods described in paragraphs (1) and (3) of subsection (b) to individuals eligible to enroll under this part. Such comparative materials shall present comparative information (in a standardized format and in language easily understandable by the target population) about all eligible organizations with contracts under this part and medicare supplemental policies under section 1882 available in the individual's payment area. The Secretary shall allocate the costs for developing and distributing such materials to such eligible organizations and issues medicare supplemental policies represented in such materials.

“(B) MATERIAL DESCRIBED.—The comparative materials distributed under subparagraph (A) shall include where applicable, with respect to eligible organizations and medicare supplemental policies, the following information:

“(i) Benefits, including maximums limitations and exclusions.

“(ii) Premiums, cost-sharing, administrative charges and availability of out-of-plan services.

“(iii) Coordination of care.

“(iv) Procedures for obtaining benefits including the locations, qualifications, and availability of participating providers.

“(v) Grievance and appeal procedures, including the right to address grievances with the organization to the Secretary and the appropriate peer review entity.

“(vi) Programs for health promotion, the prevention of diseases, disorders, disabilities, injuries and other health conditions.

“(vii) Rights and responsibilities of enrollees.

“(viii) Prior authorization requirements.

“(ix) Procedures used to monitor and control utilization of services and expenditures.

“(x) Procedures for assuring and improving quality of care.

“(xi) Risk and referral arrangements under the plan.

“(xii) Loss ratios and an easily understandable explanation that such ratio reflects the percentage of premiums spent on health services compared to total premiums paid.

“(xiii) Whether the organization is out-of-compliance with standards (as defined by the Secretary).

“(xiv) In the case of medicare supplemental policies, underwriting policies and projected premiums in age-bands.

“BENEFITS AND PREMIUMS

“SEC. 1853. (a) BENEFITS COVERED.—

“(1) IN GENERAL.—

“(A) COVERED SERVICES.—Except as provided in subparagraph (B), the organization must provide to members enrolled under this part, through providers and other persons that meet the applicable requirements of this title and part A of title XI—

“(i) only those services covered under parts A and B of this title (and such preventive health services and reduced cost-sharing as the Secretary may designate) for those members entitled to benefits under part A and enrolled under part B, or

“(ii) only those services covered under part B of this title (and such preventive health services and reduced cost-sharing designated under clause (i)) for those members enrolled only under such part.

“(B) ADDITIONAL SERVICES.—The organization may provide such members with such additional health care services as the members may elect, at their option, to have covered, and in the case of an organization with

a risk-sharing contract, the organization may provide such members with such additional health care services as the Secretary may approve. The Secretary shall approve any such additional health care services which the organization proposes to offer to such members, unless the Secretary determines that including such additional services will substantially discourage enrollment by covered individuals with the organization.

“(C) PAYMENTS IN LIEU OF OTHER AMOUNTS.—Subject to paragraph (2)(B) and section 1857(h), payments under a contract to an eligible organization under subsection (a) or (b) of section 1857 shall be instead of the amounts which (in the absence of the contract) would be otherwise payable, pursuant to sections 1814(b) and 1833(a), for services furnished by or through the organization to individuals enrolled with the organization under this part.

“(2) NATIONAL COVERAGE DETERMINATION.—If there is a national coverage determination made in the period beginning on the date of an announcement under section 1857(a)(1) and ending on the date of the next announcement under such section that the Secretary projects will result in a significant change in the costs to the organization of providing the benefits that are the subject of such national coverage determination and that was not incorporated in the determination of the per capita rate of payment included in the announcement made at the beginning of such period—

“(A) such determination shall not apply to risk-sharing contracts under this part until the first contract year that begins after the end of such period; and

“(B) if such coverage determination provides for coverage of additional benefits or under additional circumstances, paragraph (1)(C) shall not apply to payment for such additional benefits or benefits provided under such additional circumstances until the first contract year that begins after the end of such period,

unless otherwise required by law.

“(b) PREMIUMS, DEDUCTIBLES, COINSURANCE, AND COPAYMENTS.—

“(1) IN GENERAL.—In no case may—

“(A) the portion of an eligible organization's premium rate and the actuarial value of its deductibles, coinsurance, and copayments charged (with respect to services covered under parts A and B, preventive services designated under section 1853(a)(1), and, if applicable, the point-of-service benefit described in section 1851(b)(2)(A)(ii)(VI)) to individuals who are enrolled under this part with the organization and who are entitled to benefits under part A and enrolled under part B, or

“(B) the portion of its premium rate and the actuarial value of its deductibles, coinsurance, and copayments charged (with respect to services covered under part B, preventive services designated under section 1853(a)(1) and the point-of-service benefit described in section, if applicable, 1851(b)(2)(A)(ii)(VI)) to individuals who are enrolled under this part with the organization and enrolled under part B only,

exceed the actuarial value of the coinsurance and deductibles that would be applicable on the average to individuals enrolled under this part with the organization (or, if the Secretary finds that adequate data are not available to determine that actuarial value, the actuarial value of the coinsurance and deductibles applicable on the average to individuals in the area, in the State, or in the United States, eligible to enroll under this part with the organization, or other appropriate data) and entitled to benefits under part A and enrolled under part B, or enrolled under part B only, respectively, if they were not members of an eligible organization.

“(2) ADDITIONAL SERVICES.—If the eligible organization provides to its members enrolled under this part services in addition to services covered under parts A and B of this title and such preventive health services designated by the Secretary under subsection (a)(1)(A), election of coverage for such additional services (unless such services have been approved by the Secretary under subsection (a)(1)(B)) shall be optional for such members and such organization shall furnish such members with information on the portion of its premium rate or other charges applicable to such additional services. In no case may the sum of—

“(A) the portion of such organization's premium rate charged, with respect to such additional services, to members enrolled under this part, and

“(B) the actuarial value of its deductibles, coinsurance, and copayments charged, with respect to such services to such members, exceed the adjusted community rate for such services.

“(c) SECONDARY PAYER.—Notwithstanding any other provision of law, the eligible organization may (in the case of the provision of services to a member enrolled under this part for an illness or injury for which the member is entitled to benefits under a workmen's compensation law or plan of the United States or a State, under an automobile or liability insurance policy or plan, including a self-insured plan, or under no fault insurance) charge or authorize the provider of such services to charge, in accordance with the charges allowed under such law or policy—

“(1) the insurance carrier, employer, or other entity which under such law, plan, or policy is to pay for the provision of such services, or

“(2) such member to the extent that the member has been paid under such law, plan, or policy for such services.”

“PATIENT PROTECTIONS

“SEC. 1855. (a) ANTIDISCRIMINATION.—The organization must provide assurances to the Secretary that it will not expel or refuse to re-enroll any such individual because of the individual's health status or requirements for health care services, and that it will notify each such individual of such fact at the time of the individual's enrollment.

“(b) EXPLANATION OF RIGHTS.—Each eligible organization shall provide each enrollee, at the time of enrollment and not less frequently than annually thereafter, an explanation of the enrollee's rights under this part, including an explanation of—

“(1) the enrollee's rights to benefits from the organization,

“(2) if any the restrictions on payments under this title for services furnished other than by or through the organization,

“(3) out-of-area coverage provided by the organization,

“(4) the organization's coverage of emergency services and urgently needed care, and

“(5) appeal rights of enrollees.

“(c) ASSURANCES RELATING TO PREEXISTING CONDITION.—Each eligible organization that provides items and services pursuant to a contract under this part shall provide assurances to the Secretary that in the event the organization ceases to provide such items and services, the organization shall provide or arrange for supplemental coverage of benefits under this title related to a preexisting condition with respect to any exclusion period, to all individuals enrolled with the entity who receive benefits under this title, for the lesser of 6 months or the duration of such period.

“(d) NOTICE OF RIGHT TO TERMINATE CONTRACT OR REFUSE TO RENEW.—

“(1) IN GENERAL.—Each eligible organization having a risk-sharing contract under

this part shall notify individuals eligible to enroll with the organization under this part and individuals enrolled with the organization under this part that—

“(A) the organization is authorized by law to terminate or refuse to renew the contract, and

“(B) termination or nonrenewal of the contract may result in termination of the enrollments of individuals enrolled with the organization under this part.

“(2) NOTICE INCLUDED.—The notice required by paragraph (1) shall be included in—

“(A) any marketing materials described in section 1852(c)(1) that are distributed by an eligible organization to individuals eligible to enroll under this part with the organization, and

“(B) any explanation provided to enrollees by the organization pursuant to subsection (b).

“(e) ACCESS.—

“(1) IN GENERAL.—The organization must—

“(A) make the services described in section 1853(a)(1)(A) (and such other health care services as such individuals have contracted for)—

“(i) available and accessible to each such individual, within the area served by the organization, 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) provide for reimbursement with respect to emergency services which are provided to such an individual other than through the organization.

“(2) EMERGENCY SERVICES DEFINED.—For purposes of this subsection, the term ‘emergency services’ means services provided to an individual after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected by a prudent layperson (possessing an average knowledge of health and medicine) to result in placing the individual's health in serious jeopardy, the serious impairment of a bodily function, or the serious dysfunction of any bodily organ or part, and includes services furnished as a result of a call through the 911 emergency system.

“(3) NO PRIOR AUTHORIZATION.—An eligible organization with a contract under this part may not require prior authorization for emergency services.

“(f) HEARING AND GRIEVANCES.—

“(1) IN GENERAL.—The organization must provide meaningful procedures for hearing and resolving grievances between the organization (including any entity or individual through which the organization provides health care services) and members enrolled with the organization under this part.

“(2) HEARING BEFORE THE SECRETARY.—A member enrolled with an eligible organization under this part who is dissatisfied by reason of his failure to receive any health service to which he believes he is entitled and at no greater charge than he believes he is required to pay is entitled, if the amount in controversy is \$100 or more, to a hearing before the Secretary to the same extent as is provided in section 205(b), and in any such hearing the Secretary shall make the eligible organization a party. If the amount in controversy is \$1,000 or more, the individual or eligible organization shall, upon notifying the other party, be entitled to judicial review of the Secretary's final decision as provided in section 205(g), and both the individual and the eligible organization shall be entitled to be parties to that judicial review. In applying sections 205(b) and 205(g) as provided in this subparagraph, and in applying section 205(l) thereto, any reference therein

to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively.

“(g) ARRANGEMENTS FOR ONGOING QUALITY ASSURANCE.—The organization must have arrangements, established in accordance with regulations of the Secretary, for an ongoing quality assurance program for health care services it provides to such individuals, which program—

“(1) stresses health outcomes; and

“(2) provides review by physicians and other health care professionals of the process followed in the provision of such health care services.

“(h) ADVANCE DIRECTIVES.—A contract under this part shall provide that the eligible organization shall meet the requirement of section 1866(f) (relating to maintaining written policies and procedures respecting advance directives).

“(i) UTILIZATION REVIEW PROGRAM.—

“(1) IN GENERAL.—An eligible organization may not deny coverage of or payment for items and services on the basis of a utilization review program unless the program meets the standards established by the Secretary under paragraph (2).

“(2) STANDARDS.—The Secretary shall establish standards for utilization review programs of eligible organizations, consistent with paragraph (3), and shall periodically review and update such standards to reflect changes in the delivery of health care services. The Secretary shall establish such standards in consultation with appropriate parties.

“(3) CONTENTS OF STANDARDS.—Under the standards established under paragraph (2)—

“(A) individuals performing utilization review may not receive financial compensation based upon the number of denials of coverage; and

“(B) determinations regarding requests for authorization for service shall be made in a timely manner, based on the urgency of the request.

“(j) QUALIFIED HEALTH PROVIDERS.—

“(1) IN GENERAL.—The eligible organization shall demonstrate to the Secretary that the organization has a sufficient number, distribution, and variety of qualified health care providers to ensure that all covered health care services will be available and accessible in a timely manner to all individuals enrolled in the organization.

“(2) SPECIALISTS.—The eligible organization shall demonstrate to the Secretary that organization enrollees have access, when medically or clinically indicated in the judgment of the treating health professional, to specialized treatment expertise.

“(3) DISTANCE.—In order to meet the requirements of paragraph (1), any eligible organization that restricts an enrollee's choice of doctor shall provide that primary care services for each enrollee who lives in a rural area (as defined in section 1886(d)(2)(D)) are not more than 30 miles or 30 minutes in travel time from the enrollee's residence. The Secretary may provide for exceptions from this paragraph on a case-by-case basis.

“(k) 50/50 RULE.—

“(1) IN GENERAL.—Each eligible organization with which the Secretary enters into a contract under this part shall have, for the duration of such contract, an enrolled membership at least one-half of which consists of individuals who are not entitled to benefits under this title or under a State plan approved under title XIX.

“(2) MODIFICATION OR WAIVER.—Subject to paragraph (3), the Secretary may modify or waive the requirement imposed by paragraph (1) only—

“(A) to the extent that more than 50 percent of the population of the area served by

the organization consists of individuals who are entitled to benefits under this title or under a State plan approved under title XIX.

“(B) in the case of an eligible organization that is owned and operated by a governmental entity, only with respect to a period of 3 years beginning on the date the organization first enters into a contract under this part, and only if the organization has taken and is making reasonable efforts to enroll individuals who are not entitled to benefits under this title or under a State plan approved under title XIX, or

“(C) the Secretary determines (in accordance with criteria developed by the Secretary not later than January 1, 1997) that individuals who are entitled to benefits under this title who are enrolled with the eligible organization with a contract under this part in the organization's payment area receive the same quality of service as enrollees in private sector health plans in the same payment area.

“(4) FAILURE TO COMPLY.—If the Secretary determines that an eligible organization has failed to comply with the requirements of this subsection, the Secretary may provide for the suspension of enrollment of individuals under this part or of payment to the organization under this part for individuals newly enrolled with the organization, after the date the Secretary notifies the organization of such noncompliance.

“CONTRACTS WITH ELIGIBLE ORGANIZATIONS

“SEC. 1856. (a) IN GENERAL.—The Secretary shall not permit the election under section 1805 of enrollment in an eligible organization under this part, and no payment shall be made under section 1857 to an organization, unless the Secretary has entered into a contract under this part with the organization. Such contract shall provide that the organization agrees to comply with the requirements of this part and the terms of conditions of payment as provided for in this part.

“(b) REQUIREMENTS RELATING TO RISK-SHARING CONTRACTS.—

“(1) MINIMUM ENROLLMENT.—The Secretary may enter a risk-sharing contract with any eligible organization which has at least 5,000 members, except that the Secretary may enter into such a contract with an eligible organization that has fewer members if the organization primarily serves members residing outside of urban areas.

“(2) PROVISION OF ADDITIONAL BENEFITS IF ADJUSTED COMMUNITY RATE LESS THAN PER CAPITA RATE OF PAYMENT.—

“(A) IN GENERAL.—Each risk-sharing contract shall provide that—

“(i) if the adjusted community rate, as defined in section 1851(a), for services under parts A and B and such preventive services designated by the Secretary under section 1853(a)(1) (as reduced for the actuarial value of the coinsurance and deductibles under those parts and such reduced cost-sharing designated by the Secretary under such section) for members enrolled under this part with the organization and entitled to benefits under part A and enrolled in part B, or

“(ii) if the adjusted community rate for services under part B and such preventive services (as reduced for the actuarial value of the coinsurance and deductibles under that part and such reduced cost-sharing) for members enrolled under this part with the organization and entitled to benefits under part B only,

is less than the average of the per capita rates of payment to be made under section 1857(a) at the beginning of an annual contract period for members enrolled under this part with the organization and entitled to benefits under part A and enrolled in part B, or enrolled in part B only, respectively, the eligible organization shall provide to mem-

bers enrolled under a risk-sharing contract under this part with the organization and entitled to benefits under part A and enrolled in part B, or enrolled in part B only, respectively, the additional benefits described in paragraph (3) which are selected by the eligible organization and which the Secretary finds are at least equal in value to the difference between that average per capita payment and the adjusted community rate (as so reduced).

“(B) EXCEPTIONS.—

“(i) RECEIPT OF LESSER PAYMENT.—Subparagraph (A) shall not apply with respect to any organization which elects to receive a lesser payment to the extent that there is no longer a difference between the average per capita payment and adjusted community rate (as so reduced).

“(ii) STABILIZATION FUND.—An organization (with the approval of the Secretary) may provide that a part of the value of such additional benefits be withheld and reserved by the Secretary as provided in paragraph (4).

“(C) CALCULATION OF PER CAPITA RATES OF PAYMENT.—If the Secretary finds that there is insufficient enrollment experience to determine an average of the per capita rates of payment to be made under section 1857(a) at the beginning of a contract period, the Secretary may determine such an average based on the enrollment experience of other contracts entered into under this part.

“(3) ADDITIONAL BENEFITS DESCRIBED.—The additional benefits referred to in paragraph (2) are—

“(A) the reduction of the premium rate or other charges made with respect to services furnished by the organization to members enrolled under this part, or

“(B) the provision of additional health benefits, or both.

“(4) STABILIZATION FUND.—An organization having a risk-sharing contract under this part may (with the approval of the Secretary) provide that a part of the value of additional benefits otherwise required to be provided by reason of paragraph (2) be withheld and reserved in the Federal Hospital Insurance Trust Fund and in the Federal Supplementary Medical Insurance Trust Fund (in such proportions as the Secretary determines to be appropriate) by the Secretary for subsequent annual contract periods, to the extent required to stabilize and prevent undue fluctuations in the additional benefits offered in those subsequent periods by the organization in accordance with paragraph (3). Any of such value of additional benefits which is not provided to members of the organization in accordance with paragraph (3) prior to the end of such period, shall revert for the use of such trust funds.

“(5) PROMPT PAYMENT.—

“(A) IN GENERAL.—A risk-sharing contract under this part shall require the eligible organization to provide prompt payment (consistent with the provisions of sections 1816(c)(2) and 1842(c)(2)) of claims submitted for services and supplies furnished to individuals pursuant to such contract, if the services or supplies are not furnished under a contract between the organization and the provider or supplier.

“(B) FAILURE TO MAKE PROMPT PAYMENT.—In the case of an eligible organization which the Secretary determines, after notice and opportunity for a hearing, has failed to make payments of amounts in compliance with subparagraph (A), the Secretary may provide for direct payment of the amounts owed to providers and suppliers for such covered services furnished to individuals enrolled under this part under the contract. If the Secretary provides for such direct payments,

the Secretary shall provide for an appropriate reduction in the amount of payments otherwise made to the organization under this part to reflect the amount of the Secretary's payments (and costs incurred by the Secretary in making such payments).

“(c) REASONABLE COST REIMBURSEMENT CONTRACT.—

“(1) IN GENERAL.—If—

“(A) the Secretary is not satisfied that an eligible organization has the capacity to bear the risk of potential losses under a risk-sharing contract under this part, or

“(B) the eligible organization so elects or has an insufficient number of members to be eligible to enter into a risk-sharing contract under subsection (b)(1),

the Secretary may, if the Secretary is otherwise satisfied that the eligible organization is able to perform its contractual obligations effectively and efficiently, enter into a contract with such organization pursuant to which such organization is reimbursed on the basis of its reasonable cost (as defined in section 1861(v)) in the manner prescribed in paragraph (3).

“(2) REIMBURSEMENT.—A reasonable cost reimbursement contract under this part may, at the option of such organization, provide that the Secretary—

“(A) will reimburse hospitals and skilled nursing facilities either for the reasonable cost (as determined under section 1861(v)) or for payment amounts determined in accordance with section 1886, as applicable, of services furnished to individuals enrolled with such organization pursuant to section 1852(a), and

“(B) will deduct the amount of such reimbursement from payment which would otherwise be made to such organization.

If such an eligible organization pays a hospital or skilled nursing facility directly, the amount paid shall not exceed the reasonable cost of the services (as determined under section 1861(v)) or the amount determined under section 1886, as applicable, unless such organization demonstrates to the satisfaction of the Secretary that such excess payments are justified on the basis of advantages gained by the organization.

“(3) RETROACTIVE ADJUSTMENT.—Payments made to an organization with a reasonable cost reimbursement contract shall be subject to appropriate retroactive corrective adjustment at the end of each contract year so as to assure that such organization is paid for the reasonable cost actually incurred (excluding any part of incurred cost found to be unnecessary in the efficient delivery of health services) or the amounts otherwise determined under section 1886 for the types of expenses otherwise reimbursable under this title for providing services covered under this title to individuals described in section 1853(a)(1).

“(4) FINANCIAL STATEMENT.—Any reasonable cost reimbursement contract with an eligible organization under this part shall provide that the Secretary shall require, at such time following the expiration of each accounting period of the eligible organization (and in such form and in such detail) as he may prescribe—

“(A) that the organization report to him in an independently certified financial statement its per capita incurred cost based on the types of components of expenses otherwise reimbursable under this title for providing services described in section 1853(a)(1), including therein, in accordance with accounting procedures prescribed by the Secretary, its methods of allocating costs between individuals enrolled under this part and other individuals enrolled with such organization;

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

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

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

“(d) CONTRACT PERIOD AND EFFECTIVENESS.—

“(1) PERIOD.—

“(A) IN GENERAL.—Each contract under this part shall be for a term of at least 1 year, as determined by the Secretary, and may be made automatically renewable from term to term in the absence of notice by either party of intention to terminate at the end of the current term.

“(B) TERMINATION OR IMMEDIATE SANCTIONS FOR CAUSE.—The Secretary, in accordance with procedures established under paragraph (9), may terminate any such contract at any time, or may impose the intermediate sanctions described in paragraph (6)(B) or (6)(C) (whichever is applicable), if the Secretary finds that the organization—

“(i) has failed substantially to carry out the contract,

“(ii) is carrying out the contract in a manner inconsistent with the efficient and effective administration of this part, or

“(iii) no longer substantially meets the applicable conditions of this part.

“(2) EFFECTIVE DATE OF CONTRACT.—The effective date of any contract executed pursuant to this part shall be specified in the contract.

“(3) PROTECTIONS AGAINST FRAUD AND BENEFICIARY PROTECTIONS.—Each contract under this part—

“(A) shall provide that the Secretary, or any person or organization designated by him—

“(i) shall have the right to inspect or otherwise evaluate—

“(I) the quality, appropriateness, and timeliness of services performed under the contract, and

“(II) the facilities of the organization when there is reasonable evidence of some need for such inspection, and

“(ii) shall have the right to audit and inspect any books and records of the eligible organization that pertain—

“(I) to the ability of the organization to bear the risk of potential financial losses, or

“(II) to services performed or determinations of amounts payable under the contract;

“(B) shall require the organization with a risk-sharing contract to provide (and pay for) written notice in advance of the contract's termination, as well as a description of alternatives for obtaining benefits under this title, to each individual enrolled under this part with the organization; and

“(C)(i) shall require the organization to comply with subsections (a) and (c) of section 1318 of the Public Health Service Act (relating to disclosure of certain financial information) and with the requirement of

section 1301(c)(8) of such Act (relating to liability arrangements to protect members);

“(ii) shall require the organization to provide and supply information (described in section 1866(b)(2)(C)(iii)) in the manner such information is required to be provided or supplied under that section;

“(iii) shall require the organization to notify the Secretary of loans and other special financial arrangements which are made between the organization and subcontractors, affiliates, and related parties; and

“(D) shall contain such other terms and conditions not inconsistent with this part (including requiring the organization to provide the Secretary with such information) as the Secretary may find necessary and appropriate.

“(4) PREVIOUS TERMINATIONS.—The Secretary may not enter into a risk-sharing contract with an eligible organization if a previous risk-sharing contract with that organization under this part was terminated at the request of the organization within the preceding 5-year period, except in circumstances which warrant special consideration, as determined by the Secretary.

“(5) NO CONTRACTING AUTHORITY.—The authority vested in the Secretary by this part may be performed without regard to such provisions of law or regulations relating to the making, performance, amendment, or modification of contracts of the United States as the Secretary may determine to be inconsistent with the furtherance of the purpose of this title.

“(6) INTERMEDIATE SANCTIONS.—

“(A) IN GENERAL.—If the Secretary determines that an eligible organization with a contract under this part—

“(i) fails substantially to provide medically necessary items and services that are required (under law or under the contract) to be provided to an individual covered under the contract, if the failure has adversely affected (or has substantial likelihood of adversely affecting) the individual;

“(ii) imposes premiums on individuals enrolled under this part in excess of the premiums permitted;

“(iii) acts to expel or to refuse to re-enroll an individual in violation of the provisions of this part;

“(iv) engages in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment (except as permitted by this part) by eligible individuals with the organization whose medical condition or history indicates a need for substantial future medical services;

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

“(I) to the Secretary under this part, or

“(II) to an individual or to any other entity under this part;

“(vi) fails to comply with the requirements of section 1856(b)(5); or

“(vii) in the case of a risk-sharing contract, employs or contracts with any individual or entity that is excluded from participation under this title under section 1128 or 1128A for the provision of health care, utilization review, medical social work, or administrative services or employs or contracts with any entity for the provision (directly or indirectly) through such an excluded individual or entity of such services; the Secretary may provide, in addition to any other remedies authorized by law, for any of the remedies described in subparagraph (B).

“(B) REMEDIES DESCRIBED.—The remedies described in this subparagraph are—

“(i) civil money penalties of not more than \$25,000 for each determination under subparagraph (A) or, with respect to a determination under clause (iv) or (v)(I) of such

subparagraph, of not more than \$100,000 for each such determination, plus, with respect to a determination under subparagraph (A)(ii), double the excess amount charged in violation of such subparagraph (and the excess amount charged shall be deducted from the penalty and returned to the individual concerned), and plus, with respect to a determination under subparagraph (A)(iv), \$15,000 for each individual not enrolled as a result of the practice involved,

“(ii) suspension of enrollment of individuals under this part after the date the Secretary notifies the organization of a determination under subparagraph (A) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur, or

“(iii) suspension of payment to the organization under this part for individuals enrolled after the date the Secretary notifies the organization of a determination under subparagraph (A) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur.

“(C) In the case of an eligible organization for which the Secretary makes a determination under paragraph (1)(B) the basis of which is not described in subparagraph (A), the Secretary may apply the following intermediate sanctions:

“(i) Civil money penalties of not more than \$25,000 for each determination under paragraph (1) if the deficiency that is the basis of the determination has directly adversely affected (or has the substantial likelihood of adversely affecting) an individual covered under the organization's contract.

“(ii) Civil money penalties of not more than \$10,000 for each week beginning after the initiation of procedures by the Secretary under paragraph (9) during which the deficiency that is the basis of a determination under paragraph (1) exists.

“(iii) Suspension of enrollment of individuals under this section after the date the Secretary notifies the organization of a determination under paragraph (1) and until the Secretary is satisfied that the deficiency that is the basis for the determination has been corrected and is not likely to recur.

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

“(7) UTILIZATION AND PEER REVIEW ORGANIZATION.—

“(A) IN GENERAL.—Each risk-sharing contract with an eligible organization under this part shall provide that the organization will maintain a written agreement with a utilization and quality control peer review organization (which has a contract with the Secretary under part B of title XI for the area in which the eligible organization is located) or with an entity selected by the Secretary under section 1154(a)(4)(C) under which the review organization will perform functions under section 1154(a)(4)(B) and section 1154(a)(14) (other than those performed under contracts described in section 1866(a)(1)(F)) with respect to services, furnished by the eligible organization, for which payment may be made under this title.

“(B) COST OF AGREEMENT.—For purposes of payment under this title, the cost of such agreement to the eligible organization shall be considered a cost incurred by a provider of services in providing covered services under this title and shall be paid directly by the Secretary to the review organization on behalf of such eligible organization in accordance with a schedule established by the Secretary.

“(C) SOURCE OF PAYMENTS.—Such payments—

“(i) shall be transferred in appropriate proportions from the Federal Hospital Insurance Trust Fund and from the Supplementary Medical Insurance Trust Fund, without regard to amounts appropriated in advance in appropriation Acts, in the same manner as transfers are made for payment for services provided directly to beneficiaries, and

“(ii) shall not be less in the aggregate for such organizations for a fiscal year than the amounts the Secretary determines to be sufficient to cover the costs of such organizations' conducting activities described in subparagraph (A) with respect to such eligible organizations under part B of title XI.

“(8) PHYSICIAN INCENTIVE PLAN.—

“(A) IN GENERAL.—Each contract with an eligible organization under this part shall provide that the organization may not operate any physician incentive plan (as defined in subparagraph (B)) unless the following requirements are met:

“(i) No specific payment is made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit medically necessary services provided with respect to a specific individual enrolled with the organization.

“(ii) If the plan places a physician or physician group at substantial financial risk (as determined by the Secretary) for services not provided by the physician or physician group, the organization—

“(I) provides stop-loss protection for the physician or group that is adequate and appropriate, based on standards developed by the Secretary that take into account the number of physicians placed at such substantial financial risk in the group or under the plan and the number of individuals enrolled with the organization who receive services from the physician or the physician group, and

“(II) conducts periodic surveys of both individuals enrolled and individuals previously enrolled with the organization to determine the degree of access of such individuals to services provided by the organization and satisfaction with the quality of such services.

“(iii) The organization provides the Secretary with descriptive information regarding the plan, sufficient to permit the Secretary to determine whether the plan is in compliance with the requirements of this subparagraph.

“(B) PHYSICIAN INCENTIVE PLAN DEFINED.—In this paragraph, the term ‘physician incentive plan’ means any compensation arrangement between an eligible organization and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services provided with respect to individuals enrolled with the organization.

“(9) The Secretary may terminate a contract with an eligible organization under this section or may impose the intermediate sanctions described in paragraph (6) on the organization in accordance with formal investigation and compliance procedures established by the Secretary under which—

“(A) the Secretary first provides the organization with the reasonable opportunity to develop and implement a corrective action plan to correct the deficiencies that were the basis of the Secretary's determination under paragraph (1) and the organization fails to develop or implement such a plan;

“(B) in deciding whether to impose sanctions, the Secretary considers aggravating factors such as whether an entity has a history of deficiencies or has not taken action to correct deficiencies the Secretary has brought to their attention;

“(C) there are no unreasonable or unnecessary delays between the finding of a deficiency and the imposition of sanctions; and

“(D) the Secretary provides the organization with reasonable notice and opportunity for hearing (including the right to appeal an initial decision) before imposing any sanction or terminating the contract.

(e) SERVICES NOT FURNISHED BY ORGANIZATION.—

“(1) PARTICIPATING PHYSICIAN.—In the case of physicians' services or renal dialysis services described in paragraph (2) which are furnished by a participating physician or provider of services or renal dialysis facility to an individual enrolled with an eligible organization under this part and enrolled under part B, the applicable participation agreement is deemed to provide that the physician or provider of services or renal dialysis facility will accept as payment in full from the eligible organization the amount that would be payable to the physician or provider of services or renal dialysis facility under part B and from the individual under such part, if the individual were not enrolled with an eligible organization under this part.

“(2) NONPARTICIPATING PHYSICIAN.—In the case of physicians' services described in paragraph (3) which are furnished by a nonparticipating physician, the limitations on actual charges for such services otherwise applicable under part B (to services furnished by individuals not enrolled with an eligible organization under this part) shall apply in the same manner as such limitations apply to services furnished to individuals not enrolled with such an organization.

“(3) SERVICES DESCRIBED.—The physicians' services or renal dialysis services described in this paragraph are physicians' services or renal dialysis services which are furnished to an enrollee of an eligible organization under this part by a physician, provider of services, or renal dialysis facility who is not under a contract with the organization.

“(4) EXCEPTION FOR EMERGENCY SERVICES.—In the case of emergency services described in section 1855(e)(2), which are furnished by a provider that does not have a contractual relationship with the organization, the organization shall be required to reimburse the provider for the reasonable costs of providing such services.

“PAYMENT TO ELIGIBLE ORGANIZATIONS

“SEC. 1857. (a) MONTHLY PAYMENTS IN ADVANCE TO ORGANIZATION WITH RISK-SHARING CONTRACTS.—

“(1) ANNOUNCEMENT.—The Secretary shall annually determine, and shall announce (in a manner intended to provide notice to interested parties) not later than September 7 before the calendar year concerned—

“(A) a per capita rate of payment for each class of individuals who are enrolled under this part with an eligible organization which has entered into a risk-sharing contract and who are entitled to benefits under part A and enrolled under part B, and

“(B) a per capita rate of payment for each class of individuals who are so enrolled with such an organization and who are enrolled under part B only.

(2) IN GENERAL.—

“(A) MONTHLY PAYMENT.—In the case of an eligible organization with a risk-sharing contract, the Secretary shall make monthly payments in advance and in accordance with the rate determined under subparagraph (B) and except as provided in section 1856(b)(2), to the organization for each individual enrolled with the organization under this part.

“(B) METHOD OF DETERMINING PAYMENT.—

“(i) 1997.—For 1997, the modified per capita rate of payment for each class defined under clause (ii) shall be equal to the annual per capita rate of payment for such class which

would have been determined under section 1876(a)(1)(C) for 1996 if—

“(I) the applicable geographic area were the payment area; and

“(II) 50 percent of any payments attributable to sections 1886(d)(5)(B), 1886(h), and 1886(d)(5)(F) (relating to IME, GME, and DSH payments) were not taken into account, increased by 7 percent (to reflect the projected per capita rate of growth in private health care expenditures)..

“(ii) SUCCEEDING YEARS.—

“(I) IN GENERAL.—For 1998 and each succeeding calendar year, the modified per capita rate of payment for each class defined under clause (iii) shall be equal to the modified per capita rate of payment determined for such area for the preceding year, increased by 7 percent (to reflect the projected per capita rate of growth in private health care expenditures).

“(II) PHASE-OUT OF SPECIAL PAYMENTS.—In applying this clause for 1998, the modified per capita rate of payment for each such class for 1997 shall be the amount that would have been determined for 1997 if clause (i)(II) had been applied by substituting ‘100 percent’ for ‘50 percent’.

“(iii) CLASSES.—The Secretary shall define appropriate classes of members, based on age, disability status, and such other factors as the Secretary determines to be appropriate, so as to ensure actuarial equivalence. The Secretary may add to, modify, or substitute for such classes, if such changes will improve the determination of actuarial equivalence and not later than January 1, 1997, the Secretary shall implement risk-adjusters that were not in effect under section 1876 (as in effect on December 31, 1996).

“(iv) ADJUSTMENTS.—The Secretary shall adjust modified per capita rates of payment for a payment area under this subparagraph such that—

“(I) the portion of such rate attributable to part B shall not result in a modified per capita rate of payment for an area that is less than 85 percent of portion of the weighted average of the modified per capita rates determined under clause (i) or (ii) attributable to part B services for all payment areas for 1996; and

“(II) such rate reflects the cost of providing the benefits described in section 1853(a)(1) to enrollees.

Such adjustments shall be made to ensure that total payments under this subsection to eligible organizations do not exceed the amount that would have been paid under this subsection in the absence of such adjustments.

“(3) PAYMENTS ONLY TO ELIGIBLE ORGANIZATIONS.—Subject to paragraph (6) and section 1853(a)(2), if an individual is enrolled under this part with an eligible organization having a risk-sharing contract, only the eligible organization shall be entitled to receive payments from the Secretary under this title for services furnished to the individual.

“(4) RETROACTIVE ADJUSTMENT.—

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

“(B) SPECIAL RULE FOR CERTAIN ENROLLEES.—

“(i) IN GENERAL.—Subject to clause (ii), the Secretary may make retroactive adjustments under subparagraph (A) to take into account individuals enrolled during the period beginning on the date on which the individual enrolls with an eligible organization (which has a risk-sharing contract under this part) under a health benefit plan operated,

sponsored, or contributed to by the individual's employer or former employer (or the employer or former employer of the individual's spouse) and ending on the date on which the individual is enrolled in the plan under this part, except that for purposes of making such retroactive adjustments under this clause, such period may not exceed 90 days.

“(ii) EXPLANATION.—No adjustment may be made under clause (i) with respect to any individual who does not certify that the organization provided the individual with the explanation described in section 1855(b) at the time the individual enrolled with the organization.

“(5) NOTICE OF PROPOSED CHANGES.—

“(A) IN GENERAL.—At least 45 days before making the announcement under paragraph (1) for a year the Secretary shall provide for notice to eligible organizations of proposed changes to be made in the methodology or benefit coverage assumptions from the methodology and assumptions used in the previous announcement and shall provide such organizations an opportunity to comment on such proposed changes.

“(B) EXPLANATION.—In each announcement made under paragraph (1) for a year, the Secretary shall include an explanation of the assumptions (including any benefit coverage assumptions) and changes in methodology used in the announcement in sufficient detail so that eligible organizations can compute per capita rates of payment for classes of individuals located in each payment area which is in whole or in part within the service area of such an organization.

“(6) INPATIENT OF HOSPITAL AT TIME OF ENROLLMENT.—A risk-sharing contract under this part shall provide that in the case of an individual who is receiving inpatient hospital services from a subsection (d) hospital (as defined in section 1886(d)(1)(B)) as of the effective date of the individual's—

“(A) enrollment with an eligible organization under this part—

“(i) payment for such services until the date of the individual's discharge shall be made under this title as if the individual were not enrolled with the organization,

“(ii) the organization shall not be financially responsible for payment for such services until the date after the date of the individual's discharge, and

“(iii) the organization shall nonetheless be paid the full amount otherwise payable to the organization under this part; or

“(B) termination of enrollment with an eligible organization under this part—

“(i) the organization shall be financially responsible for payment for such services after such date and until the date of the individual's discharge,

“(ii) payment for such services during the stay shall not be made under section 1886(d), and

“(iii) the organization shall not receive any payment with respect to the individual under this part during the period the individual is not enrolled.

“(b) REASONABLE COST CONTRACT.—With respect to any eligible organization which has entered into a reasonable cost reimbursement contract, payments shall be made to such plan in accordance with section 1856(c) rather than subsection (a).

“(c) PAYMENT FROM TRUST FUNDS.—The payment to an eligible organization under this part for individuals enrolled under this part with the organization and entitled to benefits under part A and enrolled under part B shall be made from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund. The portion of that payment to the organization for a month to be paid by each trust fund shall be determined as follows:

“(1) In regard to expenditures by eligible organizations having risk-sharing contracts, the allocation shall be determined each year by the Secretary based on the relative weight that benefits from each fund contribute to the adjusted average per capita cost.

“(2) In regard to expenditures by eligible organizations operating under a reasonable cost reimbursement contract, the initial allocation shall be based on the plan's most recent budget, such allocation to be adjusted, as needed, after cost settlement to reflect the distribution of actual expenditures.

The remainder of that payment shall be paid by the former trust fund.

“(d) TESTING THE USE OF COMPETITIVE PRICING PRIOR TO IMPLEMENTATION.—

“(1) IN GENERAL.—Not later than January 1, 1997, the Secretary shall implement alternative payment methodologies for determining the monthly rate that will be paid to eligible organizations with risk-sharing contracts in payment areas designated by the Secretary in accordance with paragraph (2). Such alternative payment methodologies shall be based on competitive price and include a method that determines rates based on the commercial, competitively determined rates of the organizations.

“(2) CRITERIA FOR SELECTION.—The Secretary shall develop criteria for designating payment areas, determining the minimum number of bidders necessary to effectively implement and test alternative payment methodologies, and utilizing any additional health status adjusters that may be necessary to implement such methodologies. The criteria for designating payment areas shall provide that the Secretary designate relatively high and low market penetration areas, and urban and rural areas.

“(3) BIDS.—Each eligible organization desiring to enter into a risk-sharing contract under this part shall place a bid on the benefits covered under section 1853(a)(1)(A) under a methodology implemented under this paragraph. The premium structure included in the bid shall consist of enrollee cost-sharing amounts and the monthly amount to be paid from the Federal Hospital Insurance Trust Fund and Federal Supplementary Medical Insurance Trust Fund under this section. Each organization shall be required to adhere to the premium structure included in the organization's bid. An organization may offer additional benefits at a separately determined price. An organization shall not be prevented from entering into a contract under this section solely based on the level of the organization's premium bid.

“(4) REQUIRED PARTICIPATION.—

“(A) IN GENERAL.—Subject to subparagraph (B), each eligible organization that desires to enter into a risk-sharing contract under this part in a payment area designated under this subsection shall receive payment under this part in accordance with this subsection, instead of subsection (a).

“(B) EXCEPTION.—The Secretary may, at the Secretary's discretion, permit an eligible organization to receive payment under this title (without regard to this part).

“(5) PROHIBITION OF REASONABLE COST CONTRACTS.—The Secretary may prohibit the use of reasonable cost contracts in payment areas designated under this subsection.

“(6) AGGREGATE PAYMENTS.—Aggregate payments under this subsection across payment areas under this subsection shall not exceed the amount that would have, in the absence of this subsection, been paid under subsection (a) to such organization for individuals enrolled under this part. Payments to eligible organizations with risk-sharing

contracts in a single payment area may exceed the amount described in the preceding sentence but may not exceed 100 percent of the adjusted average per capita cost (as defined in subsection (a)(1)(B)(ii)) that would have, in the absence of this subsection, been determined for all individuals enrolled under this part.

“(7) TRANSITION RULES.—The Secretary shall develop transition rules for payment areas in which risk-sharing plan enrollees pay minimal or no premiums in order to prevent substantial increases in premiums as a result of an alternative payment methodology implemented under this subsection.

“(8) REPORT.—Not later than January 1, 2000, the Secretary shall report to Congress on specific recommendations for a new payment methodology under this part to be based on the results of the alternate methodologies implemented under this subsection.

“(e) PARTIAL CAPITATION DEMONSTRATION.—The Secretary shall conduct a demonstration project on the alternative partial risk-sharing arrangements between the Secretary and health care providers. Not later than December 31, 1998, the Secretary shall report to the Congress on the administrative feasibility of such partial capitation methods and the information necessary to implement such methods.

“PROVIDER-SPONSORED NETWORKS

“SEC. 1858. (a) PROVIDER-SPONSORED NETWORK DEFINED.—

“(1) IN GENERAL.—In this part, the term ‘provider-sponsored network’ means a public or private entity is a provider, or group of affiliated providers, that provides a substantial proportion (as defined by the Secretary) of the health care items and services under the contract under this part directly through the provider or affiliated group of providers.

“(2) SUBSTANTIAL PROPORTION.—In defining what is a ‘substantial proportion’ for purposes of paragraph (1), the Secretary—

“(A) shall take into account the need for such an organization to assume responsibility for a substantial proportion of services in order to assure financial stability and the practical difficulties in such an organization integrating a very wide range of service providers; and

“(B) may vary such proportion based upon relevant differences among organizations, such as their location in an urban or rural area.

“(3) AFFILIATION.—For purposes of this subsection, a provider is ‘affiliated’ with another provider if, through contract, ownership, or otherwise—

“(A) one provider, directly or indirectly, controls, is controlled by, or is under common control with the other,

“(B) each provider is a participant in a lawful combination under which each provider shares, directly or indirectly, substantial financial risk in connection with their operations,

“(C) both providers are part of a controlled group of corporations under section 1563 of the Internal Revenue Code of 1986, or

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

“(4) CONTROL.—for purposes of paragraph (3), control is presumed to exist if one party, directly or indirectly, owns, controls, or holds the power to vote, or proxies for, not less than 51 percent of the voting rights or governance rights of another.

“(b) CERTIFICATION PROCESS FOR PROVIDER-SPONSORED NETWORKS.—

“(1) FEDERAL ACTION ON CERTIFICATION.—If—

“(A) a State fails to complete action on a licensing application of an eligible organization that is a provider sponsored network

within 90 days of receipt of the completed application, or

“(B) a State denies a licensing application and the Secretary determines that the State’s licensing standards or review process create an unreasonable barrier to market entry,

the Secretary shall evaluate such application pursuant to the procedures established under paragraph (2).

“(2) FEDERAL CERTIFICATION PROCEDURES.—

“(A) IN GENERAL.—The Secretary shall establish a process for certification of an eligible organization that is a provider sponsored network) and its sponsor as meeting the requirements of this part in cases described in paragraph (1).

“(B) REQUIREMENTS.—Such process shall—

“(i) set forth the standards for certification,

“(ii) provide that final action will be taken on an application for certification within 120 business days of receipt of the completed application,

“(iii) provide that State law and regulations shall apply to the extent they have not been found to be an unreasonable barrier to market entry under paragraph (1)(A)(ii), and

“(iv) require any person receiving a certificate to provide the Secretary with all reasonable information in order to ensure compliance with the certification.

Not later than 5 business days after receipt of an application under this subsection, the Secretary shall notify the applicant as to whether the application includes all information necessary to process the application. It is received by the Secretary.

“(C) EFFECT OF CERTIFICATIONS.—

“(i) IN GENERAL.—A certificate under this subsection shall be issued for not more than 36 months and may not be renewed, unless the Secretary determines that the State’s laws and regulations provide an unreasonable barrier to market entry.

“(ii) COORDINATION WITH STATE.—A person receiving a certificate under this section shall continue to seek State licensure under paragraph (1) during the period the certificate is in effect.

“(D) STATE STANDARDS.—During the first 24 months after the issuance of the Federal rules relating to the Federal certification process established under this paragraph, a State may apply to the Secretary to demonstrate that the State’s licensure standards and process are consistent with Federal standards, incorporate appropriate flexibility to reflect the delivery system of provider-sponsored networks, and do not present an unreasonable barrier to market entry. If the Secretary approves the State licensure standards and process under this subparagraph, a provider sponsored network in such a State shall be required to obtain State licenses (as well as meet all other applicable Federal standards).

“(3) REPORT.—Not later than December 31, 1999, the Secretary shall report to Congress on the Federal certification system under paragraph (2), including an analysis of State efforts to adopt licensing standards and review processes that take into account the fact that provider-sponsored networks provide services directly to enrollees through affiliated providers.”

(b) CONFORMING AMENDMENTS.—

(1) TERMINATION OF SECTION 1876.—Section 1876 (42 U.S.C. 1395mm) is repealed.

(2) GME ADJUSTMENT.—Section 1886(h) (42 U.S.C. 1395ww(h)) is amended by inserting “, including all days attributable to patients enrolled in an eligible organization with a risk-sharing contract under part C” after “part A”.

SEC. 7004. PROVISIONS RELATING TO MEDICARE SUPPLEMENTAL POLICIES.

Section 1882(s) (42 U.S.C. 1395ss(s)) is amended—

(1) in paragraph (3), by striking “paragraphs (1) and (2)” and inserting “paragraph (1), (2), or (3)”.

(2) by redesignating paragraph (3) as paragraph (4), and

(3) by inserting after paragraph (2) the following new paragraph:

“(3) Each issuer of a medicare supplemental policy shall have an open enrollment period (which shall be the period specified for each geographic area by the Secretary under section 1852(b)(1)), of at least 30 days duration every year, during which the issuer may not deny or condition the issuance or effectiveness of a medicare supplemental policy, or discriminate in the pricing of the policy because of age, health status, claims experience, past or anticipated receipt of health care, or presence of a medical condition. The policy may not exclude benefits relating to the existence of any preexisting condition. The Secretary may require enrollment and disenrollment through a third party designated under section 1876(c)(3)(B). Each issuer of a medicare supplemental policy shall have an additional open enrollment period which shall be the period specified in section 1852(b)(4).”

SEC. 7005. SPECIAL RULE FOR CALCULATION OF PAYMENT RATES FOR 1996.

(a) IN GENERAL.—

(1) IN GENERAL.—Notwithstanding any other provision of law, the per capita rate under section 1876 of the Social Security Act (42 U.S.C. 1395ww) for 1996 for any class for a geographic area shall be equal to the amount determined for such class for such area in 1995, increased by 7 percent (to reflect the projected per capita rate of growth in private health care expenditures).

(2) FLOOR.—The Secretary shall adjust a per capita rate of payment for a geographic area determined under this subsection for a class such that the portion of such rate attributable to part B shall not be less than 85 percent of the weighted average of the portion of the per capita rates attributable to part B services for such class determined under this subsection for all geographic areas. Such adjustments shall be made to ensure that total payments under this subsection to eligible organizations do not exceed the amount that would have been paid under this subsection in the absence of such adjustments.

(b) PUBLICATION.—The Secretary shall publish the rates determined under subsection (a) no later than 30 days after the date of the enactment of this Act.

(c) REPORT.—Not later than July 1, 1996, the Prospective Payment Assessment Commission and the Physician Payment Review Commission shall jointly report to Congress on geographically-based variations in payments to eligible organizations with a risk-sharing contract under section 1876 of the Social Security Act (42 U.S.C. 1395mm).

(d) EFFECTIVE DATE.—This section shall apply on and after the date of the enactment of this Act.

SEC. 7006. GRADUATE MEDICAL EDUCATION AND DISPROPORTIONATE SHARE PAYMENT ADJUSTMENTS TO HOSPITALS PROVIDING SERVICES TO ENROLLEES IN ELIGIBLE ORGANIZATIONS.

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

“(j) GRADUATE MEDICAL EDUCATION AND DISPROPORTIONATE SHARE PAYMENT ADJUSTMENTS FOR MEDICARE CHOICE.—

“(1) IN GENERAL.—For discharges occurring on or after January 1, 1997, a subsection (d)

hospital that is a qualified provider shall receive payment for each discharge of an individual enrolled under part C with an eligible organization as follows:

“(A) For a qualified provider that qualifies for the indirect medical education adjustment under subsection (d)(5)(B), payment shall be made on a per discharge basis for each individual enrolled in an eligible organization with a risk-sharing contract who receives inpatient care at that provider as though such provider was receiving the applicable percentage of the amount such provider would receive as direct payment under this title on the basis of a diagnosis related group.

“(B) For a qualified provider that qualifies for the disproportionate share adjustment under subsection (d)(5)(F), payment shall be made on a per discharge basis for each individual enrolled in an eligible organization with a risk-sharing contract who receives inpatient care at that provider as though such provider was receiving the applicable percentage of the amount such provider would receive as direct payment under this title on the basis of a diagnosis related group.

“(C) For a qualified provider that qualifies for payment for direct graduate medical education under subsection (h), payment shall be made by counting as medicare inpatient days the applicable percentage of those days attributable to individuals enrolled in an eligible organization with a risk-sharing contract when determining the provider's medicare patient load.

“(2) QUALIFIED PROVIDER.—For purposes of paragraph (1), the term ‘qualified provider’ means a provider that—

“(A) qualifies for any or all payments under subsection (d)(5)(B), (d)(5)(F) or (h); and

“(B) provides inpatient services either as an eligible organization or under a contract with an eligible organization, to individuals enrolled with an eligible organization under part C.

“(3) APPLICABLE PERCENTAGE.—For purposes of paragraph (1), the applicable percentage is—

“(A) for calendar year 1997, 50 percent; and

“(B) for calendar years after 1997, 100 percent.”

SEC. 7007. EFFECTIVE DATE.

Except as otherwise specifically provided, the amendments made by this title shall apply with respect to services furnished under a contract on or after January 1, 1997.

CHAPTER 2—PROVISIONS RELATING TO QUALITY IMPROVEMENT AND DISTRIBUTION OF INFORMATION

SEC. 7011. QUALITY REPORT CARDS.

Title XVIII (42 U.S.C. 1395 et seq.), as amended by section 7002, is amended by inserting after section 1805 the following new section:

“QUALITY REPORT CARDS

“SEC. 1806. (a) DISTRIBUTION OF QUALITY REPORT CARDS.—Beginning with calendar year 1997, the Secretary shall include a quality report card with the comparative materials distributed under section 1852(c)(2). The quality report card shall contain information designed to assist medicare beneficiaries in choosing eligible organizations including, as appropriate, the performance measures developed under subsection (b).

“(b) DEVELOPMENT OF PERFORMANCE MEASURES.—

“(1) DELEGATION.—

“(A) IN GENERAL.—The Secretary, through the Administrator of the Health Care Financing Administration, shall, in cooperation with nonprofit organizations—

“(i) develop standardized performance measures for eligible organizations and providers which are designed to achieve the purposes described in subparagraph (B); and

“(ii) examine the feasibility of using risk adjusters to validate the performance measures developed.

“(B) PURPOSES DESCRIBED.—The purposes described in this subparagraph are as follows:

“(i) To develop a quality report card for medicare beneficiaries that will assist such beneficiaries' decisionmaking regarding health care and treatment by allowing the beneficiaries to compare quality information.

“(ii) To establish performance measures that will assist eligible organizations and providers in providing high quality health care.

“(iii) To provide information to eligible organizations and providers regarding such organizations' and providers' performance and health care processes.

“(C) PERFORMANCE MEASURES DESCRIBED.—The performance measures developed under subparagraph (A) may include the following:

“(i) The number of members of an eligible organization who disenroll from the organization, and to the extent possible, the reasons for such disenrollment.

“(ii) Outcomes of care.

“(iii) Population health status.

“(iv) Appropriateness of care.

“(v) Consumer satisfaction for general and subgroup populations.

“(vi) Access to care, including access to emergency care, waiting time for scheduled appointments, and provider location convenience.

“(vii) Prevention of diseases, disorders, disabilities, injuries, and other health conditions.

“(D) ONGOING BASIS.—Development of performance measures and risk adjusters shall be done on an ongoing basis.

“(2) COLLECTION OF DATA.—

“(A) VALIDITY PREREQUISITE.—The performance measures developed under this subsection shall not be disseminated to eligible organizations and providers before the validity of such performance measures is established.

“(B) COLLECTION SCHEDULE.—Beginning 6 months after the first dissemination of the performance measures to eligible organizations, data regarding specific performance measures shall be collected from the eligible organizations on a regular rotating basis that coincides with data collection requirements for private sector health care systems.

“(C) COMPLIANCE.—Each eligible organization shall disclose performance measure data as requested. The Administrator of the Health Care Financing Administration or an entity designated by the Secretary shall audit eligible organizations for compliance with the data collection requirements and shall enforce any noncompliance in accordance with regulations promulgated by the Secretary.

“(c) DEFINITIONS.—For purposes of this section—

“(1) the term ‘eligible organization’ means an organization with a contract under part C;

“(2) the term ‘medicare beneficiary’ means an individual entitled to benefits under part A or enrolled under part B; and

“(3) the term ‘provider’ means hospitals, physicians, nursing homes, and providers of ancillary services to medicare beneficiaries.”

CHAPTER 3—PROVISIONS TO STRENGTHEN RURAL AND UNDER-SERVED AREAS

SEC. 7021. RURAL REFERRAL CENTERS.

(a) PERMANENT GRANDFATHERING OF RURAL REFERRAL CENTER STATUS.—Section 1886(d)(5)(C) (42 U.S.C. 1395ww(d)(5)(C)) is amended by adding at the end the following new clause:

“(iii) Notwithstanding any other provision of law, any hospital that was classified as a rural referral center under clause (i) on September 30, 1991, shall continue to be classified or, as applicable, shall be reclassified, as a rural referral center and such classification or reclassification shall be effective on and after October 1, 1991, with respect to payments under this title.”

(b) GRADUATED AREA WAGE INDEX FOR RURAL REFERRAL CENTERS.—Section 1886(d)(10)(D) (42 U.S.C. 1395ww(d)(10)(D)) is amended by adding at the end the following new clauses:

“(iv) Notwithstanding section 412.230(e)(iii) of title 42, Code of Federal Regulations (relating to criteria for use of an area's wage index)—

“(I) in the case of an eligible hospital that pays an average hourly wage that is equal to or greater than 104 percent and less than 108 percent of the average hourly wage of the hospitals in the area in which the hospital is located, the wage index of such hospital shall be equal to the sum of—

“(aa) the wage index of the area in which the hospital is located; and

“(bb) 66 percent of the difference between the higher wage index area which the hospital would receive if it was reclassified (if the hospital's average hourly wage was 108 percent or more of the average hourly wage of hospitals in the area in which the hospital is located in accordance with the provisions of section 1886(d)(8)(C)) and the amount determined under item (aa); and

“(II) in the case of an eligible hospital that pays an average hourly wage that is equal to or greater than 100 percent and less than 104 percent of the average hourly wage of the hospitals in the area in which the hospital is located, the wage index of such hospital shall be determined under subclause (I) as if the reference to ‘66 percent’ in such subclause were a reference to ‘33 percent’.

“(v) For purposes of clause (iv), the term ‘eligible hospital’ means a hospital that is classified as a rural referral center under paragraph (5)(C)(i) that would be reclassified to a higher area wage index if the hospital's average hourly wage was 108 percent or more of the average hourly wage in the area in which the hospital is located and meets all other applicable Federal standards.”

(c) BUDGET NEUTRALITY.—Notwithstanding any other provision of law, for cost reporting periods beginning on or after October 1, 1995, the Secretary of Health and Human Services shall provide for such equal proportional adjustment in payments under section 1886 of the Social Security Act (42 U.S.C. 1395ww) to subsection (d) hospitals and subsection (d) Puerto Rico hospitals (as defined under such section) as may be necessary to assure that the aggregate payments to such hospitals under such section are not increased or decreased by reason of the amendments made by subsections (a) and (b).

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to cost reporting periods beginning on or after October 1, 1995.

SEC. 7022. MEDICARE-DEPENDENT, SMALL, RURAL HOSPITAL PAYMENT EXTENSION.

(a) SPECIAL TREATMENT EXTENDED.—

(1) PAYMENT METHODOLOGY.—Section 1886(d)(5)(G)(i) (42 U.S.C. 1395ww(d)(5)(G)(i)) is amended—

(A) in clause (i), by striking “October 1, 1994,” and inserting “October 1, 1994, or beginning on or after September 1, 1995, and before October 1, 2000,”; and

(B) in clause (ii)(II), by striking “October 1, 1994” and inserting “October 1, 1994, or beginning on or after September 1, 1995, and before October 1, 2000.”

(2) EXTENSION OF TARGET AMOUNT.—Section 1886(b)(3)(D) (42 U.S.C. 1395ww(b)(3)(D)) is amended—

(A) in the matter preceding clause (i), by striking "September 30, 1994," and inserting "September 30, 1994, and for cost reporting periods beginning on or after September 1, 1995, and before October 1, 2000,";

(B) in clause (ii), by striking "and" at the end;

(C) in clause (iii), by striking the period at the end and inserting ", and"; and

(D) by adding at the end the following new clause:

"(iv) with respect to discharges occurring during September 1995 through fiscal year 1999, the target amount for the preceding year increased by the applicable percentage increase under subparagraph (B)(iv)."

(3) PERMITTING HOSPITALS TO DECLINE RECLASSIFICATION.—Section 13501(e)(2) of OBRA-93 (42 U.S.C. 1395ww note) is amended by striking "or fiscal year 1994" and inserting ", fiscal year 1994, fiscal year 1995, fiscal year 1996, fiscal year 1997, fiscal year 1998, or fiscal year 1999".

(4) TECHNICAL CORRECTION.—Section 1886(d)(5)(G)(i) (42 U.S.C. 1395ww(d)(5)(G)(i)), as in effect before the amendment made by paragraph (1), is amended by striking all that follows the first period.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply with respect to discharges occurring on or after September 1, 1995.

SEC. 7023. PROPAC RECOMMENDATIONS ON URBAN MEDICARE DEPENDENT HOSPITALS.

Section 1886(e)(3)(A) (42 U.S.C. 1395ww(e)(3)(A)) is amended by adding at the end the following new sentence: "The Commission shall, beginning in 1996, report its recommendations to Congress on an appropriate update to be used for urban hospitals with a high proportion of medicare patient days and on actions to ensure that medicare beneficiaries served by such hospitals retain the same access and quality of care as medicare beneficiaries nationwide."

SEC. 7024. PAYMENTS TO PHYSICIAN ASSISTANTS AND NURSE PRACTITIONERS FOR SERVICES FURNISHED IN OUTPATIENT OR HOME SETTINGS.

(a) COVERAGE IN OUTPATIENT OR HOME SETTINGS FOR PHYSICIAN ASSISTANTS AND NURSE PRACTITIONERS.—Section 1861(s)(2)(K) (42 U.S.C. 1395x(s)(2)(K)) is amended—

(1) in clause (i)—

(A) by striking "or" at the end of subclause (II); and

(B) by inserting "or (IV) in an outpatient or home setting as defined by the Secretary" following "shortage area,"; and

(2) in clause (ii)—

(A) by striking "in a skilled" and inserting "in (I) a skilled"; and

(B) by inserting ", or (II) in an outpatient or home setting (as defined by the Secretary)," after "(as defined in section 1919(a))."

(b) PAYMENTS TO PHYSICIAN ASSISTANTS AND NURSE PRACTITIONERS IN OUTPATIENT OR HOME SETTINGS.—

(1) IN GENERAL.—Section 1833(r)(1) (42 U.S.C. 1395l(r)(1)) is amended—

(A) by inserting "services described in section 1861(s)(2)(K)(ii)(II) (relating to nurse practitioner services furnished in outpatient or home settings), and services described in section 1861(s)(2)(K)(i)(IV) (relating to physician assistant services furnished in an outpatient or home setting" after "rural area,"; and

(B) by striking "or clinical nurse specialist" and inserting "clinical nurse specialist, or physician assistant".

(2) CONFORMING AMENDMENT.—Section 1842(b)(6)(C) (42 U.S.C. 1395u(b)(6)(C)) is amended by striking "clauses (i), (ii), or

(iv)" and inserting "subclauses (I), (II), or (III) of clause (i), clause (ii)(I), or clause (iv)".

(c) PAYMENT UNDER THE FEE SCHEDULE TO PHYSICIAN ASSISTANTS AND NURSE PRACTITIONERS IN OUTPATIENT OR HOME SETTINGS.—

(1) PHYSICIAN ASSISTANTS.—Section 1842(b)(12) (42 U.S.C. 1395u(b)(12)) is amended by adding at the end the following new subparagraph:

"(C) With respect to services described in clauses (i)(IV), (ii)(II), and (iv) of section 1861(s)(2)(K) (relating to physician assistants and nurse practitioners furnishing services in outpatient or home settings)—

"(i) payment under this part may only be made on an assignment-related basis; and

"(ii) the amounts paid under this part shall be equal to 80 percent of (I) the lesser of the actual charge or 85 percent of the fee schedule amount provided under section 1848 for the same service provided by a physician who is not a specialist; or (II) in the case of services as an assistant at surgery, the lesser of the actual charge or 85 percent of the amount that would otherwise be recognized if performed by a physician who is serving as an assistant at surgery."

(2) CONFORMING AMENDMENT.—Section 1842(b)(12)(A) (42 U.S.C. 1395u(b)(12)(A)) is amended in the matter preceding clause (i) by striking "(i), (ii)," and inserting "subclauses (I), (II), or (III) of clause (i), or subclause (I) of clause (ii)".

(3) TECHNICAL AMENDMENT.—Section 1842(b)(12)(A) (42 U.S.C. 1395u(b)(12)(A)) is amended in the matter preceding clause (i) by striking "a physician assistants" and inserting "physician assistants".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after October 1, 1995.

SEC. 7025. IMPROVING HEALTH CARE ACCESS AND REDUCING HEALTH CARE COSTS THROUGH TELEMEDICINE.

(a) IN GENERAL.—Title XVII of the Public Health Service Act (42 U.S.C. 300u et seq.) is amended—

(1) in the title heading by striking out "AND HEALTH PROMOTION" and inserting "HEALTH PROMOTION AND TELEMEDICINE DEVELOPMENT";

(2) by inserting after the title heading the following:

"PART A—HEALTH INFORMATION AND HEALTH PROMOTION";

and
(3) by adding at the end thereof the following new part:

"PART B—TELEMEDICINE DEVELOPMENT

"SEC. 1711. GRANT PROGRAM FOR PROMOTING THE DEVELOPMENT OF RURAL TELEMEDICINE NETWORKS.

"(a) ESTABLISHMENT.—The Secretary shall establish a program to award grants to eligible entities in accordance with this subsection to promote the development of rural telemedicine networks.

"(b) GRANTS FOR DEVELOPMENT OF RURAL TELEMEDICINE.—The Secretary of Health and Human Services, acting through the Office of Rural Health Policy, shall award grants to eligible entities that have applications approved under subsection (d) for the purpose of expanding access to health care services for individuals in rural areas through the use of telemedicine. Grants shall be awarded under this section to—

"(1) encourage the initial development of rural telemedicine networks;

"(2) expand existing networks;

"(3) link existing networks together; or

"(4) link such networks to existing fiber optic telecommunications systems.

"(c) ELIGIBLE ENTITY DEFINED.—For the purposes of this section the term 'eligible entity' means hospitals and other health care providers operating in a health care network

of community-based providers that includes at least three of the following—

"(1) community or migrant health centers;

"(2) local health departments;

"(3) community mental health centers;

"(4) nonprofit hospitals;

"(5) private practice health professionals, including rural health clinics; or

"(6) other publicly funded health or social services agencies.

"(d) APPLICATION.—To be eligible to receive a grant under this section an eligible entity shall prepare and submit to the Secretary an application at such time, in such manner and containing such information as the Secretary may require, including a description of—

"(1) the need of the entity for the grant;

"(2) the use to which the entity would apply any amounts received under such grant;

"(3) the source and amount of non-Federal funds that the entity will pledge for the project funded under the grant;

"(4) the long-term viability of the project and evidence of the providers' commitment to the network.

"(e) PREFERENCE IN AWARDING GRANTS.—In awarding grants under this section, the Secretary shall give preference to applicants that—

"(1) are health care providers operating in rural health care networks or that propose to form such networks with the majority of the providers in such networks being located in a medically underserved area or health professional shortage area;

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

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

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

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

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

"(f) USE OF AMOUNTS.—Amounts received under a grant awarded under this section shall be utilized for the development of telemedicine networks. Such amounts may be used to cover the costs associated with the development of telemedicine networks and the acquisition of telemedicine equipment and modifications or improvements of telecommunications facilities, including—

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

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

"(3) the development and acquisition of instructional programming;

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

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

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

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

“(g) PROHIBITED USE OF AMOUNTS.—Amounts received under a grant awarded under this section shall not be used for—

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

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

“(h) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this section.

“(i) DEFINITION.—For the purposes of this section, the term ‘rural health care network’ means a group of rural hospitals or other rural health care providers (including clinics, physicians and non-physicians primary care providers) that have entered into a relationship with each other or with nonrural hospitals and health care providers for the purpose of strengthening the delivery of health care services in rural areas or specifically to improve their patients’ access to telemedicine services. At least 75 percent of hospitals and other health care providers participating in the network shall be located in rural areas.

“(j) REGULATIONS ON REIMBURSEMENT OF TELEMEDICINE.—Not later than July 1, 1996, the Secretary, in consultation with the Office of Rural Health and the Health Care Financing Administration, shall develop and submit to Congress a recommendation on a methodology for determining payments under title XVIII of the Social Security Act for telemedicine services.”

SEC. 7026. ESTABLISHMENT OF RURAL HEALTH OUTREACH GRANT PROGRAM.

Title III of the Public Health Service Act (42 U.S.C. 241 et seq.) is amended by adding at the end thereof the following new part:

“PART O—RURAL HEALTH OUTREACH GRANTS

“SEC. 3990. RURAL HEALTH OUTREACH GRANT PROGRAM.

“(a) IN GENERAL.—The Secretary may make grants to demonstrate the effectiveness of outreach to populations in rural areas that do not normally seek or do not have access to health or mental health services. Grants shall be awarded to enhance linkages, integration, and cooperation in order to provide health or mental health services, to enhance services, or increase access to or utilization of health or mental health services.

“(b) MISSION OF THE OUTREACH PROJECTS.—Projects funded under subsection (a) should be designed to facilitate the integration and coordination of services in or among rural communities in order to address the needs of populations living in rural or frontier communities.

“(c) COMPOSITION OF PROGRAM.—

“(1) CONSORTIUM ARRANGEMENT.—To be eligible to participate in the grant program established under subsection (a), an applicant entity shall be a consortium of three or more separate and distinct entities formed to carry out an outreach project under subsection (b).

“(2) CERTAIN REQUIREMENTS.—A consortium under paragraph (1) shall be composed of three or more public or private nonprofit health care or social service providers. Consortium members may include local health departments, community or migrant health

centers, community mental health centers, hospitals or private practices, or other publicly funded health or social service agencies.

“(d) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated \$30,000,000 for fiscal year 1996, and such sums as may be necessary for each of the fiscal years 1997 through 2000.”

SEC. 7027. MEDICARE RURAL HOSPITAL FLEXIBILITY PROGRAM.

(a) MEDICARE RURAL HOSPITAL FLEXIBILITY PROGRAM.—Section 1820 (42 U.S.C. 1395i-4) is amended to read as follows:

“MEDICARE RURAL HOSPITAL FLEXIBILITY PROGRAM

“SEC. 1820. (a) PURPOSE.—The purpose of this section is to—

“(1) ensure access to health care services for rural communities by allowing hospitals to be designated as critical access hospitals if such hospitals limit the scope of available inpatient acute care services;

“(2) provide more appropriate and flexible staffing and licensure standards;

“(3) enhance the financial security of critical access hospitals by requiring that Medicare reimburse such facilities on a reasonable cost basis; and

“(4) promote linkages between critical access hospitals designated by the State under this section and broader programs supporting the development of and transition to integrated provider networks.

“(b) ESTABLISHMENT.—Any State that submits an application in accordance with subsection (c) may establish a Medicare rural hospital flexibility program described in subsection (d).

“(c) APPLICATION.—A State may establish a Medicare rural hospital flexibility program described in subsection (d) if the State submits to the Secretary at such time and in such form as the Secretary may require an application containing—

“(1) assurances that the State—

“(A) has developed, or is in the process of developing, a State rural health care plan that—

“(i) provides for the creation of one or more rural health networks (as defined in subsection (e)) in the State,

“(ii) promotes regionalization of rural health services in the State, and

“(iii) improves access to hospital and other health services for rural residents of the State;

“(B) has developed the rural health care plan described in subparagraph (A) in consultation with the hospital association of the State, rural hospitals located in the State, and the State Office of Rural Health (or, in the case of a State in the process of developing such plan, that assures the Secretary that the State will consult with its State hospital association, rural hospitals located in the State, and the State Office of Rural Health in developing such plan);

“(2) assurances that the State has designated (consistent with the rural health care plan described in paragraph (1)(A)), or is in the process of so designating, rural nonprofit or public hospitals or facilities located in the State as critical access hospitals; and

“(3) such other information and assurances as the Secretary may require.

“(d) MEDICARE RURAL HOSPITAL FLEXIBILITY PROGRAM DESCRIBED.—

“(1) IN GENERAL.—A State that has submitted an application in accordance with subsection (c), may establish a Medicare rural hospital flexibility program that provides that—

“(A) the State shall develop at least one rural health network (as defined in subsection (e)) in the State; and

“(B) at least one facility in the State shall be designated as a critical access hospital in accordance with paragraph (2).

“(2) STATE DESIGNATION OF FACILITIES.—

“(A) IN GENERAL.—A State may designate one or more facilities as a critical access hospital in accordance with subparagraph (B).

“(B) CRITERIA FOR DESIGNATION AS CRITICAL ACCESS HOSPITAL.—A State may designate a facility as a critical access hospital if the facility—

“(i) is located in a county (or equivalent unit of local government) in a rural area (as defined in section 1886(d)(2)(D)) that—

“(I) is located more than a 35-mile drive from a hospital, or another facility described in this subsection, or

“(II) is certified by the State as being a necessary provider of health care services to residents in the area; and

“(ii) makes available 24-hour emergency care services that a State determines are necessary for ensuring access to emergency care services in each area served by a critical access hospital;

“(iii) provides not more than 15 acute care inpatient beds (meeting such standards as the Secretary may establish) for providing inpatient care for a period not to exceed 96 hours (unless a longer period is required because transfer to a hospital is precluded because of inclement weather or other emergency conditions), except that a peer review organization or equivalent entity may, on request, waive the 96-hour restriction on a case-by-case basis;

“(iv) meets such staffing requirements as would apply under section 1861(e) to a hospital located in a rural area, except that—

“(I) the facility need not meet hospital standards relating to the number of hours during a day, or days during a week, in which the facility must be open and fully staffed, except insofar as the facility is required to make available emergency care services as determined under clause (ii) and must have nursing services available on a 24-hour basis, but need not otherwise staff the facility except when an inpatient is present,

“(II) the facility may provide any services otherwise required to be provided by a full-time, on site dietitian, pharmacist, laboratory technician, medical technologist, and radiological technologist on a part-time, off site basis under arrangements as defined in section 1861(w)(1), and

“(III) the inpatient care described in clause (iii) may be provided by a physician’s assistant, nurse practitioner, or clinical nurse specialist subject to the oversight of a physician who need not be present in the facility; and

“(v) meets the requirements of subparagraph (1) of paragraph (2) of section 1861(aa).

“(3) DEEMED TO HAVE ESTABLISHED A PROGRAM.—A State that received a grant under this section on or before December 31, 1995, and the State of Montana shall be deemed to have established a program under this subsection.

“(e) RURAL HEALTH NETWORK DEFINED.—

“(1) IN GENERAL.—For purposes of this section, the term ‘rural health network’ means, with respect to a State, an organization consisting of—

“(A) at least 1 facility that the State has designated or plans to designate as a critical access hospital, and

“(B) at least 1 hospital that furnishes acute care services.

“(2) AGREEMENTS.—

“(A) IN GENERAL.—Each critical access hospital that is a member of a rural health network shall have an agreement with respect to each item described in subparagraph (B) with at least 1 hospital that is a member of the network.

“(B) ITEMS DESCRIBED.—The items described in this subparagraph are the following:

- “(i) Patient referral and transfer.
- “(ii) The development and use of communications systems including (where feasible)—
 - “(I) telemetry systems, and
 - “(II) systems for electronic sharing of patient data.
- “(iii) The provision of emergency and non-emergency transportation among the facility and the hospital.

“(C) CREDENTIALING AND QUALITY ASSURANCE.—Each critical access hospital that is a member of a rural health network shall have an agreement with respect to credentialing and quality assurance with at least 1—

- “(i) hospital that is a member of the network;
- “(ii) peer review organization or equivalent entity; or
- “(iii) other appropriate and qualified entity identified in the State rural health care plan.

“(f) CERTIFICATION BY THE SECRETARY.—The Secretary shall certify a facility as a critical access hospital if the facility—

- “(1) is located in a State that has established a medicare rural hospital flexibility program in accordance with subsection (d);
- “(2) is designated as a critical access hospital by the State in which it is located; and
- “(3) meets such other criteria as the Secretary may require.

“(g) PERMITTING MAINTENANCE OF SWING BEDS.—Nothing in this section shall be construed to prohibit a critical access hospital from entering into an agreement with the Secretary under section 1883 to use the beds designated for inpatient cases pursuant to subsection (d)(2)(A)(iii) for extended care services.

“(h) GRANTS.—

“(1) MEDICARE RURAL HOSPITAL FLEXIBILITY PROGRAM.—The Secretary may award grants to States that have submitted applications in accordance with subsection (c) for—

- “(A) engaging in activities relating to planning and implementing a rural health care plan;
- “(B) engaging in activities relating to planning and implementing rural health networks; and
- “(C) designating facilities as critical access hospitals.

“(2) RURAL EMERGENCY MEDICAL SERVICES.—

“(A) IN GENERAL.—The Secretary may award grants to States that have submitted applications in accordance with subparagraph (B) for the establishment or expansion of a program for the provision of rural emergency medical services.

“(B) APPLICATION.—An application is in accordance with this subparagraph if the State submits to the Secretary at such time and in such form as the Secretary may require an application containing the assurances described in subparagraphs (A)(ii), (A)(iii), and (B) of subsection (c)(1) and paragraph (3) of such subsection.

“(i) GRANDFATHERING OF CERTAIN FACILITIES.—

“(1) IN GENERAL.—Any medical assistance facility operating in Montana and any rural primary care hospital designated by the Secretary under this section prior to the date of the enactment of the Rural Health Improvement Act of 1995 shall be deemed to have been certified by the Secretary under subsection (f) as a critical access hospital if such facility or hospital is otherwise eligible to be designated by the State as a critical access hospital under subsection (d).

“(2) CONTINUATION OF MEDICAL ASSISTANCE FACILITY AND RURAL PRIMARY CARE HOSPITAL TERMS.—Notwithstanding any other provi-

sion of this title, with respect to any medical assistance facility or rural primary care hospital described in paragraph (1), any reference in this title to a ‘critical access hospital’ shall be deemed to be a reference to a ‘medical assistance facility’ or ‘rural primary care hospital’.

“(j) WAIVER OF CONFLICTING PART A PROVISIONS.—The Secretary is authorized to waive such provisions of this part and part C as are necessary to conduct the program established under this section.

“(k) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated from the Federal Hospital Insurance Trust Fund for making grants to all States under subsection (h), \$25,000,000 in each of the fiscal years 1996 through 2000.”

(b) REPORT ON ALTERNATIVE TO 96-HOUR RULE.—Not later than January 1, 1996, the Administrator of the Health Care Financing Administration shall submit to the Congress a report on the feasibility of, and administrative requirements necessary to establish an alternative for certain medical diagnoses (as determined by the Administrator) to the 96-hour limitation for inpatient care in critical access hospitals required by section 1820(d)(2)(B)(iii).

(c) PART A AMENDMENTS RELATING TO RURAL PRIMARY CARE HOSPITALS AND CRITICAL ACCESS HOSPITALS.—

(1) DEFINITIONS.—Section 1861(mm) (42 U.S.C. 1395x(mm)) is amended to read as follows:

“CRITICAL ACCESS HOSPITAL; CRITICAL ACCESS HOSPITAL SERVICES

“(mm)(1) The term ‘critical access hospital’ means a facility certified by the Secretary as a critical access hospital under section 1820(f).

“(2) The term ‘inpatient critical access hospital services’ means items and services, furnished to an inpatient of a critical access hospital by such facility, that would be inpatient hospital services if furnished to an inpatient of a hospital by a hospital.”

(2) COVERAGE AND PAYMENT.—(A) Section 1812(a)(1) (42 U.S.C. 1395d(a)(1)) is amended by striking “or inpatient rural primary care hospital services” and inserting “or inpatient critical access hospital services”.

(B) Section 1814 (42 U.S.C. 1395f) is amended—

- (i) on subsection (a)(8)—
- (I) by striking “rural primary care hospital” each place it appears and inserting “critical access hospital”; and
- (II) by striking “72” and inserting “96”;

- (ii) in subsection (b), by striking “other than a rural primary care hospital providing inpatient rural primary care hospital services,” and inserting “other than a critical access hospital providing inpatient critical access hospital services,”; and
- (iii) by amending subsection (l) to read as follows:

“(1) PAYMENT FOR INPATIENT CRITICAL ACCESS HOSPITAL SERVICES.—The amount of payment under this part for inpatient critical access hospital services is the reasonable costs of the critical access hospital in providing such services.”

(3) TREATMENT OF CRITICAL ACCESS HOSPITALS AS PROVIDERS OF SERVICES.—(A) Section 1861(u) (42 U.S.C. 1395x(u)) is amended by striking “rural primary care hospital” and inserting “critical access hospital”.

(B) The first sentence of section 1864(a) (42 U.S.C. 1395aa(a)) is amended by striking “a rural primary care hospital” and inserting “a critical access hospital”.

(4) CONFORMING AMENDMENTS.—(A) Section 1128A(b)(1) (42 U.S.C. 1320a-7a(b)(1)) is amended by striking “rural primary care hospital” each place it appears and inserting “critical access hospital”.

(B) Section 1128B(c) (42 U.S.C. 1320a-7b(c)) is amended by striking “rural primary care hospital” and inserting “critical access hospital”.

(C) Section 1134 (42 U.S.C. 1320b-4) is amended by striking “rural primary care hospitals” each place it appears and inserting “critical access hospitals”.

(D) Section 1138(a)(1) (42 U.S.C. 1320b-8(a)(1)) is amended—

- (i) in the matter preceding subparagraph (A), by striking “rural primary care hospital” and inserting “critical access hospital”; and

- (ii) in the matter preceding clause (i) of subparagraph (A), by striking “rural primary care hospital” and inserting “critical access hospital”.

(E) Section 1816(c)(2)(C) (42 U.S.C. 1395h(c)(2)(C)) is amended by striking “rural primary care hospital” and inserting “critical access hospital”.

(F) Section 1833 (42 U.S.C. 1395l) is amended—

- (i) in subsection (h)(5)(A)(iii), by striking “rural primary care hospital” and inserting “critical access hospital”;

- (ii) in subsection (i)(1)(A), by striking “rural primary care hospital” and inserting “critical access hospital”;

- (iii) in subsection (i)(3)(A), by striking “rural primary care hospital services” and inserting “critical access hospital services”;

- (iv) in subsection (l)(5)(A), by striking “rural primary care hospital” each place it appears and inserting “critical access hospital”;

- (v) in subsection (l)(5)(B), by striking “rural primary care hospital” each place it appears and inserting “critical access hospital”.

(G) Section 1835(c) (42 U.S.C. 1395n(c)) is amended by striking “rural primary care hospital” each place it appears and inserting “critical access hospital”.

(H) Section 1842(b)(6)(A)(ii) (42 U.S.C. 1395u(b)(6)(A)(ii)) is amended by striking “rural primary care hospital” and inserting “critical access hospital”.

(I) Section 1861 (42 U.S.C. 1395x) is amended—

- (i) in the last sentence of subsection (e), by striking “rural primary care hospital” and inserting “critical access hospital”;

- (ii) in subsection (v)(1)(S)(ii)(III), by striking “rural primary care hospital” and inserting “critical access hospital”;

- (iii) in subsection (w)(1), by striking “rural primary care hospital” and inserting “critical access hospital”; and

- (iv) in subsection (w)(2), by striking “rural primary care hospital” each place it appears and inserting “critical access hospital”.

(J) Section 1862(a)(14) (42 U.S.C. 1395y(a)(14)) is amended by striking “rural primary care hospital” each place it appears and inserting “critical access hospital”.

(K) Section 1866(a)(1) (42 U.S.C. 1395cc(a)(1)) is amended—

- (i) in subparagraph (F)(ii), by striking “rural primary care hospitals” and inserting “critical access hospitals”;

- (ii) in subparagraph (H), in the matter preceding clause (i), by striking “rural primary care hospitals” and “rural primary care hospital services” and inserting “critical access hospitals” and “critical access hospital services”, respectively;

- (iii) in subparagraph (I), in the matter preceding clause (i), by striking “rural primary care hospital” and inserting “critical access hospital”; and

- (iv) in subparagraph (N)—

- (i) in the matter preceding clause (i), by striking “rural primary hospitals” and inserting “critical access hospitals”, and

(II) in clause (i), by striking "rural primary care hospital" and inserting "critical access hospital".

(L) Section 1866(a)(3) (42 U.S.C. 1395cc(a)(3)) is amended—

(i) by striking "rural primary care hospital" each place it appears in subparagraphs (A) and (B) and inserting "critical access hospital"; and

(ii) in subparagraph (C)(ii)(II), by striking "rural primary care hospitals" each place it appears and inserting "critical access hospitals".

(M) Section 1867(e)(5) (42 U.S.C. 1395dd(e)(5)) is amended by striking "rural primary care hospital" and inserting "critical access hospital".

(d) PAYMENT CONTINUED TO DESIGNATED EACHS.—Section 1886(d)(5)(D) (42 U.S.C. 1395ww(d)(5)(D)) is amended—

(1) in clause (iii)(III), by inserting "as in effect or designated by the State on January 1, 1996" before the period at the end; and

(2) in clause (v)—

(A) by inserting "as in effect or designated by the State on January 1, 1996" after "1820(i)(1)"; and

(B) by striking "1820(g)" and inserting "1820(e)".

(e) PART B AMENDMENTS RELATING TO CRITICAL ACCESS HOSPITALS.—

(1) COVERAGE.—(A) Section 1861(mm) (42 U.S.C. 1395x(mm)) as amended by subsection (d)(1), is amended by adding at the end the following new paragraph:

"(3) The term 'outpatient critical access hospital services' means medical and other health services furnished by a critical access hospital on an outpatient basis."

(B) Section 1832(a)(2)(H) (42 U.S.C. 1395k(a)(2)(H)) is amended by striking "rural primary care hospital services" and inserting "critical access hospital services".

(2) PAYMENT.—(A) Section 1833(a) (42 U.S.C. 1395l(a)) is amended in paragraph (6), by striking "outpatient rural primary care hospital services" and inserting "outpatient critical access services".

(B) Section 1834(g) (42 U.S.C. 1395m(g)) is amended to read as follows:

"(g) PAYMENT FOR OUTPATIENT CRITICAL ACCESS HOSPITAL SERVICES.—

"(1) IN GENERAL.—The amount of payment for outpatient critical access hospital services provided in a critical access hospital under this part shall be determined by one of the 2 following methods, as elected by the critical access hospital:

"(A) REASONABLE COST.—The amount of payment under this part for outpatient critical access hospital services is the reasonable costs of the critical access hospital in providing such services.

"(B) ALL-INCLUSIVE RATE.—With respect to both facility services and professional medical services, there shall be paid amounts equal to the costs which are reasonable and related to the cost of furnishing such services or which are based on such other tests of reasonableness as the Secretary may prescribe in regulations, less the amount the hospital may charge as described in clause (i) of section 1866(a)(2)(A), but in no case may the payment for such services (other than for items and services described in section 1861(s)(10)(A)) exceed 80 percent of such costs. The amount of payment shall be determined under either method without regard to the amount of the customary or other charge."

(f) SWING BEDS.—Section 1883 (42 U.S.C. 1395tt) is amended by adding at the end the following new subsection:

"(g) Nothing in this section shall prohibit the Secretary from entering into an agreement with a critical access hospital."

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

SEC. 7028. PARITY FOR RURAL HOSPITALS FOR DISPROPORTIONATE SHARE PAYMENTS.

(a) DISPROPORTIONATE SHARE ADJUSTMENT PERCENTAGE.—Section 1886(d)(5)(F)(iv) (42 U.S.C. 1395ww(d)(5)(F)(iv)) is amended—

(1) in subclause (I), by inserting "or rural" after "urban";

(2) in subclause (II), by inserting "or rural" after "urban";

(3) by striking subclause (III) and redesignating subclauses (IV), (V), and (VI), as subclauses (III), (IV), and (V), respectively;

(4) in subclause (III), as redesignated, by striking "10 percent" and inserting "15 percent";

(5) in subclause (IV), as redesignated, to read as follows:

"(IV) is located in a rural area, is classified as a rural referral center under subparagraph (C), is not classified as a sole community hospital under subparagraph (D) and—

"(aa) has 100 or more beds, is equal to the percent determined in accordance with the applicable formula described in clause (vii), or

"(bb) has less than 100 beds, is equal to 5 percent; or"; and

(6) in subclause (V), as redesignated, by striking "10 percent" and inserting "15 percent".

(b) SERVES A SIGNIFICANTLY DISPROPORTIONATE NUMBER OF LOW-INCOME PATIENTS.—Section 1886(d)(5)(F)(v) (42 U.S.C. 1395ww(d)(5)(F)(v)) is amended by striking subclauses (II) through (IV) and inserting the following subclauses:

"(II) 20 percent, if the hospital is located in a rural area and has 100 or more beds,

"(III) 40 percent, if the hospital is located in a rural area and has less than 100 beds,

"(IV) 20 percent, if the hospital is located in a rural area and is classified as a sole community hospital under subparagraph (D),

"(V) 15 percent, if the hospital is located in a rural area, is classified as a rural referral center, is not classified as a sole community hospital under subparagraph (D), and has 100 or more beds, or

"(VI) 40 percent, if the hospital is located in a rural area, is classified as a rural referral center, is not classified as a sole community hospital under subparagraph (D), and has less than 100 beds."

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to discharges occurring on or after October 1, 1995.

CHAPTER 4—GENERAL PROGRAM IMPROVEMENTS AND REFORM

SEC. 7031. INCREASED FLEXIBILITY IN CONTRACTING FOR MEDICARE CLAIMS PROCESSING.

(a) CARRIERS TO INCLUDE ENTITIES THAT ARE NOT INSURANCE COMPANIES.—

(1) Section 1842(a) (42 U.S.C. 1395u(a)) is amended in the matter preceding paragraph (1) by striking "with carriers" and inserting "with agencies and organizations (hereafter in this section referred to as 'carriers')".

(2) Section 1842(f) (42 U.S.C. 1395u(f)) is repealed.

(b) CHOICE OF FISCAL INTERMEDIARIES BY PROVIDERS OF SERVICES; SECRETARIAL FLEXIBILITY IN ASSIGNING FUNCTIONS TO INTERMEDIARIES AND CARRIERS.—

(1) Section 1816(a) (42 U.S.C. 1395h(a)) to read as follows:

"(a)(1) The Secretary may enter into contracts with agencies or organizations to perform any or all of the following functions, or parts of those functions (or, to the extent provided in a contract, to secure performance thereof by other organizations):

"(A) Determination (subject to the provisions of section 1878 and to such review by the Secretary as may be provided for by the contracts) the amount of the payments required pursuant to this part to be made to providers of services.

"(B) Making payments described in subparagraph (A).

"(C) Provision of consultative services to institutions or agencies to enable them to establish and maintain fiscal records necessary for purposes of this part and otherwise to qualify as providers of services.

"(D) Serving as a center for, and communicate to individuals entitled to benefits under this part and to providers of services, any information or instructions furnished to the agency or organization by the Secretary, and serve as a channel of communication from individuals entitled to benefits under this part and from providers of services to the Secretary.

"(E) Making such audits of the records of providers of services as may be necessary to ensure that proper payments are made under this part.

"(F) Performance of the functions described under subsection (d).

"(G) Performance of such other functions as are necessary to carry out the purposes of this part.

"(2) As used in this title and title XI, the term 'fiscal intermediary' means an agency or organization with a contract under this section."

(2) Subsections (d) and (e) of section 1816 (42 U.S.C. 1395h) are amended to read as follows:

"(d) Each provider of services shall have a fiscal intermediary that—

"(1) acts as a single point of contact for the provider of services under this part,

"(2) makes its services sufficiently available to meet the needs of the provider of services, and

"(3) is responsible and accountable for arranging the resolution of issues raised under this part by the provider of services.

"(e)(1)(A) The Secretary shall, at least every 5 years, permit each provider of services (other than a home health agency or a hospice program) to choose an agency or organization (from at least 3 proposed by the Secretary, of which at least 1 shall have an office in the geographic area of the provider of services, except as provided by subparagraph (B)(ii)(II)) as the fiscal intermediary under subsection (d) for that provider of services. If a contract with that fiscal intermediary is discontinued, the Secretary shall permit the provider of services to choose under the same conditions from 3 other agencies or organizations.

"(B)(i) The Secretary, in carrying out subparagraph (A), shall permit a group of hospitals (or a group of another class of providers other than home health agencies or hospice programs) under common ownership by, or control of, a particular entity to choose one agency or organization (from at least 3 proposed by the Secretary) as the fiscal intermediary under subsection (d) for all the providers in that group if the conditions specified in clause (ii) are met.

"(ii) The conditions specified in this clause are that—

"(I) the group includes all the providers of services of that class that are under common ownership by, or control of, that particular entity, and

"(II) all the providers of services in that group agree that none of the agencies or organizations proposed by the Secretary is required to have an office in any particular geographic area.

"(2) The Secretary, in evaluating the performance of a fiscal intermediary, shall solicit comments from providers of services."

(3)(A) Section 1816(b)(1)(A) (42 U.S.C. 1395h(b)(1)(A)) is amended by striking "after applying the standards, criteria, and procedures" and inserting "after evaluating the

ability of the agency or organization to fulfill the contract performance requirements”.

(B) The first sentence of section 1816(f)(1) (42 U.S.C. 1395h(f)(1)) is amended—

(i) by striking “develop standards, criteria, and procedures” and inserting “, after public notice and opportunity for comment, develop contract performance requirements”, and

(ii) by striking “, and the Secretary shall establish standards and criteria with respect to the efficient and effective administration of this part”.

(C) The second sentence of section 1842(b)(2)(A) (42 U.S.C. 1395u(b)(2)(A)) is amended to read as follows: “The Secretary shall, after public notice and opportunity for comment, develop contract performance requirements for the efficient and effective performance of contract obligations under this section.”

(D) Section 1842(b)(2)(A) (42 U.S.C. 1395u(b)(2)(A)) is amended by striking the third sentence.

(E) Section 1842(b)(2)(B) (42 U.S.C. 1395u(b)(2)(B)) is amended in the matter preceding clause (i) by striking “establish standards” and inserting “develop contract performance requirements”.

(F) Section 1842(b)(2)(D) (42 U.S.C. 1395u(b)(2)(D)) is amended by striking “standards and criteria” each place it appears and inserting “contract performance requirements”.

(4)(A) Section 1816(b) (42 U.S.C. 1395h(b)) is amended in the matter preceding paragraph (1) by striking “an agreement” and inserting “a contract”.

(B) Paragraphs (1)(B) and (2)(A) of section 1816(b) (42 U.S.C. 1395h(b)) are each amended by striking “agreement” and inserting “contract”.

(C) The first sentence of section 1816(c)(1) (42 U.S.C. 1395h(c)(1)) is amended by striking “An agreement” and inserting “A contract”.

(D) The last sentence of section 1816(c)(1) (42 U.S.C. 1395h(c)(1)) is amended by striking “an agreement” and inserting “a contract”.

(E) Section 1816(c)(2)(A) (42 U.S.C. 1395h(c)(2)(A)) is amended in the matter preceding clause (i) by striking “agreement” and inserting “contract”.

(F) Section 1816(c)(3)(A) (42 U.S.C. 1395h(c)(3)(A)) is amended by striking “agreement” and inserting “contract”.

(G) The first sentence of section 1816(f)(1) (42 U.S.C. 1395h(f)(1)) is amended by striking “an agreement” and inserting “a contract”.

(H) Section 1816(h) (42 U.S.C. 1395h(h)) is amended—

(i) by striking “An agreement” and inserting “A contract”, and

(ii) by striking “the agreement” each place it appears and inserting “the contract”.

(I) Section 1816(i)(1) (42 U.S.C. 1395h(i)(1)) is amended by striking “an agreement” and inserting “a contract”.

(J) Section 1816(j) (42 U.S.C. 1395h(j)) is amended by striking “An agreement” and inserting “A contract”.

(K) Section 1816(k) (42 U.S.C. 1395h(k)) is amended by striking “An agreement” and inserting “A contract”.

(L) Section 1842(a) (42 U.S.C. 1395u(a)) is amended in the matter preceding paragraph (1) is amended by striking “agreements” and inserting “contracts”.

(M) Section 1842(h)(3)(A) (42 U.S.C. 1395u(h)(3)(A)) is amended by striking “an agreement” and inserting “a contract”.

(5) Section 1816(f)(1) (42 U.S.C. 1395h(f)(1)) is amended by striking the second sentence.

(6)(A) Section 1816(c)(2)(A) (42 U.S.C. 1395h(c)(2)(A)) is amended in the matter preceding clause (i) by inserting “that provides for making payments under this part” after “this section”.

(B) Section 1816(c)(3)(A) (42 U.S.C. 1395h(c)(3)(A)) is amended by inserting “that

provides for making payments under this part” after “this section”.

(C) Section 1816(k) (42 U.S.C. 1395h(k)) is amended by inserting “(as appropriate)” after “submit”.

(D) Section 1842(a) (42 U.S.C. 1395u(a)) is amended in the matter preceding paragraph (1) by striking “some or all of the following functions” and inserting “any or all of the following functions, or parts of those functions”.

(E) The first sentence of section 1842(b)(2)(C) (42 U.S.C. 1395u(b)(2)(C)) is amended by inserting “(as appropriate)” after “carriers”.

(F) Section 1842(b)(3) (42 U.S.C. 1395u(b)(3)) is amended in the matter preceding subparagraph (A) by inserting “(as appropriate)” after “contract”.

(G) Section 1842(b)(7)(A) (42 U.S.C. 1395u(b)(7)(A)) is amended in the matter preceding clause (i) by striking “the carrier” and inserting “a carrier”.

(H) Section 1842(b)(11)(A) (42 U.S.C. 1395u(b)(11)(A)) is amended in the matter preceding clause (i) by inserting “(as appropriate)” after “each carrier”.

(I) Section 1842(h)(2) (42 U.S.C. 1395u(h)(2)) is amended in the first sentence by inserting “(as appropriate)” after “shall”.

(J) Section 1842(h)(5)(A) (42 U.S.C. 1395u(h)(5)(A)) is amended by inserting “(as appropriate)” after “carriers”.

(7)(A) Section 1816(c)(2)(C) (42 U.S.C. 1395h(c)(2)(C)) is amended by striking “hospital, rural primary care hospital, skilled nursing facility, home health agency, hospice program, comprehensive outpatient rehabilitation facility, or rehabilitation agency” and inserting “provider of services”.

(B) Section 1816(j) (42 U.S.C. 1395h(j)) is amended in the matter preceding paragraph (1) by striking “for home health services, extended care services, or post-hospital extended care services”.

(8) Section 1842(a)(3) (42 U.S.C. 1395u(a)(3)) is amended by inserting “(to and from individuals enrolled under this part and to and from physicians and other entities that furnish items and services)” after “communication”.

(c) ELIMINATION OF SPECIAL PROVISIONS FOR TERMINATIONS OF CONTRACTS.—

(1) Section 1816(b) (42 U.S.C. 1395h(b)) is amended in the matter preceding paragraph (1) is amended by striking “or renew”.

(2) The last sentence of section 1816(c)(1) (42 U.S.C. 1395h(c)(1)) is amended by striking “or renewing”.

(3) Section 1816(f)(1) (42 U.S.C. 1395h(f)(1)) is amended—

(A) by striking “, renew, or terminate”, and

(B) by striking “, whether the Secretary should assign or reassign a provider of services to an agency or organization.”.

(4) Section 1816(g) (42 U.S.C. 1395h(g)) is repealed.

(5) The last sentence of section 1842(b)(2)(A) (42 U.S.C. 1395u(b)(2)(A)) is amended by striking “or renewing”.

(6) Section 1842(b) (42 U.S.C. 1395u(b)) is amended by striking paragraph (5).

(d) REPEAL OF FISCAL INTERMEDIARY REQUIREMENTS THAT ARE NOT COST-EFFECTIVE.—Section 1816(f)(2) (42 U.S.C. 1395h(f)(2)) is amended to read as follows:

“(2) The contract performance requirements developed under paragraph (1) shall include, with respect to claims for services furnished under this part by any provider of services other than a hospital, whether such agency or organization is able to process 75 percent of reconsiderations within 60 days and 90 percent of reconsiderations within 90 days.”.

(e) REPEAL OF COST REIMBURSEMENT REQUIREMENTS.—

(1) The first sentence of section 1816(c)(1) (42 U.S.C. 1395h(c)(1)) is amended—

(A) by striking the comma after “appropriate” and inserting “and”, and

(B) by striking “subsection (a)” and all that follows through the period and inserting “subsection (a).”.

(2) Section 1816(c)(1) (42 U.S.C. 1395h(c)(1)) is further amended by striking the second and third sentences.

(3) The first sentence of section 1842(c)(1) (42 U.S.C. 1395u(c)(1)) is amended—

(A) by striking “shall provide” the first place it appears and inserting “may provide”, and

(B) by striking “this part” and all that follows through the period and inserting “this part.”.

(4) Section 1842(c)(1) (42 U.S.C. 1395u(c)(1)) is further amended by striking the second and third sentences.

(5) Section 2326(a) of the Deficit Reduction Act of 1984 is repealed.

(f) COMPETITION REQUIRED FOR NEW CONTRACTS AND IN CASES OF POOR PERFORMANCE.—

(1) Section 1816(c) (42 U.S.C. 1395h(c)) is amended by adding at the end the following new paragraph:

“(4)(A) A contract with a fiscal intermediary under this section may be renewed from term to term without regard to any provision of law requiring competition if the fiscal intermediary has met or exceeded the performance requirements established in the current contract.

“(B) Functions may be transferred among fiscal intermediaries without regard to any provision of law requiring competition.”.

(2) Section 1842(b)(1) (42 U.S.C. 1395u(b)(1)) is amended to read as follows:

“(b)(1)(A) A contract with a carrier under subsection (a) may be renewed from term to term without regard to any provision of law requiring competition if the carrier has met or exceeded the performance requirements established in the current contract.

“(B) Functions may be transferred among carriers without regard to any provision of law requiring competition.”.

(g) WAIVER OF COMPETITIVE REQUIREMENTS FOR INITIAL CONTRACTS.—

(1) Contracts that have periods that begin during the 1-year period that begins on the first day of the fourth calendar month that begins after the date of enactment of this Act may be entered into under section 1816(a) of the Social Security Act (42 U.S.C. 1395h(a)) without regard to any provision of law requiring competition.

(2) The amendments made by subsection (f) apply to contracts that have periods beginning after the end of the 1-year period specified in paragraph (1).

(h) EFFECTIVE DATES.—

(1) The amendments made by subsection (c) apply to contracts that have periods ending on, or after, the end of the third calendar month that begins after the date of enactment of this Act.

(2) The amendments made by subsections (a), (b), (d), and (e) apply to contracts that have periods beginning after the third calendar month that begins after the date of enactment of this Act.

SEC. 7032. EXPANSION OF CENTERS OF EXCELLENCE.

(a) IN GENERAL.—The Secretary of Health and Human Services (hereafter referred to as the “Secretary”) shall use a competitive process to contract with centers of excellence for cataract surgery and coronary artery bypass surgery, and any other appropriate services designated by the Secretary. Payment under title XVIII of the Social Security Act will be made for services subject to such contracts on the basis of negotiated or all-inclusive rates as follows:

(1) The center shall cover services provided in an urban area (as defined in section 1886(d)(2)(D) of the Social Security Act) for years beginning with fiscal year 1996.

(2) The amount of payment made by the Secretary to the center under title XVIII of the Social Security Act for services covered under the contract shall be less than the aggregate amount of the payments that the Secretary would have made to the center for such services had the contract not been in effect.

(3) The Secretary shall make payments to the center on such a basis for the following services furnished to individuals entitled to benefits under such title:

(A) Facility, professional, and related services relating to cataract surgery.

(B) Coronary artery bypass surgery and related services.

(b) REBATE OF PORTION OF SAVINGS.—In the case of any services provided under a contract conducted under subsection (a), the Secretary shall make a payment to each individual to whom such services are furnished (at such time and in such manner as the Secretary may provide) in an amount equal to 10 percent of the amount by which—

(1) the amount of payment that would have been made by the Secretary under title XVIII of the Social Security Act to the center for such services if the services had not been provided under the contract, exceeds

(2) the amount of payment made by the Secretary under such title to the center for such services.

(c) INFORMATION.—The Secretary shall include in the annual notice mailed under section 1804 of the Social Security Act (42 U.S.C. 1395b-2) information regarding the availability of centers of excellence under this section and notification that an individual may be directed to local centers of excellence by calling the toll-free number established under subsection (b) of such section.

SEC. 7033. SELECTIVE CONTRACTING.

(a) IN GENERAL.—The Secretary of Health and Human Services (hereafter referred to as the "Secretary") may selectively contract with specialized programs that manage chronic diseases, complex acute care needs, and the needs of disabled medicare beneficiaries. Payment under title XVIII of the Social Security Act will be made for services subject to such contracts subject to such contracts on the basis of negotiated rates. The Secretary shall ensure that such contracts do not limit access to services in rural and undesirable areas.

(b) BASIS OF CONTRACTS.—The Secretary shall enter into contracts under subsection (a) on the basis of objective measures of quality, service, and cost.

(c) INNOVATIONS.—A specialized program with a contract under this section may use alternatives to inpatient or institutional care and may use specialized networks of caregivers.

(d) NO REQUIREMENT TO OBTAIN SERVICES FROM PROGRAMS.—No medicare beneficiary shall be required to receive health care services from a specialized program with a contract under this section.

CHAPTER 5—REDUCTION OF WASTE, FRAUD, AND ABUSE

Subchapter A—Improving Coordination, Communication, and Enforcement

PART I—MEDICARE ANTI-FRAUD AND ABUSE PROGRAM

SEC. 7041. MEDICARE ANTI-FRAUD AND ABUSE PROGRAM.

(a) FINDINGS AND STATEMENT OF PURPOSE.—

(1) FINDINGS.—The Congress finds that—

(A) a significant amount of funds expended on the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et

seq.) are lost to fraud, medically unnecessary services, and other abuse;

(B) the Office of Inspector General of the Department of Health and Human Services (hereinafter referred to as the Inspector General) and the Attorney General is effective in combating fraud and abuse under the medicare program and returning misspent funds to the Federal Treasury at a rate many times the amount invested in Inspector General and Attorney General activities; and

(C) the investigations, audits, and other activities of the Inspector General and the Attorney General have been severely curtailed by budget constraints, particularly the limits imposed by the ceilings on discretionary spending.

(2) PURPOSE.—It is the purpose of this Act to ensure a continued and adequate source of funding for the medicare anti-fraud and abuse activities of the Inspector General and the Attorney General.

(b) ESTABLISHMENT OF PROGRAM.—Title XI (42 U.S.C. 1301 et seq.) is amended by adding at the end the following new part:

SEC. . FRAUD AND ABUSE CONTROL PROGRAM.

(a) ESTABLISHMENT OF PROGRAM.—Title XI (42 U.S.C. 1301 et seq.) is amended by inserting after section 1128B the following new section:

"FRAUD AND ABUSE CONTROL PROGRAM

"SEC. 1128C. (a) ESTABLISHMENT OF PROGRAM.—

"(1) IN GENERAL.—Not later than January 1, 1996, the Secretary, acting through the Office of the Inspector General of the Department of Health and Human Services, and the Attorney General shall establish a program—

"(A) to coordinate Federal, State, and local law enforcement programs to control fraud and abuse with respect to the delivery of and payment for health care in the United States,

"(B) to conduct investigations, audits, evaluations, and inspections relating to the delivery of and payment for health care in the United States,

"(C) to facilitate the enforcement of the provisions of sections 1128, 1128A, and 1128B and other statutes applicable to health care fraud and abuse, and

"(D) to provide for the modification and establishment of safe harbors and to issue interpretative rulings and special fraud alerts pursuant to section 1128D.

"(2) COORDINATION WITH HEALTH PLANS.—In carrying out the program established under paragraph (1), the Secretary and the Attorney General shall consult with, and arrange for the sharing of data with representatives of health plans.

"(3) GUIDELINES.—

"(A) IN GENERAL.—The Secretary and the Attorney General shall issue guidelines to carry out the program under paragraph (1). The provisions of sections 553, 556, and 557 of title 5, United States Code, shall not apply in the issuance of such guidelines.

"(B) INFORMATION GUIDELINES.—

"(i) IN GENERAL.—Such guidelines shall include guidelines relating to the furnishing of information by health plans, providers, and others to enable the Secretary and the Attorney General to carry out the program (including coordination with health plans under paragraph (2)).

"(ii) CONFIDENTIALITY.—Such guidelines shall include procedures to assure that such information is provided and utilized in a manner that appropriately protects the confidentiality of the information and the privacy of individuals receiving health care services and items.

"(iii) QUALIFIED IMMUNITY FOR PROVIDING INFORMATION.—The provisions of section 1157(a) (relating to limitation on liability)

shall apply to a person providing information to the Secretary or the Attorney General in conjunction with their performance of duties under this section.

"(4) ENSURING ACCESS TO DOCUMENTATION.—The Inspector General of the Department of Health and Human Services is authorized to exercise such authority described in paragraphs (3) through (9) of section 6 of the Inspector General Act of 1978 (5 U.S.C. App.) as necessary with respect to the activities under the fraud and abuse control program established under this subsection.

"(5) AUTHORITY OF INSPECTOR GENERAL.—Nothing in this Act shall be construed to diminish the authority of any Inspector General, including such authority as provided in the Inspector General Act of 1978 (5 U.S.C. App.).

"(b) ADDITIONAL USE OF FUNDS BY INSPECTOR GENERAL.—

"(1) REIMBURSEMENTS FOR INVESTIGATIONS.—The Inspector General of the Department of Health and Human Services is authorized to receive and retain for current use reimbursement for the costs of conducting investigations and audits and for monitoring compliance plans when such costs are ordered by a court, voluntarily agreed to by the payer, or otherwise.

"(2) CREDITING.—Funds received by the Inspector General under paragraph (1) as reimbursement for costs of conducting investigations shall be deposited to the credit of the appropriation from which initially paid, or to appropriations for similar purposes currently available at the time of deposit, and shall remain available for obligation for 1 year from the date of the deposit of such funds.

"(c) HEALTH PLAN DEFINED.—For purposes of this section, the term 'health plan' means a plan or program that provides health benefits, whether directly, through insurance, or otherwise, and includes—

"(1) a policy of health insurance;

"(2) a contract of a service benefit organization; and

"(3) a membership agreement with a health maintenance organization or other prepaid health plan."

(b) ESTABLISHMENT OF HEALTH CARE FRAUD AND ABUSE CONTROL ACCOUNT IN FEDERAL HOSPITAL INSURANCE TRUST FUND.—Section 1817 (42 U.S.C. 1395i) is amended by adding at the end the following new subsection:

"(k) HEALTH CARE FRAUD AND ABUSE CONTROL ACCOUNT.—

"(1) ESTABLISHMENT.—There is hereby established in the Trust Fund an expenditure account to be known as the 'Health Care Fraud and Abuse Control Account' (in this subsection referred to as the 'Account').

"(2) APPROPRIATED AMOUNTS TO TRUST FUND.—

"(A) IN GENERAL.—There are hereby appropriated to the Trust Fund—

"(i) such gifts and bequests as may be made as provided in subparagraph (B);

"(ii) such amounts as may be deposited in the Trust Fund as provided in sections 7141(b) and 7142(c) of the Balanced Budget Reconciliation Act of 1995, and title XI; and

"(iii) such amounts as are transferred to the Trust Fund under subparagraph (C).

"(B) AUTHORIZATION TO ACCEPT GIFTS.—The Trust Fund is authorized to accept on behalf of the United States money gifts and bequests made unconditionally to the Trust Fund, for the benefit of the Account or any activity financed through the Account.

"(C) TRANSFER OF AMOUNTS.—The Managing Trustee shall transfer to the Trust Fund, under rules similar to the rules in section 9601 of the Internal Revenue Code of 1986, an amount equal to the sum of the following:

“(i) Criminal fines recovered in cases involving a Federal health care offense (as defined in section 982(a)(6)(B) of title 18, United States Code).

“(ii) Civil monetary penalties and assessments imposed in health care cases, including amounts recovered under titles XI, XVIII, and XXI, and chapter 38 of title 31, United States Code (except as otherwise provided by law).

“(iii) Amounts resulting from the forfeiture of property by reason of a Federal health care offense.

“(iv) Penalties and damages obtained and otherwise creditable to miscellaneous receipts of the general fund of the Treasury obtained under sections 3729 through 3733 of title 31, United States Code (known as the False Claims Act), in cases involving claims related to the provision of health care items and services (other than funds awarded to a relator, for restitution or otherwise authorized by law).

“(3) APPROPRIATED AMOUNTS TO ACCOUNT.—

“(A) IN GENERAL.—There are hereby appropriated to the Account from the Trust Fund such sums as the Secretary and the Attorney General certify are necessary to carry out the purposes described in subparagraph (B), to be available without further appropriation, in an amount—

“(i) with respect to activities of the Office of the Inspector General of the Department of Health and Human Services and the Federal Bureau of Investigations in carrying out such purposes, not less than—

“(I) for fiscal year 1996, \$110,000,000,

“(II) for fiscal year 1997, \$140,000,000,

“(III) for fiscal year 1998, \$160,000,000,

“(IV) for fiscal year 1999, \$185,000,000,

“(V) for fiscal year 2000, \$215,000,000,

“(VI) for fiscal year 2001, \$240,000,000, and

“(VII) for fiscal year 2002, \$270,000,000; and

“(ii) with respect to all activities (including the activities described in clause (i)) in carrying out such purposes, not more than—

“(I) for fiscal year 1996, \$200,000,000, and

“(II) for each of the fiscal years 1997 through 2002, the limit for the preceding fiscal year, increased by 15 percent; and

“(iii) for each fiscal year after fiscal year 2002, within the limits for fiscal year 2002 as determined under clauses (i) and (ii).

“(B) USE OF FUNDS.—The purposes described in this subparagraph are as follows:

“(i) GENERAL USE.—To cover the costs (including equipment, salaries and benefits, and travel and training) of the administration and operation of the health care fraud and abuse control program established under section 1128C(a), including the costs of—

“(I) prosecuting health care matters (through criminal, civil, and administrative proceedings);

“(II) investigations;

“(III) financial and performance audits of health care programs and operations;

“(IV) inspections and other evaluations; and

“(V) provider and consumer education regarding compliance with the provisions of title XI.

“(ii) USE BY STATE MEDICAID FRAUD CONTROL UNITS FOR INVESTIGATION REIMBURSEMENTS.—To reimburse the various State Medicaid fraud control units upon request to the Secretary for the costs of the activities authorized under section 2134(b).

“(4) ANNUAL REPORT.—The Secretary and the Attorney General shall submit jointly an annual report to Congress on the amount of revenue which is generated and disbursed, and the justification for such disbursements, by the Account in each fiscal year.”

SEC. 7042. APPLICATION OF CERTAIN HEALTH ANTI-FRAUD AND ABUSE SANCTIONS TO FRAUD AND ABUSE AGAINST FEDERAL HEALTH PROGRAMS.

(a) CRIMES.—

(1) SOCIAL SECURITY ACT.—Section 1128B (42 U.S.C. 1320a-7b) is amended as follows:

(A) In the heading, by striking “MEDICARE OR STATE HEALTH CARE PROGRAMS” and inserting “FEDERAL HEALTH CARE PROGRAMS”.

(B) In subsection (a)(1), by striking “a program under title XVIII or a State health care program (as defined in section 1128(h))” and inserting “a Federal health care program”.

(C) In subsection (a)(5), by striking “a program under title XVIII or a State health care program” and inserting “a Federal health care program”.

(D) In the second sentence of subsection (a)—

(i) by striking “a State plan approved under title XIX” and inserting “a Federal health care program”; and

(ii) by striking “the State may at its option (notwithstanding any other provision of that title or of such plan)” and inserting “the administrator of such program may at its option (notwithstanding any other provision of such program)”.

(E) In subsection (b)—

(i) by striking “and willfully” each place it appears;

(ii) by striking “\$25,000” each place it appears and inserting “\$50,000”;

(iii) by striking “title XVIII or a State health care program” each place it appears and inserting “Federal health care program”;

(iv) in paragraph (1) in the matter preceding subparagraph (A), by striking “kind—” and inserting “kind with intent to be influenced—”;

(v) in paragraph (1)(A), by striking “in return for referring” and inserting “to refer”;

(vi) in paragraph (1)(B), by striking “in return for purchasing, leasing, ordering, or arranging for or recommending” and inserting “to purchase, lease, order, or arrange for or recommend”;

(vii) in paragraph (2) in the matter preceding subparagraph (A), by striking “to induce such person” and inserting “with intent to influence such person”;

(viii) by adding at the end of paragraphs (1) and (2) the following sentence: “A violation exists under this paragraph if one or more purposes of the remuneration is unlawful under this paragraph.”;

(ix) by redesignating paragraph (3) as paragraph (4);

(x) in paragraph (4) (as redesignated), by striking “Paragraphs (1) and (2)” and inserting “Paragraphs (1), (2), and (3)”;

(xi) by inserting after paragraph (2) the following new paragraph:

“(3)(A) The Attorney General may bring an action in the district courts to impose upon any person who carries out any activity in violation of this subsection a civil penalty of not less than \$25,000 and not more than \$50,000 for each such violation, plus three times the total remuneration offered, paid, solicited, or received.

“(B) A violation exists under this paragraph if one or more purposes of the remuneration is unlawful, and the damages shall be the full amount of such remuneration.

“(C) Section 3731 of title 31, United States Code, and the Federal Rules of Civil Procedure shall apply to actions brought under this paragraph.

“(D) The provisions of this paragraph do not affect the availability of other criminal and civil remedies for such violations.”.

(F) In subsection (c), by inserting “(as defined in section 1128(h))” after “a State health care program”.

(G) By adding at the end the following new subsections:

“(f) For purposes of this section, the term ‘Federal health care program’ means—

“(1) any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded, in whole or in part, by the United States Government; or

“(2) any State health care program, as defined in section 1128(h).

“(g)(1) The Secretary and Administrator of the departments and agencies with a Federal health care program may conduct an investigation or audit relating to violations of this section and claims within the jurisdiction of other Federal departments or agencies if the following conditions are satisfied:

“(A) The investigation or audit involves primarily claims submitted to the Federal health care programs of the department or agency conducting the investigation or audit.

“(B) The Secretary or Administrator of the department or agency conducting the investigation or audit gives notice and an opportunity to participate in the investigation or audit to the Inspector General of the department or agency with primary jurisdiction over the Federal health care programs to which the claims were submitted.

“(2) If the conditions specified in paragraph (1) are fulfilled, the Inspector General of the department or agency conducting the investigation or audit may exercise all powers granted under the Inspector General Act of 1978 with respect to the claims submitted to the other departments or agencies to the same manner and extent as provided in that Act with respect to claims submitted to such departments or agencies.”.

(2) IDENTIFICATION OF COMMUNITY SERVICE OPPORTUNITIES.—Section 1128B (42 U.S.C. 1320a-7b) is further amended by adding at the end the following new subsection:

“(h) The Secretary may—

“(1) in consultation with State and local health care officials, identify opportunities for the satisfaction of community service obligations that a court may impose upon the conviction of an offense under this section, and

“(2) make information concerning such opportunities available to Federal and State law enforcement officers and State and local health care officials.”.

(b) EFFECTIVE DATE.—The amendments made by this section shall take effect on January 1, 1996.

SEC. 7043. HEALTH CARE FRAUD AND ABUSE PROVIDER GUIDANCE.

(a) SOLICITATION AND PUBLICATION OF MODIFICATIONS TO EXISTING SAFE HARBORS AND NEW SAFE HARBORS.—

(1) IN GENERAL.—

(A) SOLICITATION OF PROPOSALS FOR SAFE HARBORS.—Not later than January 1, 1996, and not less than annually thereafter, the Secretary shall publish a notice in the Federal Register soliciting proposals, which will be accepted during a 60-day period, for—

(i) modifications to existing safe harbors issued pursuant to section 14(a) of the Medicare and Medicaid Patient and Program Protection Act of 1987 (42 U.S.C. 1320a-7b note);

(ii) additional safe harbors specifying payment practices that shall not be treated as a criminal offense under section 1128B(b) of the Social Security Act (42 U.S.C. 1320a-7b(b)) and shall not serve as the basis for an exclusion under section 1128(b)(7) of such Act (42 U.S.C. 1320a-7(b)(7));

(iii) interpretive rulings to be issued pursuant to subsection (b); and

(iv) special fraud alerts to be issued pursuant to subsection (c).

(B) PUBLICATION OF PROPOSED MODIFICATIONS AND PROPOSED ADDITIONAL SAFE HARBORS.—After considering the proposals described in clauses (i) and (ii) of subparagraph (A), the Secretary, in consultation with the Attorney General, shall publish in the Federal Register proposed modifications to existing safe harbors and proposed additional safe harbors, if appropriate, with a 60-day comment period. After considering any public comments received during this period, the Secretary shall issue final rules modifying the existing safe harbors and establishing new safe harbors, as appropriate.

(C) REPORT.—The Inspector General of the Department of Health and Human Services (in this section referred to as the "Inspector General") shall, in an annual report to Congress or as part of the year-end semiannual report required by section 5 of the Inspector General Act of 1978 (5 U.S.C. App.), describe the proposals received under clauses (i) and (ii) of subparagraph (A) and explain which proposals were included in the publication described in subparagraph (B), which proposals were not included in that publication, and the reasons for the rejection of the proposals that were not included.

(2) CRITERIA FOR MODIFYING AND ESTABLISHING SAFE HARBORS.—In modifying and establishing safe harbors under paragraph (1)(B), the Secretary may consider the extent to which providing a safe harbor for the specified payment practice may result in any of the following:

(A) An increase or decrease in access to health care services.

(B) An increase or decrease in the quality of health care services.

(C) An increase or decrease in patient freedom of choice among health care providers.

(D) An increase or decrease in competition among health care providers.

(E) An increase or decrease in the ability of health care facilities to provide services in medically underserved areas or to medically underserved populations.

(F) An increase or decrease in the cost to Federal health care programs (as defined in section 1128B(f) of the Social Security Act (42 U.S.C. 1320a-7b(f))).

(G) An increase or decrease in the potential overutilization of health care services.

(H) The existence or nonexistence of any potential financial benefit to a health care professional or provider which may vary based on their decisions of—

(i) whether to order a health care item or service; or

(ii) whether to arrange for a referral of health care items or services to a particular practitioner or provider.

(I) Any other factors the Secretary deems appropriate in the interest of preventing fraud and abuse in Federal health care programs (as so defined).

(b) INTERPRETIVE RULINGS.—

(1) IN GENERAL.—

(A) REQUEST FOR INTERPRETIVE RULING.—Any person may present, at any time, a request to the Inspector General for a statement of the Inspector General's current interpretation of the meaning of a specific aspect of the application of sections 1128A and 1128B of the Social Security Act (42 U.S.C. 1320a-7a and 1320a-7b) (in this section referred to as an "interpretive ruling").

(B) ISSUANCE AND EFFECT OF INTERPRETIVE RULING.—

(i) IN GENERAL.—If appropriate, the Inspector General shall in consultation with the Attorney General, issue an interpretive ruling not later than 120 days after receiving a request described in subparagraph (A). Interpretive rulings shall not have the force of law and shall be treated as an interpretive rule within the meaning of section 553(b) of title 5, United States Code. All interpretive

rulings issued pursuant to this clause shall be published in the Federal Register or otherwise made available for public inspection.

(ii) REASONS FOR DENIAL.—If the Inspector General does not issue an interpretive ruling in response to a request described in subparagraph (A), the Inspector General shall notify the requesting party of such decision not later than 120 days after receiving such a request and shall identify the reasons for such decision.

(2) CRITERIA FOR INTERPRETIVE RULINGS.—

(A) IN GENERAL.—In determining whether to issue an interpretive ruling under paragraph (1)(B), the Inspector General may consider—

(i) whether and to what extent the request identifies an ambiguity within the language of the statute, the existing safe harbors, or previous interpretive rulings; and

(ii) whether the subject of the requested interpretive ruling can be adequately addressed by interpretation of the language of the statute, the existing safe harbor rules, or previous interpretive rulings, or whether the request would require a substantive ruling (as defined in section 552 of title 5, United States Code) not authorized under this subsection.

(B) NO RULINGS ON FACTUAL ISSUES.—The Inspector General shall not give an interpretive ruling on any factual issue, including the intent of the parties or the fair market value of particular leased space or equipment.

(c) SPECIAL FRAUD ALERTS.—

(1) IN GENERAL.—

(A) REQUEST FOR SPECIAL FRAUD ALERTS.—Any person may present, at any time, a request to the Inspector General for a notice which informs the public of practices which the Inspector General considers to be suspect or of particular concern under section 1128B(b) of the Social Security Act (42 U.S.C. 1320a-7b(b)) (in this subsection referred to as a "special fraud alert").

(B) ISSUANCE AND PUBLICATION OF SPECIAL FRAUD ALERTS.—Upon receipt of a request described in subparagraph (A), the Inspector General shall investigate the subject matter of the request to determine whether a special fraud alert should be issued. If appropriate, the Inspector General shall issue a special fraud alert in response to the request. All special fraud alerts issued pursuant to this subparagraph shall be published in the Federal Register.

(2) CRITERIA FOR SPECIAL FRAUD ALERTS.—In determining whether to issue a special fraud alert upon a request described in paragraph (1), the Inspector General may consider—

(A) whether and to what extent the practices that would be identified in the special fraud alert may result in any of the consequences described in subsection (a)(2); and

(B) the volume and frequency of the conduct that would be identified in the special fraud alert.

SEC. 7044. MEDICARE/MEDICAID BENEFICIARY PROTECTION PROGRAM.

(a) ESTABLISHMENT OF PROGRAM.—Not later than January 1, 1996, the Secretary (through the Administrator of the Health Care Financing Administration and the Inspector General of the Department of Health and Human Services) shall establish the Medicare/Medicaid Beneficiary Protection Program. Under such program the Secretary shall—

(1) educate medicare and medicaid beneficiaries regarding—

(A) medicare and medicaid program coverage;

(B) fraudulent and abusive practices;

(C) medically unnecessary health care items and services; and

(D) substandard health care items and services;

(2) identify and publicize fraudulent and abusive practices with respect to the delivery of health care items and services; and

(3) establish a procedure for the reporting of fraudulent and abusive health care providers, practitioners, claims, items, and services to appropriate law enforcement and payer agencies.

(b) RECOGNITION AND PUBLICATION OF CONTRIBUTIONS.—The program established by the Secretary under this section shall recognize and publicize significant contributions made by individual health care patients toward the combating of health care fraud and abuse.

(c) DISSEMINATION OF INFORMATION.—The Secretary shall provide for the broad dissemination of information regarding the Medicare/Medicaid Beneficiary Protection Program.

PART II—REVISIONS TO CURRENT SANCTIONS FOR FRAUD AND ABUSE

SEC. 7051. MANDATORY EXCLUSION FROM PARTICIPATION IN MEDICARE AND STATE HEALTH CARE PROGRAMS.

(a) INDIVIDUAL CONVICTED OF FELONY RELATING TO HEALTH CARE FRAUD.—

(1) IN GENERAL.—Section 1128(a) (42 U.S.C. 1320a-7(a)) is amended by adding at the end the following new paragraph:

"(3) FELONY CONVICTION RELATING TO HEALTH CARE FRAUD.—Any individual or entity that has been convicted after the date of the enactment of the Medicare Improvement and Solvency Protection Act of 1995, under Federal or State law, in connection with the delivery of a health care item or service or with respect to any act or omission in a health care program (other than those specifically described in paragraph (1)) operated by or financed in whole or in part by any Federal, State, or local government agency, of a criminal offense consisting of a felony relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct."

(2) CONFORMING AMENDMENT.—Paragraph (1) of section 1128(b) (42 U.S.C. 1320a-7(b)) is amended to read as follows:

"(1) CONVICTION RELATING TO FRAUD.—Any individual or entity that has been convicted after the date of the enactment of the Medicare Improvement and Solvency Protection Act of 1995, under Federal or State law—

"(A) of a criminal offense consisting of a misdemeanor relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct—

"(i) in connection with the delivery of a health care item or service, or

"(ii) with respect to any act or omission in a health care program (other than those specifically described in subsection (a)(1)) operated by or financed in whole or in part by any Federal, State, or local government agency; or

"(B) of a criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct with respect to any act or omission in a program (other than a health care program) operated by or financed in whole or in part by any Federal, State, or local government agency."

(b) INDIVIDUAL CONVICTED OF FELONY RELATING TO CONTROLLED SUBSTANCE.—

(1) IN GENERAL.—Section 1128(a) (42 U.S.C. 1320a-7(a)), as amended by subsection (a), is amended by adding at the end the following new paragraph:

"(4) FELONY CONVICTION RELATING TO CONTROLLED SUBSTANCE.—Any individual or entity that has been convicted after the date of the enactment of the Medicare Improvement and Solvency Protection Act of 1995, under

Federal or State law, of a criminal offense consisting of a felony relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.”.

(2) CONFORMING AMENDMENT.—Section 1128(b)(3) (42 U.S.C. 1320a-7(b)(3)) is amended—

(A) in the heading, by striking “CONVICTION” and inserting “MISDEMEANOR CONVICTION”; and

(B) by striking “criminal offense” and inserting “criminal offense consisting of a misdemeanor”.

SEC. 7052. ESTABLISHMENT OF MINIMUM PERIOD OF EXCLUSION FOR CERTAIN INDIVIDUALS AND ENTITIES SUBJECT TO PERMISSIVE EXCLUSION FROM MEDICARE AND STATE HEALTH CARE PROGRAMS.

Section 1128(c)(3) (42 U.S.C. 1320a-7(c)(3)) is amended by adding at the end the following new subparagraphs:

“(D) In the case of an exclusion of an individual or entity under paragraph (1), (2), or (3) of subsection (b), the period of the exclusion shall be 3 years, unless the Secretary determines in accordance with published regulations that a shorter period is appropriate because of mitigating circumstances or that a longer period is appropriate because of aggravating circumstances.

“(E) In the case of an exclusion of an individual or entity under subsection (b)(4) or (b)(5), the period of the exclusion shall not be less than the period during which the individual's or entity's license to provide health care is revoked, suspended, or surrendered, or the individual or the entity is excluded or suspended from a Federal or State health care program.

“(F) In the case of an exclusion of an individual or entity under subsection (b)(6)(B), the period of the exclusion shall be not less than 1 year.”.

SEC. 7053. PERMISSIVE EXCLUSION OF INDIVIDUALS WITH OWNERSHIP OR CONTROL INTEREST IN SANCTIONED ENTITIES.

Section 1128(b) (42 U.S.C. 1320a-7(b)) is amended by adding at the end the following new paragraph:

“(15) INDIVIDUALS CONTROLLING A SANCTIONED ENTITY.—Any individual who has a direct or indirect ownership or control interest of 5 percent or more, or an ownership or control interest (as defined in section 1124(a)(3)) in, or who is an officer or managing employee (as defined in section 1126(b)) of, an entity—

“(A) that has been convicted of any offense described in subsection (a) or in paragraph (1), (2), or (3) of this subsection; or

“(B) that has been excluded from participation under a program under title XVIII or under a State health care program.”.

SEC. 7054. SANCTIONS AGAINST PRACTITIONERS AND PERSONS FOR FAILURE TO COMPLY WITH STATUTORY OBLIGATIONS.

(a) MINIMUM PERIOD OF EXCLUSION FOR PRACTITIONERS AND PERSONS FAILING TO MEET STATUTORY OBLIGATIONS.—

(1) IN GENERAL.—The second sentence of section 1156(b)(1) (42 U.S.C. 1320c-5(b)(1)) is amended by striking “may prescribe)” and inserting “may prescribe, except that such period may not be less than 1 year)”.

(2) CONFORMING AMENDMENT.—Section 1156(b)(2) (42 U.S.C. 1320c-5(b)(2)) is amended by striking “shall remain” and inserting “shall (subject to the minimum period specified in the second sentence of paragraph (1)) remain”.

(b) REPEAL OF “UNWILLING OR UNABLE” CONDITION FOR IMPOSITION OF SANCTION.—Section 1156(b)(1) (42 U.S.C. 1320c-5(b)(1)) is amended—

(1) in the second sentence, by striking “and determines” and all that follows through “such obligations,”; and

(2) by striking the third sentence.

SEC. 7055. SANCTIONS AGAINST PROVIDERS FOR EXCESSIVE FEES OR PRICES.

Section 1128(b)(6)(A) (42 U.S.C. 1320a-7(b)(6)(A)) is amended—

(1) by inserting “(as specified by the Secretary in regulations)” after “substantially in excess of such individual's or entity's usual charges”; and

(2) striking “(or, in applicable cases, substantially in excess of such individual's or entity's costs)” and inserting “, costs or fees”.

SEC. 7056. APPLICABILITY OF THE BANKRUPTCY CODE TO PROGRAM SANCTIONS.

(a) EXCLUSION OF INDIVIDUALS AND ENTITIES FROM PARTICIPATION IN FEDERAL HEALTH CARE PROGRAMS.—Section 1128 (42 U.S.C. 1320a-7) is amended by adding at the end the following new subsection:

“(j) APPLICABILITY OF BANKRUPTCY PROVISIONS.—An exclusion imposed under this section is not subject to the automatic stay imposed under section 362 of title 11, United States Code.”.

(b) CIVIL MONETARY PENALTIES.—Section 1128A(a) (42 U.S.C. 1320a-7a(a)) is amended by adding at the end the following sentence:

“An exclusion imposed under this subsection is not subject to the automatic stay imposed under section 362 of title 11, United States Code, and any penalties and assessments imposed under this section shall be nondischargeable under the provisions of such title.”.

(c) OFFSET OF PAYMENTS TO INDIVIDUALS.—Section 1892(a)(4) (42 U.S.C. 1395ccc(a)(4)) is amended by adding at the end the following sentence: “An exclusion imposed under paragraph (2)(C)(ii) or paragraph (3)(B) is not subject to the automatic stay imposed under section 362 of title 11, United States Code.”

SEC. 7057. AGREEMENTS WITH PEER REVIEW ORGANIZATIONS FOR MEDICARE COORDINATED CARE ORGANIZATIONS.

(a) DEVELOPMENT OF MODEL AGREEMENT.—Not later than July 1, 1996, the Secretary shall develop a model of the agreement that an eligible organization with a risk-sharing contract under part C of title XVIII of the Social Security Act must enter into with an entity providing peer review services with respect to services provided by the organization under section 1856(d)(7)(A) of such Act, as added by section 7003(a).

(b) REPORT BY GAO.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study of the costs incurred by eligible organizations with risk-sharing contracts under part C of title XVIII of the Social Security Act of complying with the requirement of entering into a written agreement with an entity providing peer review services with respect to services provided by the organization, together with an analysis of how information generated by such entities is used by the Secretary to assess the quality of services provided by such eligible organizations.

(2) REPORT TO CONGRESS.—Not later than July 1, 1998, the Comptroller General shall submit a report to the Committee on Ways and Means and the Committee on Commerce of the House of Representatives and the Committee on Finance and the Special Committee on Aging of the Senate on the study conducted under paragraph (1).

SEC. 7058. EFFECTIVE DATE.

The amendments made by this chapter shall take effect January 1, 1996.

PART III—ADMINISTRATIVE AND MISCELLANEOUS PROVISIONS

SEC. 7061. ESTABLISHMENT OF THE HEALTH CARE FRAUD AND ABUSE DATA COLLECTION PROGRAM.

(a) GENERAL PURPOSE.—Not later than January 1, 1996, the Secretary shall establish a

national health care fraud and abuse data collection program for the reporting of final adverse actions (not including settlements in which no findings of liability have been made) against health care providers, suppliers, or practitioners as required by subsection (b), with access as set forth in subsection (c).

(b) REPORTING OF INFORMATION.—

(1) IN GENERAL.—Each government agency and health plan shall report any final adverse action (not including settlements in which no findings of liability have been made) taken against a health care provider, supplier, or practitioner.

(2) INFORMATION TO BE REPORTED.—The information to be reported under paragraph (1) includes:

(A) The name and TIN (as defined in section 7701(a)(41) of the Internal Revenue Code of 1986) of any health care provider, supplier, or practitioner who is the subject of a final adverse action.

(B) The name (if known) of any health care entity with which a health care provider, supplier, or practitioner is affiliated or associated.

(C) The nature of the final adverse action and whether such action is on appeal.

(D) A description of the acts or omissions and injuries upon which the final adverse action was based, and such other information as the Secretary determines by regulation is required for appropriate interpretation of information reported under this section.

(3) CONFIDENTIALITY.—In determining what information is required, the Secretary shall include procedures to assure that the privacy of individuals receiving health care services is appropriately protected.

(4) TIMING AND FORM OF REPORTING.—The information required to be reported under this subsection shall be reported regularly (but not less often than monthly) and in such form and manner as the Secretary prescribes. Such information shall first be required to be reported on a date specified by the Secretary.

(5) TO WHOM REPORTED.—The information required to be reported under this subsection shall be reported to the Secretary.

(c) DISCLOSURE AND CORRECTION OF INFORMATION.—

(1) DISCLOSURE.—With respect to the information about final adverse actions (not including settlements in which no findings of liability have been made) reported to the Secretary under this section respecting a health care provider, supplier, or practitioner, the Secretary shall, by regulation, provide for—

(A) disclosure of the information, upon request, to the health care provider, supplier, or licensed practitioner, and

(B) procedures in the case of disputed accuracy of the information.

(2) CORRECTIONS.—Each Government agency and health plan shall report corrections of information already reported about any final adverse action taken against a health care provider, supplier, or practitioner, in such form and manner that the Secretary prescribes by regulation.

(d) ACCESS TO REPORTED INFORMATION.—

(1) AVAILABILITY.—The information in this database shall be available to Federal and State government agencies, health plans, and the public pursuant to procedures that the Secretary shall provide by regulation.

(2) FEES FOR DISCLOSURE.—The Secretary may establish or approve reasonable fees for

the disclosure of information in this database (other than with respect to requests by Federal agencies). The amount of such a fee may be sufficient to recover the full costs of carrying out the provisions of this section, including reporting, disclosure, and administration. Such fees shall be available to the Secretary or, in the Secretary's discretion to the agency designated under this section to cover such costs.

(e) **PROTECTION FROM LIABILITY FOR REPORTING.**—No person or entity shall be held liable in any civil action with respect to any report made as required by this section, without knowledge of the falsity of the information contained in the report.

(f) **DEFINITIONS AND SPECIAL RULES.**—For purposes of this section:

(1)(A) The term "final adverse action" includes:

(i) Civil judgments against a health care provider or practitioner in Federal or State court related to the delivery of a health care item or service.

(ii) Federal or State criminal convictions related to the delivery of a health care item or service.

(iii) Actions by Federal or State agencies responsible for the licensing and certification of health care providers, suppliers, and licensed health care practitioners, including—

(I) formal or official actions, such as revocation or suspension of a license (and the length of any such suspension), reprimand, censure or probation,

(II) any other loss of license, or the right to apply for or renew a license of the provider, supplier, or practitioner, whether by operation of law, voluntary surrender, nonrenewability, or otherwise, or

(III) any other negative action or finding by such Federal or State agency that is publicly available information.

(iv) Exclusion from participation in Federal or State health care programs.

(v) Any other adjudicated actions or decisions that the Secretary shall establish by regulation.

(B) The term does not include any action with respect to a malpractice claim.

(2) The terms "licensed health care practitioner", "licensed practitioner", and "practitioner" mean, with respect to a State, an individual who is licensed or otherwise authorized by the State to provide health care services (or any individual who, without authority holds himself or herself out to be so licensed or authorized).

(3) The term "health care provider" means a provider of services as defined in section 1861(u) of the Social Security Act (42 U.S.C. 1395x(u)), and any person or entity, including a health maintenance organization, group medical practice, or any other entity listed by the Secretary in regulation, that provides health care services.

(4) The term "supplier" means a supplier of health care items and services described in section 1819(a) and (b), and section 1861 of the Social Security Act (42 U.S.C. 1395i-3(a) and (b), and 1395x).

(5) The term "Government agency" shall include:

(A) The Department of Justice.

(B) The Department of Health and Human Services.

(C) Any other Federal agency that either administers or provides payment for the delivery of health care services, including, but not limited to the Department of Defense and the Veterans' Administration.

(D) State law enforcement agencies.

(E) State Medicaid fraud and abuse units.

(F) Federal or State agencies responsible for the licensing and certification of health care providers and licensed health care practitioners.

(6) The term "health plan" means a plan or program that provides health benefits, whether directly, through insurance, or otherwise, and includes—

(A) a policy of health insurance;

(B) a contract of a service benefit organization;

(C) a membership agreement with a health maintenance organization or other prepaid health plan; and

(D) an employee welfare benefit plan or a multiple employer welfare plan (as such terms are defined in section 3 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002)).

(7) For purposes of paragraph (1), the existence of a conviction shall be determined under section 1128(i) of the Social Security Act.

(g) **CONFORMING AMENDMENT.**—Section 1921(d) (42 U.S.C. 1396r-2(d)) is amended by inserting "and section 7061 of the Medicare Improvement and Solvency Protection Act of 1995" after "section 422 of the Health Care Quality Improvement Act of 1986".

SEC. 7062. INSPECTOR GENERAL ACCESS TO ADDITIONAL PRACTITIONER DATA BANK.

Section 427 of the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11137) is amended—

(1) in subsection (a), by adding at the end the following sentence: "Information reported under this part shall also be made available, upon request, to the Inspector General of the Departments of Health and Human Services, Defense, and Labor, the Office of Personnel Management, and the Railroad Retirement Board."; and

(2) by amending subsection (b)(4) to read as follows:

"(4) **FEES.**—The Secretary may impose fees for the disclosure of information under this part sufficient to recover the full costs of carrying out the provisions of this part, including reporting, disclosure, and administration, except that a fee may not be imposed for requests made by the Inspector General of the Department of Health and Human Services. Such fees shall remain available to the Secretary (or, in the Secretary's discretion, to the agency designated in section 424(b)) until expended."

SEC. 7063. CORPORATE WHISTLEBLOWER PROGRAM.

Title XI (42 U.S.C. 1301 et seq.) is amended by inserting after section 1128B the following new section:

"CORPORATE WHISTLEBLOWER PROGRAM

"SEC. 1128C. (a) **ESTABLISHMENT OF PROGRAM.**—The Secretary, through the Inspector General of the Department of Health and Human Services, shall establish a procedure whereby corporations, partnerships, and other legal entities specified by the Secretary, may voluntarily disclose instances of unlawful conduct and seek to resolve liability for such conduct through means specified by the Secretary.

"(b) **LIMITATION.**—No person may bring an action under section 3730(b) of title 31, United States Code, if, on the date of filing—

"(1) the matter set forth in the complaint has been voluntarily disclosed to the United States by the proposed defendant and the defendant has been accepted into the voluntary disclosure program established pursuant to subsection (a); and

"(2) any new information provided in the complaint under such section does not add substantial grounds for additional recovery beyond those encompassed within the scope of the voluntary disclosure."

PART IV—CIVIL MONETARY PENALTIES

SEC. 7071. SOCIAL SECURITY ACT CIVIL MONETARY PENALTIES.

(a) **GENERAL CIVIL MONETARY PENALTIES.**—Section 1128A (42 U.S.C. 1320a-7a) is amended as follows:

(1) In the third sentence of subsection (a), by striking "programs under title XVIII" and inserting "Federal health care programs (as defined in section 1128B(b)(f))".

(2) In subsection (f)—

(A) by redesignating paragraph (3) as paragraph (4); and

(B) by inserting after paragraph (2) the following new paragraph:

"(3) With respect to amounts recovered arising out of a claim under a Federal health care program (as defined in section 1128B(f)), the portion of such amounts as is determined to have been paid by the program shall be repaid to the program, and the portion of such amounts attributable to the amounts recovered under this section by reason of the amendments made by the Medicare Improvement and Solvency Protection Act of 1995 (as estimated by the Secretary) shall be deposited into the general fund of the Treasury."

(3) In subsection (i)—

(A) in paragraph (2), by striking "title V, XVIII, XIX, or XX of this Act" and inserting "a Federal health care program (as defined in section 1128B(f))";

(B) in paragraph (4), by striking "a health insurance or medical services program under title XVIII or XIX of this Act" and inserting "a Federal health care program (as so defined)"; and

(C) in paragraph (5), by striking "title V, XVIII, XIX, or XX" and inserting "a Federal health care program (as so defined)".

(4) By adding at the end the following new subsection:

"(m)(1) For purposes of this section, with respect to a Federal health care program not contained in this Act, references to the Secretary in this section shall be deemed to be references to the Secretary or Administrator of the department or agency with jurisdiction over such program and references to the Inspector General of the Department of Health and Human Services in this section shall be deemed to be references to the Inspector General of the applicable department or agency.

"(2)(A) The Secretary and Administrator of the departments and agencies referred to in paragraph (1) may include in any action pursuant to this section, claims within the jurisdiction of other Federal departments or agencies as long as the following conditions are satisfied:

"(i) The case involves primarily claims submitted to the Federal health care programs of the department or agency initiating the action.

"(ii) The Secretary or Administrator of the department or agency initiating the action gives notice and an opportunity to participate in the investigation to the Inspector General of the department or agency with primary jurisdiction over the Federal health care programs to which the claims were submitted.

"(B) If the conditions specified in subparagraph (A) are fulfilled, the Inspector General of the department or agency initiating the action is authorized to exercise all powers granted under the Inspector General Act of 1978 with respect to the claims submitted to the other departments or agencies to the same manner and extent as provided in that Act with respect to claims submitted to such departments or agencies."

(b) **EXCLUDED INDIVIDUAL RETAINING OWNERSHIP OR CONTROL INTEREST IN PARTICIPATING ENTITY.**—Section 1128A(a) (42 U.S.C. 1320a-7a(a)) is amended—

(1) by striking "or" at the end of paragraph (1)(D);

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

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

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

"(4) in the case of a person who is not an organization, agency, or other entity, is excluded from participating in a program under title XVIII or a State health care program in accordance with this subsection or under section 1128 and who, at the time of a violation of this subsection, retains a direct or indirect ownership or control interest of 5 percent or more, or an ownership or control interest (as defined in section 1124(a)(3)) in, or who is an officer or managing employee (as defined in section 1126(b)) of, an entity that is participating in a program under title XVIII or a State health care program;"

(c) EMPLOYER BILLING FOR SERVICES FURNISHED, DIRECTED, OR PRESCRIBED BY AN EXCLUDED EMPLOYEE.—Section 1128A(a)(1) (42 U.S.C. 1320a-7a(a)(1)) is amended—

(1) by striking "or" at the end of subparagraph (C);

(2) by striking "; or" at the end of subparagraph (D) and inserting ", or"; and

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

"(E) is for a medical or other item or service furnished, directed, or prescribed by an individual who is an employee or agent of the person during a period in which such employee or agent was excluded from the program under which the claim was made on any of the grounds for exclusion described in subparagraph (D);"

(d) CIVIL MONEY PENALTIES FOR ITEMS OR SERVICES FURNISHED, DIRECTED, OR PRESCRIBED BY AN EXCLUDED INDIVIDUAL.—Section 1128A(a)(1)(D) (42 U.S.C. 1320a-7a(a)(1)(D)) is amended by inserting ", directed, or prescribed" after "furnished".

(e) MODIFICATIONS OF AMOUNTS OF PENALTIES AND ASSESSMENTS.—Section 1128A(a) (42 U.S.C. 1320a-7a(a)), as amended by subsection (b), is amended in the matter following paragraph (4)—

(1) by striking "\$2,000" and inserting "\$10,000";

(2) by inserting "; in cases under paragraph (4), \$10,000 for each day the prohibited relationship occurs" after "false or misleading information was given"; and

(3) by striking "twice the amount" and inserting "3 times the amount".

(f) CLAIM FOR ITEM OR SERVICE BASED ON INCORRECT CODING OR MEDICALLY UNNECESSARY SERVICES.—Section 1128A(a)(1) (42 U.S.C. 1320a-7a(a)(1)) is amended—

(1) in subparagraph (A) by striking "claimed," and inserting "claimed, including any person who engages in a pattern or practice of presenting or causing to be presented a claim for an item or service that is based on a code that the person knows or has reason to know will result in a greater payment to the person than the code the person knows or has reason to know is applicable to the item or service actually provided,";

(2) in subparagraph (C), by striking "or" at the end;

(3) in subparagraph (D), by striking "; or" and inserting ", or"; and

(4) by inserting after subparagraph (D) the following new subparagraph:

"(E) is for a medical or other item or service that a person knows or has reason to know is not medically necessary; or"

(g) PERMITTING SECRETARY TO IMPOSE CIVIL MONETARY PENALTY.—Section 1128A(b) (42 U.S.C. 1320a-7a(a)) is amended by adding the following new paragraph:

"(3) Any person (including any organization, agency, or other entity, but excluding a

beneficiary as defined in subsection (i)(5)) who the Secretary determines has violated section 1128B(b) of this title shall be subject to a civil monetary penalty of not more than \$10,000 for each such violation. In addition, such person shall be subject to an assessment of not more than twice the total amount of the remuneration offered, paid, solicited, or received in violation of section 1128B(b). The total amount of remuneration subject to an assessment shall be calculated without regard to whether some portion thereof also may have been intended to serve a purpose other than one proscribed by section 1128B(b)."

(h) SANCTIONS AGAINST PRACTITIONERS AND PERSONS FOR FAILURE TO COMPLY WITH STATUTORY OBLIGATIONS.—Section 1156(b)(3) (42 U.S.C. 1320c-5(b)(3)) is amended by striking "the actual or estimated cost" and inserting "up to \$10,000 for each instance".

(i) PROHIBITION AGAINST OFFERING INDUCEMENTS TO INDIVIDUALS ENROLLED UNDER PROGRAMS OR PLANS.—

(1) OFFER OF REMUNERATION.—Section 1128A(a) (42 U.S.C. 1320a-7a(a)) is amended—

(A) by striking "or" at the end of paragraph (1)(D);

(B) by striking ", or" at the end of paragraph (2) and inserting a semicolon;

(C) by striking the semicolon at the end of paragraph (3) and inserting "; or"; and

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

"(4) offers to or transfers remuneration to any individual eligible for benefits under title XVIII of this Act, or under a State health care program (as defined in section 1128(h)) that such person knows or should know is likely to influence such individual to order or receive from a particular provider, practitioner, or supplier any item or service for which payment may be made, in whole or in part, under title XVIII, or a State health care program;"

(2) REMUNERATION DEFINED.—Section 1128A(i) (42 U.S.C. 1320a-7a(i)) is amended by adding the following new paragraph:

"(6) The term 'remuneration' includes the waiver of coinsurance and deductible amounts (or any part thereof), and transfers of items or services for free or for other than fair market value. The term 'remuneration' does not include—

"(A) the waiver of coinsurance and deductible amounts by a person, if—

"(i) the waiver is not offered as part of any advertisement or solicitation;

"(ii) the person does not routinely waive coinsurance or deductible amounts; and

"(iii) the person—

"(I) waives the coinsurance and deductible amounts after determining in good faith that the individual is in financial need;

"(II) fails to collect coinsurance or deductible amounts after making reasonable collection efforts; or

"(III) provides for any permissible waiver as specified in section 1128B(b)(3) or in regulations issued by the Secretary;

"(B) differentials in coinsurance and deductible amounts as part of a benefit plan design as long as the differentials have been disclosed in writing to all beneficiaries, third party payors, and providers, to whom claims are presented and as long as the differentials meet the standards as defined in regulations promulgated by the Secretary not later than 180 days after the date of the enactment of the Medicare Improvement and Solvency Protection Act of 1995; or

"(C) incentives given to individuals to promote the delivery of preventive care as determined by the Secretary in regulations so promulgated."

(j) EFFECTIVE DATE.—The amendments made by this section shall take effect January 1, 1996.

PART V—CHAPTER 5—AMENDMENTS TO CRIMINAL LAW

SEC. 7081. HEALTH CARE FRAUD.

(a) FINES AND IMPRISONMENT FOR HEALTH CARE FRAUD VIOLATIONS.—Chapter 63 of title 18, United States Code, is amended by adding at the end the following new section:

"§ 1347. Health care fraud

"(a) Whoever knowingly and willfully executes, or attempts to execute, a scheme or artifice—

"(1) to defraud any health plan or other person, in connection with the delivery of or payment for health care benefits, items, or services; or

"(2) to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health plan, or person in connection with the delivery of or payment for health care benefits, items, or services;

shall be fined under this title or imprisoned not more than 10 years, or both. If the violation results in serious bodily injury (as defined in section 1365(g)(3) of this title), such person may be imprisoned for any term of years.

"(b) For purposes of this section, the term 'health plan' has the same meaning given such term in section 7061(f)(6) of the Medicare Improvement and Solvency Protection Act of 1995."

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 63 of title 18, United States Code, is amended by adding at the end the following:

"1347. Health care fraud."

SEC. 7082. FORFEITURES FOR FEDERAL HEALTH CARE OFFENSES.

Section 982(a) of title 18, United States Code, is amended by adding after paragraph (5) the following new paragraph:

"(6)(A) The court, in imposing sentence on a person convicted of a Federal health care offense, shall order the person to forfeit property, real or personal, that constitutes or is derived, directly or indirectly, from proceeds traceable to the commission of the offense.

"(B) For purposes of this paragraph, the term 'Federal health care offense' means a violation of, or a criminal conspiracy to violate—

"(i) section 1347 of this title;

"(ii) section 1128B of the Social Security Act;

"(iii) sections 287, 371, 664, 666, 1001, 1027, 1341, 1343, 1920, or 1954 of this title if the violation or conspiracy relates to health care fraud; and

"(iv) section 501 or 511 of the Employee Retirement Income Security Act of 1974, if the violation or conspiracy relates to health care fraud."

SEC. 7083. INJUNCTIVE RELIEF RELATING TO FEDERAL HEALTH CARE OFFENSES.

(a) IN GENERAL.—Section 1345(a)(1) of title 18, United States Code, is amended—

(1) by striking "or" at the end of subparagraph (A);

(2) by inserting "or" at the end of subparagraph (B); and

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

"(C) committing or about to commit a Federal health care offense (as defined in section 982(a)(6)(B) of this title);"

(b) FREEZING OF ASSETS.—Section 1345(a)(2) of title 18, United States Code, is amended by inserting "or a Federal health care offense (as defined in section 982(a)(6)(B))" after "title)".

SEC. 7084. GRAND JURY DISCLOSURE.

Section 3322 of title 18, United States Code, is amended—

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

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

“(c) A person who is privy to grand jury information concerning a Federal health care offense (as defined in section 982(a)(6)(B))—

“(1) received in the course of duty as an attorney for the Government; or

“(2) disclosed under rule 6(e)(3)(A)(ii) of the Federal Rules of Criminal Procedure;

may disclose that information to an attorney for the Government to use in any investigation or civil proceeding relating to health care fraud.”.

SEC. 7085. FALSE STATEMENTS.

(a) IN GENERAL.—Chapter 47, of title 18, United States Code, is amended by adding at the end the following new section:

“§1035. False statements relating to health care matters

“(a) Whoever, in any matter involving a health plan, knowingly and willfully falsifies, conceals, or covers up by any trick, scheme, or device a material fact, or makes any false, fictitious, or fraudulent statements or representations, or makes or uses any false writing or document knowing the same to contain any false, fictitious, or fraudulent statement or entry, shall be fined under this title or imprisoned not more than 5 years, or both.

“(b) For purposes of this section, the term ‘health plan’ has the same meaning given such term in section 7061(f)(6) of the Medicare Improvement and Solvency Protection Act of 1995.”.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 47 of title 18, United States Code, is amended by adding at the end the following:

“1035. False statements relating to health care matters.”.

SEC. 7086. OBSTRUCTION OF CRIMINAL INVESTIGATIONS, AUDITS, OR INSPECTIONS OF FEDERAL HEALTH CARE OFFENSES.

(a) IN GENERAL.—Chapter 73 of title 18, United States Code, is amended by adding at the end the following new section:

“§1518. Obstruction of criminal investigations, audits, or inspections of Federal health care offenses

“(a) IN GENERAL.—Whoever willfully prevents, obstructs, misleads, delays or attempts to prevent, obstruct, mislead, or delay the communication of information or records relating to a Federal health care offense to a Federal agent or employee involved in an investigation, audit, inspection, or other activity related to such an offense, shall be fined under this title or imprisoned not more than 5 years, or both.

“(b) FEDERAL HEALTH CARE OFFENSE.—As used in this section the term ‘Federal health care offense’ has the same meaning given such term in section 982(a)(6)(B) of this title.

“(c) CRIMINAL INVESTIGATOR.—As used in this section the term ‘criminal investigator’ means any individual duly authorized by a department, agency, or armed force of the United States to conduct or engage in investigations for prosecutions for violations of health care offenses.”.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 73 of title 18, United States Code, is amended by adding at the end the following:

“1518. Obstruction of criminal investigations, audits, or inspections of Federal health care offenses.”.

SEC. 7087. THEFT OR EMBEZZLEMENT.

(a) IN GENERAL.—Chapter 31 of title 18, United States Code, is amended by adding at the end the following new section:

“§669. Theft or embezzlement in connection with health care

“(a) IN GENERAL.—Whoever willfully embezzles, steals, or otherwise without authority willfully and unlawfully converts to the use of any person other than the rightful owner, or intentionally misapplies any of the moneys, funds, securities, premiums, credits, property, or other assets of a health plan, shall be fined under this title or imprisoned not more than 10 years, or both.

“(b) HEALTH PLAN.—As used in this section the term ‘health plan’ has the same meaning given such term in section 7061(f)(6) of the Medicare Improvement and Solvency Protection Act of 1995.”.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 31 of title 18, United States Code, is amended by adding at the end the following:

“669. Theft or embezzlement in connection with health care.”.

SEC. 7088. LAUNDERING OF MONETARY INSTRUMENTS.

Section 1956(c)(7) of title 18, United States Code, is amended by adding at the end the following new subparagraph:

“(F) Any act or activity constituting an offense involving a Federal health care offense as that term is defined in section 982(a)(6)(B) of this title.”.

SEC. 7089. AUTHORIZED INVESTIGATIVE DEMAND PROCEDURES.

(a) IN GENERAL.—Chapter 233 of title 18, United States Code, is amended by adding after section 3485 the following new section:

“§3486. Authorized investigative demand procedures

“(a) AUTHORIZATION.—

“(1) In any investigation relating to functions set forth in paragraph (2), the Attorney General or designee may issue in writing and cause to be served a subpoena compelling production of any records (including any books, papers, documents, electronic media, or other objects or tangible things), which may be relevant to an authorized law enforcement inquiry, that a person or legal entity may possess or have care, custody, or control. A custodian of records may be required to give testimony concerning the production and authentication of such records. The production of records may be required from any place in any State or in any territory or other place subject to the jurisdiction of the United States at any designated place; except that such production shall not be required more than 500 miles distant from the place where the subpoena is served. Witnesses summoned under this section shall be paid the same fees and mileage that are paid witnesses in the courts of the United States. A subpoena requiring the production of records shall describe the objects required to be produced and prescribe a return date within a reasonable period of time within which the objects can be assembled and made available.

“(2) Investigative demands utilizing an administrative subpoena are authorized for any investigation with respect to any act or activity constituting or involving health care fraud, including a scheme or artifice—

“(A) to defraud any health plan or other person, in connection with the delivery of or payment for health care benefits, items, or services; or

“(B) to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control or, any health plan, or person in connection with the delivery of or payment for health care benefits, items, or services.

“(b) SERVICE.—A subpoena issued under this section may be served by any person

designated in the subpoena to serve it. Service upon a natural person may be made by personal delivery of the subpoena to such person. Service may be made upon a domestic or foreign association which is subject to suit under a common name, by delivering the subpoena to an officer, to a managing or general agent, or to any other agent authorized by appointment or by law to receive service of process. The affidavit of the person serving the subpoena entered on a true copy thereof by the person serving it shall be proof of service.

“(c) ENFORCEMENT.—In the case of contumacy by or refusal to obey a subpoena issued to any person, the Attorney General may invoke the aid of any court of the United States within the jurisdiction of which the investigation is carried on or of which the subpoenaed person is an inhabitant, or in which such person carries on business or may be found, to compel compliance with the subpoena. The court may issue an order requiring the subpoenaed person to appear before the Attorney General to produce records, if go ordered, or to give testimony touching the matter under investigation. Any failure to obey the order of the court may be punished by the court as a contempt thereof. All process in any such case may be served in any judicial district in which such person may be found.

“(d) IMMUNITY FROM CIVIL LIABILITY.—Notwithstanding any Federal, State, or local law, any person, including officers, agents, and employees, receiving a subpoena under this section, who complies in good faith with the subpoena and thus produces the materials sought, shall not be liable in any court of any State or the United States to any customer or other person for such production or for nondisclosure of that production to the customer.

“(e) USE IN ACTION AGAINST INDIVIDUALS.—

“(1) Health information about an individual that is disclosed under this section may not be used in, or disclosed to any person for use in, any administrative, civil, or criminal action or investigation directed against the individual who is the subject of the information unless the action or investigation arises out of and is directly related to receipt of health care or payment for health care or action involving a fraudulent claim related to health; or if authorized by an appropriate order of a court of competent jurisdiction, granted after application showing good cause therefore.

“(2) In assessing good cause, the court shall weigh the public interest and the need for disclosure against the injury to the patient, to the physician-patient relationship, and to the treatment services.

“(3) Upon the granting of such order, the court, in determining the extent to which any disclosure of all or any part of any record is necessary, shall impose appropriate safeguards against unauthorized disclosure.

“(f) HEALTH PLAN.—As used in this section the term ‘health plan’ has the same meaning given such term in section 7061(f)(6) of the Medicare Improvement and Solvency Protection Act of 1995.”.

(b) CLERICAL AMENDMENT.—The table of sections for chapter 223 of title 18, United States Code, is amended by inserting after the item relating to section 3485 the following new item:

“3486. Authorized investigative demand procedures.”.

(c) CONFORMING AMENDMENT.—Section 1510(b)(3)(B) of title 18, United States Code, is amended by inserting “or a Department of Justice subpoena (issued under section 3486),” after “subpoena”.

PART VI—STATE HEALTH CARE FRAUD CONTROL UNITS

SEC. 7091. STATE HEALTH CARE FRAUD CONTROL UNITS.

(a) EXTENSION OF CONCURRENT AUTHORITY TO INVESTIGATE AND PROSECUTE FRAUD IN OTHER FEDERAL PROGRAMS.—Section 1903(q)(3) (42 U.S.C. 1396b(q)(3)) is amended—

(1) by inserting “(A)” after “in connection with”; and

(2) by striking “title.” and inserting “title; and (B) in cases where the entity’s function is also described by subparagraph (A), and upon the approval of the relevant Federal agency, any aspect of the provision of health care services and activities of providers of such services under any Federal health care program (as defined in section 1128B(b)(1)).”.

(b) EXTENSION OF AUTHORITY TO INVESTIGATE AND PROSECUTE PATIENT ABUSE IN NON-MEDICAID BOARD AND CARE FACILITIES.—Section 1903(q)(4) (42 U.S.C. 1396b(q)(4)) is amended to read as follows:

“(4)(A) The entity has—

“(i) procedures for reviewing complaints of abuse or neglect of patients in health care facilities which receive payments under the State plan under this title;

“(ii) at the option of the entity, procedures for reviewing complaints of abuse or neglect of patients residing in board and care facilities; and

“(iii) procedures for acting upon such complaints under the criminal laws of the State or for referring such complaints to other State agencies for action.

“(B) For purposes of this paragraph, the term ‘board and care facility’ means a residential setting which receives payment from or on behalf of two or more unrelated adults who reside in such facility, and for whom one or both of the following is provided:

“(i) Nursing care services provided by, or under the supervision of, a registered nurse, licensed practical nurse, or licensed nursing assistant.

“(ii) Personal care services that assist residents with the activities of daily living, including personal hygiene, dressing, bathing, eating, toileting, ambulation, transfer, positioning, self-medication, body care, travel to medical services, essential shopping, meal preparation, laundry, and housework.”.

PART VII—MEDICARE/MEDICAID BILLING ABUSE PREVENTION

SEC. 7101. UNIFORM MEDICARE/MEDICAID APPLICATION PROCESS.

Not later than 1 year after the date of the enactment of this Act, the Secretary shall establish procedures and a uniform application form for use by any individual or entity that seeks to participate in the programs under titles XVIII and XIX of the Social Security Act (42 U.S.C. 1395 et seq.; 42 U.S.C. 1396 et seq.). The procedures established shall include the following:

(1) Execution of a standard authorization form by all individuals and entities prior to submission of claims for payment which shall include the social security number of the beneficiary and the TIN (as defined in section 7701(a)(41) of the Internal Revenue Code of 1986) of any health care provider, supplier, or practitioner providing items or services under the claim.

(2) Assumption of responsibility and liability for all claims submitted.

(3) A right of access by the Secretary to provider records relating to items and services rendered to beneficiaries of such programs.

(4) Retention of source documentation.

(5) Provision of complete and accurate documentation to support all claims for payment.

(6) A statement of the legal consequences for the submission of false or fraudulent claims for payment.

SEC. 7102. STANDARDS FOR UNIFORM CLAIMS.

(a) ESTABLISHMENT OF STANDARDS.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall establish standards for the form and submission of claims for payment under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) and the medicare program under title XIX of such Act (42 U.S.C. 1396 et seq.).

(b) ENSURING PROVIDER RESPONSIBILITY.—In establishing standards under subsection (a), the Secretary, in consultation with appropriate agencies including the Department of Justice, shall include such methods of ensuring provider responsibility and accountability for claims submitted as necessary to control fraud and abuse.

(c) USE OF ELECTRONIC MEDIA.—The Secretary shall develop specific standards which govern the submission of claims through electronic media in order to control fraud and abuse in the submission of such claims.

SEC. 7103. UNIQUE PROVIDER IDENTIFICATION CODE.

(a) ESTABLISHMENT OF SYSTEM.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall establish a system which provides for the issuance of a unique identifier code for each individual or entity furnishing items or services for which payment may be made under title XVIII or XIX of the Social Security Act (42 U.S.C. 1395 et seq.; 1396 et seq.), and the notation of such unique identifier codes on all claims for payment.

(b) APPLICATION FEE.—The Secretary shall require an individual applying for a unique identifier code under subsection (a) to submit a fee in an amount determined by the Secretary to be sufficient to cover the cost of investigating the information on the application and the individual’s suitability for receiving such a code.

SEC. 7104. USE OF NEW PROCEDURES.

No payment may be made under either title XVIII or XIX of the Social Security Act (42 U.S.C. 1395 et seq.; 42 U.S.C. 1396 et seq.) for any item or service furnished by an individual or entity unless the requirements of sections 7102 and 7103 are satisfied.

SEC. 7105. REQUIRED BILLING, PAYMENT, AND COST LIMIT CALCULATION TO BE BASED ON SITE WHERE SERVICE IS FURNISHED.

(a) CONDITIONS OF PARTICIPATION.—Section 1891 (42 U.S.C. 1395bbb) is amended by adding at the end the following new subsection:

“(g) A home health agency shall submit claims for payment of home health services under this title only on the basis of the geographic location at which the service is furnished, as determined by the Secretary.”.

(b) WAGE ADJUSTMENT.—Section 1861(v)(1)(L)(iii) (42 U.S.C. 1395x(v)(1)(L)(iii)) is amended by striking “agency is located” and inserting “service is furnished”.

Subchapter B—Additional Provisions to Combat Waste, Fraud, and Abuse

PART I—WASTE AND ABUSE REDUCTION

SEC. 7111. PROHIBITING UNNECESSARY AND WASTEFUL MEDICARE PAYMENTS FOR CERTAIN ITEMS.

Notwithstanding any other provision of law, including any regulation or payment policy, the following categories of charges shall not be reimbursable under title XVIII of the Social Security Act:

(1) Tickets to sporting or other entertainment events.

(2) Gifts or donations.

(3) Costs related to team sports.

(4) Personal use of motor vehicles.

(5) Costs for fines and penalties resulting from violations of Federal, State, or local laws.

(6) Tuition or other education fees for spouses or dependents of providers of services, their employees, or contractors.

SEC. 7112. APPLICATION OF COMPETITIVE ACQUISITION PROCESS FOR PART B ITEMS AND SERVICES.

(a) GENERAL RULE.—Part B of title XVIII is amended by inserting after section 1846 the following new section:

“COMPETITION ACQUISITION FOR ITEMS AND SERVICES

“SEC. 1847. (a) ESTABLISHMENT OF BIDDING AREAS.—

“(1) IN GENERAL.—The Secretary shall establish competitive acquisition areas for the purpose of awarding a contract or contracts for the furnishing under this part of the items and services described in subsection (c) on or after January 1, 1996. The Secretary may establish different competitive acquisition areas under this subsection for different classes of items and services under this part.

“(2) CRITERIA FOR ESTABLISHMENT.—The competitive acquisition areas established under paragraph (1) shall—

“(A) initially be within, or be centered around metropolitan statistical areas;

“(B) be chosen based on the availability and accessibility of suppliers and the probable savings to be realized by the use of competitive bidding in the furnishing of items and services in the area; and

“(C) be chosen so as to not reduce access to such items and services to individuals residing in rural and other underserved areas..

“(b) AWARDING OF CONTRACTS IN AREAS.—

“(1) IN GENERAL.—The Secretary shall conduct a competition among individuals and entities supplying items and services under this part for each competitive acquisition area established under subsection (a) for each class of items and services.

“(2) CONDITIONS FOR AWARDING CONTRACT.—The Secretary may not award a contract to any individual or entity under the competition conducted pursuant to paragraph (1) to furnish an item or service under this part unless the Secretary finds that the individual or entity—

“(A) meets quality standards specified by the Secretary for the furnishing of such item or service; and

“(B) offers to furnish a total quantity of such item or service that is sufficient to meet the expected need within the competitive acquisition area and to assure that access to such items (including appropriate customized items) and services to individuals residing in rural and other underserved areas is not reduced.

“(3) CONTENTS OF CONTRACT.—A contract entered into with an individual or entity under the competition conducted pursuant to paragraph (1) shall specify (for all of the items and services within a class)—

“(A) the quantity of items and services the entity shall provide; and

“(B) such other terms and conditions as the Secretary may require.

“(c) SERVICES DESCRIBED.—The items and services to which the provisions of this section shall apply are as follows:

“(1) Durable medical equipment and medical supplies.

“(2) Oxygen and oxygen equipment.

“(3) Such other items and services with respect to which the Secretary determines the use of competitive acquisition under this section to be appropriate and cost-effective.”.

(b) ITEMS AND SERVICES TO BE FURNISHED ONLY THROUGH COMPETITIVE ACQUISITION.—Section 1862(a) (42 U.S.C. 1395y(a)) is amended—

(1) by striking “or” at the end of paragraph (14);

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

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

“(16) where such expenses are for an item or service furnished in a competitive acquisition area (as established by the Secretary under section 1847(a)) by an individual or entity other than the supplier with whom the Secretary has entered into a contract under section 1847(b) for the furnishing of such item or service in that area, unless the Secretary finds that such expenses were incurred in a case of urgent need.”.

(c) REDUCTION IN PAYMENT AMOUNTS IF COMPETITIVE ACQUISITION FAILS TO ACHIEVE MINIMUM REDUCTION IN PAYMENTS.—Notwithstanding any other provision of title XVIII of the Social Security Act, if the establishment of competitive acquisition areas under section 1847 of such Act (as added by subsection (a)) and the limitation of coverage for items and services under part B of such title to items and services furnished by providers with competitive acquisition contracts under such section does not result in a reduction, beginning on January 1, 1997, of at least 20 percent (30 percent in the case of oxygen and oxygen equipment) in the projected payment amount that would have applied to an item or service under part B if the item or service had not been furnished through competitive acquisition under such section, the Secretary shall reduce such payment amount by such percentage as the Secretary determines necessary to result in such a reduction.

SEC. 7113. INTERIM REDUCTION IN EXCESSIVE PAYMENTS.

Section 1834(a)(1)(D) (42 U.S.C. 1395m(a)(1)(D)) is amended by adding at the end the following new sentence: “With respect to services described in section 1847(c) furnished between January 1, 1996, and the date on which competitive acquisition under section 1847 is fully implemented, the Secretary shall reduce the payment amount applied for such services by 10 percent, except that with respect to oxygen and oxygen equipment items, the Secretary shall reduce the payment amount applied for such items by 20 percent.”.

SEC. 7114. REDUCING EXCESSIVE BILLINGS AND UTILIZATION FOR CERTAIN ITEMS.

Section 1834(a)(15) (42 U.S.C. 1395m(a)(15)) is amended by striking “Secretary may” both places it appears and inserting “Secretary shall”.

SEC. 7115. IMPROVED CARRIER AUTHORITY TO REDUCE EXCESSIVE MEDICARE PAYMENTS.

(a) GENERAL RULE.—Section 1834(a)(10)(B) (42 U.S.C. 1395m(a)(10)(B)) is amended by striking “paragraphs (8) and (9)” and all that follows through the end of the sentence and inserting “section 1842(b)(8) to covered items and suppliers of such items and payments under this subsection as such provisions (relating to determinations of grossly excessive payment amounts) apply to items and services and entities and a reasonable charge under section 1842(b)”.

(b) REPEAL OF OBSOLETE PROVISIONS.—

(1) Section 1842(b)(8) (42 U.S.C. 1395u(b)(8)) is amended—

(A) by striking subparagraphs (B) and (C), (B) by striking “(8)(A)” and inserting “(8)”, and

(C) by redesignating clauses (i) and (ii) as subparagraphs (A) and (B), respectively.

(2) Section 1842(b)(9) (42 U.S.C. 1395u(b)(9)) is repealed.

(c) PAYMENT FOR SURGICAL DRESSINGS.—Section 1834(i) (42 U.S.C. 1395m(i)) is amended by adding at the end the following new paragraph:

“(3) GROSSLY EXCESSIVE PAYMENT AMOUNTS.—Notwithstanding paragraph (1), the Secretary may apply the provisions of section 1842(b)(8) to payments under this subsection.”.

SEC. 7116. EFFECTIVE DATE.

The amendments made by this chapter shall apply to items and services furnished under title XVIII of the Social Security Act on or after January 1, 1996.

PART II—MEDICARE BILLING ABUSE PREVENTION

SEC. 7121. IMPLEMENTATION OF GENERAL ACCOUNTING OFFICE RECOMMENDATIONS REGARDING MEDICARE CLAIMS PROCESSING.

(a) IN GENERAL.—Not later than 90 days after the date of the enactment of this Act, the Secretary shall, by regulation, contract, change order, or otherwise, require medicare carriers to acquire commercial automatic data processing equipment (in this subchapter referred to as “ADPE”) meeting the requirements of section 7122 to process medicare part B claims for the purpose of identifying billing code abuse.

(b) SUPPLEMENTATION.—Any ADPE acquired in accordance with subsection (a) shall be used as a supplement to any other ADPE used in claims processing by medicare carriers.

(c) STANDARDIZATION.—In order to ensure uniformity, the Secretary may require that medicare carriers that use a common claims processing system acquire common ADPE in implementing subsection (a).

(d) IMPLEMENTATION DATE.—Any ADPE acquired in accordance with subsection (a) shall be in use by medicare carriers not later than 180 days after the date of the enactment of this Act.

SEC. 7122. MINIMUM SOFTWARE REQUIREMENTS.

(a) IN GENERAL.—The requirements described in this section are as follows:

(1) The ADPE shall be a commercial item.

(2) The ADPE shall surpass the capability of ADPE used in the processing of medicare part B claims for identification of code manipulation on the day before the date of the enactment of this Act.

(3) The ADPE shall be capable of being modified to—

(A) satisfy pertinent statutory requirements of the medicare program; and

(B) conform to general policies of the Health Care Financing Administration regarding claims processing.

(b) MINIMUM STANDARDS.—Nothing in this subchapter shall be construed as preventing the use of ADPE which exceeds the minimum requirements described in subsection (a).

SEC. 7123. DISCLOSURE.

(a) IN GENERAL.—Notwithstanding any other provision of law, and except as provided in subsection (b), any ADPE or data related thereto acquired by medicare carriers in accordance with section 7121(a) shall not be subject to public disclosure.

(b) EXCEPTION.—The Secretary may authorize the public disclosure of any ADPE or data related thereto acquired by medicare carriers in accordance with section 7121(a) if the Secretary determines that—

(1) release of such information is in the public interest; and

(2) the information to be released is not protected from disclosure under section 552(b) of title 5, United States Code.

SEC. 7124. REVIEW AND MODIFICATION OF REGULATIONS.

Not later than 30 days after the date of the enactment of this Act, the Secretary shall order a review of existing regulations, guidelines, and other guidance governing medicare payment policies and billing code abuse to determine if revision of or addition to those regulations, guidelines, or guidance is necessary to maximize the benefits to the Federal Government of the use of ADPE acquired pursuant to section 7121.

SEC. 7125. DEFINITIONS.

For purposes of this chapter—

(1) The term “automatic data processing equipment” (ADPE) has the same meaning as in section 111(a)(2) of the Federal Property and Administrative Services Act of 1949 (40 U.S.C. 759(a)(2)).

(2) The term “billing code abuse” means the submission to medicare carriers of claims for services that include procedure codes that do not appropriately describe the total services provided or otherwise violate medicare payment policies.

(3) The term “commercial item” has the same meaning as in section 4(12) of the Office of Federal Procurement Policy Act (41 U.S.C. 403(12)).

(4) The term “medicare part B” means the supplementary medical insurance program authorized under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j–1395w–4).

(5) The term “medicare carrier” means an entity that has a contract with the Health Care Financing Administration to determine and make medicare payments for medicare part B benefits payable on a charge basis and to perform other related functions.

(6) The term “payment policies” means regulations and other rules that govern billing code abuses such as unbundling, global service violations, double billing, and unnecessary use of assistants at surgery.

(7) The term “Secretary” means the Secretary of Health and Human Services.

PART III—REFORMING PAYMENTS FOR AMBULANCE SERVICES

SEC. 7131. REFORMING PAYMENTS FOR AMBULANCE SERVICES.

(a) IN GENERAL.—Section 1834 (42 U.S.C. 1395m) is amended by adding at the end the following new subsection:

“(k) PAYMENT FOR AMBULANCE SERVICES.—

“(1) IN GENERAL.—Notwithstanding any other provision of this part, with respect to ambulance services described in section 1861(s)(7), payment shall be made based on the lesser of—

“(A) the actual charges for the services; or

“(B) the amount determined by a fee schedule developed by the Secretary.

“(2) FEE SCHEDULE.—The fee schedule established under paragraph (1) shall be established on a regional, statewide, or carrier service area basis (as the Secretary may determine to be appropriate) for services performed on or after January 1, 1996.

“(3) SEPARATE PAYMENT LEVELS.—

“(A) IN GENERAL.—In establishing the fee schedule under paragraph (2), the Secretary shall establish separate payment rates for advanced life support and basic life support services. Payment levels shall be restricted to the basic life support level unless the patient’s medical condition or other circumstance necessitates (as determined by the Secretary in regulations) the provisions of advanced life support services.

“(B) NONROUTINE BASIS.—The Secretary shall also establish appropriate payment levels for the provision of ambulance services that are provided on a routine or scheduled basis. Such payment levels shall not exceed 80 percent of the applicable rate for unscheduled transports.

“(4) ANNUAL ADJUSTMENT.—

“(A) IN GENERAL.—Except as provided in subparagraph (B), the fee schedules shall be adjusted annually (to become effective on January 1 of each year) by a percentage increase or decrease equal to the percentage increase or decrease in the consumer price index for all urban consumers (United States city average).

“(B) SPECIAL RULE.—Notwithstanding subparagraph (B), the annual adjustment in the fee schedules determined under such subparagraph for each of the years 1996 through

2002 shall be such consumer price index for the year minus 1 percentage point.

"(5) FURTHER ADJUSTMENTS.—The Secretary shall adjust the fee schedule to the extent necessary to ensure that the fee schedule takes into consideration the costs incurred in providing the transportation and associated services as well as technological changes.

"(6) SPECIAL RULE FOR END STAGE RENAL DISEASE BENEFICIARIES.—The Secretary shall direct the carriers to identify end stage renal disease beneficiaries who receive ambulance transports and—

"(A) make no payment for scheduled ambulance transports unless authorized in advance by the carrier; or

"(B) make no additional payment for scheduled ambulance transports for beneficiaries that have utilized ambulance services twice within 4 continuous days, or 7 times within a continuous 15-day period, unless authorized in advance by the carrier; or

"(C) institute other such safeguards as the Secretary may determine are necessary to ensure appropriate utilization of ambulance transports by such beneficiaries."

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished under title XVIII of the Social Security Act on and after January 1, 1997.

PART IV—REWARDS FOR INFORMATION

SEC. 7141. REWARDS FOR INFORMATION LEADING TO HEALTH CARE FRAUD PROSECUTION AND CONVICTION.

(a) IN GENERAL.—In special circumstances, the Secretary of Health and Human Services and the Attorney General of the United States may jointly make a payment of up to \$10,000 to a person who furnishes information unknown to the Government relating to a possible prosecution for health care fraud.

(b) INELIGIBLE PERSONS.—A person is not eligible for a payment under subsection (a) if—

(1) the person is a current or former officer or employee of a Federal or State government agency or instrumentality who furnishes information discovered or gathered in the course of government employment;

(2) the person knowingly participated in the offense;

(3) the information furnished by the person consists of allegations or transactions that have been disclosed to the public—

(A) in a criminal, civil, or administrative proceeding;

(B) in a congressional, administrative, or General Accounting Office report, hearing, audit, or investigation; or

(C) by the news media, unless the person is the original source of the information; or

(4) in the judgment of the Attorney General, it appears that a person whose illegal activities are being prosecuted or investigated could benefit from the award.

(c) DEFINITIONS.—

(1) HEALTH CARE FRAUD.—For purposes of this section, the term "health care fraud" means health care fraud within the meaning of section 1347 of title 18, United States Code.

(2) ORIGINAL SOURCE.—For the purposes of subsection (b)(3)(C), the term "original source" means a person who has direct and independent knowledge of the information that is furnished and has voluntarily provided the information to the Government prior to disclosure by the news media.

(d) NO JUDICIAL REVIEW.—Neither the failure of the Secretary of Health and Human Services and the Attorney General to authorize a payment under subsection (a) nor the amount authorized shall be subject to judicial review.

SEC. . INTERMEDIATE SANCTIONS FOR MEDICARE HEALTH MAINTENANCE ORGANIZATIONS.

(a) APPLICATION OF INTERMEDIATE SANCTIONS FOR ANY PROGRAM VIOLATIONS.—

(1) IN GENERAL.—Section 1876(i)(1) (42 U.S.C. 1395mm(i)(1)) is amended by striking "the Secretary may terminate" and all that follows and inserting "in accordance with procedures established under paragraph (9), the Secretary may at any time terminate any such contract or may impose the intermediate sanctions described in paragraph (6)(B) or (6)(C) (whichever is applicable) on the eligible organization if the Secretary determines that the organization—

"(A) has failed substantially to carry out the contract;

"(B) is carrying out the contract in a manner substantially inconsistent with the efficient and effective administration of this section; or

"(C) no longer substantially meets the applicable conditions of subsections (b), (c), (e), and (f)."

(2) OTHER INTERMEDIATE SANCTIONS FOR MISCELLANEOUS PROGRAM VIOLATIONS.—Section 1876(i)(6) (42 U.S.C. 1395mm(i)(6)) is amended by adding at the end the following new subparagraph:

"(C) In the case of an eligible organization for which the Secretary makes a determination under paragraph (1) the basis of which is not described in subparagraph (A), the Secretary may apply the following intermediate sanctions:

"(i) Civil money penalties of not more than \$25,000 for each determination under paragraph (1) if the deficiency that is the basis of the determination has directly adversely affected (or has the substantial likelihood of adversely affecting) an individual covered under the organization's contract.

"(ii) Civil money penalties of not more than \$10,000 for each week beginning after the initiation of procedures by the Secretary under paragraph (9) during which the deficiency that is the basis of a determination under paragraph (1) exists.

"(iii) Suspension of enrollment of individuals under this section after the date the Secretary notifies the organization of a determination under paragraph (1) and until the Secretary is satisfied that the deficiency that is the basis for the determination has been corrected and is not likely to recur."

(3) PROCEDURES FOR IMPOSING SANCTIONS.—Section 1876(i) (42 U.S.C. 1395mm(i)) is amended by adding at the end the following new paragraph:

"(9) The Secretary may terminate a contract with an eligible organization under this section or may impose the intermediate sanctions described in paragraph (6) on the organization in accordance with formal investigation and compliance procedures established by the Secretary under which—

"(A) the Secretary first provides the organization with the reasonable opportunity to develop and implement a corrective action plan to correct the deficiencies that were the basis of the Secretary's determination under paragraph (1) and the organization fails to develop or implement such a plan;

"(B) in deciding whether to impose sanctions, the Secretary considers aggravating factors such as whether an organization has a history of deficiencies or has not taken action to correct deficiencies the Secretary has brought to the organization's attention;

"(C) there are no unreasonable or unnecessary delays between the finding of a deficiency and the imposition of sanctions; and

"(D) the Secretary provides the organization with reasonable notice and opportunity for hearing (including the right to appeal an initial decision) before imposing any sanction or terminating the contract."

(4) CONFORMING AMENDMENTS.—Section 1876(i)(6)(B) (42 U.S.C. 1395mm(i)(6)(B)) is amended by striking the second sentence.

(b) AGREEMENTS WITH PEER REVIEW ORGANIZATIONS.—Section 1876(i)(7)(A) (42 U.S.C.

1395mm(i)(7)(A)) is amended by striking "an agreement" and inserting "a written agreement".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to contract years beginning on or after January 1, 1996.

CHAPTER 6—ESTABLISHMENT OF COMMISSION TO PREPARE FOR THE 21ST CENTURY.

SEC. 7161. ESTABLISHMENT.

(a) ESTABLISHMENT.—There is established a commission to be known as the Medicare Commission To Prepare For The 21st Century (hereafter in this Act referred to as the "Commission").

(b) MEMBERSHIP.—

(1) IN GENERAL.—The Commission shall be composed of 7 members appointed by the President and confirmed by the Senate. Not more than 4 members selected by the President shall be members of the same political party.

(2) EXPERTISE.—The membership of the Commission shall include individuals with national recognition for their expertise on health matters.

(3) DATE.—The appointments of the members of the Commission shall be made no later than December 31, 1995.

(c) PERIOD OF APPOINTMENT; VACANCIES.—Members shall be appointed for the life of the Commission. Any vacancy in the Commission shall not affect its powers, but shall be filled in the same manner as the original appointment.

(d) INITIAL MEETING.—No later than 30 days after the date on which all members of the Commission have been appointed, the Commission shall hold its first meeting.

(e) MEETINGS.—The Commission shall meet at the call of the Chairman.

(f) QUORUM.—A majority of the members of the Commission shall constitute a quorum, but a lesser number of members may hold hearings.

(g) CHAIRPERSON.—The President shall designate one person as Chairperson from among its members.

SEC. 7162. DUTIES OF THE COMMISSION.

(a) ANALYSES AND RECOMMENDATIONS.—

(1) IN GENERAL.—The Commission is charged with long-term strategic planning (for years after 2010) for the medicare program. The Commission shall—

(A) review long-term problems and opportunities facing the medicare program within the context of the overall health care system, including an analysis of the long-term financial condition of the medicare trust funds;

(B) analyze potential measures to assure continued adequacy of financing of the medicare program within the context of comprehensive health care reform and to guarantee medicare beneficiaries affordable and high quality health care services that takes into account—

(i) the health needs and financial status of senior citizens and the disabled,

(ii) overall trends in national health care costs,

(iii) the number of Americans without health insurance, and

(iv) the impact of its recommendations on the private sector and on the medicaid program;

(C) consider a range of program improvements, including measures to—

(i) reduce waste, fraud, and abuse,

(ii) improve program efficiency,

(iii) improve quality of care and access, and

(iv) examine ways to improve access to preventive care and primary care services,

(v) improve beneficiary cost consciousness, including an analysis of proposals that would restructure medicare from a defined benefits program to a defined contribution program and other means, and

(vi) measures to maintain a medicare beneficiary's ability to select a health care provider of the beneficiary's choice;

(D) prepare findings on the impact of all proposals on senior citizens' out-of-pocket health care costs and on any special considerations that should be made for seniors that live in rural areas and inner cities;

(E) recognize the uncertainties of long range estimates; and

(F) provide appropriate recommendations to the Secretary of Health and Human Services, the President, and the Congress.

(2) DEFINITION OF MEDICARE TRUST FUNDS.—For purposes of this subsection, the term "medicare trust funds" means the Federal Hospital Insurance Trust Fund established under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of such Act (42 U.S.C. 1395t).

(b) REPORT.—The Commission shall submit its report to the President and the Congress not later than July 31, 1996.

SEC. 7163. POWERS OF THE COMMISSION.

(a) HEARINGS.—The Commission may hold such hearings, sit and act at such times and places, take such testimony, and receive such evidence as the Commission considers advisable to carry out the purposes of this Act.

(b) INFORMATION FROM FEDERAL AGENCIES.—The Commission may secure directly from any Federal department or agency such information as the Commission considers necessary to carry out the provisions of this Act. Upon request of the Chairman of the Commission, the head of such department or agency shall furnish such information to the Commission.

(c) POSTAL SERVICES.—The Commission may use the United States mails in the same manner and under the same conditions as other departments and agencies of the Federal Government.

SEC. 7164. COMMISSION PERSONNEL MATTERS.

(a) COMPENSATION OF MEMBERS.—

(1) OFFICERS AND EMPLOYEES OF THE FEDERAL GOVERNMENT.—All members of the Commission who are officers or employees of the Federal Government shall serve without compensation in addition to that received for their services as officers or employees of the United States.

(2) PRIVATE CITIZENS OF THE UNITED STATES.—

(A) IN GENERAL.—Subject to subparagraph (B), all members of the Commission who are not officers or employees of the Federal Government shall serve without compensation for their work on the Commission.

(B) TRAVEL EXPENSES.—The members of the Commission who are not officers or employees of the Federal Government 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 Commission, to the extent funds are available therefor.

(b) STAFF.—

(1) IN GENERAL.—The Chairman of the Commission may, without regard to the civil service laws and regulations, appoint and terminate an executive director and such other additional personnel as may be necessary to enable the Commission to perform

its duties. At the request of the Chairman, the Secretary of Health and Human Services shall provide the Commission with any necessary administrative and support services. The employment of an executive director shall be subject to confirmation by the Commission.

(2) COMPENSATION.—The Chairman of the Commission may fix the compensation of the executive director and other personnel without regard to the provisions of chapter 51 and subchapter III of chapter 53 of title 5, United States Code, relating to classification of positions and General Schedule pay rates, except that the rate of pay for the executive director and other personnel may not exceed the rate payable for level V of the Executive Schedule under section 5316 of such title.

(c) DETAIL OF GOVERNMENT EMPLOYEES.—Any Federal Government employee may be detailed to the Commission without reimbursement, and such detail shall be without interruption or loss of civil service status or privilege.

(d) PROCUREMENT OF TEMPORARY AND INTERMITTENT SERVICES.—The Chairman of the Commission may procure temporary and intermittent services under section 3109(b) of title 5, United States Code, at rates for individuals which do not exceed the daily equivalent of the annual rate of basic pay prescribed for level V of the Executive Schedule under section 5316 of such title.

SEC. 7165. TERMINATION OF THE COMMISSION.

The Commission shall terminate 30 days after the date on which the Commission submits its report under section 7702(b).

SEC. 7166. FUNDING FOR THE COMMISSION.

Any expenses of the Commission shall be paid from such funds as may be otherwise available to the Secretary of Health and Human Services.

CHAPTER 7—MEASURES TO IMPROVE THE SOLVENCY OF THE TRUST FUNDS

Subchapter A—Provisions Relating to Part A

PART I—GENERAL PROVISIONS

SEC. 7171. PPS HOSPITAL PAYMENT UPDATE.

Section 1886(b)(3)(B)(i) (42 U.S.C. 1395ww(b)(3)(B)(i)) is amended by striking subclauses (XII) and (XIII) and inserting the following new subclauses:

"(XII) for fiscal year 1997 through 2002, the market basket percentage increase minus 1.0 percentage point for hospitals located in a large urban or other urban area, and the market basket percentage increase minus 0.5 percentage point for hospitals located in a rural area, and

"(XIII) for fiscal year 2003 and each subsequent fiscal year, the market basket percentage increase for hospitals in all areas."

SEC. 7172. MODIFICATION IN PAYMENT POLICIES REGARDING GRADUATE MEDICAL EDUCATION.

(a) INDIRECT COSTS OF MEDICAL EDUCATION; APPLICABLE PERCENTAGE.—

(1) IN GENERAL.—Section 1886(d)(5)(B)(ii) (42 U.S.C. 1395ww(d)(5)(B)(ii)) is amended to read as follows:

"(ii) For purposes of clause (i)(II), the indirect teaching adjustment factor is equal to $c(((1+r) \text{ to the } n\text{th power}) - 1)$, where 'r' is the ratio of the hospital's full-time equivalent interns and residents to beds and 'n' equals .405. For discharges occurring on or after—

"(I) May 1, 1986, and before October 1, 1995, 'c' is equal to 1.89; and

"(II) October 1, 1995, 'c' is equal to 1.48.

(2) NO RESTANDARDIZATION OF PAYMENT AMOUNTS REQUIRED.—Section 1886(d)(2)(C)(i) (42 U.S.C. 1395ww(d)(2)(C)(i)) is amended by striking "of 1985" and inserting "of 1985, but not taking into account the amendments made by section 7172(a)(1) of the Medicare Improvement and Solvency Protection Act of 1995".

(b) LIMITATION ON NUMBER OF RESIDENTS.—

(1) DIRECT GRADUATE MEDICAL EDUCATION.—Section 1886(h)(4) (42 U.S.C. 1395ww(h)(4)) is amended by adding at the end the following new subparagraph:

"(F) LIMITATION ON NUMBER OF RESIDENTS FOR CERTAIN FISCAL YEARS.—Such rules shall provide that for purposes of a cost reporting period beginning on or after October 1, 1995, and on or before September 30, 2002, the number of full-time-equivalent residents (and full-time-equivalent residents who are not primary care residents) determined under this paragraph with respect to an approved medical residency training program may not exceed the number of full-time-equivalent residents (and full-time-equivalent residents who are not primary care residents) with respect to the program as of August 1, 1995. This subparagraph does not apply to any nonphysician postgraduate training program that, under paragraph (5)(A), is an approved medical residency training program."

(2) INDIRECT MEDICAL EDUCATION.—Section 1886(d)(5)(B) (42 U.S.C. 1395ww(d)(5)(B)) is amended—

(A) in clause (ii), by striking "to beds" and inserting "to beds (subject to clause (v))"; and

(B) by adding at the end the following new clauses:

"(v) For purposes of this subparagraph, as of July 1, 1996, 'r' may not exceed the ratio of the number of interns and residents as determined under section 1886(h)(4) with respect to the hospital as of August 1, 1995, to the hospital's number of usable beds as of August 1, 1995.

"(vi) In determining such adjustment with respect to discharges of a hospital occurring on or after October 1, 1995, and on or before September 30, 2002, the number of interns and residents determined under clause (ii) with respect to a hospital may not exceed a number determined by the Secretary by applying rules similar to the rules of subsection (h)(4)(F)."

SEC. 7173. ELIMINATION OF DSH AND IME FOR OUTLIERS.

(a) INDIRECT MEDICAL EDUCATION ADJUSTMENTS.—Section 1886(d)(5)(B)(i)(I) (42 U.S.C. 1395ww(d)(5)(B)(i)(I)) is amended by striking "and the amount paid to the hospital under subparagraph (A)".

(b) DISPROPORTIONATE SHARE ADJUSTMENT.—Section 1886(d)(5)(F)(ii)(I) (42 U.S.C. 1395ww(d)(5)(F)(ii)(I)) is amended by striking "and the amount paid to the hospital under subparagraph (A) for that discharge".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to discharges occurring on or after October 1, 1995.

SEC. 7174. CAPITAL PAYMENTS FOR PPS INPATIENT HOSPITALS.

Section 1886(g)(1)(A) (42 U.S.C. 1395ww(g)(1)(A)) is amended by—

(1) by striking "through 1995" and inserting "through 2002"; and

(2) by inserting after "reduction" the following: "(or a 15 percent reduction in the case of payments during fiscal years 1996 through 2002)".

SEC. 7175. TREATMENT OF PPS-EXEMPT HOSPITALS.

(a) REBASING FOR PPS-EXEMPT HOSPITALS.—Section 1886(b)(3)(A) (42 U.S.C. 1395ww(b)(3)(A)) is amended to read as follows:

"(A)(i) Subject to clause (ii), and except as provided in subparagraphs (C), (D), and (E), for purposes of this subsection, the term 'target amount' means—

"(I) with respect to the first 12-month cost reporting period in which this subparagraph is applied to the hospital, the average allowable operating costs of inpatient hospital

services (as defined in subsection (a)(4)) recognized under this title for the hospital for the hospital's 2 most recent 12-month cost reporting periods beginning on or after October 1, 1990, increased in a compounded manner by the applicable percentage increases determined under subparagraph (B)(ii) for the hospital's succeeding cost reporting periods through fiscal year 1996; or

"(II) with respect to a later cost reporting period, the target amount for the preceding cost reporting period, increased by the applicable percentage increase under subparagraph (B)(ii) for that later cost reporting period.

"(ii) Notwithstanding subsection (a), in the case of a hospital (or unit) that did not have a cost reporting period beginning on or before October 1, 1990—

"(I) with respect to cost reporting periods beginning during the hospital's first fiscal year of operation, the amount of payments that may be made under this title with respect to operating costs of inpatient hospital services (as defined in subsection (a)(4)) shall be the reasonable costs for providing such services, except that such amount may not exceed 150 percent of the national average allowable operating costs of inpatient hospital services for a hospital (or unit) of the same grouping as such hospital for the hospital's first fiscal year of operation;

"(II) with respect to cost reporting periods beginning during the hospital's second fiscal year of operation, the amount determined under subclause (I), increased by the market basket percentage increase for such year (determined under subparagraph (B)(iii)); and

"(III) with respect to succeeding cost reporting periods, clause (i) shall apply to such hospital except that the 'target amount' for such hospital shall be the average allowable operating costs of inpatient hospital services (as defined in subsection (a)(4)) recognized under this title for the hospital for the hospital's 2 12-month cost reporting periods beginning 1 year after the hospital accepts its first patient."

(b) NON-PPS HOSPITAL PAYMENT UPDATE.—Section 1886(b)(3)(B)(ii) (42 U.S.C. 1395ww(b)(3)(B)(ii)) is amended—

(1) in subclause (V)—

(A) by striking "1997" and inserting "1995"; and

(B) by striking "and" at the end; and

(2) by striking subclause (VI) and inserting the following subclauses:

"(VI) for fiscal year 1996, the market basket percentage increase minus 2 percentage points for hospitals located in all areas,

"(VII) for fiscal years 1997 through 2002, the market basket percentage increase minus 1.0 percentage point for hospitals located in a large urban or other urban area, and the market basket percentage increase minus 0.5 percentage point for hospitals located in a rural area, and

"(IX) for fiscal year 2003 and each subsequent fiscal year, the market basket percentage increase for hospitals in all areas."

(c) EXCEPTIONS AND ADJUSTMENTS.—Section 1886(b)(4)(A)(i) (42 U.S.C. 1395ww(b)(4)(A)(i)) is amended by striking the first sentence and inserting the following:

"The Secretary shall provide for an exemption from, or an exception and adjustment to, the method under his subsection for determining the amount of payment to a hospital with respect to the hospital's 12-month cost reporting period beginning in a fiscal year where the hospital's allowable operating costs of inpatient hospital services recognized under this title for the hospital's 12-month cost reporting period beginning in the preceding fiscal year, exceeds the hospital's target amount (as determined under subparagraph (A)) for such cost reporting period by at least 50 percent."

(d) ELIMINATION OF INCENTIVE PAYMENTS.—Section 1886(b)(1) (42 U.S.C. 1395ww(b)(1)) is amended to read as follows:

"(b)(1)(A) Notwithstanding section 1814(b) but subject to the provisions of section 1813 and paragraph (2), if the operating costs of inpatient hospital services (as defined in subsection (a)(4)) of a hospital (other than a subsection (d) hospital, as defined in subsection (d)(1)(B)) for a cost reporting period subject to this paragraph are greater than the target amount by at least 10 percent, the amount of the payment with respect to such operating costs payable under part A on a per discharge or per admission basis (as the case may be) shall be equal to the sum of—

"(i) the target amount, plus

"(ii) an additional amount equal to 50 percent of the amount by which the operating costs exceed 110 percent of the target amount (except that such additional amount may not exceed 20 percent of the target amount) after any exceptions or adjustments are made to such target amount for the cost reporting period.

"(B) In no case may the amount payable under this title (other than on the basis of a DRG prospective payment rate determined under subsection (d)) with respect to operating costs of inpatient hospital services exceed the maximum amount payable with respect to such costs pursuant to subsection (a)."

(e) FLOORS AND CEILINGS FOR TARGET AMOUNTS.—Section 1886(b)(3)(A) (42 U.S.C. 1395ww(b)(3)(A)), as amended by subsection (a), is amended by adding at the end the following new clauses:

"(ii) Notwithstanding clause (i), in the case of a hospital (or unit thereof)—

"(I) the target amount determined under this subparagraph for such hospital or unit for a cost reporting period beginning during a fiscal year shall not be less than 70 percent of the national mean (weighted by caseload) of the target amounts determined under this paragraph for all hospitals (and units thereof) of such grouping for cost reporting periods beginning during such fiscal year (determined without regard to this clause); and

"(II) such target amount may not be greater than 130 percent of the national mean (weighted by caseload) of the target amounts for such hospitals (and units thereof) of such grouping for cost reporting periods beginning during such fiscal year."

(f) EFFECTIVE DATE.—The amendment made by this section shall apply to discharges occurring during cost reporting periods beginning on or after October 1, 1995.

SEC. 7176. PPS-EXEMPT CAPITAL PAYMENTS.

Section 1886(g) (42 U.S.C. 1395ww(g)) is amended by adding at the end the following new paragraph:

"(4) In determining the amount of the payments that may be made under this title with respect to all the capital-related costs of inpatient hospital services furnished during fiscal years 1996 through 2005 of a hospital which is not a subsection (d) hospital or a subsection (d) Puerto Rico hospital, the Secretary shall reduce the amounts of such payments otherwise determined under this title by 15 percent."

SEC. 7177. PROHIBITION OF PPS EXEMPTION FOR NEW LONG-TERM HOSPITALS.

Section 1886(d)(1)(B)(iv) (42 U.S.C. 1395ww(d)(1)(B)(iv)) is amended by striking "25 days" and inserting "25 days and which received payment under this section on or before November 30, 1995".

SEC. 7178. REVISION OF DEFINITION OF TRANSFERS FROM HOSPITALS TO POST-ACUTE FACILITIES.

(a) IN GENERAL.—Section 1886(d)(5)(I) (42 U.S.C. 1395ww(d)(5)(I)) is amended by adding at the end the following new clause:

"(iii) Effective for discharges occurring on or after October 1, 1995, transfer cases (as

otherwise defined by the Secretary) shall also include cases in which a patient is transferred from a subsection (d) hospital to a hospital or hospital unit that is not a subsection (d) hospital (under section 1886(d)(1)(B)) or to a skilled nursing facility."

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to discharges occurring on or after October 1, 1995.

SEC. 7179. DIRECTION OF SAVINGS TO HOSPITAL INSURANCE TRUST FUND.

Section 1841 (42 U.S.C. 1395t) is amended by adding at the end the following new subsection:

"(j) There are hereby appropriated for each fiscal year to the Federal Hospital Insurance Trust Fund amounts equal to the estimated savings to the general fund of the Treasury for such year resulting from the provisions of and amendments made by the Medicare Improvement and Solvency Protection Act of 1995. The Secretary of the Treasury shall from time to time transfer from the general fund of the Treasury to the Federal Hospital Insurance Trust Fund amounts equal to such estimated savings in the form of public-debt obligations issued exclusively to the Federal Hospital Insurance Trust Fund."

PART II—SKILLED NURSING FACILITIES

SEC. 7181. PROSPECTIVE PAYMENT FOR SKILLED NURSING FACILITIES.

Section 1888 (42 U.S.C. 1395yy) is amended by adding at the end the following new subsections:

"(e) Notwithstanding any other provision of this title, the Secretary shall, for cost reporting periods beginning on or after October 1, 1996, provide for payment for routine costs of extended care services in accordance with a prospective payment system established by the Secretary, subject to the limitations in subsections (f) through (h).

"(f)(1) The amount of payment under subsection (e) shall be determined on a per diem basis.

"(2) The Secretary shall compute the routine costs per diem in a base year (determined by the Secretary) for each skilled nursing facility, and shall update the per diem rate on the basis of a market basket and other factors as the Secretary determines appropriate.

"(3) The per diem rate applicable to a skilled nursing facility may not exceed the following limits:

"(A) With respect to skilled nursing facilities located in rural areas, the limit shall be equal to 112 percent of the mean per diem routine costs in a base year (determined by the Secretary) for freestanding skilled nursing facilities located in rural areas within the same region, as updated by the same percentage determined under paragraph (2).

"(B) With respect to skilled nursing facilities located in urban areas, the limit shall be equal to 112 percent of the mean per diem routine costs in a base year (determined by the Secretary) for freestanding skilled nursing facilities located in urban areas within the same region, updated by the same percentage determined under paragraph (2).

"(C) With respect a skilled nursing facility that does not have a base year (determined by the Secretary under subparagraph (A) or (B)), the limit for such facility for cost reporting periods (or portions of cost reporting periods) beginning prior to October 1, 1998, shall be equal to 100 percent of the mean costs of freestanding skilled nursing facilities located in rural or urban areas (as applicable).

For purposes of this paragraph, the terms 'urban', 'rural', and 'region' have the meaning given such terms in section 1886(d)(2)(D).

"(4)(A) Subject to subparagraph (B), the Secretary may not make adjustments or exceptions to the limits determined under paragraph (3).

"(B) For periods prior to October 1, 1998, a facility's payment for routine costs shall be the greater of—

"(i) the facility's limit as of the date of the enactment of the Medicare Improvement and Solvency Protection Act of 1995; or

"(ii) the regional limit determined under this paragraph (3) (including any exception amounts that were in effect in the base year), updated in accordance with paragraph (2).

"(C) The Secretary shall not provide for new provider exemptions under this subsection under section 413.30(e)(2) of title 42 of the Code of Federal Regulations and shall not include such exemption amounts determined in the base year for purposes of subparagraph (B)(ii).

"(I) In the case of a skilled nursing facility which received an adjustment to the facility's limit in the base year (determined by the Secretary under paragraph (3)), the facility shall receive an adjustment to the limit determined under paragraph (3) for a fiscal year if the magnitude and scope of the case mix or circumstances resulting in the base year adjustment are at least as great for such fiscal year.

"(g)(I) In the case of a hospital-based skilled nursing facility receiving payments under this title as of the date of enactment of this subsection, the amount of payment to the facility based on application of subsections (e) and (f) may not be less than the per diem rate applicable to the facility for routine costs on the date of enactment of this subsection.

"(2) In the case of a skilled nursing facility receiving payment under subsection (d) as of the date of enactment of this subsection, such facility may elect, in lieu of payment otherwise determined under this section for routine service costs, to receive payments under this section in an amount equal to a rate equal to 100 percent of the mean routine service costs of free standing skilled nursing facilities by rural or urban area, as applicable.

"(h) The Secretary shall, for cost reporting periods beginning on or after October 1, 1996, and before the prospective payment system is established under subsection (i), the Secretary shall not provide for payment for ancillary costs of extended care services in accordance with section 1861(v) in excess of the amount that would be paid under the fee schedules applicable to such services under sections 1834 and 1848.

"(i)(1) Notwithstanding any other provision of this title, the Secretary shall, for cost reporting periods beginning on or after October 1, 1998, provide for payment for all costs of extended care services (including routine service costs, ancillary costs, and capital-related costs) in accordance with a prospective payment system established by the Secretary.

"(2)(A) Prior to implementing the prospective system described in paragraph (1) in a budget-neutral fashion, the Secretary shall reduce by 5 percent the per diem rates for routine costs, and the cost limits for ancillary services and capital for skilled nursing facilities as such rates and costs are in effect on September 30, 1998.

"(B) Subject to the reduction under subparagraph (B), the Secretary shall establish the prospective payment system described in paragraph (1) such that aggregate payments under such system for a fiscal year shall not exceed the payments that would have otherwise been made for such fiscal year.

"(j) Each skilled nursing facility shall be required to include uniform coding (includ-

ing HCPCS codes, if applicable) on the facility's cost reports".

SEC. 7182. MAINTAINING SAVINGS RESULTING FROM TEMPORARY FREEZE ON PAYMENT INCREASES FOR SKILLED NURSING FACILITIES.

(a) BASING UPDATES TO PER DIEM COST LIMITS ON LIMITS FOR FISCAL YEAR 1993.—

(1) IN GENERAL.—The last sentence of section 1888(a) (42 U.S.C. 1395yy(a)) is amended by adding at the end the following: "(except that such updates may not take into account any changes in the routine service costs of skilled nursing facilities occurring during cost reporting periods which began during fiscal year 1994 or fiscal year 1995)."

(2) NO EXCEPTIONS PERMITTED BASED ON AMENDMENT.—The Secretary of Health and Human Services shall not consider the amendment made by paragraph (1) in making any adjustments pursuant to section 1888(c) of the Social Security Act.

(b) PAYMENTS DETERMINED ON PROSPECTIVE BASIS.—Any change made by the Secretary of Health and Human Services in the amount of any prospective payment paid to a skilled nursing facility under section 1888(d) of the Social Security Act for cost reporting periods beginning on or after October 1, 1995, may not take into account any changes in the costs of services occurring during cost reporting periods which began during fiscal year 1994 or fiscal year 1995.

SEC. 7183. CONSOLIDATED BILLING.

(a) REQUIREMENT OF ARRANGEMENTS.—Section 1862(a) (42 U.S.C. 1395y(a)) is amended—

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

(2) by striking the period at the end of paragraph (15) and inserting the following:

"(16) which are other than physicians' services, services described by clauses (i) or (ii) of section 1861(s)(2)(K), certified nurse-midwife services, qualified psychologist services, or services of a certified registered nurse anesthetist, and which are furnished to an individual who is a resident of a skilled nursing facility by an entity other than the skilled nursing facility, unless the services are furnished under arrangements (as defined in section 1861(w)(1)) with the entity made by the skilled nursing facility."

(b) AGREEMENTS WITH PROVIDERS OF SERVICES.—Section 1866(a)(1)(H) (42 U.S.C. 1395cc(a)(1)(H)) is amended—

(1) by redesignating clauses (i) and (ii), as subclauses (I) and (II), respectively;

(2) by inserting "(i)" after "(H)"; and

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

"(i) in the case of skilled nursing facilities which provide services for which payment may be made under this title, to have all items and services (other than physicians services, and other than services described by sections 1861(s)(2)(K) (i) or (ii), certified nurse-midwife services, qualified psychologist services, or services of a certified registered nurse anesthetist—

"(I) that are furnished to an individual who is a resident of the skilled nursing facility, and

"(II) for which the individual is entitled to have payment made under this title, furnished by the skilled nursing facility or otherwise under arrangements (as defined in section 1861(w)(1)) made by the skilled nursing facility."

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after October 1, 1996.

Subchapter B—Provisions Relating to Part B
SEC. 7184. PHYSICIAN UPDATE FOR 1996.

(a) SPECIAL RULE FOR 1996.—Section 1848(d)(3) is amended by adding at the end the following new subparagraph:

"(C) SPECIAL RULE FOR 1996.—In determining the update under subparagraphs (A) and

(B) for 1996, the Secretary shall use the same percentage increase for all categories of service, determined in a budget-neutral manner, weighting the percentage increase for each of the 3 categories of service by the category's respective share of expenditures. The update determined in the previous sentence shall be reduced by 0.8 percentage points for all physicians' services, except for primary care services (as defined in section 1842(i)(4))."

SEC. 7185. PRACTICE EXPENSE RELATIVE VALUE UNITS.

(a) EXTENSION TO 1997.—Section 1848(c)(2)(E) is amended—

(1) by striking "and" at the end of clause (i)(II),

(2) by striking the period at the end of clause (i)(III) and inserting ", and", and

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

"(IV) 1997, by an additional 25 percent of such excess."

(b) CHANGE IN FLOOR ON REDUCTIONS AND SERVICES COVERED.—Clauses (ii) and (iii)(II) of section 1848(c)(2)(E) are amended by inserting "(or 115 percent in the case of 1997)" after "128 percent".

SEC. 7186. CORRECTION OF MVPS UPWARD BIAS.

(a) IN GENERAL.—Section 1848(f)(2)(A)(iv) (42 U.S.C. 1395w-4(f)(2)(A)(iv)) is amended by striking "including changes in law and regulations affecting the percentage increase described in clause (i)" and inserting "excluding anticipated responses to such changes".

(b) REPEAL OF RESTRICTION ON MAXIMUM REDUCTION.—Section 1848(d)(3)(B)(ii) (42 U.S.C. 1395w-4(d)(3)(B)(ii)) is amended—

(1) in the heading by inserting "IN CERTAIN YEARS" AFTER "ADJUSTMENT";

(2) in the matter preceding subclause (I), by striking "for a year";

(3) in subclause (II), by striking "and"; and

(4) in subclause (III), by striking "any succeeding year" and inserting "1995, 1996, and 1997".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to performance standard rates of increase determined for fiscal year 1996 and succeeding fiscal years.

SEC. 7187. LIMITATIONS ON PAYMENT FOR PHYSICIANS' SERVICES FURNISHED BY HIGH-COST HOSPITAL MEDICAL STAFFS.

(a) IN GENERAL.—

(1) LIMITATIONS DESCRIBED.—Part B of title XVIII, is amended by inserting after section 1848 the following new section:

"LIMITATIONS ON PAYMENT FOR PHYSICIANS' SERVICES FURNISHED BY HIGH-COST HOSPITAL MEDICAL STAFFS

"SEC. 1849. (a) SERVICES SUBJECT TO REDUCTION.—

"(1) DETERMINATION OF HOSPITAL-SPECIFIC PER ADMISSION RELATIVE VALUE.—Not later than October 1 of each year (beginning with 1997), the Secretary shall determine for each hospital—

"(A) the hospital-specific per admission relative value under subsection (b)(2) for the following year; and

"(B) whether such hospital-specific relative value is projected to exceed the allowable average per admission relative value applicable to the hospital for the following year under subsection (b)(1).

"(2) REDUCTION FOR SERVICES AT HOSPITALS EXCEEDING ALLOWABLE AVERAGE PER ADMISSION RELATIVE VALUE.—If the Secretary determines (under paragraph (1)) that a medical staff's hospital-specific per admission relative value for a year (beginning with 1998) is projected to exceed the allowable average per admission relative value applicable to the medical staff for the year, the Secretary shall reduce (in accordance with subsection

(c) the amount of payment otherwise determined under this part for each physician's service furnished during the year to an inpatient of the hospital by an individual who is a member of the hospital's medical staff.

“(3) TIMING OF DETERMINATION; NOTICE TO HOSPITALS AND CARRIERS.—Not later than October 1 of each year (beginning with 1997), the Secretary shall notify the medical executive committee of each hospital (as set forth in the Standards of the Joint Commission on the Accreditation of Health Organizations) of the determinations made with respect to the medical staff under paragraph (1).

“(b) DETERMINATION OF ALLOWABLE AVERAGE PER ADMISSION RELATIVE VALUE AND HOSPITAL-SPECIFIC PER ADMISSION RELATIVE VALUES.—

“(1) ALLOWABLE AVERAGE PER ADMISSION RELATIVE VALUE.—

“(A) URBAN HOSPITALS.—In the case of a hospital located in an urban area, the allowable average per admission relative value established under this subsection for a year is equal to 125 percent (or 120 percent for years after 1999) of the median of 1996 hospital-specific per admission relative values determined under paragraph (2) for all hospital medical staffs.

“(B) RURAL HOSPITALS.—In the case of a hospital located in a rural area, the allowable average per admission relative value established under this subsection for 1998 and each succeeding year, is equal to 140 percent of the median of the 1996 hospital-specific per admission relative values determined under paragraph (2) for all hospital medical staffs.

“(2) HOSPITAL-SPECIFIC PER ADMISSION RELATIVE VALUE.—

“(A) IN GENERAL.—The hospital-specific per admission relative value projected for a hospital (other than a teaching hospital) for a calendar year, shall be equal to the average per admission relative value (as determined under section 1848(c)(2)) for physicians' services furnished to inpatients of the hospital by the hospital's medical staff (excluding interns and residents) during the second calendar year preceding such calendar year, adjusted for variations in case-mix and disproportionate share status among hospitals (as determined by the Secretary under subparagraph (C)).

“(B) SPECIAL RULE FOR TEACHING HOSPITALS.—The hospital-specific relative value projected for a teaching hospital in a calendar year shall be equal to the sum of—

“(i) the average per admission relative value (as determined under section 1848(c)(2)) for physicians' services furnished to inpatients of the hospital by the hospital's medical staff (excluding interns and residents) during the second year preceding such calendar year; and

“(ii) the equivalent per admission relative value (as determined under section 1848(c)(2)) for physicians' services furnished to inpatients of the hospital by interns and residents of the hospital during the second year preceding such calendar year, adjusted for variations in case-mix, disproportionate share status, and teaching status among hospitals (as determined by the Secretary under subparagraph (C)). The Secretary shall determine such equivalent relative value unit per admission for interns and residents based on the best available data for teaching hospitals and may make such adjustment in the aggregate.

“(C) ADJUSTMENT FOR TEACHING AND DISPROPORTIONATE SHARE HOSPITALS.—The Secretary shall adjust the allowable per admission relative values otherwise determined under this paragraph to take into account the needs of teaching hospitals and hospitals receiving additional payments under subparagraphs (F) and (G) of section 1886(d)(5).

The adjustment for teaching status or disproportionate share shall not be less than zero.

“(c) AMOUNT OF REDUCTION.—The amount of payment otherwise made under this part for a physician's service that is subject to a reduction under subsection (a) during a year shall be reduced 15 percent, in the case of a service furnished by a member of the medical staff of the hospital for which the Secretary determines under subsection (a)(1) that the hospital medical staff's projected relative value per admission exceeds the allowable average per admission relative value.

“(d) RECONCILIATION OF REDUCTIONS BASED ON HOSPITAL-SPECIFIC RELATIVE VALUE PER ADMISSION WITH ACTUAL RELATIVE VALUES.—

“(1) DETERMINATION OF ACTUAL AVERAGE PER ADMISSION RELATIVE VALUE.—Not later than October 1 of each year (beginning with 1999), the Secretary shall determine the actual average per admission relative value (as determined pursuant to section 1848(c)(2)) for the physicians' services furnished by members of a hospital's medical staff to inpatients of the hospital during the previous year, on the basis of claims for payment for such services that are submitted to the Secretary not later than 90 days after the last day of such previous year. The actual average per admission shall be adjusted by the appropriate case-mix, disproportionate share factor, and teaching factor for the hospital medical staff (as determined by the Secretary under subsection (b)(2)(C)). Notwithstanding any other provision of this title, no payment may be made under this part for any physician's service furnished by a member of a hospital's medical staff to an inpatient of the hospital during a year unless the hospital submits a claim to the Secretary for payment for such service not later than 90 days after the last day of the year.

“(2) RECONCILIATION WITH REDUCTIONS TAKEN.—In the case of a hospital for which the payment amounts for physicians' services furnished by members of the hospital's medical staff to inpatients of the hospital were reduced under this section for a year—

“(A) if the actual average per admission relative value for such hospital's medical staff during the year (as determined by the Secretary under paragraph (1)) did not exceed the allowable average per admission relative value applicable to the hospital's medical staff under subsection (b)(1) for the year, the Secretary shall reimburse the fiduciary agent for the medical staff by the amount by which payments for such services were reduced for the year under subsection (c), including interest at an appropriate rate determined by the Secretary;

“(B) if the actual average per admission relative value for such hospital's medical staff during the year is less than 15 percentage points above the allowable average per admission relative value applicable to the hospital's medical staff under subsection (b)(1) for the year, the Secretary shall reimburse the fiduciary agent for the medical staff, as a percent of the total allowed charges for physicians' services performed in such hospital (prior to the withhold), the difference between 15 percentage points and the actual number of percentage points that the staff exceeds the limit allowable average per admission relative value, including interest at an appropriate rate determined by the Secretary; and

“(C) if the actual average per admission relative value for such hospital's medical staff during the year exceeded the allowable average per admission relative value applicable to the hospital's medical staff by 15 percentage points or more, none of the withhold is paid to the fiduciary agent for the medical staff.

“(3) MEDICAL EXECUTIVE COMMITTEE OF A HOSPITAL.—Each medical executive committee of a hospital whose medical staff is projected to exceed the allowable relative value per admission for a year, shall have one year from the date of notification that such medical staff is projected to exceed the allowable relative value per admission to designate a fiduciary agent for the medical staff to receive and disburse any appropriate withhold amount made by the carrier.

“(4) ALTERNATIVE REIMBURSEMENT TO MEMBERS OF STAFF.—At the request of a fiduciary agent for the medical staff, if the fiduciary agent for the medical staff is owed the reimbursement described in paragraph (2)(B) for excess reductions in payments during a year, the Secretary shall make such reimbursement to the members of the hospital's medical staff, on a pro-rata basis according to the proportion of physicians' services furnished to inpatients of the hospital during the year that were furnished by each member of the medical staff.

“(e) DEFINITIONS.—In this section, the following definitions apply:

“(1) MEDICAL STAFF.—An individual furnishing a physician's service is considered to be on the medical staff of a hospital—

“(A) if (in accordance with requirements for hospitals established by the Joint Commission on Accreditation of Health Organizations)—

“(i) the individual is subject to bylaws, rules, and regulations established by the hospital to provide a framework for the self-governance of medical staff activities;

“(ii) subject to such bylaws, rules, and regulations, the individual has clinical privileges granted by the hospital's governing body; and

“(iii) under such clinical privileges, the individual may provide physicians' services independently within the scope of the individual's clinical privileges, or

“(B) if such physician provides at least one service to a medicare beneficiary in such hospital.

“(2) RURAL AREA; URBAN AREA.—The terms ‘rural area’ and ‘urban area’ have the meaning given such terms under section 1886(d)(2)(D).

“(3) TEACHING HOSPITAL.—The term ‘teaching hospital’ means a hospital which has a teaching program approved as specified in section 1861(b)(6).”

(2) CONFORMING AMENDMENTS.—(A) Section 1833(a)(1)(N) (42 U.S.C. 1395l(a)(1)(N)) is amended by inserting “(subject to reduction under section 1849)” after “1848(a)(1)”.’

(B) Section 1848(a)(1)(B) (42 U.S.C. 1395w-4(a)(1)(B)) is amended by striking “this subsection,” and inserting “this subsection and section 1849.”

(b) REQUIRING PHYSICIANS TO IDENTIFY HOSPITAL AT WHICH SERVICE FURNISHED.—Section 1848(g)(4)(A)(i) (42 U.S.C. 1395w-4(g)(4)(A)(i)) is amended by striking “beneficiary,” and inserting “beneficiary (and, in the case of a service furnished to an inpatient of a hospital, report the hospital identification number on such claim form).”

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 1998.

SEC. 7188. ELIMINATION OF CERTAIN ANOMALIES IN PAYMENTS FOR SURGERY.

(a) GENERAL RULE.—

(1) Part B of title XVIII is amended by inserting after section 1846 the following section:

“ELIMINATION OF CERTAIN ANOMALIES IN PAYMENTS FOR SURGERY

“SEC. 1847. (a) IN GENERAL.—Payment under this part for surgical services (as defined by the Secretary under section 1848(j)(1)), when a separate payment is also

made for the services of a physician or physician assistant acting as an assistant at surgery, may not (except as provided by subsection (b)), when added to the separate payment made for the services of that other practitioner, exceed the amount that would be paid for the surgical services if a separate payment were not made for the services of that other practitioner.

“(b) ESTABLISHMENT OF EXCEPTIONS.—The Secretary may specify surgery procedures or situations to which subsection (a) shall not apply.”

(2) Section 1848(g)(2)(D) is amended by inserting “(or the lower amount determined under section 1847)” after “subsection (a)”.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) apply to services furnished after calendar year 1995.

SEC. 7189. UPGRADED DURABLE MEDICAL EQUIPMENT.

Section 1834(a) (42 U.S.C. 1395m(a)) is amended by inserting after paragraph (15) the following new paragraph:

“(16) CERTAIN UPGRADED ITEMS.—

“(A) INDIVIDUAL'S RIGHT TO CHOOSE UPGRADED ITEM.—Notwithstanding any other provision of law, effective on the date on which the Secretary issues regulations under subparagraph (C), an individual may purchase or rent from a supplier an item of upgraded durable medical equipment for which payment would be made under this subsection if the item were a standard item.

“(B) PAYMENTS TO SUPPLIER.—In the case of the purchase or rental of an upgraded item under subparagraph (A)—

“(i) the supplier shall receive payment under this subsection with respect to such item as if such item were a standard item; and

“(ii) the individual purchasing or renting the item shall pay the supplier an amount equal to the difference between the supplier's charge and the amount under clause (i). In no event may the supplier's charge for an upgraded item exceed the applicable fee schedule amount (if any) for such item.

“(C) CONSUMER PROTECTION SAFEGUARDS.—The Secretary shall issue regulations providing for consumer protection standards with respect to the furnishing of upgraded equipment under subparagraph (A). Such regulations shall provide for—

“(i) determination of fair market prices with respect to an upgraded item;

“(ii) full disclosure of the availability and price of standard items and proof of receipt of such disclosure information by the beneficiary before the furnishing of the upgraded item;

“(iii) conditions of participation for suppliers in the simplified billing arrangement;

“(iv) sanctions of suppliers who are determined to engage in coercive or abusive practices, including exclusion; and

“(v) such other safeguards as the Secretary determines are necessary.”

Subchapter C—Provisions Relating to Parts A and B

PART I—SECONDARY PAYOR

SEC. 7189A. EXTENSION AND EXPANSION OF EXISTING MEDICARE SECONDARY PAYOR REQUIREMENTS.

(a) DATA MATCH.—

(1) Section 1862(b)(5)(C) (42 U.S.C. 1395y(b)(5)(C)) is amended by striking clause (iii).

(2) Section 6103(l)(12) of the Internal Revenue Code of 1986 is amended by striking subparagraph (F).

(b) APPLICATION TO DISABLED INDIVIDUALS IN LARGE GROUP HEALTH PLANS.—Section 1862(b)(1)(B)(iii) (42 U.S.C. 1395y(b)(1)(B)(iii)) is amended by striking “and before October 1, 1998”.

(c) EXPANSION OF PERIOD OF APPLICATION TO INDIVIDUALS WITH END-STAGE RENAL DIS-

EASE.—Section 1862(b)(1)(C) (42 U.S.C. 1395y(b)(1)(C)) is amended—

(1) in the first sentence, by striking “12-month” each place it appears and inserting “30-month”, and

(2) by striking the second sentence.

PART II—HOME HEALTH AGENCIES

SEC. 7189B. INTERIM PAYMENTS FOR HOME HEALTH SERVICES.

(a) REDUCTIONS IN COST LIMITS.—Section 1861(v)(1)(L)(i) (42 U.S.C. 1395x(v)(1)(L)(i)) is amended—

(1) by inserting “and before October 1, 1996,” after “July 1, 1987” in subclause (III),

(2) by striking the period at the end of the matter following subclause (III), and inserting “, and”, and

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

“(IV) October 1, 1996, 105 percent of the median of the labor-related and nonlabor per visit costs for freestanding home health agencies.”

(b) DELAY IN UPDATES.—Section 1861(v)(1)(L)(iii) (42 U.S.C. 1395x(v)(1)(L)(iii)) is amended by striking “July 1, 1996” and inserting “October 1, 1996”.

(c) ADDITIONS TO COST LIMITS.—Section 1861(v)(1)(L) (42 U.S.C. 1395x(v)(1)(L)) is amended by adding at the end the following new clauses:

“(iv) For services furnished by home health agencies for cost reporting periods beginning on or after October 1, 1996, the Secretary shall provide for an interim system of limits. Payment shall be the lower of—

“(I) costs determined under the preceding provisions of this subparagraph, or

“(II) an agency-specific per beneficiary annual limit calculated from the agency's 12-month cost reporting period ending on or after January 1, 1994 and on or before December 31, 1994 based on reasonable costs (including nonroutine medical supplies), updated by the home health market basket index. The per beneficiary limitation shall be multiplied by the agency's unduplicated census count of medicare patients for the year subject to the limitation. The limitation shall represent total medicare reasonable costs divided by the unduplicated census count of medicare patients.

“(v) For services furnished by home health agencies for cost reporting periods beginning on or after October 1, 1996, the following rules shall apply:

“(I) For new providers and those providers without a 12-month cost reporting period ending in calendar year 1994, the per beneficiary limit shall be equal to the mean of these limits (or the Secretary's best estimates thereof) applied to home health agencies as determined by the Secretary. Home health agencies that have altered their corporate structure or name may not be considered new providers for payment purposes.

“(II) For beneficiaries who use services furnished by more than one home health agency, the per beneficiary limitations shall be prorated among agencies.

“(vi) Home health agencies whose cost or utilization experience is below 125 percent of the mean national or census region aggregate per beneficiary cost or utilization experience for 1994, or best estimates thereof, and whose year-end reasonable costs are below the agency-specific per beneficiary limit, shall receive payment equal to 50 percent of the difference between the agency's reasonable costs and its limit for fiscal years 1996, 1997, 1998, and 1999. Such payments may not exceed 5 percent of an agency's aggregate medicare reasonable cost in a year.

“(vii) Effective January 1, 1997, or as soon as feasible, the Secretary shall modify the agency-specific per beneficiary annual limit described in clause (iv) to provide for regional or national variations in utilization.

For purposes of determining payment under clause (iv), the limit shall be calculated through a blend of 75 percent of the agency-specific cost or utilization experience in 1994 with 25 percent of the national or census region cost or utilization experience in 1994, or the Secretary's best estimates thereof.”

(d) USE OF INTERIM FINAL REGULATIONS.—The Secretary shall implement the payment limits described in section 1861(v)(1)(L)(iv) of the Social Security Act by publishing in the Federal Register a notice of interim final payment limits by August 1, 1996 and allowing for a period of public comments thereon. Payments subject to these limits will be effective for cost reporting periods beginning on or after October 1, 1996, without the necessity for consideration of comments received, but the Secretary shall, by Federal Register notice, affirm or modify the limits after considering those comments.

(e) STUDIES.—The Secretary shall expand research on a prospective payment system for home health agencies that shall tie prospective payments to an episode of care, including an intensive effort to develop a reliable case mix adjuster that explains a significant amount of the variances in costs. The Secretary shall develop such a system for implementation in fiscal year 2000.

(f) SUBMISSION OF DATA FOR CASE-MIX SYSTEM.—Effective for cost reporting periods beginning on or after October 1, 1998, the Secretary shall require all home health agencies to submit such additional information as the Secretary may deem necessary for the development of a reliable case-mix adjuster.

SEC. 7189C. PROSPECTIVE PAYMENTS.

Title XVIII is amended by adding at the end the following new section:

“PROSPECTIVE PAYMENT FOR HOME HEALTH SERVICES

“SEC. 1893. (a) Notwithstanding section 1861(v), the Secretary shall, for cost reporting periods beginning on or after fiscal year 2000, provide for payments for home health services in accordance with a prospective payment system, which pays home health agencies on a per episode basis, established by the Secretary.

“(b) Such a system shall include the following:

“(1) All services covered and paid on a reasonable cost basis under the medicare home health benefit as of the date of the enactment of the Medicare Improvement and Solvency Protection Act of 1995, including medical supplies, shall be subject to the per episode amount. In defining an episode of care, the Secretary shall consider an appropriate length of time for an episode, the use of services, and the number of visits provided within an episode, potential changes in the mix of services provided within an episode and their cost, and a general system design that will provide for continued access to quality services. The per episode amount shall be based on the most current audited cost report data available to the Secretary.

“(2) The Secretary shall employ an appropriate case mix adjuster that explains a significant amount of the variation in cost.

“(3) The episode payment amount shall be adjusted annually by the home health market basket index. The labor portion of the episode amount shall be adjusted for geographic differences in labor-related costs based on the most current hospital wage index.

“(4) The Secretary may designate a payment provision for outliers, recognizing the need to adjust payments due to unusual variations in the type or amount of medically necessary care.

“(5) A home health agency shall be responsible for coordinating all care for a beneficiary. If a beneficiary elects to transfer to,

or receive services from, another home health agency within an episode period, the episode payment shall be prorated between home health agencies."

"(c) Prior to implementing the prospective system described in subsections (a) and (b) in a budget-neutral fashion, the Secretary shall first reduce, by 15 percent, the cost limits, per beneficiary limits, and actual costs, described in section 1861(v)(1)(L)(iv), as such limits are in effect on September 30, 1999."

SEC. 7189D. MAINTAINING SAVINGS RESULTING FROM TEMPORARY FREEZE ON PAYMENT INCREASES.

(a) **BASING UPDATES TO PER VISIT COST LIMITS ON LIMITS FOR FISCAL YEAR 1993.**—Section 1861(v)(1)(L)(iii) (42 U.S.C. 1395x(v)(1)(L)(iii)) is amended by adding at the end the following sentence: "In establishing limits under this subparagraph, the Secretary may not take into account any changes in the costs of the provision of services furnished by home health agencies with respect to cost reporting periods which began on or after July 1, 1994, and before July 1, 1996."

(b) **NO EXCEPTIONS PERMITTED BASED ON AMENDMENT.**—The Secretary of Health and Human Services shall not consider the amendment made by subsection (a) in making any exemptions and exceptions pursuant to section 1861(v)(1)(L)(ii) of the Social Security Act.

SEC. 7189E. ELIMINATION OF PERIODIC INTERIM PAYMENTS FOR HOME HEALTH AGENCIES.

(a) **IN GENERAL.**—Section 1815(e)(2) (42 U.S.C. 1395g(e)(2)) is amended—

(1) by inserting "and" at the end of subparagraph (C);

(2) by striking subparagraph (D); and

(3) by redesignating subparagraph (E) as subparagraph (D).

(b) **EFFECTIVE DATE.**—The amendments made by subsection (a) shall apply to payments made on or after October 1, 1999.

SEC. 7189F. EFFECTIVE DATE.

Except as otherwise specifically provided, the amendments made by this subtitle shall apply to items and services provided on or after October 1, 1995.

Amend the table of contents for title VII accordingly.

Mr. CRAIG addressed the Chair.

The PRESIDING OFFICER. The Senator from Idaho.

(The remarks of Mr. CRAIG pertaining to the introduction of S. 1374 are located in today's RECORD under "Statements on Introduced Bills and Joint Resolutions.")

Mr. MCCAIN addressed the Chair.

The PRESIDING OFFICER. The Senator from Arizona.

CAMPAIGN FINANCE REFORM

Mr. MCCAIN. Mr. President, today, two of our colleagues on the other side of the aisle, Senators DODD and KERREY, held a press conference endorsing legislation that Senator FEINGOLD and I and Senator THOMPSON and others introduced some time ago. This follows on the heels of an announcement in the other body by Congresswoman SMITH and Congressman MARKEY of Massachusetts and Congressman SHAYS of support for this legislation as well, including announcement by the Speaker of the House that hearings would begin on the issue of campaign finance reform.

Mr. President, I welcome all of these initiatives and support. I believe that

the issue of campaign finance reform is one that is very important to the American people and becomes more important almost on a daily basis.

I wish to emphasize, after having been through this issue for a number of years, that if the issue is not bipartisan, then there will be no resolution to the campaign finance reform issue. And I worry sometimes that this legislation may tilt to one side or the other. That is why the Senator from Wisconsin and I have tried to maintain a balance as far as cosponsors are concerned.

If there is one lesson about reform in this body, and reform in the way we do business not only inside the Congress but in the way we conduct our campaigns, it is that any reform must be done on a bipartisan basis. I urge my colleagues who have similar ideas—I understand there are at least about 40 or 50 other campaign reform proposals now floating around—they engage it on a bipartisan basis, in which I and my friend from Wisconsin would be glad to join them.

Mr. President, I yield the floor.

MEASURE PLACED ON CALENDAR—S. 1372

The PRESIDING OFFICER. Pursuant to rule XIV of the Standing Rules of the Senate, the clerk will read S. 1372 for a second time.

The assistant legislative clerk read as follows.

A bill (S. 1372) to amend the Social Security Act to increase the earnings limit, and for other purposes.

The PRESIDING OFFICER. Is there objection to further proceeding?

Mr. LOTT. Mr. President, I object.

The PRESIDING OFFICER. Objection is heard. The bill will be placed on the Legislative Calendar.

CAMPAIGN FINANCE REFORM

Mr. FEINGOLD. Mr. President, I would like to strongly associate myself with the remarks of the Senator from Arizona with regard to the recent news on our efforts on campaign finance reform.

Last week, we were extremely pleased to see a bipartisan group in the House essentially agree to introduce the kind of legislation that the Senator from Arizona and I have proposed.

Today, we are also pleased by the announcement of the support by the chairman of the Democratic National Committee and the chairman of the Democratic Senatorial Campaign Committee.

We are not so excited about the fact that these people happen to be leaders in the Democratic Party—that is good—but the more important thing is that it is another sign of the importance and the value of the bipartisan nature of this proposal.

The House proposal last week was bipartisan. Adding these two Senators to this group makes it another significant step in bringing both parties together

with regard to this issue. I have been very pleased with the quick response from various Senators on signing on to this bill. Week by week, we have added new people.

I also want to note the editorial endorsements that the Senator from Arizona alluded to. The Feingold-McCain-Thompson bill has been endorsed by the New York Times, the Washington Post, Los Angeles Times, Dallas Morning News, Milwaukee Journal, St. Louis Post-Dispatch, Kansas City Star, Houston Chronicle, Nashville Tennessean, the Boston Globe, and many others. Of course, this was added to last week in addition by the endorsement of Ross Perot, who has indicated a lot of support on this issue.

Today, the addition of the support of Senator BOB KERREY of Nebraska and Senator DODD of Connecticut helps us move in that direction.

It takes about 100 steps to pass this bill. It is a complicated, very controversial bill that has been a knotty problem for the Congress for many years, but I think we have taken about 25 or 35 of those steps already. These endorsements are very important today.

Senator DODD's response at the news conference to the question of, "Why do you think this bill has a chance of actually passing?" was right on target. The fact that this bill has Republican and Democrat cosponsors and represents the first truly bipartisan bill, the first truly bipartisan bill in nearly 10 years, automatically makes this effort different, dramatically different than past efforts.

Senator BOB KERREY of Nebraska also made an excellent point about nobody understanding the need for reform better than those of us who are charged with the responsibility of raising these awful amounts of money. So this is progress.

I want to emphasize what the Senator from Arizona did. It is only progress in the context of a continued bipartisan effort. If either party thinks they can gain political advantage by turning this into a partisan issue, all they will succeed in doing is killing this effort.

This effort can win. There is every sign that it will win and that the President would be willing to sign it. With that caveat, with that effort to make sure that this is a continuation of the effort of bipartisanship, I welcome their support, and I look forward to further support from Members on both sides of the aisle.

I thank the Senator from Arizona and the Chair, and I yield the floor.

The PRESIDING OFFICER. Who seeks recognition?

Mr. FEINGOLD. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.