

104TH CONGRESS
1ST SESSION

H. R. 1200

To provide for health care for every American and to control the cost and enhance the quality of the health care system.

IN THE HOUSE OF REPRESENTATIVES

MARCH 9, 1995

Mr. McDERMOTT (for himself, Mr. WAXMAN, Mr. CONYERS, Mr. ABERCROMBIE, Mr. PAYNE of New Jersey, Ms. VELÁZQUEZ, Mr. OBERSTAR, Mr. STARK, Mr. SCOTT, Mr. VENTO, Mr. GONZALEZ, Mr. YATES, Mr. DELLUMS, Mr. BECERRA, Ms. WOOLSEY, Mr. SANDERS, Mr. MARTINEZ, Mr. DIXON, Mr. OLVER, Mrs. COLLINS of Illinois, Mr. GIBBONS, Mr. WATT of North Carolina, Mr. GUTIERREZ, Mr. HINCHEY, Mr. EVANS, Mr. ENGEL, Mr. FRANK of Massachusetts, Ms. PELOSI, Ms. EDDIE BERNICE JOHNSON of Texas, Mr. MILLER of California, Mr. COYNE, Mr. SABO, Mr. CLAY, Mr. BERMAN, Mrs. MEEK of Florida, Mr. TORRES, Mr. OWENS, Mr. SCHUMER, Mr. STOKES, Mr. ROMERO-BARCELÓ, Mr. LEWIS of Georgia, Mr. STUDDS, Mr. TOWNS, Mr. NADLER, Ms. NORTON, Mr. FATTAH, Mr. SERRANO, Mr. FORD, Mr. RANGEL, Mrs. MINK of Hawaii, Mr. FRAZER, Ms. RIVERS, Mr. FLAKE, Mr. MOAKLEY, Mr. KENNEDY of Massachusetts, and Ms. WATERS) introduced the following bill; which was referred to the Committee on Commerce, and in addition to the Committees on Ways and Means, Government Reform and Oversight, National Security, and Veterans' Affairs, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To provide for health care for every American and to control the cost and enhance the quality of the health care system.

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

1 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

2 (a) SHORT TITLE.—This Act may be cited as the
3 “American Health Security Act of 1995”.

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

Sec. 1. Short title; table of contents.

TITLE I—ESTABLISHMENT OF A STATE-BASED AMERICAN
HEALTH SECURITY PROGRAM; UNIVERSAL ENTITLEMENT; EN-
ROLLMENT

- Sec. 101. Establishment of a State-based American Health Security Program.
- Sec. 102. Universal entitlement.
- Sec. 103. Enrollment.
- Sec. 104. Portability of benefits.
- Sec. 105. Effective date of benefits.
- Sec. 106. Relationship to existing Federal health programs.

TITLE II—COMPREHENSIVE BENEFITS, INCLUDING PREVENTIVE
BENEFITS AND BENEFITS FOR LONG TERM CARE

- Sec. 201. Comprehensive benefits.
- Sec. 202. Definitions relating to services.
- Sec. 203. Special rules for home and community-based long-term care services.
- Sec. 204. Exclusions and limitations.
- Sec. 205. Certification; quality review; plans of care.

TITLE III—PROVIDER PARTICIPATION

- Sec. 301. Provider participation and standards.
- Sec. 302. Qualifications for providers.
- Sec. 303. Qualifications for comprehensive health service organizations.
- Sec. 304. Limitation on certain physician referrals.

TITLE IV—ADMINISTRATION

Subtitle A—General Administrative Provisions

- Sec. 401. American Health Security Standards Board.
- Sec. 402. American Health Security Advisory Council.
- Sec. 403. Consultation with private entities.
- Sec. 404. State health security programs.
- Sec. 405. Complementary conduct of related health programs.

Subtitle B—Control Over Fraud and Abuse

- Sec. 411. Application of Federal sanctions to all fraud and abuse under Amer-
ican Health Security Program.
- Sec. 412. National health care fraud data base.
- Sec. 413. Requirements for operation of State health care fraud and abuse con-
trol units.
- Sec. 414. Assignment of unique provider and patient identifiers.

TITLE V—QUALITY ASSESSMENT

- Sec. 501. American Health Security Quality Council.
- Sec. 502. Development of certain methodologies, guidelines, and standards.
- Sec. 503. State quality review programs.
- Sec. 504. Elimination of existing utilization review programs; transition.
- Sec. 505. Uniform electronic data bases.

TITLE VI—NATIONAL HEALTH SECURITY BUDGET; PAYMENTS;
COST CONTAINMENT MEASURES

Subtitle A—Budgeting and Payments to States

- Sec. 601. National health security budget.
- Sec. 602. Computation of individual and State capitation amounts.
- Sec. 603. State health security budgets.
- Sec. 604. Federal payments to States.
- Sec. 605. Account for health professional education expenditures.

Subtitle B—Payments by States to Providers

- Sec. 611. Payments to hospitals and other facility-based services for operating expenses on the basis of approved global budgets.
- Sec. 612. Payments to health care practitioners based on prospective fee schedule.
- Sec. 613. Payments to comprehensive health service organizations.
- Sec. 614. Payments for community-based primary health services.
- Sec. 615. Payments for prescription drugs.
- Sec. 616. Approved devices and equipment.
- Sec. 617. Payments for other items and services.
- Sec. 618. Payment incentives for medically underserved areas.
- Sec. 619. Authority for alternative payment methodologies.

Subtitle C—Mandatory Assignment and Administrative Provisions

- Sec. 621. Mandatory assignment.
- Sec. 622. Procedures for reimbursement; appeals.

TITLE VII—PROMOTION OF PRIMARY HEALTH CARE; DEVELOPMENT OF HEALTH SERVICE CAPACITY; PROGRAMS TO ASSIST THE MEDICALLY UNDERSERVED

Subtitle A—Promotion and Expansion of Primary Care Professional Training

- Sec. 701. Role of Board; establishment of primary care professional output goals.
- Sec. 702. Establishment of Advisory Committee on Health Professional Education.
- Sec. 703. Grants for health professions education, nurse education, and the National Health Service Corps.

Subtitle B—Direct Health Care Delivery

- Sec. 711. Setaside for public health block grants.
- Sec. 712. Setaside for primary health care delivery.
- Sec. 713. Primary care service expansion grants.

Subtitle C—Primary Care and Outcomes Research

- Sec. 721. Set-aside for outcomes research.
- Sec. 722. Office of Primary Care and Prevention Research.

Subtitle D—School-Related Health Services

- Sec. 731. Authorizations of appropriations.
- Sec. 732. Eligibility for development and operation grants.
- Sec. 733. Preferences.
- Sec. 734. Grants for development of projects.
- Sec. 735. Grants for operation of projects.
- Sec. 736. Federal administrative costs.
- Sec. 737. Definitions.

TITLE VIII—FINANCING PROVISIONS; AMERICAN HEALTH
SECURITY TRUST FUND

- Sec. 800. Amendment of 1986 code; section 15 not to apply.

Subtitle A—American Health Security Trust Fund

- Sec. 801. American Health Security Trust Fund.

Subtitle B—Taxes Based on Income and Wages

- Sec. 811. Payroll tax on employers.
- Sec. 812. Health care income tax.

Subtitle C—Increase in Excise Taxes on Tobacco Products

- Sec. 821. Increase in excise taxes on tobacco products.

TITLE IX—CONFORMING AMENDMENTS TO THE EMPLOYEE
RETIREMENT INCOME SECURITY ACT OF 1974

- Sec. 901. ERISA inapplicable to health coverage arrangements under State health security programs.
- Sec. 902. Exemption of State health security programs from ERISA preemption.
- Sec. 903. Prohibition of employee benefits duplicative of benefits under State health security programs; coordination in case of workers' compensation.
- Sec. 904. Repeal of continuation coverage requirements under ERISA and certain other requirements relating to group health plans.
- Sec. 905. Effective date of title.

1 **TITLE I—ESTABLISHMENT OF A**
2 **STATE-BASED AMERICAN**
3 **HEALTH SECURITY PRO-**
4 **GRAM; UNIVERSAL ENTITLE-**
5 **MENT; ENROLLMENT**

6 **SEC. 101. ESTABLISHMENT OF A STATE-BASED AMERICAN**
7 **HEALTH SECURITY PROGRAM.**

8 (a) IN GENERAL.—There is hereby established in the
9 United States a State-Based American Health Security
10 Program to be administered by the individual States in
11 accordance with Federal standards specified in, or estab-
12 lished under, this Act.

13 (b) STATE HEALTH SECURITY PROGRAMS.—In order
14 for a State to be eligible to receive payment under section
15 604, a State must establish a State health security pro-
16 gram in accordance with this Act.

17 (c) STATE DEFINED.—

18 (1) IN GENERAL.—In this Act, subject to para-
19 graph (2), the term “State” means each of the fifty
20 States and the District of Columbia.

21 (2) ELECTION.—If the Governor of Puerto
22 Rico, the Virgin Islands, Guam, American Samoa, or
23 the Northern Mariana Islands certifies to the Presi-
24 dent that the legislature of the Commonwealth or
25 territory has enacted legislation desiring that the

1 Commonwealth or territory be included as a State
2 under the provisions of this Act, such Common-
3 wealth or territory shall be included as a “State”
4 under this Act beginning January 1 of the first year
5 beginning ninety days after the President receives
6 the notification.

7 **SEC. 102. UNIVERSAL ENTITLEMENT.**

8 (a) IN GENERAL.—Every individual who is a resident
9 of the United States and is a citizen or national of the
10 United States or lawful resident alien (as defined in sub-
11 section (d) is entitled to benefits for health care services
12 under this Act under the appropriate State health security
13 program. In this section, the term “appropriate State
14 health security program” means, with respect to an indi-
15 vidual, the State health security program for the State in
16 which the individual maintains a primary residence.

17 (b) TREATMENT OF CERTAIN NONIMMIGRANTS.—

18 (1) IN GENERAL.—The American Health Secu-
19 rity Standards Board (in this Act referred to as the
20 “Board”) may make eligible for benefits for health
21 care services under the appropriate State health se-
22 curity program under this Act such classes of aliens
23 admitted to the United States as nonimmigrants as
24 the Board may provide.

1 (2) CONSIDERATION.—In providing for eligi-
2 bility under paragraph (1), the Board shall consider
3 reciprocity in health care services offered to United
4 States citizens who are nonimmigrants in other for-
5 eign states, and such other factors as the Board
6 determines to be appropriate.

7 (c) TREATMENT OF OTHER INDIVIDUALS.—

8 (1) BY BOARD.—The Board also may make eli-
9 gible for benefits for health care services under the
10 appropriate State health security program under this
11 Act other individuals not described in subsection (a)
12 or (b), and regulate the nature of the eligibility of
13 such individuals, in order—

14 (A) to preserve the public health of
15 communities,

16 (B) to compensate States for the addi-
17 tional health care financing burdens created by
18 such individuals, and

19 (C) to prevent adverse financial and medi-
20 cal consequences of uncompensated care,
21 while inhibiting travel and immigration to the
22 United States for the sole purpose of obtaining
23 health care services.

1 (2) BY STATES.—Any State health security pro-
2 gram may make individuals described in paragraph
3 (1) eligible for benefits at the expense of the State.

4 (d) LAWFUL RESIDENT ALIEN DEFINED.—For pur-
5 poses of this section, the term “lawful resident alien”
6 means an alien lawfully admitted for permanent residence
7 and any other alien lawfully residing permanently in the
8 United States under color of law, including an alien with
9 lawful temporary resident status under section 210, 210A,
10 or 234A of the Immigration and Nationality Act (8 U.S.C.
11 1160, 1161, or 1255a).

12 **SEC. 103. ENROLLMENT.**

13 (a) IN GENERAL.—Each State health security pro-
14 gram shall provide a mechanism for the enrollment of indi-
15 viduals entitled or eligible for benefits under this Act. The
16 mechanism shall—

17 (1) include a process for the automatic enroll-
18 ment of individuals at the time of birth in the
19 United States and at the time of immigration into
20 the United States or other acquisition of lawful resi-
21 dent status in the United States,

22 (2) provide for the enrollment, as of January 1,
23 1997, of all individuals who are eligible to be en-
24 rolled as of such date, and

1 (3) include a process for the enrollment of indi-
2 viduals made eligible for health care services under
3 subsections (b) and (c) of section 102.

4 (b) AVAILABILITY OF APPLICATIONS.—Each State
5 health security program shall make applications for enroll-
6 ment under the program available—

7 (1) at employment and payroll offices of em-
8 ployers located in the State,

9 (2) at local offices of the Social Security
10 Administration,

11 (3) at social services locations,

12 (4) at out-reach sites (such as provider and
13 practitioner locations), and

14 (5) at other locations (including post offices
15 and schools) accessible to a broad cross-section of
16 individuals eligible to enroll.

17 (c) ISSUANCE OF HEALTH SECURITY CARDS.—In
18 conjunction with an individual's enrollment for benefits
19 under this Act, the State health security program shall
20 provide for the issuance of a health security card which
21 shall be used for purposes of identification and processing
22 of claims for benefits under the program. The State health
23 security program may provide for issuance of such cards
24 by employers for purposes of carrying out enrollment pur-
25 suant to subsection (a)(2).

1 **SEC. 104. PORTABILITY OF BENEFITS.**

2 (a) IN GENERAL.—To ensure continuous access to
3 benefits for health care services covered under this Act,
4 each State health security program—

5 (1) shall not impose any minimum period of
6 residence in the State, or waiting period, in excess
7 of three months before residents of the State are
8 entitled to, or eligible for, such benefits under the
9 program;

10 (2) shall provide continuation of payment for
11 covered health care services to individuals who have
12 terminated their residence in the State and estab-
13 lished their residence in another State, for the dura-
14 tion of any waiting period imposed in the State of
15 new residency for establishing entitlement to, or
16 eligibility for, such services; and

17 (3) shall provide for the payment for health
18 care services covered under this Act provided to indi-
19 viduals while temporarily absent from the State
20 based on the following principles:

21 (A) Payment for such health care services
22 is at the rate that is approved by the State
23 health security program in the State in which
24 the services are provided, unless the States con-
25 cerned agree to apportion the cost between
26 them in a different manner.

1 (B) Payment for such health care services
2 provided outside the United States is made on
3 the basis of the amount that would have been
4 paid by the State health security program for
5 similar services rendered in the State, with due
6 regard, in the case of hospital services, to the
7 size of the hospital, standards of service, and
8 other relevant factors.

9 (b) CROSS-BORDER ARRANGEMENTS.—A State
10 health security program for a State may negotiate with
11 such a program in an adjacent State a reciprocal arrange-
12 ment for the coverage under such other program of health
13 care services to enrollees residing in the border region.

14 **SEC. 105. EFFECTIVE DATE OF BENEFITS.**

15 Benefits shall first be available under this Act for
16 items and services furnished on or after January 1, 1997.

17 **SEC. 106. RELATIONSHIP TO EXISTING FEDERAL HEALTH**
18 **PROGRAMS.**

19 (a) MEDICARE AND MEDICAID.—

20 (1) IN GENERAL.—Notwithstanding any other
21 provision of law, subject to paragraph (2)—

22 (A) no benefits shall be available under
23 title XVIII of the Social Security Act for any
24 item or service furnished after December 31,
25 1996,

1 (B) no individual is entitled to medical as-
2 sistance under a State plan approved under
3 title XIX of such Act for any item or service
4 furnished after such date, and

5 (C) no payment shall be made to a State
6 under section 1903(a) of such Act with respect
7 to medical assistance for any item or service
8 furnished after such date.

9 (2) TRANSITION.—In the case of inpatient hos-
10 pital services and extended care services during a
11 continuous period of stay which began before Janu-
12 ary 1, 1997, and which had not ended as of such
13 date, for which benefits are provided under title
14 XVIII, or under a State plan under title XIX, of the
15 Social Security Act, the Secretary of Health and
16 Human Services and each State plan, respectively,
17 shall provide for continuation of benefits under such
18 title or plan until the end of the period of stay.

19 (b) FEDERAL EMPLOYEES HEALTH BENEFITS PRO-
20 GRAM.—No benefits shall be made available under chapter
21 89 of title 5, United States Code, for any part of a cov-
22 erage period occurring after December 31, 1996.

23 (c) CHAMPUS.—No benefits shall be made available
24 under sections 1079 and 1086 of title 10, United States

1 Code, for items or services furnished after December 31,
2 1996.

3 (d) TREATMENT OF BENEFITS FOR VETERANS AND
4 NATIVE AMERICANS.—Nothing in this Act shall affect the
5 eligibility of veterans for the medical benefits and services
6 provided under title 38, United States Code, or of Indians
7 for the medical benefits and services provided by or
8 through the Indian Health Service.

9 **TITLE II—COMPREHENSIVE BEN-**
10 **EFITS, INCLUDING PREVEN-**
11 **TIVE BENEFITS AND BENE-**
12 **FITS FOR LONG-TERM CARE**

13 **SEC. 201. COMPREHENSIVE BENEFITS.**

14 (a) IN GENERAL.—Subject to the succeeding provi-
15 sions of this title, individuals enrolled for benefits under
16 this Act are entitled to have payment made under a State
17 health security program for the following items and serv-
18 ices if medically necessary or appropriate for the mainte-
19 nance of health or for the diagnosis, treatment, or rehabili-
20 tation of a health condition:

21 (1) HOSPITAL SERVICES.—Inpatient and out-
22 patient hospital care, including 24-hour-a-day emer-
23 gency services.

24 (2) PROFESSIONAL SERVICES.—Professional
25 services of health care practitioners authorized to

1 provide health care services under State law, includ-
2 ing patient education and training in self-manage-
3 ment techniques.

4 (3) COMMUNITY-BASED PRIMARY HEALTH
5 SERVICES.—Community-based primary health serv-
6 ices (as defined in section 202(a)).

7 (4) PREVENTIVE SERVICES.—Preventive serv-
8 ices (as defined in section 202(b)).

9 (5) LONG-TERM, ACUTE, AND CHRONIC CARE
10 SERVICES.—

11 (A) Nursing facility services.

12 (B) Home health services.

13 (C) Home and community-based long-term
14 care services (as defined in section 202(c)) for
15 individuals described in section 203(a).

16 (D) Hospice care.

17 (E) Services in intermediate care facilities
18 for individuals with mental retardation.

19 (6) PRESCRIPTION DRUGS, BIOLOGICALS, INSU-
20 LIN, MEDICAL FOODS.—

21 (A) Outpatient prescription drugs and
22 biologicals, as specified by the Board consistent
23 with section 515.

24 (B) Insulin.

1 (C) Medical foods (as defined in section
2 202(e)).

3 (7) DENTAL SERVICES.—Dental services (as de-
4 fined in section 202(h)).

5 (8) MENTAL HEALTH AND SUBSTANCE ABUSE
6 TREATMENT SERVICES.—Mental health and sub-
7 stance abuse treatment services (as defined in sec-
8 tion 202(f)).

9 (9) DIAGNOSTIC TESTS.—Diagnostic tests.

10 (10) OTHER ITEMS AND SERVICES.—

11 (A) OUTPATIENT THERAPY.—Outpatient
12 physical therapy services, outpatient speech pa-
13 thology services, and outpatient occupational
14 therapy services in all settings.

15 (B) DURABLE MEDICAL EQUIPMENT.—Du-
16 rable medical equipment.

17 (C) HOME DIALYSIS.—Home dialysis sup-
18 plies and equipment.

19 (D) AMBULANCE.—Emergency ambulance
20 service.

21 (E) PROSTHETIC DEVICES.—Prosthetic de-
22 vices, including replacements of such devices.

23 (F) ADDITIONAL ITEMS AND SERVICES.—
24 Such other medical or health care items or
25 services as the Board may specify.

1 (b) COST-SHARING.—

2 (1) IN GENERAL.—Except as provided in this
3 subsection, there are no deductibles, coinsurance, or
4 copayments applicable to acute care and preventive
5 benefits provided under this title.

6 (2) COST-SHARING FOR LONG-TERM CARE
7 SERVICES.—

8 (A) IN GENERAL.—

9 (i) payments for home and commu-
10 nity-based long-term care services are sub-
11 ject to coinsurance of 20 percent, and

12 (ii) payments for nursing facility serv-
13 ices are subject to coinsurance of 35 per-
14 cent.

15 (B) EXCEPTION.—With respect to the co-
16 insurance established under subparagraph
17 (A)—

18 (i) such coinsurance shall not apply to
19 an individual with income (as defined by
20 the Secretary) of not more than 100 per-
21 cent of the income official poverty line ap-
22 plicable to a family of the size involved;
23 and

24 (ii) in the case of an individual with
25 such income that exceeds 100 percent, but

1 is less than 200 percent, of such applicable
2 poverty line, the coinsurance shall be re-
3 duced in the same proportion as the pro-
4 portion of such income is less than 200
5 percent of such applicable poverty line.

6 (c) PROHIBITION OF BALANCE BILLING.—As pro-
7 vided in section 531, no person may impose a charge for
8 covered services for which benefits are provided under this
9 Act.

10 (d) NO DUPLICATE HEALTH INSURANCE.—Each
11 State health security program shall prohibit the sale of
12 health insurance in the State if payment under the insur-
13 ance duplicates payment for any items or services for
14 which payment may be made under such a program.

15 (e) STATE PROGRAM MAY PROVIDE ADDITIONAL
16 BENEFITS.—Nothing in this Act shall be construed as
17 limiting the benefits that may be made available under a
18 State health security program to residents of the State
19 at the expense of the State.

20 (f) EMPLOYERS MAY PROVIDE ADDITIONAL BENE-
21 FITS.—Nothing in this Act shall be construed as limiting
22 the additional benefits that an employer may provide to
23 employees or their dependents, or to former employees or
24 their dependents.

1 **SEC. 202. DEFINITIONS RELATING TO SERVICES.**

2 (a) COMMUNITY-BASED PRIMARY HEALTH SERV-
3 ICES.—In this title, the term “community-based primary
4 health services” means ambulatory health services fur-
5 nished—

6 (1) by a rural health clinic;

7 (2) by a Federally qualified health center (as
8 defined in section 1905(l)(2)(B) of the Social Secu-
9 rity Act), and which, for purposes of this Act, in-
10 clude services furnished by State and local health
11 agencies;

12 (3) in a school-based setting;

13 (4) by public educational agencies and other
14 providers of services to children entitled to assist-
15 ance under the Individuals with Disabilities Edu-
16 cation Act for services furnished pursuant to a
17 written Individualized Family Services Plan or
18 Individual Education Plan under such Act; and

19 (5) public and private nonprofit entities receiv-
20 ing Federal assistance under the Public Health
21 Service Act.

22 (b) PREVENTIVE SERVICES.—

23 (1) IN GENERAL.—In this title, the term “pre-
24 ventive services” means items and services—

25 (A) which—

26 (i) are specified in paragraph (2), or

1 (ii) the Board determines to be effective in the maintenance and promotion of
2 health or minimizing the effect of illness,
3 disease, or medical condition; and
4

5 (B) which are provided consistent with the
6 periodicity schedule established under para-
7 graph (3).

8 (2) SPECIFIED PREVENTIVE SERVICES.—The
9 services specified in this paragraph are as follows:

10 (A) Basic immunizations.

11 (B) Prenatal and well-baby care (for in-
12 fants under one year of age).

13 (C) Well-child care (including periodic
14 physical examinations, hearing and vision
15 screening, and developmental screening and ex-
16 aminations) for individuals under 18 years of
17 age.

18 (D) Periodic screening mammography, Pap
19 smears, and colorectal examinations and exami-
20 nations for prostate cancer.

21 (E) Physical examinations.

22 (F) Family planning services.

23 (G) Routine eye examinations, eyeglasses,
24 and contact lenses.

1 (H) Hearing aids, but only upon a deter-
2 mination of a certified audiologist or physician
3 that a hearing problem exists and is caused by
4 a condition that can be corrected by use of a
5 hearing aid.

6 (3) SCHEDULE.—The Board shall establish, in
7 consultation with experts in preventive medicine and
8 public health and taking into consideration those
9 preventive services recommended by the Preventive
10 Services Task Force and published as the Guide to
11 Clinical Preventive Services, a periodicity schedule
12 for the coverage of preventive services under para-
13 graph (1). Such schedule shall take into consider-
14 ation the cost-effectiveness of appropriate preventive
15 care and shall be revised not less frequently than
16 once every 5 years, in consultation with experts in
17 preventive medicine and public health.

18 (c) HOME AND COMMUNITY-BASED LONG-TERM
19 CARE SERVICES.—In this title, the term “home and com-
20 munity-based long-term care services” means the following
21 services provided to an individual to enable the individual
22 to remain in such individual’s place of residence within
23 the community:

24 (1) Home health aide services.

1 (2) Adult day health care, social day care or
2 psychiatric day care.

3 (3) Medical social work services.

4 (4) Care coordination services, as defined in
5 subsection (g)(1).

6 (5) Respite care, including training for informal
7 caregivers.

8 (6) Personal assistance services, and home-
9 maker services (including meals) incidental to the
10 provision of personal assistance services.

11 (d) HOME HEALTH SERVICES.—

12 (1) IN GENERAL.—The term “home health
13 services” means items and services described in sec-
14 tion 1861(m) of the Social Security Act and includes
15 home infusion services.

16 (2) HOME INFUSION SERVICES.—The term
17 “home infusion services” includes the nursing, phar-
18 macy, and related services that are necessary to con-
19 duct the home infusion of a drug regimen safely and
20 effectively under a plan established and periodically
21 reviewed by a physician and that are provided in
22 compliance with quality assurance requirements es-
23 tablished by the Secretary.

24 (e) MEDICAL FOODS.—In this title, the term “medi-
25 cal foods” means foods which are formulated to be

1 consumed or administered enterally under the supervision
2 of a physician and which are intended for the specific die-
3 tary management of a disease or condition for which
4 distinctive nutritional requirements, based on recognized
5 scientific principles, are established by medical evaluation.

6 (f) MENTAL HEALTH AND SUBSTANCE ABUSE
7 TREATMENT SERVICES.—

8 (1) SERVICES DESCRIBED.—In this title, the
9 term “mental health and substance abuse treatment
10 services” means the following services related to the
11 prevention, diagnosis, treatment, and rehabilitation
12 of mental illness and promotion of mental health:

13 (A) INPATIENT HOSPITAL SERVICES.—In-
14 patient hospital services furnished primarily for
15 the diagnosis or treatment of mental illness or
16 substance abuse for up to 60 days during a
17 year, reduced by a number of days determined
18 by the Secretary so that the actuarial value of
19 providing such number of days of services
20 under this paragraph to the individual is equal
21 to the actuarial value of the days of inpatient
22 residential services furnished to the individual
23 under subparagraph (B) during the year after
24 such services have been furnished to the indi-
25 vidual for 120 days during the year (rounded to

1 the nearest day), but only if (with respect to
2 services furnished to an individual described in
3 section 204(b)(1)) such services are furnished
4 in conformity with the plan of an organized sys-
5 tem of care for mental health and substance
6 abuse services in accordance with section
7 204(b)(2).

8 (B) INTENSIVE RESIDENTIAL SERVICES.—

9 Intensive residential services (as defined in
10 paragraph (2)) furnished to an individual for
11 up to 120 days during any calendar year, ex-
12 cept that—

13 (i) such services may be furnished to
14 the individual for additional days during
15 the year if necessary for the individual to
16 complete a course of treatment to the ex-
17 tent that the number of days of inpatient
18 hospital services described in subparagraph
19 (A) that may be furnished to the individual
20 during the year (as reduced under such
21 subparagraph) is not less than 15; and

22 (ii) reduced by a number of days de-
23 termined by the Secretary so that the actu-
24 arial value of providing such number of
25 days of services under this paragraph to

1 the individual is equal to the actuarial
2 value of the days of intensive community-
3 based services furnished to the individual
4 under subparagraph (D) during the year
5 after such services have been furnished to
6 the individual for 90 days (or, in the case
7 of services described in subparagraph
8 (D)(ii), for 180 days) during the year
9 (rounded to the nearest day).

10 (C) OUTPATIENT SERVICES.—Outpatient
11 treatment services of mental illness or sub-
12 stance abuse (other than intensive community-
13 based services under subparagraph (D)) for an
14 unlimited number of days during any calendar
15 year furnished in accordance with standards es-
16 tablished by the Secretary for the management
17 of such services, and, in the case of services fur-
18 nished to an individual described in section
19 204(b)(1) who is not an inpatient of a hospital,
20 in conformity with the plan of an organized sys-
21 tem of care for mental health and substance
22 abuse services in accordance with section
23 204(b)(2).

1 (D) INTENSIVE COMMUNITY-BASED SERV-
2 ICES.—Intensive community-based services (as
3 described in paragraph (3))—

4 (i) for an unlimited number of days
5 during any calendar year, in the case of
6 services described in section 1861(ff)(2)(E)
7 that are furnished to an individual who is
8 a seriously mentally ill adult, a seriously
9 emotionally disturbed child, or an adult or
10 child with serious substance abuse disorder
11 (as determined in accordance with criteria
12 established by the Secretary);

13 (ii) in the case of services described in
14 section 1861(ff)(2)(C), for up to 180 days
15 during any calendar year, except that such
16 services may be furnished to the individual
17 for a number of additional days during the
18 year equal to the difference between the
19 total number of days of intensive residen-
20 tial services which the individual may re-
21 ceive during the year under part A (as de-
22 termined under subparagraph (B)) and the
23 number of days of such services which the
24 individual has received during the year, or

1 (iii) in the case of any other such
2 services, for up to 90 days during any cal-
3 endar year, except that such services may
4 be furnished to the individual for the num-
5 ber of additional days during the year de-
6 scribed in clause (ii).

7 (2) INTENSIVE RESIDENTIAL SERVICES DE-
8 FINED.—

9 (A) IN GENERAL.—Subject to subpara-
10 graphs (B) and (C), the term “intensive resi-
11 dential services” means inpatient services pro-
12 vided in any of the following facilities:

13 (i) Residential detoxification centers.

14 (ii) Crisis residential programs or
15 mental illness residential treatment pro-
16 grams.

17 (iii) Therapeutic family or group
18 treatment homes.

19 (iv) Residential centers for substance
20 abuse treatment.

21 (B) REQUIREMENTS FOR FACILITIES.—No
22 service may be treated as an intensive residen-
23 tial service under subparagraph (A) unless the
24 facility at which the service is provided—

1 (i) is legally authorized to provide
2 such service under the law of the State (or
3 under a State regulatory mechanism pro-
4 vided by State law) in which the facility is
5 located or is certified to provide such serv-
6 ice by an appropriate accreditation entity
7 approved by the State in consultation with
8 the Secretary; and

9 (ii) meets such other requirements as
10 the Secretary may impose to assure the
11 quality of the intensive residential services
12 provided.

13 (C) SERVICES FURNISHED TO AT-RISK
14 CHILDREN.—In the case of services furnished
15 to an individual described in section 204(b)(1),
16 no service may be treated as an intensive resi-
17 dential service under this subsection unless the
18 service is furnished in conformity with the plan
19 of an organized system of care for mental
20 health and substance abuse services in accord-
21 ance with section 204(b)(2).

22 (D) MANAGEMENT STANDARDS.—No serv-
23 ice may be treated as an intensive residential
24 service under subparagraph (A) unless the serv-
25 ice is furnished in accordance with standards

1 established by the Secretary for the manage-
2 ment of such services.

3 (3) INTENSIVE COMMUNITY-BASED SERVICES
4 DEFINED.—

5 (A) IN GENERAL.—The term “intensive
6 community-based services” means the items
7 and services described in subparagraph (B) pre-
8 scribed by a physician (or, in the case of serv-
9 ices furnished to an individual described in sec-
10 tion 204(b)(1), by an organized system of care
11 for mental health and substance abuse services
12 in accordance with such section) and provided
13 under a program described in subparagraph
14 (D) under the supervision of a physician (or, to
15 the extent permitted under the law of the State
16 in which the services are furnished, a non-phy-
17 sician mental health professional) pursuant to
18 an individualized, written plan of treatment es-
19 tablished and periodically reviewed by a physi-
20 cian (in consultation with appropriate staff par-
21 ticipating in such program) which sets forth the
22 physician’s diagnosis, the type, amount, fre-
23 quency, and duration of the items and services
24 provided under the plan, and the goals for
25 treatment under the plan, but does not include

1 any item or service that is not furnished in ac-
2 cordance with standards established by the Sec-
3 retary for the management of such services.

4 (B) ITEMS AND SERVICES DESCRIBED.—

5 The items and services described in this sub-
6 paragraph are—

7 (i) partial hospitalization services con-
8 sisting of the items and services described
9 in subparagraph (C);

10 (ii) psychiatric rehabilitation services;

11 (iii) day treatment services for indi-
12 viduals under 19 years of age;

13 (iv) in-home services;

14 (v) case management services, includ-
15 ing collateral services designated as such
16 case management services by the Sec-
17 retary;

18 (vi) ambulatory detoxification services;

19 (vii) such other items and services as
20 the Secretary may provide (but in no event
21 to include meals and transportation),

22 that are reasonable and necessary for the diag-
23 nosis or active treatment of the individual's
24 condition, reasonably expected to improve or
25 maintain the individual's condition and func-

1 tional level and to prevent relapse or hos-
2 pitalization, and furnished pursuant to such
3 guidelines relating to frequency and duration of
4 services as the Secretary shall by regulation es-
5 tablish (taking into account accepted norms of
6 medical practice and the reasonable expectation
7 of patient improvement).

8 (C) ITEMS AND SERVICES INCLUDED AS
9 PARTIAL HOSPITALIZATION SERVICES.—For
10 purposes of subparagraph (B)(i), partial hos-
11 pitalization services consist of the following:

12 (i) Individual and group therapy with
13 physicians or psychologists (or other men-
14 tal health professionals to the extent au-
15 thorized under State law).

16 (ii) Occupational therapy requiring
17 the skills of a qualified occupational thera-
18 pist.

19 (iii) Services of social workers, trained
20 psychiatric nurses, behavioral aides, and
21 other staff trained to work with psychiatric
22 patients (to the extent authorized under
23 State law).

24 (iv) Drugs and biologicals furnished
25 for therapeutic purposes (which cannot, as

1 determined in accordance with regulations,
2 be self-administered).

3 (v) Individualized activity therapies
4 that are not primarily recreational or di-
5 versionary.

6 (vi) Family counseling (the primary
7 purpose of which is treatment of the indi-
8 vidual's condition).

9 (vii) Patient training and education
10 (to the extent that training and edu-
11 cational activities are closely and clearly
12 related to the individual's care and treat-
13 ment).

14 (viii) Diagnostic services.

15 (D) PROGRAMS DESCRIBED.—A program
16 described in this subparagraph is a program
17 (whether facility-based or freestanding) which is
18 furnished by an entity—

19 (i) legally authorized to furnish such a
20 program under State law (or the State reg-
21 ulatory mechanism provided by State law)
22 or certified to furnish such a program by
23 an appropriate accreditation entity ap-
24 proved by the State in consultation with
25 the Secretary; and

1 (ii) meeting such other requirements
2 as the Secretary may impose to assure the
3 quality of the intensive community-based
4 services provided.

5 (g) CARE COORDINATION SERVICES.—

6 (1) IN GENERAL.—In this title, the term “care
7 coordination services” means services provided by
8 care coordinators (as defined in paragraph (2)) to
9 individuals described in paragraph (3) for the co-
10 ordination and monitoring of home and community-
11 based long term care services to ensure appropriate,
12 cost-effective utilization of such services in a com-
13 prehensive and continuous manner, and includes—

14 (A) transition management between inpa-
15 tient facilities and community-based services,
16 including assisting patients in identifying and
17 gaining access to appropriate ancillary services;
18 and

19 (B) evaluating and recommending appro-
20 priate treatment services, in cooperation with
21 patients and other providers and in conjunction
22 with any quality review program or plan of care
23 under section 205.

24 (2) CARE COORDINATOR.—

1 (A) IN GENERAL.—In this title, the term
2 “care coordinator” means an individual or non-
3 profit or public agency or organization which
4 the State health security program determines—

5 (i) is capable of performing directly,
6 efficiently, and effectively the duties of a
7 care coordinator described in paragraph
8 (1), and

9 (ii) demonstrates capability in estab-
10 lishing and periodically reviewing and re-
11 vising plans of care, and in arranging for
12 and monitoring the provision and quality
13 of services under any plan.

14 (B) INDEPENDENCE.—State health secu-
15 rity programs shall establish safeguards to as-
16 sure that care coordinators have no financial in-
17 terest in treatment decisions or placements.
18 Care coordination may not be provided through
19 any structure or mechanism through which
20 quality review is performed.

21 (3) ELIGIBLE INDIVIDUALS.—An individual de-
22 scribed in this paragraph is an individual described
23 in section 203 (relating to individuals qualifying for
24 long term and chronic care services).

25 (h) DENTAL SERVICES.—

1 (1) IN GENERAL.—In this title, subject to sub-
2 section (b), the term “dental services” means the
3 following:

4 (A) Emergency dental treatment, including
5 extractions, for bleeding, pain, acute infections,
6 and injuries to the maxillofacial region.

7 (B) Prevention and diagnosis of dental dis-
8 ease, including examinations of the hard and
9 soft tissues of the oral cavity and related struc-
10 tures, radiographs, dental sealants, fluorides,
11 and dental prophylaxis.

12 (C) Treatment of dental disease, including
13 non-cast fillings, periodontal maintenance serv-
14 ices, and endodontic services.

15 (D) Space maintenance procedures to pre-
16 vent orthodontic complications.

17 (E) Orthodontic treatment to prevent se-
18 vere malocclusions.

19 (F) Full dentures.

20 (G) Medically necessary oral health care.

21 (H) Any items and services for special
22 needs patients that are not described in sub-
23 paragraphs (A) through (G) and that—

1 (i) are required to provide such pa-
2 tients the items and services described in
3 subparagraphs (A) through (G);

4 (ii) are required to establish oral func-
5 tion (including general anesthesia for indi-
6 viduals with physical or emotional limita-
7 tions that prevent the provision of dental
8 care without such anesthesia);

9 (iii) consist of orthodontic care for se-
10 vere dentofacial abnormalities; or

11 (iv) consist of prosthetic dental de-
12 vices for genetic or birth defects or fitting
13 for such devices.

14 (I) Any dental care for individuals with a
15 seizure disorder that is not described in sub-
16 paragraphs (A) through (H) and that is re-
17 quired because of an illness, injury, disorder, or
18 other health condition that results from such
19 seizure disorder.

20 (2) LIMITATIONS.—Dental services are subject
21 to the following limitations:

22 (A) PREVENTION AND DIAGNOSIS.—

23 (i) EXAMINATIONS AND PROPHY-
24 LAXIS.—The examinations and prophylaxis
25 described in paragraph (1)(B) are covered

1 only consistent with a periodicity schedule
2 established by the Board, which schedule
3 may provide for special treatment of indi-
4 viduals less than 18 years of age and of
5 special needs patients.

6 (ii) DENTAL SEALANTS.—The dental
7 sealants described in such paragraph are
8 not covered for individuals 18 years of age
9 or older. Such sealants are covered for in-
10 dividuals less than 10 years of age for pro-
11 tection of the 1st permanent molars. Such
12 sealants are covered for individuals 10
13 years of age or older for protection of the
14 2d permanent molars.

15 (B) TREATMENT OF DENTAL DISEASE.—
16 Prior to January 1, 2002, the items and serv-
17 ices described in paragraph (1)(C) are covered
18 only for individuals less than 18 years of age
19 and special needs patients. On or after such
20 date, such items and services are covered for all
21 individuals enrolled for benefits under this Act,
22 except that endodontic services are not covered
23 for individuals 18 years of age or older.

24 (C) SPACE MAINTENANCE.—The items and
25 services described in paragraph (1)(D) are cov-

1 ered only for individuals at least 3 years of age,
2 but less than 13 years of age and—

3 (i) are limited to posterior teeth;

4 (ii) involve maintenance of a space or
5 spaces for permanent posterior teeth that
6 would otherwise be prevented from normal
7 eruption if the space were not maintained;
8 and

9 (iii) do not include a space maintainer
10 that is placed within 6 months of the ex-
11 pected eruption of the permanent posterior
12 tooth concerned.

13 (D) ORTHODONTIC TREATMENT.—Prior to
14 January 1, 2002, the items and services de-
15 scribed in paragraph (1)(E) are covered only
16 for individuals at least 6 years of age, but less
17 than 12 years of age, who have severe
18 dentofacial abnormalities. On or after such
19 date, such items and services are covered only
20 for individuals at least 6 years of age, but less
21 than 12 years of age.

22 (E) DENTURES.—Prior to January 1,
23 2002, the dentures described in paragraph
24 (1)(F) are not covered, except for special needs
25 patients. On or after such date, dentures are

1 covered for an individual consistent with a peri-
2 odicity schedule established by the Board, ex-
3 cept that the limitation of periodicity provided
4 in such schedule shall not apply to a special
5 needs patient.

6 (3) DEFINITIONS.—For purposes of this title:

7 (A) MEDICALLY NECESSARY ORAL HEALTH
8 CARE.—The term “medically necessary oral
9 health care” means oral health care that is re-
10 quired as a direct result of, or would have a di-
11 rect impact on, an underlying medical condi-
12 tion. Such term includes oral health care di-
13 rected toward control or elimination of pain, in-
14 fection, or reestablishment of oral function.

15 (B) SPECIAL NEEDS PATIENT.—The term
16 “special needs patient” includes an individual
17 with a genetic or birth defect, a developmental
18 disability, or an acquired medical disability.

19 (i) NURSING FACILITY; NURSING FACILITY SERV-
20 ICES.—Except as may be provided by the Board, the
21 terms “nursing facility” and “nursing facility services”
22 have the meanings given such terms in sections 1919(a)
23 and 1905(f), respectively, of the Social Security Act.

1 (j) SERVICES IN INTERMEDIATE CARE FACILITIES
2 FOR INDIVIDUALS WITH MENTAL RETARDATION.—Ex-
3 cept as may be provided by the Board—

4 (1) the term “intermediate care facility for indi-
5 viduals with mental retardation” has the meaning
6 specified in section 1905(d) of the Social Security
7 Act (as in effect before the enactment of this Act);
8 and

9 (2) the term “services in intermediate care fa-
10 cilities for individuals with mental retardation”
11 means services described in section 1905(a)(15) of
12 such Act (as so in effect) in an intermediate care fa-
13 cility for individuals with mental retardation to an
14 individual determined to require such services in ac-
15 cordance with standards specified by the Board and
16 comparable to the standards described in section
17 1902(a)(31)(A) of such Act (as so in effect).

18 (k) OTHER TERMS.—Except as may be provided by
19 the Board, the definitions contained in section 1861 of the
20 Social Security Act shall apply.

21 **SEC. 203. SPECIAL RULES FOR HOME AND COMMUNITY-**
22 **BASED LONG-TERM CARE SERVICES.**

23 (a) QUALIFYING INDIVIDUALS.—For purposes of sec-
24 tion 201(a)(5)(C), individuals described in this subsection
25 are the following individuals:

1 (1) ADULTS.—Individuals 18 years of age or
2 older determined (in a manner specified by the
3 Board)—

4 (A) to be unable to perform, without the
5 assistance of an individual, at least 2 of the fol-
6 lowing 5 activities of daily living (or who has a
7 similar level of disability due to cognitive
8 impairment)—

9 (i) bathing;

10 (ii) eating;

11 (iii) dressing;

12 (iv) toileting; and

13 (v) transferring in and out of a bed or
14 in and out of a chair;

15 (B) due to cognitive or mental impair-
16 ments, to require supervision because the indi-
17 vidual behaves in a manner that poses health or
18 safety hazards to himself or herself or others;
19 or

20 (C) due to cognitive or mental impair-
21 ments, to require queuing to perform activities
22 of daily living.

23 (2) CHILDREN.—Individuals under 18 years of
24 age determined (in a manner specified by the Board)
25 to meet such alternative standard of disability for

1 children as the Board develops. Such alternative
2 standard shall be comparable to the standard for
3 adults and appropriate for children.

4 (b) LIMIT ON SERVICES.—

5 (1) IN GENERAL.—The aggregate expenditures
6 by a State health security program with respect to
7 home and community-based long-term care services
8 in a period (specified by the Board) may not exceed
9 65 percent (or such alternative ratio as the Board
10 establishes under paragraph (2)) of the average of
11 the amount of payment that would have been made
12 under the program during the period if all the home-
13 based long-term care beneficiaries had been resi-
14 dents of nursing facilities in the same area in which
15 the services were provided.

16 (2) ALTERNATIVE RATIO.—The Board may es-
17 tablish for purposes of paragraph (1) an alternative
18 ratio (of payments for home and community-based
19 long term care services to payments for nursing fa-
20 cility services) as the Board determines to be more
21 consistent with the goal of providing cost-effective
22 long-term care in the most appropriate and least
23 restrictive setting.

1 **SEC. 204. EXCLUSIONS AND LIMITATIONS.**

2 (a) IN GENERAL.—Subject to section 201(e), benefits
3 for service are not available under this Act unless the
4 services meet the standards specified in section 201(a).

5 (b) SPECIAL DELIVERY REQUIREMENTS FOR MEN-
6 TAL HEALTH AND SUBSTANCE ABUSE TREATMENT SERV-
7 ICES PROVIDED TO AT-RISK CHILDREN.—

8 (1) REQUIRING SERVICES TO BE PROVIDED
9 THROUGH ORGANIZED SYSTEMS OF CARE.—A State
10 health security program shall ensure that mental
11 health services and substance abuse treatment serv-
12 ices are furnished through an organized system of
13 care, as described in paragraph (2), if—

14 (A) the services are provided to an individ-
15 ual less than 22 years of age;

16 (B) the individual has a serious emotional
17 disturbance or a substance abuse disorder; and

18 (C) the individual is, or is at imminent risk
19 of being, subject to the authority of, or in need
20 of the services of, at least 1 public agency that
21 serves the needs of children, including an agen-
22 cy involved with child welfare, special education,
23 juvenile justice, or criminal justice.

24 (2) REQUIREMENTS FOR SYSTEM OF CARE.—In
25 this subsection, an “organized system of care” is a
26 community-based service delivery network, which

1 may consist of public and private providers, that
2 meets the following requirements:

3 (A) The system has established linkages
4 with existing mental health services and sub-
5 stance abuse treatment service delivery pro-
6 grams in the plan service area (or is in the
7 process of developing or operating a system
8 with appropriate public agencies in the area to
9 coordinate the delivery of such services to indi-
10 viduals in the area).

11 (B) The system provides for the participa-
12 tion and coordination of multiple agencies and
13 providers that serve the needs of children in the
14 area, including agencies and providers involved
15 with child welfare, education, juvenile justice,
16 criminal justice, health care, mental health, and
17 substance abuse prevention and treatment.

18 (C) The system provides for the involve-
19 ment of the families of children to whom mental
20 health services and substance abuse treatment
21 services are provided in the planning of treat-
22 ment and the delivery of services.

23 (D) The system provides for the develop-
24 ment and implementation of individualized
25 treatment plans by multidisciplinary and multi-

1 agency teams, which are recognized and fol-
2 lowed by the applicable agencies and providers
3 in the area.

4 (E) The system ensures the delivery and
5 coordination of the range of mental health serv-
6 ices and substance abuse treatment services re-
7 quired by individuals under 22 years of age who
8 have a serious emotion disturbance or a sub-
9 stance abuse disorder.

10 (F) The system provides for the manage-
11 ment of the individualized treatment plans de-
12 scribed in subparagraph (D) and for a flexible
13 response to changes in treatment needs over
14 time.

15 (c) TREATMENT OF EXPERIMENTAL SERVICES.—In
16 applying subsection (a), the Board shall make national
17 coverage determinations with respect to those services that
18 are experimental in nature. Such determinations shall be
19 made consistent with a process that provides for input
20 from representatives of health care professionals and pa-
21 tients and public comment.

22 (d) APPLICATION OF PRACTICE GUIDELINES.—In
23 the case of services for which the American Health Secu-
24 rity Quality Council (established under section 501) has
25 recognized a national practice guideline, the services are

1 considered to meet the standards specified in section
2 201(a) if they have been provided in accordance with such
3 guideline or in accordance with such guidelines as are pro-
4 vided by the State health security program consistent with
5 title V. For purposes of this subsection, a service shall
6 be considered to have been provided in accordance with
7 a practice guideline if the health care provider providing
8 the service exercised appropriate professional discretion to
9 deviate from the guideline in a manner authorized or an-
10 ticipated by the guideline.

11 (e) SPECIFIC LIMITATIONS.—

12 (1) LIMITATIONS ON EYEGLASSES, CONTACT
13 LENSES, HEARING AIDS, AND DURABLE MEDICAL
14 EQUIPMENT.—Subject to section 201(e), the Board
15 may impose such limits relating to the costs and fre-
16 quency of replacement of eyeglasses, contact lenses,
17 hearing aids, and durable medical equipment to
18 which individuals enrolled for benefits under this Act
19 are entitled to have payment made under a State
20 health security program as the Board deems appro-
21 priate.

22 (2) OVERLAP WITH PREVENTIVE SERVICES.—

23 The coverage of services described in section 201(a)
24 (other than paragraph (3)) which also are preventive
25 services are required to be covered only to the extent

1 that they are required to be covered as preventive
2 services.

3 (3) MISCELLANEOUS EXCLUSIONS FROM COV-
4 ERED SERVICES.—Covered services under this Act
5 do not include the following:

6 (A) Surgery and other procedures (such as
7 orthodontia) performed solely for cosmetic pur-
8 poses (as defined in regulations) and hospital or
9 other services incident thereto, unless—

10 (i) required to correct a congenital
11 anomaly;

12 (ii) required to restore or correct a
13 part of the body which has been altered as
14 a result of accidental injury, disease, or
15 surgery; or

16 (iii) otherwise determined to be medi-
17 cally necessary and appropriate under sec-
18 tion 201(a).

19 (B) Personal comfort items or private
20 rooms in inpatient facilities, unless determined
21 to be medically necessary and appropriate
22 under section 201(a).

23 (C) The services of a professional practi-
24 tioner if they are furnished in a hospital or

1 other facility which is not a participating pro-
2 vider.

3 (f) NURSING FACILITY SERVICES AND HOME
4 HEALTH SERVICES.—Nursing facility services and home
5 health services (other than post-hospital services, as de-
6 fined by the Board) furnished to an individual who is not
7 described in section 203(a) are not covered services unless
8 the services are determined to meet the standards speci-
9 fied in section 201(a) and, with respect to nursing facility
10 services, to be provided in the least restrictive and most
11 appropriate setting.

12 **SEC. 205. CERTIFICATION; QUALITY REVIEW; PLANS OF**
13 **CARE.**

14 (a) CERTIFICATIONS.—State health security pro-
15 grams may require, as a condition of payment for institu-
16 tional health care services and other services of the type
17 described in such sections 1814(a) and 1835(a) of the So-
18 cial Security Act, periodic professional certifications of the
19 kind described in such sections.

20 (b) QUALITY REVIEW.—For requirement that each
21 State health security program establish a quality review
22 program that meets the requirements for such a program
23 under title V, see section 404(b)(1)(H).

24 (c) PLAN OF CARE REQUIREMENTS.—A State health
25 security program may require, consistent with standards

1 established by the Board, that payment for services ex-
2 ceeding specified levels or duration be provided only as
3 consistent with a plan of care or treatment formulated by
4 one or more providers of the services or other qualified
5 professionals. Such a plan may include, consistent with
6 subsection (b), case management at specified intervals as
7 a further condition of payment for services.

8 **TITLE III—PROVIDER** 9 **PARTICIPATION**

10 **SEC. 301. PROVIDER PARTICIPATION AND STANDARDS.**

11 (a) IN GENERAL.—An individual or other entity fur-
12 nishing any covered service under a State health security
13 program under this Act is not a qualified provider unless
14 the individual or entity—

15 (1) is a qualified provider of the services under
16 section 302;

17 (2) has filed with the State health security pro-
18 gram a participation agreement described in sub-
19 section (b); and

20 (3) meets such other qualifications and condi-
21 tions as are established by the Board or the State
22 health security program under this Act.

23 (b) REQUIREMENTS IN PARTICIPATION AGREE-
24 MENT.—

1 (1) IN GENERAL.—A participation agreement
2 described in this subsection between a State health
3 security program and a provider shall provide at
4 least for the following:

5 (A) Services to eligible persons will be fur-
6 nished by the provider without discrimination
7 on the ground of race, national origin, income,
8 religion, age, sex or sexual orientation, disabil-
9 ity, handicapping condition, or (subject to the
10 professional qualifications of the provider) ill-
11 ness. Nothing in this subparagraph shall be
12 construed as requiring the provision of a type
13 or class of services which services are outside
14 the scope of the provider's normal practice.

15 (B) No charge will be made for any cov-
16 ered services other than for payment authorized
17 by this Act.

18 (C) The provider agrees to furnish such in-
19 formation as may be reasonably required by the
20 Board or a State health security program, in
21 accordance with uniform reporting standards
22 established under section 401(g)(1), for—

23 (i) quality review by designated enti-
24 ties;

1 (ii) the making of payments under
2 this Act (including the examination of
3 records as may be necessary for the ver-
4 ification of information on which payments
5 are based);

6 (iii) statistical or other studies re-
7 quired for the implementation of this Act;
8 and

9 (iv) such other purposes as the Board
10 or State may specify.

11 (D) The provider agrees not to bill the pro-
12 gram for any services for which benefits are not
13 available because of section 204(d).

14 (E) In the case of a provider that is not
15 an individual, the provider agrees not to employ
16 or use for the provision of health services any
17 individual or other provider who or which has
18 had a participation agreement under this sub-
19 section terminated for cause.

20 (F) In the case of a provider paid under a
21 fee-for-service basis under section 612, the pro-
22 vider agrees to submit bills and any required
23 supporting documentation relating to the provi-
24 sion of covered services within 30 days (or such
25 shorter period as a State health security pro-

1 gram may require) after the date of providing
2 such services.

3 (2) TERMINATION OF PARTICIPATION AGREE-
4 MENTS.—

5 (A) IN GENERAL.—Participation agree-
6 ments may be terminated, with appropriate no-
7 tice—

8 (i) by the Board or a State health se-
9 curity program for failure to meet the
10 requirements of this title, or

11 (ii) by a provider.

12 (B) TERMINATION PROCESS.—Providers
13 shall be provided notice and a reasonable oppor-
14 tunity to correct deficiencies before the Board
15 or a State health security program terminates
16 an agreement unless a more immediate termi-
17 nation is required for public safety or similar
18 reasons.

19 **SEC. 302. QUALIFICATIONS FOR PROVIDERS.**

20 (a) IN GENERAL.—A health care provider is consid-
21 ered to be qualified to provide covered services if the pro-
22 vider is licensed or certified and meets—

23 (1) all the requirements of State law to provide
24 such services,

1 (2) applicable requirements of Federal law to
2 provide such services, and

3 (3) any applicable standards established under
4 subsection (b).

5 (b) MINIMUM PROVIDER STANDARDS.—

6 (1) IN GENERAL.—The Board shall establish,
7 evaluate, and update national minimum standards to
8 assure the quality of services provided under this
9 Act and to monitor efforts by State health security
10 programs to assure the quality of such services. A
11 State health security program may also establish ad-
12 ditional minimum standards which providers must
13 meet.

14 (2) NATIONAL MINIMUM STANDARDS.—The na-
15 tional minimum standards under paragraph (1) shall
16 be established for institutional providers of services,
17 individual health care practitioners, and comprehen-
18 sive health service organizations. Except as the
19 Board may specify in order to carry out this title,
20 a hospital, nursing facility, or other institutional
21 provider of services shall meet standards for such a
22 facility under the medicare program under title
23 XVIII of the Social Security Act. Such standards
24 also may include, where appropriate, elements relat-
25 ing to—

- 1 (A) adequacy and quality of facilities;
2 (B) training and competence of personnel
3 (including continuing education requirements);
4 (C) comprehensiveness of service;
5 (D) continuity of service;
6 (E) patient satisfaction (including waiting
7 time and access to services); and
8 (F) performance standards (including or-
9 ganization, facilities, structure of services, effi-
10 ciency of operation, and outcome in palliation,
11 improvement of health, stabilization, cure, or
12 rehabilitation).

13 (3) TRANSITION IN APPLICATION.—If the
14 Board provides for additional requirements for pro-
15 viders under this subsection, any such additional re-
16 quirement shall be implemented in a manner that
17 provides for a reasonable period during which a pre-
18 viously qualified provider is permitted to meet such
19 an additional requirement.

20 (4) EXCHANGE OF INFORMATION.—The Board
21 shall provide for an exchange, at least annually,
22 among State health security programs of informa-
23 tion with respect to quality assurance and cost
24 containment.

1 **SEC. 303. QUALIFICATIONS FOR COMPREHENSIVE HEALTH**
2 **SERVICE ORGANIZATIONS.**

3 (a) IN GENERAL.—For purposes of this Act, a com-
4 prehensive health service organization (in this section re-
5 ferred to as a “CHSO”) is a public or private organization
6 which, in return for a capitated payment amount, under-
7 takes to furnish, arrange for the provision of, or provide
8 payment with respect to—

9 (1) a full range of health services (as identified
10 by the Board), including at least hospital services
11 and physicians services, and

12 (2) out-of-area coverage in the case of urgently
13 needed services,
14 to an identified population which is living in or near a
15 specified service area and which enrolls voluntarily in the
16 organization.

17 (b) ENROLLMENT.—

18 (1) IN GENERAL.—All eligible persons living in
19 or near the specified service area of a CHSO are eli-
20 gible to enroll in the organization; except that the
21 number of enrollees may be limited to avoid overtax-
22 ing the resources of the organization.

23 (2) MINIMUM ENROLLMENT PERIOD.—Subject
24 to paragraph (3), the minimum period of enrollment
25 with a CHSO shall be twelve months, unless the en-

1 rolled individual becomes ineligible to enroll with the
2 organization.

3 (3) WITHDRAWAL FOR CAUSE.—Each CHSO
4 shall permit an enrolled individual to disenroll from
5 the organization for cause at any time.

6 (c) REQUIREMENTS FOR CHSOs.—

7 (1) ACCESSIBLE SERVICES.—Each CHSO, to
8 the maximum extent feasible, shall make all services
9 readily and promptly accessible to enrollees who live
10 in the specified service area.

11 (2) CONTINUITY OF CARE.—Each CHSO shall
12 furnish services in such manner as to provide con-
13 tinuity of care and (when services are furnished by
14 different providers) shall provide ready referral of
15 patients to such services and at such times as may
16 be medically appropriate.

17 (3) BOARD OF DIRECTORS.—In the case of a
18 CHSO that is a private organization—

19 (A) CONSUMER REPRESENTATION.—At
20 least one-third of the members of the CHSO's
21 board of directors must be consumer members
22 with no direct or indirect, personal or family
23 financial relationship to the organization.

24 (B) PROVIDER REPRESENTATION.—The
25 CHSO's board of directors must include at

1 least one member who represents health care
2 providers.

3 (4) PATIENT GRIEVANCE PROGRAM.—Each
4 CHSO must have in effect a patient grievance pro-
5 gram and must conduct regularly surveys of the sat-
6 isfaction of members with services provided by or
7 through the organization.

8 (5) MEDICAL STANDARDS.—Each CHSO must
9 provide that a committee or committees of health
10 care practitioners associated with the organization
11 will promulgate medical standards, oversee the pro-
12 fessional aspects of the delivery of care, perform the
13 functions of a pharmacy and drug therapeutics com-
14 mittee, and monitor and review the quality of all
15 health services (including drugs, education, and pre-
16 ventive services).

17 (6) PREMIUMS.—Premiums or other charges by
18 a CHSO for any services not paid for under this Act
19 must be reasonable.

20 (7) UTILIZATION AND BONUS INFORMATION.—
21 Each CHSO must—

22 (A) comply with the requirements of sec-
23 tion 1876(i)(8) of the Social Security Act (re-
24 lating to prohibiting physician incentive plans

1 that provide specific inducements to reduce or
2 limit medically necessary services), and

3 (B) make available to its membership utili-
4 zation information and data regarding financial
5 performance, including bonus or incentive pay-
6 ment arrangements to practitioners.

7 (8) PROVISION OF SERVICES TO ENROLLEES AT
8 INSTITUTIONS OPERATING UNDER GLOBAL BUDG-
9 ETS.—The organization shall arrange to reimburse
10 for hospital services and other facility-based services
11 (as identified by the Board) for services provided to
12 members of the organization in accordance with the
13 global operating budget of the hospital or facility ap-
14 proved under section 611.

15 (9) BROAD MARKETING.—Each CHSO must
16 provide for the marketing of its services (including
17 dissemination of marketing materials) to potential
18 enrollees in a manner that is designed to enroll indi-
19 viduals representative of the different population
20 groups and geographic areas included within its
21 service area and meets such requirements as the
22 Board or a State health security program may
23 specify.

24 (10) ADDITIONAL REQUIREMENTS.—Each
25 CHSO must meet—

1 (A) such requirements relating to mini-
2 mum enrollment,

3 (B) such requirements relating to financial
4 solvency,

5 (C) such requirements relating to quality
6 and availability of care, and

7 (D) such other requirements,

8 as the Board or a State health security program
9 may specify.

10 (d) PROVISION OF EMERGENCY SERVICES TO
11 NONENROLLEES.—A CHSO may furnish emergency serv-
12 ices to persons who are not enrolled in the organization.
13 Payment for such services, if they are covered services to
14 eligible persons, shall be made to the organization unless
15 the organization requests that it be made to the individual
16 provider who furnished the services.

17 **SEC. 304. LIMITATION ON CERTAIN PHYSICIAN REFERRALS.**

18 (a) APPLICATION TO AMERICAN HEALTH SECURITY
19 PROGRAM.—Section 1877 of the Social Security Act, as
20 amended by subsections (b) and (c), shall apply under this
21 Act in the same manner as it applies under title XVIII
22 of the Social Security Act; except that in applying such
23 section under this Act any references in such section to
24 the Secretary or title XVIII of the Social Security Act are

1 deemed references to the Board and the American Health
2 Security Program under this Act, respectively.

3 (b) EXPANSION OF PROHIBITION TO CERTAIN ADDI-
4 TIONAL DESIGNATED SERVICES.—Section 1877(h)(6) of
5 the Social Security Act (42 U.S.C. 1395nn(h)(6)) is
6 amended by adding at the end the following:

7 “(L) Ambulance services.

8 “(M) Home infusion therapy services.”.

9 (c) CONFORMING AMENDMENTS.—Section 1877 of
10 such Act is further amended—

11 (1) in subsection (a)(1)(A), by striking “for
12 which payment otherwise may be made under this
13 title” and by inserting “for which a charge is
14 imposed”;

15 (2) in subsection (a)(1)(B), by striking “under
16 this title”;

17 (3) by amending paragraph (1) of subsection
18 (g) to read as follows:

19 “(1) DENIAL OF PAYMENT.—No payment may
20 be made under a State health security program for
21 a designated health service for which a claim is pre-
22 sented in violation of subsection (a)(1)(B). No indi-
23 vidual, third party payor, or other entity is liable for
24 payment for designated health services for which a

1 claim is presented in violation of such subsection.”;
2 and

3 (4) in subsection (g)(3), by striking “for which
4 payment may not be made under paragraph (1)”
5 and by inserting “for which such a claim may not
6 be presented under subsection (a)(1)”.

7 **TITLE IV—ADMINISTRATION**
8 **Subtitle A—General Administrative**
9 **Provisions**

10 **SEC. 401. AMERICAN HEALTH SECURITY STANDARDS**
11 **BOARD.**

12 (a) ESTABLISHMENT.—There is hereby established
13 an American Health Security Standards Board.

14 (b) APPOINTMENT AND TERMS OF MEMBERS.—

15 (1) IN GENERAL.—The Board shall be com-
16 posed of—

17 (A) the Secretary of Health and Human
18 Services, and

19 (B) 6 other individuals (described in para-
20 graph (2)) appointed by the President with the
21 advice and consent of the Senate.

22 The President shall first nominate individuals under
23 subparagraph (B) on a timely basis so as to provide
24 for the operation of the Board by not later than
25 January 1, 1995.

1 (2) SELECTION OF APPOINTED MEMBERS.—

2 With respect to the individuals appointed under
3 paragraph (1)(B):

4 (A) They shall be chosen on the basis of
5 backgrounds in health policy, health economics,
6 the healing professions, and the administration
7 of health care institutions.

8 (B) They shall provide a balanced point of
9 view with respect to the various health care in-
10 terests and at least two of them shall represent
11 the interests of individual consumers.

12 (C) Not more than three of them shall be
13 from the same political party.

14 (D) To the greatest extent feasible, they
15 shall represent the various geographic regions
16 of the United States and shall reflect the racial,
17 ethnic, and gender composition of the popu-
18 lation of the United States.

19 (3) TERMS OF APPOINTED MEMBERS.—Individ-
20 uals appointed under paragraph (1)(B) shall serve
21 for a term of 6 years, except that the terms of 5 of
22 the individuals initially appointed shall be, as des-
23 ignated by the President at the time of their ap-
24 pointment, for 1, 2, 3, 4, and 5 years. During a
25 term of membership on the Board, no member shall

1 engage in any other business, vocation or employ-
2 ment.

3 (c) VACANCIES.—

4 (1) IN GENERAL.—The President shall fill any
5 vacancy in the membership of the Board in the same
6 manner as the original appointment. The vacancy
7 shall not affect the power of the remaining members
8 to execute the duties of the Board.

9 (2) VACANCY APPOINTMENTS.—Any member
10 appointed to fill a vacancy shall serve for the re-
11 mainder of the term for which the predecessor of the
12 member was appointed.

13 (3) REAPPOINTMENT.—The President may re-
14 appoint an appointed member of the Board for a
15 second term in the same manner as the original ap-
16 pointment. A member who has served for two con-
17 secutive 6-year terms shall not be eligible for re-
18 appointment until two years after the member has
19 ceased to serve.

20 (4) REMOVAL FOR CAUSE.—Upon confirmation,
21 members of the Board may not be removed except
22 by the President for cause.

23 (d) CHAIR.—The President shall designate one of the
24 members of the Board, other than the Secretary, to serve
25 at the will of the President as Chair of the Board.

1 (e) COMPENSATION.—Members of the Board (other
2 than the Secretary) shall be entitled to compensation at
3 a level equivalent to level II of the Executive Schedule,
4 in accordance with section 5313 of title 5, United States
5 Code.

6 (f) GENERAL DUTIES OF THE BOARD.—

7 (1) IN GENERAL.—The Board shall develop
8 policies, procedures, guidelines, and requirements to
9 carry out this Act, including those related to—

10 (A) eligibility;

11 (B) enrollment;

12 (C) benefits;

13 (D) provider participation standards and
14 qualifications, as defined in title III;

15 (E) national and State funding levels;

16 (F) methods for determining amounts of
17 payments to providers of covered services, con-
18 sistent with subtitle B of title VI;

19 (G) the determination of medical necessity
20 and appropriateness with respect to coverage of
21 certain services;

22 (H) assisting State health security pro-
23 grams with planning for capital expenditures
24 and service delivery;

1 (I) planning for health professional edu-
2 cation funding (as specified in title VI);

3 (J) allocating funds provided under title
4 VII; and

5 (K) encouraging States to develop regional
6 planning mechanisms (described in section
7 404(a)(3)).

8 (2) REGULATIONS.—Regulations authorized by
9 this Act shall be issued by the Board in accordance
10 with the provisions of section 553 of title 5, United
11 States Code.

12 (g) UNIFORM REPORTING STANDARDS; ANNUAL RE-
13 PORT; STUDIES.—

14 (1) UNIFORM REPORTING STANDARDS.—

15 (A) IN GENERAL.—The Board shall estab-
16 lish uniform reporting requirements and stand-
17 ards to ensure an adequate national data base
18 regarding health services practitioners, services
19 and finances of State health security programs,
20 approved plans, providers, and the costs of fa-
21 cilities and practitioners providing services.
22 Such standards shall include, to the maximum
23 extent feasible, health outcome measures.

24 (B) REPORTS.—The Board shall analyze
25 regularly information reported to it, and to

1 State health security programs pursuant to
2 such requirements and standards.

3 (2) ANNUAL REPORT.—Beginning January 1,
4 of the second year beginning after the date of the
5 enactment of this Act, the Board shall annually
6 report to Congress on the following:

7 (A) The status of implementation of the
8 Act.

9 (B) Enrollment under this Act.

10 (C) Benefits under this Act.

11 (D) Expenditures and financing under this
12 Act.

13 (E) Cost-containment measures and
14 achievements under this Act.

15 (F) Quality assurance.

16 (G) Health care utilization patterns, in-
17 cluding any changes attributable to the pro-
18 gram.

19 (H) Long-range plans and goals for the de-
20 livery of health services.

21 (I) Differences in the health status of the
22 populations of the different States, including in-
23 come and racial characteristics.

24 (J) Necessary changes in the education of
25 health personnel.

1 (K) Plans for improving service to medi-
2 cally underserved populations.

3 (L) Transition problems as a result of im-
4 plementation of this Act.

5 (M) Opportunities for improvements under
6 this Act.

7 (3) STATISTICAL ANALYSES AND OTHER STUD-
8 IES.—The Board may, either directly or by con-
9 tract—

10 (A) make statistical and other studies, on
11 a nationwide, regional, state, or local basis, of
12 any aspect of the operation of this Act, includ-
13 ing studies of the effect of the Act upon the
14 health of the people of the United States and
15 the effect of comprehensive health services upon
16 the health of persons receiving such services;

17 (B) develop and test methods of providing
18 through payment for services or otherwise, ad-
19 ditional incentives for adherence by providers to
20 standards of adequacy, access, and quality;
21 methods of consumer and peer review and peer
22 control of the utilization of drugs, of laboratory
23 services, and of other services; and methods of
24 consumer and peer review of the quality of serv-
25 ices;

1 (C) develop and test, for use by the Board,
2 records and information retrieval systems and
3 budget systems for health services administra-
4 tion, and develop and test model systems for
5 use by providers of services;

6 (D) develop and test, for use by providers
7 of services, records and information retrieval
8 systems useful in the furnishing of preventive
9 or diagnostic services;

10 (E) develop, in collaboration with the phar-
11 maceutical profession, and test, improved ad-
12 ministrative practices or improved methods for
13 the reimbursement of independent pharmacies
14 for the cost of furnishing drugs as a covered
15 service; and

16 (F) make such other studies as it may con-
17 sider necessary or promising for the evaluation,
18 or for the improvement, of the operation of this
19 Act.

20 (4) REPORT ON USE OF EXISTING FEDERAL
21 HEALTH CARE FACILITIES.—Not later than one year
22 after the date of the enactment of this Act, the
23 Board shall recommend to the Congress one or more
24 proposals for the treatment of health care facilities
25 of the Federal Government.

1 (h) EXECUTIVE DIRECTOR.—

2 (1) APPOINTMENT.—There is hereby estab-
3 lished the position of Executive Director of the
4 Board. The Director shall be appointed by the
5 Board and shall serve as secretary to the Board and
6 perform such duties in the administration of this
7 title as the Board may assign.

8 (2) DELEGATION.—The Board is authorized to
9 delegate to the Director or to any other officer or
10 employee of the Board or, with the approval of the
11 Secretary of Health and Human Services (and sub-
12 ject to reimbursement of identifiable costs), to any
13 other officer or employee of the Department of
14 Health and Human Services, any of its functions or
15 duties under this Act other than—

16 (A) the issuance of regulations; or

17 (B) the determination of the availability of
18 funds and their allocation to implement this
19 Act.

20 (3) COMPENSATION.—The Executive Director
21 of the Board shall be entitled to compensation at a
22 level equivalent to level III of the Executive Sched-
23 ule, in accordance with section 5314 of title 5,
24 United States Code.

1 (i) INSPECTOR GENERAL.—The Inspector General
2 Act of 1978 (5 U.S.C. App.) is amended—

3 (1) in section 11(1) by inserting after “Cor-
4 poration;” the following: “the Chair of the American
5 Health Security Standards Board;”;

6 (2) in section 11(2) by inserting after “Infor-
7 mation Agency,” the following: “the American
8 Health Security Standards Board;” and

9 (3) by inserting after the second section 8G the
10 following:

11 **“§8I. Special provisions concerning American Health**
12 **Security Standards Board**

13 “The Inspector General of the American Health Se-
14 curity Standards Board, in addition to the other authori-
15 ties vested by this Act, shall have the same authority, with
16 respect to the Board and the American Health Security
17 Program under this Act, as the Inspector General for the
18 Department of Health and Human Services has with re-
19 spect to the Secretary of Health and Human Services and
20 the medicare and medicaid programs, respectively.”.

21 (j) STAFF.—The Board shall employ such staff as the
22 Board may deem necessary.

23 (k) ACCESS TO INFORMATION.—The Secretary of
24 Health and Human Services shall make available to the
25 Board all information available from sources within the

1 Department or from other sources, pertaining to the
2 duties of the Board.

3 **SEC. 402. AMERICAN HEALTH SECURITY ADVISORY COUN-**
4 **CIL.**

5 (a) IN GENERAL.—The Board shall provide for an
6 American Health Security Advisory Council (in this sec-
7 tion referred to as the “Council”) to advise the Board on
8 its activities.

9 (b) MEMBERSHIP.—The Council shall be composed
10 of—

11 (1) the Chair of the Board, who shall serve as
12 Chair of the Council, and

13 (2) twenty members, not otherwise in the em-
14 ploy of the United States, appointed by the Board
15 without regard to the provisions of title 5, United
16 States Code, governing appointments in the competi-
17 tive service.

18 The appointed members shall include, in accordance with
19 subsection (e), individuals who are representative of State
20 health security programs, public health professionals, pro-
21 viders of health services, and of individuals (who shall con-
22 stitute a majority of the Council) who are representative
23 of consumers of such services, including a balanced rep-
24 resentation of employers, unions, consumer organizations,
25 and population groups with special health care needs. To

1 the greatest extent feasible, the membership of the Council
2 shall represent the various geographic regions of the Unit-
3 ed States and shall reflect the racial, ethnic, and gender
4 composition of the population of the United States.

5 (c) TERMS OF MEMBERS.—Each appointed member
6 shall hold office for a term of four years, except that—

7 (1) any member appointed to fill a vacancy oc-
8 curring during the term for which the member's
9 predecessor was appointed shall be appointed for the
10 remainder of that term; and

11 (2) the terms of the members first taking office
12 shall expire, as designated by the Board at the time
13 of appointment, five at the end of the first year, five
14 at the end of the second year, five at the end of the
15 third year, and five at the end of the fourth year
16 after the date of enactment of this Act.

17 (d) VACANCIES.—

18 (1) IN GENERAL.—The Board shall fill any va-
19 cancy in the membership of the Council in the same
20 manner as the original appointment. The vacancy
21 shall not affect the power of the remaining members
22 to execute the duties of the Council.

23 (2) VACANCY APPOINTMENTS.—Any member
24 appointed to fill a vacancy shall serve for the re-

1 mainder of the term for which the predecessor of the
2 member was appointed.

3 (3) REAPPOINTMENT.—The Board may re-
4 appoint an appointed member of the Council for a
5 second term in the same manner as the original
6 appointment.

7 (e) QUALIFICATIONS.—

8 (1) PUBLIC HEALTH REPRESENTATIVES.—
9 Members of the Council who are representative of
10 State health security programs and public health
11 professionals shall be individuals who have extensive
12 experience in the financing and delivery of care
13 under public health programs.

14 (2) PROVIDERS.—Members of the Council who
15 are representative of providers of health care shall
16 be individuals who are outstanding in fields related
17 to medical, hospital, or other health activities, or
18 who are representative of organizations or associa-
19 tions of professional health practitioners.

20 (3) CONSUMERS.—Members who are represent-
21 ative of consumers of such care shall be individuals,
22 not engaged in and having no financial interest in
23 the furnishing of health services, who are familiar
24 with the needs of various segments of the population
25 for personal health services and are experienced in

1 dealing with problems associated with the consump-
2 tion of such services.

3 (f) DUTIES.—

4 (1) IN GENERAL.—It shall be the duty of the
5 Council—

6 (A) to advise the Board on matters of gen-
7 eral policy in the administration of this Act, in
8 the formulation of regulations, and in the per-
9 formance of the Board's duties under section
10 401; and

11 (B) to study the operation of this Act and
12 the utilization of health services under it, with
13 a view to recommending any changes in the ad-
14 ministration of the Act or in its provisions
15 which may appear desirable.

16 (2) REPORT.—The Council shall make an an-
17 nual report to the Board on the performance of its
18 functions, including any recommendations it may
19 have with respect thereto, and the Board shall
20 promptly transmit the report to the Congress, to-
21 gether with a report by the Board on any rec-
22 ommendations of the Council that have not been
23 followed.

24 (g) STAFF.—The Council, its members, and any com-
25 mittees of the Council shall be provided with such sec-

1 retarial, clerical, or other assistance as may be authorized
2 by the Board for carrying out their respective functions.

3 (h) MEETINGS.—The Council shall meet as fre-
4 quently as the Board deems necessary, but not less than
5 four times each year. Upon request by seven or more mem-
6 bers it shall be the duty of the Chair to call a meeting
7 of the Council.

8 (i) COMPENSATION.—Members of the Council shall
9 be reimbursed by the Board for travel and per diem in
10 lieu of subsistence expenses during the performance of du-
11 ties of the Board in accordance with subchapter I of chap-
12 ter 57 of title 5, United States Code.

13 (j) FACA NOT APPLICABLE.—The provisions of the
14 Federal Advisory Committee Act shall not apply to the
15 Council.

16 **SEC. 403. CONSULTATION WITH PRIVATE ENTITIES.**

17 The Secretary and the Board shall consult with pri-
18 vate entities, such as professional societies, national asso-
19 ciations, nationally recognized associations of experts,
20 medical schools and academic health centers, consumer
21 groups, and labor and business organizations in the for-
22 mulation of guidelines, regulations, policy initiatives, and
23 information gathering to assure the broadest and most in-
24 formed input in the administration of this Act. Nothing
25 in this Act shall prevent the Secretary from adopting

1 guidelines developed by such a private entity if, in the Sec-
2 retary's and Board's judgment, such guidelines are gen-
3 erally accepted as reasonable and prudent and consistent
4 with this Act.

5 **SEC. 404. STATE HEALTH SECURITY PROGRAMS.**

6 (a) SUBMISSION OF PLANS.—

7 (1) IN GENERAL.—Each State shall submit to
8 the Board a plan for a State health security pro-
9 gram for providing for health care services to the
10 residents of the State in accordance with this Act.

11 (2) REGIONAL PROGRAMS.—A State may join
12 with one or more neighboring States to submit to
13 the Board a plan for a regional health security pro-
14 gram instead of separate State health security
15 programs.

16 (3) REGIONAL PLANNING MECHANISMS.—The
17 Board shall provide incentives for States to develop
18 regional planning mechanisms to promote the ration-
19 al distribution of, adequate access to, and efficient
20 use of, tertiary care facilities, equipment, and
21 services.

22 (b) REVIEW AND APPROVAL OF PLANS.—

23 (1) IN GENERAL.—The Board shall review
24 plans submitted under subsection (a) and determine
25 whether such plans meet the requirements for ap-

1 proval. The Board shall not approve such a plan un-
2 less it finds that the plan (or State law) provides,
3 consistent with the provisions of this Act, for the
4 following:

5 (A) Payment for required health services
6 for eligible individuals in the State in accord-
7 ance with this Act.

8 (B) Adequate administration, including the
9 designation of a single State agency responsible
10 for the administration (or supervision of the
11 administration) of the program.

12 (C) The establishment of a State health
13 security budget.

14 (D) Establishment of payment methodolo-
15 gies (consistent with subtitle B of title VII).

16 (E) Assurances that individuals have the
17 freedom to choose practitioners and other
18 health care providers for services covered under
19 this Act.

20 (F) A procedure for carrying out long-term
21 regional management and planning functions
22 with respect to the delivery and distribution of
23 health care services that—

1 (i) ensures participation of consumers
2 of health services and providers of health
3 services, and

4 (ii) gives priority to the most acute
5 shortages and maldistributions of health
6 personnel and facilities and the most seri-
7 ous deficiencies in the delivery of covered
8 services and to the means for the speedy
9 alleviation of these shortcomings.

10 (G) The licensure and regulation of all
11 health providers and facilities to ensure compli-
12 ance with Federal and State laws and to
13 promote quality of care.

14 (H) Establishment of a quality review sys-
15 tem in accordance with section 503.

16 (I) Establishment of an independent om-
17 budsman for consumers to register complaints
18 about the organization and administration of
19 the State health security program and to help
20 resolve complaints and disputes between con-
21 sumers and providers.

22 (J) Publication of an annual report on the
23 operation of the State health security program,
24 which report shall include information on cost,
25 progress towards achieving full enrollment, pub-

1 lic access to health services, quality review,
2 health outcomes, health professional training,
3 and the needs of medically underserved
4 populations.

5 (K) Provision of a fraud and abuse preven-
6 tion and control unit that the Inspector General
7 determines meets the requirements of section
8 413(a).

9 (L) Provision that—

10 (i) all claims or requests for payment
11 for services shall be accompanied by the
12 unique provider identifier assigned under
13 section 414(a) to the provider and the
14 unique patient identifier assigned to the
15 individual under section 414(b);

16 (ii) no payment shall be made under
17 the program for the provision of health
18 care services by any provider unless the
19 provider has furnished the program with
20 the unique provider identifier assigned
21 under section 414(a);

22 (iii) the plan shall use the unique pa-
23 tient identifier assigned under section
24 414(b) to an individual as the identifier of
25 the individual in the processing of claims

1 and other purposes (as specified by the
2 Board); and

3 (iv) queries made under section
4 412(c)(2) shall be made using the unique
5 provider identifier specified under section
6 414(a).

7 (M) Prohibit payment in cases of prohib-
8 ited physician referrals under section 304.

9 (N) Effective January 1, 2002, provide for
10 use of a uniform electronic data base in accord-
11 ance with section 505(a).

12 (2) CONSEQUENCES OF FAILURE TO COMPLY.—

13 If the Board finds that a State plan submitted
14 under paragraph (1) does not meet the requirements
15 for approval under this section or that a State
16 health security program or specific portion of such
17 program, the plan for which was previously ap-
18 proved, no longer meets such requirements, the
19 Board shall provide notice to the State of such fail-
20 ure and that unless corrective action is taken within
21 a period specified by the Board, the Board shall
22 place the State health security program (or specific
23 portions of such program) in receivership under the
24 jurisdiction of the Board.

1 (c) STATE HEALTH SECURITY ADVISORY COUN-
2 CILS.—

3 (1) IN GENERAL.—For each State, the Gov-
4 ernor shall provide for appointment of a State
5 Health Security Advisory Council to advise and
6 make recommendations to the Governor and State
7 with respect to the implementation of the State
8 health security program in the State.

9 (2) MEMBERSHIP.—Each State Health Security
10 Advisory Council shall be composed of at least 11 in-
11 dividuals. The appointed members shall include indi-
12 viduals who are representative of the State health
13 security program, public health professionals, provid-
14 ers of health services, and of individuals (who shall
15 constitute a majority) who are representative of con-
16 sumers of such services, including a balanced
17 representation of employers, unions and consumer
18 organizations. To the greatest extent feasible, the
19 membership of each State Health Security Advisory
20 Council shall represent the various geographic re-
21 gions of the State and shall reflect the racial, ethnic,
22 and gender composition of the population of the
23 State.

24 (3) DUTIES.—

1 (A) IN GENERAL.—Each State Health Se-
2 curity Advisory Council shall review, and sub-
3 mit comments to the Governor concerning the
4 implementation of the State health security pro-
5 gram in the State.

6 (B) ASSISTANCE.—Each State Health Se-
7 curity Advisory Council shall provide assistance
8 and technical support to community organiza-
9 tions and public and private non-profit agencies
10 submitting applications for funding under ap-
11 propriate State and Federal public health pro-
12 grams, with particular emphasis placed on as-
13 sisting those applicants with broad consumer
14 representation.

15 (d) STATE USE OF FISCAL AGENTS.—

16 (1) IN GENERAL.—Each State health security
17 program, using competitive bidding procedures, may
18 enter into such contracts with qualified entities, such
19 as voluntary associations, as the State determines to
20 be appropriate to process claims and to perform
21 other related functions of fiscal agents under the
22 State health security program.

23 (2) RESTRICTION.—Except as the Board may
24 provide for good cause shown, in no case may more

1 than one contract described in paragraph (1) be
2 entered into under a State health security program.

3 **SEC. 405. COMPLEMENTARY CONDUCT OF RELATED**
4 **HEALTH PROGRAMS.**

5 In performing functions with respect to health per-
6 sonnel education and training, health research, environ-
7 mental health, disability insurance, vocational rehabilita-
8 tion, the regulation of food and drugs, and all other mat-
9 ters pertaining to health, the Secretary of Health and
10 Human Services shall direct all activities of the Depart-
11 ment of Health and Human Services toward contributions
12 to the health of the people complementary to this Act.

13 **Subtitle B—Control Over Fraud**
14 **and Abuse**

15 **SEC. 411. APPLICATION OF FEDERAL SANCTIONS TO ALL**
16 **FRAUD AND ABUSE UNDER AMERICAN**
17 **HEALTH SECURITY PROGRAM.**

18 The following sections of the Social Security Act shall
19 apply to State health security programs in the same man-
20 ner as they apply to State medical assistance plans under
21 title XIX of such Act (except that in applying such provi-
22 sions any reference to the Secretary is deemed a reference
23 to the Board):

24 (1) Section 1128 (relating to exclusion of indi-
25 viduals and entities).

1 (2) Section 1128A (civil monetary penalties).

2 (3) Section 1128B (criminal penalties).

3 (4) Section 1124 (relating to disclosure of own-
4 ership and related information).

5 (5) Section 1126 (relating to disclosure of cer-
6 tain owners).

7 **SEC. 412. NATIONAL HEALTH CARE FRAUD DATA BASE.**

8 (a) ESTABLISHMENT.—The American Health Secu-
9 rity Standards Board, through the Inspector General,
10 shall establish a national data base (in this section
11 referred to as the “data base”) containing information
12 relating to health care fraud and abuse.

13 (b) DATA INCLUDED.—

14 (1) IN GENERAL.—The data base shall include
15 such information as the Inspector General, in con-
16 sultation with the Board, shall specify, and shall
17 include at least the information described in
18 paragraph (2).

19 (2) SPECIFIED INFORMATION.—The informa-
20 tion specified in this paragraph is, with respect to
21 providers of health care services, the identity of any
22 provider—

23 (A) that has been convicted of a crime for
24 which the provider may be excluded from par-

1 ticipation under a health program (as defined
2 in paragraph (3));

3 (B) whose license to provide health care
4 has been revoked or suspended (as described in
5 section 1128(b)(5) of the Social Security Act);

6 (C) that has been excluded or suspended
7 from a health program under section 1128 of
8 the Social Security Act or from any other
9 Federal or State health care program;

10 (D) with respect to whom a civil money
11 penalty has been imposed under this Act or the
12 Social Security Act; or

13 (E) that otherwise is subject to exclusion
14 from participation under a health program.

15 (3) HEALTH PROGRAM DEFINED.—In this sec-
16 tion, the term “health program” means a State
17 health security program and includes the medicare
18 program (under title XVIII of the Social Security
19 Act) and a State health care program (as defined in
20 section 1128(h) of such Act).

21 (c) REPORTING REQUIREMENT.—

22 (1) REPORTING.—Each State health security
23 program shall provide such information to the In-
24 spector General as the Inspector General may re-
25 quire in order to carry out fraud and abuse control

1 activities and for purposes of maintaining the data
2 base.

3 (2) QUERYING.—In accordance with rules es-
4 tablished by the Board (in consultation with the In-
5 spector General), each State health security program
6 shall query periodically (as specified by the Inspector
7 General)—

8 (A) the data base to determine if providers
9 of health services for which the program makes
10 payment are not disqualified from providing
11 such services, and

12 (B) the Secretary of Health and Human
13 Services, concerning information obtained by
14 the Secretary under part B of the Health Care
15 Quality Improvement Act of 1986 relating to
16 practitioners.

17 (3) COORDINATION WITH MALPRACTICE DATA
18 BASE.—The Secretary of Health and Human Serv-
19 ices shall provide for the coordination of the report-
20 ing and disclosure of information under this section
21 with information under part B of the Health Care
22 Quality Improvement Act of 1986.

23 (4) UNIFORM MANNER.—Information shall be
24 reported under this subsection in a uniform manner
25 (in accordance with standards of the Inspector Gen-

1 eral) that permits aggregation of reported informa-
2 tion.

3 (5) ACCESS FOR AUDIT.—Each State health se-
4 curity program shall provide the Inspector General
5 such access to information as may be required to
6 verify the information reported under this sub-
7 section.

8 (6) PENALTY FOR FALSE INFORMATION.—Any
9 person that submits false information required to be
10 provided under this subsection or that denies access
11 to information under paragraph (5) may be impris-
12 oned for not more than 5 years, or fined, or both,
13 in accordance with title 18, United States Code.

14 (7) CONFIDENTIALITY.—The Board shall estab-
15 lish rules that protect the confidentiality of the
16 information in the data base.

17 **SEC. 413. REQUIREMENTS FOR OPERATION OF STATE**
18 **HEALTH CARE FRAUD AND ABUSE CONTROL**
19 **UNITS.**

20 (a) REQUIREMENT.—In order to meet the require-
21 ment of section 404(b)(1)(K), each State health security
22 program must establish and maintain a health care fraud
23 and abuse control unit (in this section referred to as a
24 “fraud unit”) that meets requirements of this section and
25 other requirements of the Board. Such a unit may be a

1 State medicaid fraud control unit (described in section
2 1903(q) of the Social Security Act).

3 (b) STRUCTURE OF UNIT.—The fraud unit must—

4 (1) be a single identifiable entity of the State
5 government;

6 (2) be separate and distinct from the State
7 agency with principal responsibility for the adminis-
8 tration of the State health security program; and

9 (3) meet 1 of the following requirements:

10 (A) It must be a unit of the office of the
11 State Attorney General or of another depart-
12 ment of State government which possesses
13 statewide authority to prosecute individuals for
14 criminal violations.

15 (B) If it is in a State the constitution of
16 which does not provide for the criminal prosecu-
17 tion of individuals by a statewide authority and
18 has formal procedures, approved by the Board,
19 that (i) assure its referral of suspected criminal
20 violations relating to the State health insurance
21 plan to the appropriate authority or authorities
22 in the States for prosecution, and (ii) assure its
23 assistance of, and coordination with, such au-
24 thority or authorities in such prosecutions.

1 (C) It must have a formal working rela-
2 tionship with the office of the State Attorney
3 General and have formal procedures (including
4 procedures for its referral of suspected criminal
5 violations to such office) which are approved by
6 the Board and which provide effective coordina-
7 tion of activities between the fraud unit and
8 such office with respect to the detection, inves-
9 tigation, and prosecution of suspected criminal
10 violations relating to the State health insurance
11 plan.

12 (c) FUNCTIONS.—The fraud unit must—

13 (1) have the function of conducting a statewide
14 program for the investigation and prosecution of vio-
15 lations of all applicable State laws regarding any
16 and all aspects of fraud in connection with any as-
17 pect of the provision of health care services and ac-
18 tivities of providers of such services under the State
19 health security program;

20 (2) have procedures for reviewing complaints of
21 the abuse and neglect of patients of providers and
22 facilities that receive payments under the State
23 health security program, and, where appropriate, for
24 acting upon such complaints under the criminal laws

1 of the State or for referring them to other State
2 agencies for action; and

3 (3) provide for the collection, or referral for col-
4 lection to a single State agency, of overpayments
5 that are made under the State health security pro-
6 gram to providers and that are discovered by the
7 fraud unit in carrying out its activities.

8 (d) RESOURCES.—The fraud unit must—

9 (1) employ such auditors, attorneys, investiga-
10 tors, and other necessary personnel,

11 (2) be organized in such a manner, and

12 (3) provide sufficient resources (as specified by
13 the Board), as is necessary to promote the effective
14 and efficient conduct of the unit's activities.

15 (e) COOPERATIVE AGREEMENTS.—The fraud unit
16 must have cooperative agreements (as specified by the
17 Board) with—

18 (1) similar fraud units in other States,

19 (2) the Inspector General, and

20 (3) the Attorney General of the United States.

21 (f) REPORTS.—The fraud unit must submit to the
22 Inspector General an application and annual reports con-
23 taining such information as the Inspector General deter-
24 mines to be necessary to determine whether the unit meets
25 the previous requirements of this section.

1 **SEC. 414. ASSIGNMENT OF UNIQUE PROVIDER AND PA-**
2 **TIENT IDENTIFIERS.**

3 (a) PROVIDER IDENTIFIERS.—

4 (1) IN GENERAL.—The Board shall provide for
5 the assignment, to each individual or entity provid-
6 ing health care services under a State health secu-
7 rity program, of a unique provider identifier.

8 (2) RESPONSE TO QUERIES.—Upon the request
9 of a State health security program with respect to
10 a provider, the Board shall provide the program with
11 the unique provider identifier (if any) assigned to
12 the provider under paragraph (1).

13 (b) PATIENT IDENTIFIERS.—The Board shall provide
14 for the assignment, to each eligible individual, of a unique
15 patient identifier. The identifier so assigned may be the
16 Social Security account number of the individual.

17 (c) REQUIREMENT TO USE IDENTIFIERS.—Each
18 State health security program is required under section
19 404(b)(1)(L) to use the unique identifiers assigned under
20 this section.

21 **TITLE V—QUALITY ASSESSMENT**

22 **SEC. 501. AMERICAN HEALTH SECURITY QUALITY COUNCIL.**

23 (a) ESTABLISHMENT.—There is hereby established
24 an American Health Security Quality Council (in this title
25 referred to as the “Council”).

1 (b) DUTIES OF THE COUNCIL.—The Council shall
2 perform the following duties:

3 (1) PRACTICE GUIDELINES.—The Council shall
4 review and evaluate each practice guideline devel-
5 oped under part B of title IX of the Public Health
6 Service Act. The Council shall determine whether
7 the guideline should be recognized as a national
8 practice guideline to be used under section 204(d)
9 for purposes of determining payments under a State
10 health security program.

11 (2) STANDARDS OF QUALITY, PERFORMANCE
12 MEASURES, AND MEDICAL REVIEW CRITERIA.—The
13 Council shall review and evaluate each standard of
14 quality, performance measure, and medical review
15 criterion developed under part B of title IX of the
16 Public Health Service Act. The Council shall deter-
17 mine whether the standard, measure, or criterion is
18 appropriate for use in assessing or reviewing the
19 quality of services provided by State health security
20 programs, health care institutions, or health care
21 professionals.

22 (3) CRITERIA FOR ENTITIES CONDUCTING
23 QUALITY REVIEWS.—The Council shall develop mini-
24 mum criteria for competence for entities that can
25 qualify to conduct ongoing and continuous external

1 quality review for State quality review programs
2 under section 503. Such criteria shall require such
3 an entity to be administratively independent of the
4 individual or board that administers the State health
5 security program and shall ensure that such entities
6 do not provide financial incentives to reviewers to
7 favor one pattern of practice over another. The
8 Council shall ensure coordination and reporting by
9 such entities to assure national consistency in qual-
10 ity standards.

11 (4) REPORTING.—The Council shall report to
12 the Board annually on the conduct of activities
13 under such title and shall report to the Board annu-
14 ally specifically on findings from outcomes research
15 and development of practice guidelines that may af-
16 fect the Board’s determination of coverage of serv-
17 ices under section 401(f)(1)(G).

18 (5) OTHER FUNCTIONS.—The Council shall
19 perform the functions of the Council described in
20 sections 502 and 505.

21 (c) APPOINTMENT AND TERMS OF MEMBERS.—

22 (1) IN GENERAL.—The Council shall be com-
23 posed of 10 members appointed by the President.
24 The President shall first appoint individuals on a

1 timely basis so as to provide for the operation of the
2 Council by not later than January 1, 1996.

3 (2) SELECTION OF MEMBERS.—Each member
4 of the Council shall be a member of a health profes-
5 sion. Five members of the Council shall be physi-
6 cians. Individuals shall be appointed to the Council
7 on the basis of national reputations for clinical and
8 academic excellence. To the greatest extent feasible,
9 the membership of the Council shall represent the
10 various geographic regions of the United States and
11 shall reflect the racial, ethnic, and gender composi-
12 tion of the population of the United States.

13 (3) TERMS OF MEMBERS.—Individuals ap-
14 pointed to the Council shall serve for a term of 5
15 years, except that the terms of 4 of the individuals
16 initially appointed shall be, as designated by the
17 President at the time of their appointment, for 1, 2,
18 3, and 4 years.

19 (d) VACANCIES.—

20 (1) IN GENERAL.—The President shall fill any
21 vacancy in the membership of the Council in the
22 same manner as the original appointment. The va-
23 cancy shall not affect the power of the remaining
24 members to execute the duties of the Council.

1 (2) VACANCY APPOINTMENTS.—Any member
2 appointed to fill a vacancy shall serve for the re-
3 mainder of the term for which the predecessor of the
4 member was appointed.

5 (3) REAPPOINTMENT.—The President may re-
6 appoint a member of the Council for a second term
7 in the same manner as the original appointment. A
8 member who has served for two consecutive 5-year
9 terms shall not be eligible for reappointment until
10 two years after the member has ceased to serve.

11 (e) CHAIR.—The President shall designate one of the
12 members of the Council to serve at the will of the Presi-
13 dent as Chair of the Council.

14 (f) COMPENSATION.—Members of the Council who
15 are not employees of the Federal Government shall be en-
16 titled to compensation at a level equivalent to level II of
17 the Executive Schedule, in accordance with section 5313
18 of title 5, United States Code.

19 **SEC. 502. DEVELOPMENT OF CERTAIN METHODOLOGIES,**
20 **GUIDELINES, AND STANDARDS.**

21 (a) PROFILING OF PATTERNS OF PRACTICE; IDENTI-
22 FICATION OF OUTLIERS.—The Council shall adopt meth-
23 odologies for profiling the patterns of practice of health
24 care professionals and for identifying outliers (as defined
25 in subsection (e)).

1 (b) CENTERS OF EXCELLENCE.—The Council shall
2 develop guidelines for certain medical procedures des-
3 ignated by the Board to be performed only at tertiary care
4 centers which can meet standards for frequency of proce-
5 dure performance and intensity of support mechanisms
6 that are consistent with the high probability of desired pa-
7 tient outcome. Reimbursement under this Act for such a
8 designated procedure may only be provided if the proce-
9 dure was performed at a center that meets such stand-
10 ards.

11 (c) REMEDIAL ACTIONS.—The Council shall develop
12 standards for education and sanctions with respect to
13 outliers so as to assure the quality of health care services
14 provided under this Act. The Council shall develop criteria
15 for referral of providers to the State licensing board if edu-
16 cation proves ineffective in correcting provider practice be-
17 havior.

18 (d) DISSEMINATION.—The Council shall disseminate
19 to the State—

20 (1) the methodologies adopted under subsection

21 (a),

22 (2) the guidelines developed under subsection

23 (b), and

24 (3) the standards developed under subsection

25 (c),

1 for use by the States under section 503.

2 (e) OUTLIER DEFINED.—In this title, the term
3 “outlier” means a health care provider whose pattern of
4 practice, relative to applicable practice guidelines, suggests
5 deficiencies in the quality of health care services being pro-
6 vided.

7 **SEC. 503. STATE QUALITY REVIEW PROGRAMS.**

8 (a) REQUIREMENT.—In order to meet the require-
9 ment of section 404(b)(1)(H), each State health security
10 program shall establish one or more qualified entities to
11 conduct quality reviews of persons providing covered serv-
12 ices under the program, in accordance with standards es-
13 tablished under subsection (b)(1) (except as provided in
14 subsection (b)(2)) and subsection (d).

15 (b) FEDERAL STANDARDS.—

16 (1) IN GENERAL.—The Council shall establish
17 standards with respect to—

18 (A) the adoption of practice guidelines
19 (whether developed by the Federal Government
20 or other entities),

21 (B) the identification of outliers (consist-
22 ent with methodologies adopted under section
23 502(a)),

24 (C) the development of remedial programs
25 and monitoring for outliers, and

1 (D) the application of sanctions (consistent
2 with the standards developed under section
3 502(c)).

4 (2) STATE DISCRETION.—A State may apply
5 under subsection (a) standards other than those es-
6 tablished under paragraph (1) so long as the State
7 demonstrates to the satisfaction of the Council on an
8 annual basis that the standards applied have been as
9 efficacious in promoting and achieving improved
10 quality of care as the application of the standards
11 established under paragraph (1). Positive improve-
12 ments in quality shall be documented by reductions
13 in the variations of clinical care process and im-
14 provement in patient outcomes.

15 (c) QUALIFICATIONS.—An entity is not qualified to
16 conduct quality reviews under subsection (a) unless the
17 entity satisfies the criteria for competence for such entities
18 developed by the Council under section 501(b)(3).

19 (d) INTERNAL QUALITY REVIEW.—Nothing in this
20 section shall preclude an institutional provider from estab-
21 lishing its own internal quality review and enhancement
22 programs.

1 **SEC. 504. ELIMINATION OF UTILIZATION REVIEW PRO-**
2 **GRAMS; TRANSITION.**

3 (a) INTENT.—It is the intention of this title to re-
4 place by January 1, 1999, random utilization controls with
5 a systematic review of patterns of practice that com-
6 promise the quality of care.

7 (b) SUPERSEDING CASE REVIEWS.—

8 (1) IN GENERAL.—Subject to the succeeding
9 provisions of this subsection, the program of quality
10 review provided under the previous sections of this
11 title supersede all existing Federal requirements for
12 utilization review programs, including requirements
13 for random case-by-case reviews and programs re-
14 quiring pre-certification of medical procedures on a
15 case-by-case basis.

16 (2) TRANSITION.—Before January 1, 1999, the
17 Board and the States may employ existing utiliza-
18 tion review standards and mechanisms as may be
19 necessary to effect the transition to pattern of prac-
20 tice-based reviews.

21 (3) CONSTRUCTION.—Nothing in this sub-
22 section shall be construed—

23 (A) as precluding the case-by-case review
24 of the provision of care—

- 1 (i) in individual incidents where the
2 quality of care has significantly deviated
3 from acceptable standards of practice, and
4 (ii) with respect to a provider who has
5 been determined to be an outlier; or
6 (B) as precluding the case management of
7 catastrophic, mental health, or substance abuse
8 cases or long-term care where such manage-
9 ment is necessary to achieve appropriate, cost-
10 effective, and beneficial comprehensive medical
11 care, as provided for in section 204.

12 **SEC. 505. UNIFORM ELECTRONIC DATA BASES.**

13 (a) IN GENERAL.—In order to meet the requirement
14 of this section, for purposes of section 404(b)(1)(N)), each
15 State health security program shall develop and use a uni-
16 form electronic data base in order to perform systematic
17 quality review and support comparative outcomes research
18 and analysis. Each data base shall contain the data de-
19 scribed in subsection (b) and use the software described
20 in subsection (c). Information in such a data base may
21 be used or disclosed only in a manner consistent with the
22 standards established by the Council under subsection (d).

23 (b) MEDICAL RECORD DATA SET.—

24 (1) ESTABLISHMENT.—Not later than January
25 1, 2005, the Council shall establish a set of clinical

1 data derived from patient medical records to be
2 transmitted by health care providers to the elec-
3 tronic data bases used by State health security pro-
4 grams for the purposes described in subsection (a).

5 (2) TRANSMISSION.—Each health care provider,
6 as a condition for being considered a qualified pro-
7 vider of services under section 302, shall transmit
8 (on a periodic basis determined appropriate by the
9 Council and using a uniform electronic format speci-
10 fied by the Council) the set of clinical data described
11 in paragraph (1) to the State health security pro-
12 gram data base used by each State in which the pro-
13 vider is licensed.

14 (c) COMPATIBLE SOFTWARE.—The Board shall des-
15 ignate the standards that software, used by States in the
16 operation of their electronic data bases, must meet in
17 order to assure compatibility among the States. The
18 Board shall not grant any waiver of the requirement of
19 the previous sentence.

20 (d) USE AND DISCLOSURE OF DATA.—

21 (1) IN GENERAL.—The Council shall establish
22 standards concerning the purposes for which, and
23 the procedures by which, data that is transmitted to
24 an electronic data base under this section may be
25 used or disclosed by a State health security program

1 (or by any other person using or operating such a
2 data base).

3 (2) INDIVIDUALLY IDENTIFIABLE DATA.—The
4 standards under paragraph (1) shall include stand-
5 ards that prohibit a State health security program
6 (or any other person using or operating a data base
7 established under this section) from disclosing, to
8 any person or public agency other than the State
9 health security program for which the data base was
10 developed, data from the data base that identify a
11 patient (or with respect to which there is a reason-
12 able basis to believe that the data can be used to
13 identify a patient) unless the following conditions
14 are met:

15 (A) The person or agency is conducting a
16 biomedical, epidemiological, or health services
17 research or statistics project, or a research
18 project on behavioral or social factors affecting
19 health.

20 (B) The project involves outcomes research
21 or analysis.

22 (C) The project is—

23 (i) of sufficient importance so as to
24 outweigh the intrusion into the privacy of

1 the patient that would result from the dis-
2 closure; and

3 (ii) impracticable to conduct without
4 the data.

5 (D) The disclosure is limited to the mini-
6 mum amount of data necessary to accomplish
7 the purpose for which the data are disclosed.

8 (E) The person who, or agency that, re-
9 ceives the data agrees—

10 (i) to use the data solely for purposes
11 of the project; and

12 (ii) to remove or destroy, at the earli-
13 est opportunity consistent with the pur-
14 poses of the project, data that would en-
15 able a patient to be identified, unless the
16 State health security program has deter-
17 mined that there is a health or research
18 justification for retention of such identifi-
19 ers and there is an adequate plan to pro-
20 tect the identifiers from use and disclosure
21 that is inconsistent with this section.

22 (3) MANDATORY DISCLOSURES.—The standards
23 under paragraph (1) shall require a State health se-
24 curity program to disclose data in the uniform elec-

1 tronic data base used by the program to any person
2 or public agency requesting such data if—

3 (A) the person or agency is conducting a
4 project of the type described in subparagraphs
5 (A) and (B) of paragraph (2); and

6 (B) the disclosure otherwise satisfies any
7 applicable standard established by the Council.

8 **TITLE VI—HEALTH SECURITY**
9 **BUDGET; PAYMENTS; COST**
10 **CONTAINMENT MEASURES**
11 **Subtitle A—Budgeting and**
12 **Payments to States**

13 **SEC. 601. NATIONAL HEALTH SECURITY BUDGET.**

14 (a) NATIONAL HEALTH SECURITY BUDGET.—

15 (1) IN GENERAL.—By not later than September
16 1 before the beginning of each year (beginning with
17 1996), the Board shall establish a national health
18 security budget, which—

19 (A) specifies the total expenditures (includ-
20 ing expenditures for administrative costs) to be
21 made by the Federal Government and the
22 States for covered health care services under
23 this Act, and

24 (B) allocates those expenditures among the
25 States consistent with section 604.

1 Pursuant to subsection (b), such budget for a year
2 shall not exceed the budget for the preceding year
3 increased by the percentage increase in gross domes-
4 tic product.

5 (2) DIVISION OF BUDGET INTO COMPONENTS.—
6 The national health security budget shall consist of
7 at least 4 components:

8 (A) A component for quality assessment
9 activities (described in title V).

10 (B) A component for health professional
11 education expenditures.

12 (C) A component for administrative costs.

13 (D) A component (in this title referred to
14 as the “operating component”) for operating
15 and other expenditures not described in sub-
16 paragraphs (A) through (C), consisting of
17 amounts not included in the other components.

18 A State may provide for the allocation of this
19 component between capital expenditures and
20 other expenditures.

21 (3) ALLOCATION AMONG COMPONENTS.—Tak-
22 ing into account the State health security budgets
23 established and submitted under section 603, the
24 Board shall allocate the national health security
25 budget among the components in a manner that—

1 (A) assures a fair allocation for quality as-
2 sessment activities (consistent with the national
3 health security spending growth limit); and

4 (B) assures that the health professional
5 education expenditure component is sufficient
6 to provide for the amount of health professional
7 education expenditures sufficient to meet the
8 need for covered health care services (consistent
9 with the national health security spending
10 growth limit under subsection (b)(2)).

11 (b) BASIS FOR TOTAL EXPENDITURES.—

12 (1) IN GENERAL.—The total expenditures speci-
13 fied in such budget shall be the sum of the capita-
14 tion amounts computed under section 602(a) and
15 the amount of Federal administrative expenditures
16 needed to carry out this Act.

17 (2) NATIONAL HEALTH SECURITY SPENDING
18 GROWTH LIMIT.—For purposes of this subtitle, the
19 national health security spending growth limit de-
20 scribed in this paragraph for a year is (A) zero, or,
21 if greater, (B) the average annual percentage in-
22 crease in the gross domestic product (in current dol-
23 lars) during the 3-year period beginning with the
24 first quarter of the fourth previous year to the first
25 quarter of the previous year minus the percentage

1 increase (if any) in the number of eligible individuals
2 residing in any State the United States from the
3 first quarter of the second previous year to the first
4 quarter of the previous year.

5 (c) DEFINITIONS.—In this title:

6 (1) CAPITAL EXPENDITURES.—The term “cap-
7 ital expenditures” means expenses for the purchase,
8 lease, construction, or renovation of capital facilities
9 and for equipment and includes return on equity
10 capital.

11 (2) HEALTH PROFESSIONAL EDUCATION EX-
12 PENDITURES.—The term “health professional edu-
13 cation expenditures” means expenditures in hospitals
14 and other health care facilities to cover costs associ-
15 ated with teaching and related research activities.

16 **SEC. 602. COMPUTATION OF INDIVIDUAL AND STATE CAPI-**
17 **TATION AMOUNTS.**

18 (a) CAPITATION AMOUNTS.—

19 (1) INDIVIDUAL CAPITATION AMOUNTS.—In es-
20 tablishing the national health security budget under
21 section 601(a) and in computing the national aver-
22 age per capita cost under subsection (b) for each
23 year, the Board shall establish a method for comput-
24 ing the capitation amount for each eligible individual
25 residing in each State. The capitation amount for an

1 eligible individual in a State classified within a risk
2 group (established under subsection (d)(2)) is the
3 product of—

4 (A) a national average per capita cost for
5 all covered health care services (computed
6 under subsection (b)),

7 (B) the State adjustment factor (estab-
8 lished under subsection (c)) for the State, and

9 (C) the risk adjustment factor (established
10 under subsection (d)) for the risk group.

11 (2) STATE CAPITATION AMOUNT.—

12 (A) IN GENERAL.—For purposes of this
13 title, the term “State capitation amount”
14 means, for a State for a year, the sum of the
15 capitation amounts computed under paragraph
16 (1) for all the residents of the State in the year,
17 as estimated by the Board before the beginning
18 of the year involved.

19 (B) USE OF STATISTICAL MODEL.—The
20 Board may provide for the computation of
21 State capitation amounts based on statistical
22 models that fairly reflect the elements that com-
23 prise the State capitation amount described in
24 subparagraph (A).

1 (C) POPULATION INFORMATION.—The Bu-
2 reau of the Census shall assist the Board in de-
3 termining the number, place of residence, and
4 risk group classification of eligible individuals.

5 (b) COMPUTATION OF NATIONAL AVERAGE PER CAP-
6 ITA COST.—

7 (1) FOR 1996.—For 1996, the national average
8 per capita cost under this paragraph is equal to—

9 (A) the average per capita health care ex-
10 penditures in the United States in 1994 (as
11 estimated by the Board),

12 (B) increased to 1995 by the Board's esti-
13 mate of the actual amount of such per capita
14 expenditures during 1995, and

15 (C) updated to 1996 by the national health
16 security spending growth limit specified in sec-
17 tion 601(b)(2) for 1996.

18 (2) FOR SUCCEEDING YEARS.—For each suc-
19 ceeding year, the national average per capita cost
20 under this subsection is equal to the national aver-
21 age per capita cost computed under this subsection
22 for the previous year increased by the national
23 health security spending growth limit (specified in
24 section 601(b)(2)) for the year involved.

25 (c) STATE ADJUSTMENT FACTORS.—

1 (1) IN GENERAL.—Subject to the succeeding
2 paragraphs of this subsection, the Board shall de-
3 velop for each State a factor to adjust the national
4 average per capita costs to reflect differences
5 between the State and the United States in—

6 (A) average labor and nonlabor costs that
7 are necessary to provide covered health services;

8 (B) any social, environmental, or geo-
9 graphic condition affecting health status or the
10 need for health care services, to the extent such
11 a condition is not taken into account in the es-
12 tablishment of risk groups under subsection (d);

13 (C) the geographic distribution of the
14 State’s population, particularly the proportion
15 of the population residing in medically under-
16 served areas, to the extent such a condition is
17 not taken into account in the establishment of
18 risk groups under subsection (d); and

19 (D) any other factor relating to operating
20 costs required to assure equitable distribution
21 of funds among the States.

22 (2) MODIFICATION OF HEALTH PROFESSIONAL
23 EDUCATION COMPONENT.—With respect to the por-
24 tion of the national health security budget allocated
25 to expenditures for health professional education, the

1 Board shall modify the State adjustment factors so
2 as to take into account—

3 (A) differences among States in health
4 professional education programs in operation as
5 of the date of the enactment of this Act, and

6 (B) differences among States in their rel-
7 ative need for expenditures for health profes-
8 sional education, taking into account the health
9 professional education expenditures proposed in
10 State health security budgets under section
11 603(a).

12 (3) BUDGET NEUTRALITY.—The State adjust-
13 ment factors, as modified under paragraph (2), shall
14 be applied under this subsection in a manner that
15 results in neither an increase nor a decrease in the
16 total amount of the Federal contributions to all
17 State health security programs under subsection (b)
18 as a result of the application of such factors.

19 (4) PHASE-IN.—In applying State adjustment
20 factors under this subsection during the five-year pe-
21 riod beginning with 1996, the Board shall phase-in,
22 over such period, the use of factors described in
23 paragraph (1) in a manner so that the adjustment
24 factor for a State is based on a blend of such factors
25 and a factor that reflects the relative actual average

1 per capita costs of health services of the different
2 States as of the time of enactment of this Act.

3 (5) PERIODIC ADJUSTMENT.—In establishing
4 the national health security budget before the begin-
5 ning of each year, the Board shall provide for appro-
6 priate adjustments in the State adjustment factors
7 under this subsection.

8 (d) ADJUSTMENTS FOR RISK GROUP CLASSIFICA-
9 TION.—

10 (1) IN GENERAL.—The Board shall develop an
11 adjustment factor to the national average per capita
12 costs computed under subsection (b) for individuals
13 classified in each risk group (as designated under
14 paragraph (2)) to reflect the difference between the
15 average national average per capita costs and the
16 national average per capita cost for individuals clas-
17 sified in the risk group.

18 (2) RISK GROUPS.—The Board shall designate
19 a series of risk groups, determined by age, health in-
20 dicators, and other factors that represent distinct
21 patterns of health care services utilization and costs.

22 (3) PERIODIC ADJUSTMENT.—In establishing
23 the national health security budget before the begin-
24 ning of each year, the Board shall provide for appro-

1 piate adjustments in the risk adjustment factors
2 under this subsection.

3 **SEC. 603. STATE HEALTH SECURITY BUDGETS.**

4 (a) ESTABLISHMENT AND SUBMISSION OF BUDG-
5 ETS.—

6 (1) IN GENERAL.—Each State health security
7 program shall establish and submit to the Board for
8 each year a proposed and a final State health secu-
9 rity budget, which specifies the following:

10 (A) The total expenditures (including ex-
11 penditures for administrative costs) to be made
12 under the program in the State for covered
13 health care services under this Act, consistent
14 with subsection (b), broken down as follows:

15 (i) By the 4 components (described in
16 section 601(a)(2)), consistent with sub-
17 section (b).

18 (ii) Within the operating component—

19 (I) expenditures for operating
20 costs of hospitals and other facility-
21 based services in the State,

22 (II) expenditures for payment to
23 comprehensive health service organiza-
24 tions,

1 (III) expenditures for payment of
2 services provided by health care prac-
3 titioners, and

4 (IV) expenditures for other cov-
5 ered items and services.

6 Amounts included in the operating compo-
7 nent include amounts that may be used by
8 providers for capital expenditures.

9 (B) The total revenues required to meet
10 the State health security expenditures.

11 (2) PROPOSED BUDGET DEADLINE.—The pro-
12 posed budget for a year shall be submitted under
13 paragraph (1) not later than June 1 before the year.

14 (3) FINAL BUDGET.—The final budget for a
15 year shall—

16 (A) be established and submitted under
17 paragraph (1) not later than October 1 before
18 the year, and

19 (B) take into account the amounts estab-
20 lished under the national health security budget
21 under section 601 for the year.

22 (4) ADJUSTMENT IN ALLOCATIONS PER-
23 MITTED.—

24 (A) IN GENERAL.—Subject to subpara-
25 graphs (B) and (C), in the case of a final

1 budget, a State may change the allocation of
2 amounts among components.

3 (B) NOTICE.—No such change may be
4 made unless the State has provided prior notice
5 of the change to the Board.

6 (C) DENIAL.—Such a change may not be
7 made if the Board, within such time period as
8 the Board specifies, disapproves such change.

9 (b) EXPENDITURE LIMITS.—

10 (1) IN GENERAL.—The total expenditures speci-
11 fied in each State health security budget under sub-
12 section (a)(1) shall take into account Federal
13 contributions made under section 604.

14 (2) LIMIT ON CLAIMS PROCESSING AND BILL-
15 ING EXPENDITURES.—Each State health security
16 budget shall provide that State administrative ex-
17 penditures, including expenditures for claims proc-
18 essing and billing, shall not exceed 3 percent of the
19 total expenditures under the State health security
20 program, unless the Board determines, on a case-by-
21 case basis, that additional administrative expendi-
22 tures would improve health care quality and cost
23 effectiveness.

24 (3) WORKER ASSISTANCE.—A State health se-
25 curity program may provide that, for budgets for

1 years before 2001, up to 1 percent of the budget
2 may be used for purposes of programs providing as-
3 sistance to workers who are currently performing
4 functions in the administration of the health insur-
5 ance system and who may experience economic dis-
6 location as a result of the implementation of the
7 program.

8 (c) APPROVAL PROCESS FOR CAPITAL EXPENDI-
9 TURES PERMITTED.—Nothing in this title shall be con-
10 strued as preventing a State health security program from
11 providing for a process for the approval of capital expendi-
12 tures based on information derived from regional planning
13 agencies.

14 **SEC. 604. FEDERAL PAYMENTS TO STATES.**

15 (a) IN GENERAL.—Each State with an approved
16 State health security program is entitled to receive, from
17 amounts in the American Health Security Trust Fund, on
18 a monthly basis each year, of an amount equal to one-
19 twelfth of the product of—

20 (1) the State capitation amount (computed
21 under section 602(a)(2)) for the State for the year,
22 and

23 (2) the Federal contribution percentage (estab-
24 lished under subsection (b)).

1 (b) FEDERAL CONTRIBUTION PERCENTAGE.—The
2 Board shall establish a formula for the establishment of
3 a Federal contribution percentage for each State. Such
4 formula shall take into consideration a State's per capita
5 income and revenue capacity and such other relevant eco-
6 nomic indicators as the Board determines to be appro-
7 priate. In addition, during the 5-year period beginning
8 with 1996, the Board may provide for a transition adjust-
9 ment to the formula in order to take into account current
10 expenditures by the State (and local governments thereof)
11 for health services covered under the State health security
12 program. The weighted-average Federal contribution per-
13 centage for all States shall equal 86 percent and in no
14 event shall such percentage be less than 81 percent nor
15 more than 91 percent.

16 (c) USE OF PAYMENTS.—All payments made under
17 this section may only be used to carry out the State health
18 security program.

19 (d) EFFECT OF SPENDING EXCESS OR SURPLUS.—

20 (1) SPENDING EXCESS.—If a State exceeds its
21 budget in a given year, the State shall continue to
22 fund covered health services from its own revenues.

23 (2) SURPLUS.—If a State provides all covered
24 health services for less than the budgeted amount

1 for a year, it may retain its Federal payment for
2 that year for uses consistent with this Act.

3 **SEC. 605. ACCOUNT FOR HEALTH PROFESSIONAL EDU-**
4 **CATION EXPENDITURES.**

5 (a) SEPARATE ACCOUNT.—Each State health secu-
6 rity program shall—

7 (1) include a separate account for health pro-
8 fessional education expenditures, and

9 (2) specify the general manner, consistent with
10 subsection (b), in which such expenditures are to be
11 distributed among different types of institutions and
12 the different areas of the State.

13 (b) DISTRIBUTION RULES.—The distribution of
14 funds to hospitals and other health care facilities from the
15 account must conform to the following principles:

16 (1) The disbursement of funds must be consist-
17 ent with achievement of the national and program
18 goals (specified in section 701(b)) within the State
19 health security program and the distribution of
20 funds from the account must be conditioned upon
21 the receipt of such reports as the Board may require
22 in order to monitor compliance with such goals.

23 (2) The distribution of funds from the account
24 must take into account the potentially higher costs
25 of placing health professional students in clinical

1 education programs in health professional shortage
2 areas.

3 **Subtitle B—Payments by States to**
4 **Providers**

5 **SEC. 611. PAYMENTS TO HOSPITALS AND OTHER FACILITY-**
6 **BASED SERVICES FOR OPERATING EXPENSES**
7 **ON THE BASIS OF APPROVED GLOBAL**
8 **BUDGETS.**

9 (a) DIRECT PAYMENT UNDER GLOBAL BUDGET.—
10 Payment for operating expenses for institutional and facil-
11 ity-based care, including hospital services and nursing fa-
12 cility services, under State health security programs shall
13 be made directly to each institution or facility by each
14 State health security program under an annual prospec-
15 tive global budget approved under the program. Such a
16 budget shall include payment for outpatient care and non-
17 facility-based care that is furnished by or through the fa-
18 cility. In the case of a hospital that is wholly owned (or
19 controlled) by a comprehensive health service organization
20 that is paid under section 614 on the basis of a global
21 budget, the global budget of the organization shall include
22 the budget for the hospital.

23 (b) ANNUAL NEGOTIATIONS; BUDGET APPROVAL.—

24 (1) IN GENERAL.—The prospective global budg-
25 et for an institution or facility shall—

1 (A) be developed through annual negotia-
2 tions between (i) a panel of individuals who are
3 appointed by the Governor of the State and who
4 represent consumers, labor, business, and the
5 State government, and (ii) the institution or fa-
6 cility, and

7 (B) be based on a nationally uniform sys-
8 tem of cost accounting established under stand-
9 ards of the Board.

10 (2) CONSIDERATIONS.—In developing a budget
11 through negotiations, there shall be taken into
12 account at least the following:

13 (A) With respect to inpatient hospital serv-
14 ices, the number, and classification by diag-
15 nosis-related group, of discharges.

16 (B) An institution's or facility's past ex-
17 penditures.

18 (C) The extent to which debt service for
19 capital expenditures has been included in the
20 proposed operating budget.

21 (D) The extent to which capital expendi-
22 tures are financed directly or indirectly through
23 reductions in direct care to patients, including
24 (but not limited to) reductions in registered
25 nursing staffing patterns or changes in emer-

1 agency room or primary care services or avail-
2 ability.

3 (E) Change in the consumer price index
4 and other price indices.

5 (F) The cost of reasonable compensation
6 to health care practitioners.

7 (G) The compensation level of the institu-
8 tion's or facility's work force.

9 (H) The extent to which the institution or
10 facility is providing health care services to meet
11 the needs of residents in the area served by the
12 institution or facility, including the institution's
13 or facility's occupancy level.

14 (I) The institution's or facility's previous
15 financial and clinical performance, based on uti-
16 lization and outcomes data provided under this
17 Act.

18 (J) The type of institution or facility, in-
19 cluding whether the institution or facility is
20 part of a clinical education program or serves
21 a health professional education, research or
22 other training purpose.

23 (K) Technological advances or changes.

1 (L) Costs of the institution or facility asso-
2 ciated with meeting Federal and State regula-
3 tions.

4 (M) The costs associated with necessary
5 public outreach activities.

6 (N) In the case of a for-profit facility, a
7 reasonable rate of return on equity capital,
8 independent of those operating expenses nec-
9 essary to fulfill the objectives of this Act.

10 (O) Incentives to facilities that maintain
11 costs below previous reasonable budgeted levels
12 without reducing the care provided.

13 (P) With respect to facilities that provide
14 mental health services and substance abuse
15 treatment services, any additional costs involved
16 in the treatment of dually diagnosed individ-
17 uals.

18 The portion of such a budget that relates to expendi-
19 tures for health professional education shall be con-
20 sistent with the State health security budget for
21 such expenditures.

22 (3) PROVISION OF REQUIRED INFORMATION; DI-
23 AGNOSIS-RELATED GROUP.—No budget for an insti-
24 tution or facility for a year may be approved unless
25 the institution or facility has submitted on a timely

1 basis to the State health security program such in-
2 formation as the program or the Board shall specify,
3 including in the case of hospitals information on dis-
4 charges classified by diagnosis-related group.

5 (c) ADJUSTMENTS IN APPROVED BUDGETS.—

6 (1) ADJUSTMENTS TO GLOBAL BUDGETS THAT
7 CONTRACT WITH COMPREHENSIVE HEALTH SERVICE
8 ORGANIZATIONS.—Each State health security pro-
9 gram shall develop an administrative mechanism for
10 reducing operating funds to institutions or facilities
11 in proportion to payments made to such institutions
12 or facilities for services contracted for by a com-
13 prehensive health service organization.

14 (2) AMENDMENTS.—In accordance with stand-
15 ards established by the Board, an operating and
16 capital budget approved under this section for a year
17 may be amended before, during, or after the year if
18 there is a substantial change in any of the factors
19 relevant to budget approval.

20 (d) DONATIONS PERMISSIBLE.—The States health
21 security programs may permit institutions and facilities
22 to raise funds from private sources to pay for newly con-
23 structed facilities, major renovations, and equipment. The
24 expenditure of such funds, whether for operating or cap-
25 ital expenditures, does not obligate the State health secu-

1 rity program to provide for continued support for such ex-
2 penditures unless included in an approved global budget.

3 **SEC. 612. PAYMENTS TO HEALTH CARE PRACTITIONERS**

4 **BASED ON PROSPECTIVE FEE SCHEDULE.**

5 (a) FEE FOR SERVICE.—

6 (1) IN GENERAL.—Every independent health
7 care practitioner is entitled to be paid, for the provi-
8 sion of covered health services under the State
9 health security program, a fee for each billable cov-
10 ered service.

11 (2) GLOBAL FEE PAYMENT METHODOLOGIES.—

12 The Board shall establish models and encourage
13 State health security programs to implement alter-
14 native payment methodologies that incorporate glob-
15 al fees for related services (such as all outpatient
16 procedures for treatment of a condition) or for a
17 basic group of services (such as primary care serv-
18 ices) furnished to an individual over a period of
19 time, in order to encourage continuity and efficiency
20 in the provision of services. Such methodologies shall
21 be designed to ensure a high quality of care.

22 (3) BILLING DEADLINES; ELECTRONIC BILL-
23 ING.—A State health security program may deny
24 payment for any service of an independent health
25 care practitioner for which it did not receive a bill

1 and appropriate supporting documentation (which
2 had been previously specified) within 30 days after
3 the date the service was provided. Such a program
4 may require that bills for services for which payment
5 may be made under this section, or for any class of
6 such services, be submitted electronically.

7 (b) PAYMENT RATES BASED ON NEGOTIATED PRO-
8 SPECTIVE FEE SCHEDULES.—With respect to any pay-
9 ment method for a class of services of practitioners, the
10 State health security program shall establish, on a pro-
11 spective basis, a payment schedule. The State health secu-
12 rity program may establish such a schedule after negotia-
13 tions with organizations representing the practitioners in-
14 volved. Such fee schedules shall be designed to provide in-
15 centives for practitioners to choose primary care medicine,
16 including general internal medicine and pediatrics, over
17 medical specialization. Nothing in this section shall be con-
18 strued as preventing a State from adjusting the payment
19 schedule amounts on a quarterly or other periodic basis
20 depending on whether expenditures under the schedule will
21 exceed the budgeted amount with respect to such expendi-
22 tures.

23 (c) BILLABLE COVERED SERVICE DEFINED.—In this
24 section, the term “billable covered service” means a service
25 covered under section 201 for which a practitioner is enti-

1 tled to compensation by payment of a fee determined
2 under this section.

3 **SEC. 613. PAYMENTS TO COMPREHENSIVE HEALTH SERV-**
4 **ICE ORGANIZATIONS.**

5 (a) IN GENERAL.—Payment under a State health se-
6 curity program to a comprehensive health service organi-
7 zation to its enrollees shall be determined by the State—

8 (1) based on a global budget described in sec-
9 tion 611, or

10 (2) based on the basic capitation amount de-
11 scribed in subsection (b) for each of its enrollees.

12 (b) BASIC CAPITATION AMOUNT.—

13 (1) IN GENERAL.—The basic capitation amount
14 described in this subsection for an enrollee shall be
15 determined by the State health security program on
16 the basis of the average amount of expenditures that
17 is estimated would be made under the State health
18 security program for covered health care services for
19 an enrollee, based on actuarial characteristics (as de-
20 fined by the State health security program).

21 (2) ADJUSTMENT FOR SPECIAL HEALTH
22 NEEDS.—The State health security program shall
23 adjust such average amounts to take into account
24 the special health needs, including a disproportionate

1 number of medically underserved individuals, of pop-
2 ulations served by the organization.

3 (3) ADJUSTMENT FOR SERVICES NOT PRO-
4 VIDED.—The State health security program shall ad-
5 just such average amounts to take into account the
6 cost of covered health care services that are not pro-
7 vided by the comprehensive health service organiza-
8 tion under section 303(a).

9 **SEC. 614. PAYMENTS FOR COMMUNITY-BASED PRIMARY**
10 **HEALTH SERVICES.**

11 (a) IN GENERAL.—In the case of community-based
12 primary health services, subject to subsection (b), pay-
13 ments under a State health security program shall—

14 (1) be based on a global budget described in
15 section 611,

16 (2) be based on the basic primary care capita-
17 tion amount described in subsection (c) for each in-
18 dividual enrolled with the provider of such services,
19 or

20 (3) be made on a fee-for-service basis under
21 section 612.

22 (b) PAYMENT ADJUSTMENT.—Payments under sub-
23 section (a) may include, consistent with the budgets devel-
24 oped under this title—

1 (1) an additional amount, as set by the State
2 health security program, to cover the costs incurred
3 by a provider which serves persons not covered by
4 this Act whose health care is essential to overall
5 community health and the control of communicable
6 disease, and for whom the cost of such care is other-
7 wise uncompensated,

8 (2) an additional amount, as set by the State
9 health security program, to cover the reasonable
10 costs incurred by a provider that furnishes case
11 management services (as defined in section
12 1915(g)(2) of the Social Security Act), transpor-
13 tation services, and translation services, and

14 (3) an additional amount, as set by the State
15 health security program, to cover the costs incurred
16 by a provider in conducting health professional edu-
17 cation programs in connection with the provision of
18 such services.

19 (c) BASIC PRIMARY CARE CAPITATION AMOUNT.—

20 (1) IN GENERAL.—The basic primary care capi-
21 tation amount described in this subsection for an en-
22 rollee with a provider of community-based primary
23 health services shall be determined by the State
24 health security program on the basis of the average
25 amount of expenditures that is estimated would be

1 made under the State health security program for
2 such an enrollee, based on actuarial characteristics
3 (as defined by the State health security program).

4 (2) ADJUSTMENT FOR SPECIAL HEALTH
5 NEEDS.—The State health security program shall
6 adjust such average amounts to take into account
7 the special health needs, including a disproportionate
8 number of medically underserved individuals, of pop-
9 ulations served by the provider.

10 (3) ADJUSTMENT FOR SERVICES NOT PRO-
11 VIDED.—The State health security program shall ad-
12 just such average amounts to take into account the
13 cost of community-based primary health services
14 that are not provided by the provider.

15 (d) COMMUNITY-BASED PRIMARY HEALTH SERVICES
16 DEFINED.—In this section, the term “community-based
17 primary health services” has the meaning given such term
18 in section 202(a).

19 **SEC. 615. PAYMENTS FOR PRESCRIPTION DRUGS.**

20 (a) ESTABLISHMENT OF LIST.—

21 (1) IN GENERAL.—The Board shall establish a
22 list of approved prescription drugs and biologicals
23 that the Board determines are necessary for the
24 maintenance or restoration of health or of employ-

1 ability or self-management and eligible for coverage
2 under this Act.

3 (2) EXCLUSIONS.—The Board may exclude re-
4 imbursement under this Act for ineffective, unsafe,
5 or over-priced products where better alternatives are
6 determined to be available.

7 (b) PRICES.—For each such listed prescription drug
8 or biological covered under this Act, for insulin, and for
9 medical foods, the Board shall from time to time deter-
10 mine a product price or prices which shall constitute the
11 maximum to be recognized under this Act as the cost of
12 a drug to a provider thereof. The Board may conduct ne-
13 gotiations, on behalf of State health security programs,
14 with product manufacturers and distributors in determin-
15 ing the applicable product price or prices.

16 (c) CHARGES BY INDEPENDENT PHARMACIES.—
17 Each State health security program shall provide for pay-
18 ment for a prescription drug or biological or insulin fur-
19 nished by an independent pharmacy based on the drug's
20 cost to the pharmacy (not in excess of the applicable prod-
21 uct price established under subsection (b)) plus a dispens-
22 ing fee. In accordance with standards established by the
23 Board, each State health security program, after consulta-
24 tion with representatives of the pharmaceutical profession,
25 shall establish schedules of dispensing fees, designed to af-

1 ford reasonable compensation to independent pharmacies
2 after taking into account variations in their cost of oper-
3 ation resulting from regional differences, differences in the
4 volume of prescription drugs dispensed, differences in
5 services provided, the need to maintain expenditures with-
6 in the budgets established under this title, and other
7 relevant factors.

8 **SEC. 616. PAYMENTS FOR APPROVED DEVICES AND EQUIP-**
9 **MENT.**

10 (a) ESTABLISHMENT OF LIST.—The Board shall es-
11 tablish a list of approved durable medical equipment and
12 therapeutic devices and equipment (including eyeglasses,
13 hearing aids, and prosthetic appliances), that the Board
14 determines are necessary for the maintenance or restora-
15 tion of health or of employability or self-management and
16 eligible for coverage under this Act.

17 (b) CONSIDERATIONS AND CONDITIONS.—In estab-
18 lishing the list under subsection (a), the Board shall take
19 into consideration the efficacy, safety, and cost of each
20 item contained on such list, and shall attach to any item
21 such conditions as the Board determines appropriate with
22 respect to the circumstances under which, or the frequency
23 with which, the item may be prescribed.

24 (c) PRICES.—For each such listed item covered under
25 this Act, the Board shall from time to time determine a

1 product price or prices which shall constitute the maxi-
2 mum to be recognized under this Act as the cost of the
3 item to a provider thereof. The Board may conduct nego-
4 tiations, on behalf of State health security programs, with
5 equipment and device manufacturers and distributors in
6 determining the applicable product price or prices.

7 (d) EXCLUSIONS.—The Board may exclude from cov-
8 erage under this Act ineffective, unsafe, or overpriced
9 products where better alternatives are determined to be
10 available.

11 **SEC. 617. PAYMENTS FOR OTHER ITEMS AND SERVICES.**

12 In the case of payment for other covered health serv-
13 ices, the amount of payment under a State health security
14 program shall be established by the program—

15 (1) in accordance with payment methodologies
16 which are specified by the Board, after consultation
17 with the American Health Security Advisory Coun-
18 cil, or methodologies established by the State under
19 section 620, and

20 (2) consistent with the State health security
21 budget.

22 **SEC. 618. PAYMENT INCENTIVES FOR MEDICALLY UNDER-**
23 **SERVED AREAS.**

24 (a) MODEL PAYMENT METHODOLOGIES.—In addi-
25 tion to the payment amounts otherwise provided in this

1 title, the Board shall establish model payment methodolo-
2 gies and other incentives that promote the provision of
3 covered health care services in medically underserved
4 areas, particularly in rural and inner-city underserved
5 areas.

6 (b) CONSTRUCTION.—Nothing in this title shall be
7 construed as limiting the authority of State health security
8 programs to increase payment amounts or otherwise pro-
9 vide additional incentives, consistent with the State health
10 security budget, to encourage the provision of medically
11 necessary and appropriate services in underserved areas.

12 **SEC. 619. AUTHORITY FOR ALTERNATIVE PAYMENT METH-**
13 **ODOLOGIES.**

14 A State health security program, as part of its plan
15 under section 404(a), may use a payment methodology
16 other than a methodology required under this subtitle so
17 long as—

18 (1) such payment methodology does not affect
19 the entitlement of individuals to coverage, the
20 weighting of fee schedules to encourage an increase
21 in the number of primary care providers, the ability
22 of individuals to choose among qualified providers,
23 the benefits covered under the program, or the com-
24 pliance of the program with the State health security
25 budget under subtitle A, and

1 (2) the program submits periodic reports to the
2 Board showing the operation and effectiveness of the
3 alternative methodology, in order for the Board to
4 evaluate the appropriateness of applying the alter-
5 native methodology to other States.

6 **Subtitle C—Mandatory Assignment**
7 **and Administrative Provisions**

8 **SEC. 631. MANDATORY ASSIGNMENT.**

9 (a) NO BALANCE BILLING.—Payments for benefits
10 under this Act shall constitute payment in full for such
11 benefits and the entity furnishing an item or service for
12 which payment is made under this Act shall accept such
13 payment as payment in full for the item or service and
14 may not accept any payment or impose any charge for
15 any such item or service other than accepting payment
16 from the State health security program in accordance with
17 this Act.

18 (b) ENFORCEMENT.—If an entity knowingly and will-
19 fully bills for an item or service or accepts payment in
20 violation of subsection (a), the Board may apply sanctions
21 against the entity in the same manner as sanctions could
22 have been imposed under section 1842(j)(2) of the Social
23 Security Act for a violation of section 1842(j)(1) of such
24 Act. Such sanctions are in addition to any sanctions that

1 a State may impose under its State health security
2 program.

3 **SEC. 632. PROCEDURES FOR REIMBURSEMENT; APPEALS.**

4 (a) PROCEDURES FOR REIMBURSEMENT.—In accord-
5 ance with standards issued by the Board, a State health
6 security program shall establish a timely and administra-
7 tively simple procedure to assure payment within 60 days
8 of the date of submission of clean claims by providers
9 under this Act.

10 (b) APPEALS PROCESS.—Each State health security
11 program shall establish an appeals process to handle all
12 grievances pertaining to payment to providers under this
13 title.

14 **TITLE VII—PROMOTION OF PRI-**
15 **MARY HEALTH CARE; DEVEL-**
16 **OPMENT OF HEALTH SERV-**
17 **ICE CAPACITY; PROGRAMS TO**
18 **ASSIST THE MEDICALLY UN-**
19 **DESERVED**

20 **Subtitle A—Promotion and Expans-**
21 **ion of Primary Care Profes-**
22 **sional Training**

23 **SEC. 701. ROLE OF BOARD; ESTABLISHMENT OF PRIMARY**
24 **CARE PROFESSIONAL OUTPUT GOALS.**

25 (a) IN GENERAL.—The Board is responsible for—

1 (1) coordinating health professional education
2 policies and goals, in consultation with the Secretary
3 of Health and Human Services (in this title referred
4 to as the “Secretary”), to achieve the national goals
5 specified in subsection (b);

6 (2) overseeing the health professional education
7 expenditures of the State health security programs
8 from the account established under section 602(c);

9 (3) developing and maintaining, in cooperation
10 with the Secretary, a system to monitor the number
11 and specialties of individuals through their health
12 professional education, any postgraduate training,
13 and professional practice; and

14 (4) developing, coordinating, and promoting
15 other policies that expand the number of primary
16 care practitioners.

17 (b) NATIONAL GOALS.—The national goals specified
18 in this subsection are as follows:

19 (1) GRADUATE MEDICAL EDUCATION.—By not
20 later than 5 years after the date of the enactment
21 of this Act, at least 50 percent of the residents in
22 medical residency education programs (as defined in
23 subsection (e)(1)) are primary care residents (as
24 defined in subsection (e)(3)).

1 (2) MIDDLELEVEL PRIMARY CARE PRACTITION-
2 ERS.—To assure an adequate supply of primary care
3 practitioners, there shall be a number, specified by
4 the Board, of midlevel primary care practitioners (as
5 defined in subsection (e)(2)) employed in the health
6 care system as of January 1, 2001.

7 (c) METHOD FOR ATTAINMENT OF NATIONAL GOAL
8 FOR GRADUATE MEDICAL EDUCATION; PROGRAM
9 GOALS.—

10 (1) IN GENERAL.—The Board shall establish a
11 method of applying the national goal in subsection
12 (b)(1) to program goals for each medical residency
13 education program or to medical residency education
14 consortia.

15 (2) CONSIDERATION.—The program goals
16 under paragraph (1) shall be based on the distribu-
17 tion of medical schools and other teaching facilities
18 within each State health security program, and the
19 number of positions for graduate medical education.

20 (3) MEDICAL RESIDENCY EDUCATION CONSOR-
21 TIUM.—In this subsection, the term “medical resi-
22 dency education consortium” means a consortium of
23 medical residency education programs in a contig-
24 uous geographic area (which may be an interstate
25 area) if the consortium—

1 (A) includes at least one medical school
2 with a teaching hospital and related teaching
3 settings, and

4 (B) has an affiliation with qualified com-
5 munity-based primary health service providers
6 described in section 202(a) and with at least
7 one comprehensive health service organization
8 established under section 303.

9 (4) ENFORCEMENT THROUGH STATE HEALTH
10 SECURITY BUDGETS.—The Board shall develop a
11 formula for reducing payments to State health secu-
12 rity programs (that provide for payments to a medi-
13 cal residency education program) that failed to meet
14 the goal for the program established under this sub-
15 section.

16 (d) METHOD FOR ATTAINMENT OF NATIONAL GOAL
17 FOR MIDDLELEVEL PRIMARY CARE PRACTITIONERS.—To as-
18 sist in attaining the national goal identified in subsection
19 (b)(2), the Board shall—

20 (1) advise the Public Health Service on alloca-
21 tions of funding under titles VII and VIII of the
22 Public Health Service Act, the National Health
23 Service Corps, and other programs in order to in-
24 crease the supply of midlevel primary care practi-
25 tioners, and

1 (2) commission a study of the potential benefits
2 and disadvantages of expanding the scope of practice
3 authorized under State laws for any class of midlevel
4 primary care practitioners.

5 (e) DEFINITIONS.—In this title:

6 (1) MEDICAL RESIDENCY EDUCATION PRO-
7 GRAM.—The term “medical residency education pro-
8 gram” means a program that provides education
9 and training to graduates of medical schools in order
10 to meet requirements for licensing and certification
11 as a physician, and includes the medical school su-
12 pervising the program and includes the hospital or
13 other facility in which the program is operated.

14 (2) MIDLEVEL PRIMARY CARE PRACTI-
15 TIONER.—The term “midlevel primary care practi-
16 tioner” means a clinical nurse practitioner, certified
17 nurse midwife, physician assistance, or other non-
18 physician practitioner, specified by the Board, as
19 authorized to practice under State law.

20 (3) PRIMARY CARE RESIDENT.—The term “pri-
21 mary care resident” means (in accordance with cri-
22 teria established by the Board) a resident being
23 trained in a distinct program of family practice med-
24 icine, general practice, general internal medicine, or
25 general pediatrics.

1 **SEC. 702. ESTABLISHMENT OF ADVISORY COMMITTEE ON**
2 **HEALTH PROFESSIONAL EDUCATION.**

3 (a) IN GENERAL.—The Board shall provide for an
4 Advisory Committee on Health Professional Education (in
5 this section referred to as the “Committee”) to advise the
6 Board on its activities under section 701.

7 (b) MEMBERSHIP.—The Committee shall be com-
8 posed of—

9 (1) the Chair of the Board, who shall serve as
10 Chair of the Committee, and

11 (2) 12 members, not otherwise in the employ of
12 the United States, appointed by the Board without
13 regard to the provisions of title 5, United States
14 Code, governing appointments in the competitive
15 service.

16 The appointed members shall provide a balanced point of
17 view with respect to health professional education, primary
18 care disciplines, and health care policy and shall include
19 individuals who are representative of medical schools,
20 other health professional schools, residency programs, pri-
21 mary care practitioners, teaching hospitals, professional
22 associations, public health organizations, State health
23 security programs, and consumers.

24 (c) TERMS OF MEMBERS.—Each appointed member
25 shall hold office for a term of five years, except that—

1 (1) any member appointed to fill a vacancy oc-
2 curring during the term for which the member's
3 predecessor was appointed shall be appointed for the
4 remainder of that term; and

5 (2) the terms of the members first taking office
6 shall expire, as designated by the Board at the time
7 of appointment, two at the end of the second year,
8 two at the end of the third year, two at the end of
9 the fourth year, and three at the end of the fifth
10 year after the date of enactment of this Act.

11 (d) VACANCIES.—

12 (1) IN GENERAL.—The Board shall fill any va-
13 cancy in the membership of the Committee in the
14 same manner as the original appointment. The va-
15 cancy shall not affect the power of the remaining
16 members to execute the duties of the Committee.

17 (2) VACANCY APPOINTMENTS.—Any member
18 appointed to fill a vacancy shall serve for the re-
19 mainder of the term for which the predecessor of the
20 member was appointed.

21 (3) REAPPOINTMENT.—The Board may re-
22 appoint an appointed member of the Committee for
23 a second term in the same manner as the original
24 appointment.

1 (e) DUTIES.—It shall be the duty of the Committee
2 to advise the Board concerning graduate medical edu-
3 cation policies under this title.

4 (f) STAFF.—The Committee, its members, and any
5 committees of the Committee shall be provided with such
6 secretarial, clerical, or other assistance as may be author-
7 ized by the Board for carrying out their respective
8 functions.

9 (g) MEETINGS.—The Committee shall meet as fre-
10 quently as the Board deems necessary, but not less than
11 4 times each year. Upon request by four or more members
12 it shall be the duty of the Chair to call a meeting of the
13 Committee.

14 (h) COMPENSATION.—Members of the Committee
15 shall be reimbursed by the Board for travel and per diem
16 in lieu of subsistence expenses during the performance of
17 duties of the Board in accordance with subchapter I of
18 chapter 57 of title 5, United States Code.

19 (i) FACA NOT APPLICABLE.—The provisions of the
20 Federal Advisory Committee Act shall not apply to the
21 Committee.

1 **SEC. 703. GRANTS FOR HEALTH PROFESSIONS EDUCATION,**
2 **NURSE EDUCATION, AND THE NATIONAL**
3 **HEALTH SERVICE CORPS.**

4 (a) TRANSFERS TO PUBLIC HEALTH SERVICE.—
5 From the amounts provided under subsection (c), the
6 Board shall make transfers from the American Health Se-
7 curity Trust Fund to the Public Health Service under sub-
8 part II of part D of title III, title VII, and title VIII of
9 the Public Health Service Act for the support of the Na-
10 tional Health Service Corps, health professions education,
11 and nursing education, including education of clinical
12 nurse practitioners, certified registered nurse anesthetists,
13 certified nurse midwives, and physician assistants. Of the
14 amounts so transferred in each year, not less than 50 per-
15 cent shall be expended for the support of the National
16 Health Service Corps.

17 (b) RANGE OF FUNDS.—The amount of transfers
18 under subsection (a) for any fiscal year shall be an amount
19 (specified by the Board each year) not less than $\frac{4}{100}$ per-
20 cent and not to exceed $\frac{6}{100}$ percent of the amounts the
21 Board estimates will be expended from the Trust Fund
22 in the fiscal year.

23 (c) FUNDS SUPPLEMENTAL TO OTHER FUNDS.—The
24 funds provided under this section with respect to provision
25 of services are in addition to, and not in replacement of,
26 funds made available under the provisions referred to in

1 subsection (a) and shall be administered in accordance
2 with the terms of such provisions. The Board shall make
3 no transfer of funds under this section for any fiscal year
4 for which the total appropriations for the programs au-
5 thorized by such provisions are less than the total amount
6 appropriated for such programs in fiscal year 1994.

7 **Subtitle B—Direct Health Care**
8 **Delivery**

9 **SEC. 711. SETASIDE FOR PUBLIC HEALTH.**

10 (a) TRANSFERS TO PUBLIC HEALTH SERVICE.—
11 From the amounts provided under subsection (c), the
12 Board shall make transfers from the American Health Se-
13 curity Trust Fund to the Public Health Service for the
14 following purposes (other than payment for services cov-
15 ered under title II):

16 (1) For payments to States under the maternal
17 and child health block grants under title V of the
18 Social Security Act.

19 (2) For prevention and treatment of tuber-
20 culosis under section 317 of the Public Health Serv-
21 ice Act.

22 (3) For the prevention and treatment of sexu-
23 ally transmitted diseases under section 318 of the
24 Public Health Service Act.

1 (4) Preventive health block grants under part A
2 of title XIX of the Public Health Service Act.

3 (5) Grants to States for community mental
4 health services under subpart I of part B of title
5 XIX of the Public Health Service Act.

6 (6) Grants to States for prevention and treat-
7 ment of substance abuse under subpart II of part B
8 of title XIX of the Public Health Service Act.

9 (7) Grants for HIV health care services under
10 parts A, B, and C of title XXVI of the Public
11 Health Service Act.

12 (8) Public health formula grants described in
13 subsection (d).

14 (b) RANGE OF FUNDS.—The amount of transfers
15 under subsection (a) for any fiscal year shall be an amount
16 (specified by the Board each year) not less than $\frac{1}{10}$ per-
17 cent and not to exceed $\frac{14}{100}$ percent of the amounts the
18 Board estimates will be expended from the Trust Fund
19 in the fiscal year.

20 (c) FUNDS SUPPLEMENTAL TO OTHER FUNDS.—The
21 funds provided under this section with respect to provision
22 of services are in addition to, and not in replacement of,
23 funds made available under the programs referred to in
24 subsection (a) and shall be administered in accordance
25 with the terms of such programs.

1 (d) REQUIRED REPORTS ON HEALTH STATUS.—The
2 Secretary shall require each State receiving funds under
3 this section to submit annual reports to the Secretary on
4 the health status of the population and measurable objec-
5 tives for improving the health of the public in the State.
6 Such reports shall include the following:

7 (1) A comparison of the measures of the State
8 and local public health system compared to relevant
9 objectives set forth in “Health People 2000” or sub-
10 sequent national objectives set by the Secretary.

11 (2) A description of health status measures to
12 be improved within the State (at the State and local
13 levels) through expanded public health functions and
14 health promotion and disease prevention programs.

15 (3) Measurable outcomes and process objectives
16 for improving health status, and a report on out-
17 comes from the previous year.

18 (4) Information regarding how Federal funding
19 has improved population-based prevention activities
20 and programs.

21 (5) A description of the core public health func-
22 tions to be carried out at the local level.

23 (6) A description of the relationship between
24 the State’s public health system, community-based

1 health promotion and disease prevention providers,
2 and the State health security program.

3 (e) LIMITATION ON FUND TRANSFERS.—The Board
4 shall make no transfer of funds under this section for any
5 fiscal year for which the total appropriations for such pro-
6 grams are less than the total amount appropriated for
7 such programs in fiscal year 1994.

8 (f) PUBLIC HEALTH FORMULA GRANTS.—The Sec-
9 retary shall provide stable funds to States through for-
10 mula grants for the purpose of carrying out core public
11 health functions to monitor and protect the health of com-
12 munities from communicable diseases and exposure to
13 toxic environmental pollutants, occupational hazards,
14 harmful products, and poor health outcomes. Such func-
15 tions include the following:

16 (1) Data collection, analysis, and assessment of
17 public health data, vital statistics, and personal
18 health data to assess community health status and
19 outcomes reporting. This function includes the ac-
20 quisition and installation of hardware and software,
21 and personnel training and technical assistance to
22 operate and support automated and integrated infor-
23 mation systems.

1 (2) Activities to protect the environment and to
2 assure the safety of housing, workplaces, food, and
3 water.

4 (3) Investigation and control of adverse health
5 conditions, and threats to the health status of indi-
6 viduals and the community. This function includes
7 the identification and control of outbreaks of infec-
8 tious disease, patterns of chronic disease and injury,
9 and cooperative activities to reduce the levels of vio-
10 lence.

11 (4) Health promotion and disease prevention
12 activities for which there is a significant need and a
13 high priority of the Public Health Service.

14 (5) The provision of public health laboratory
15 services to complement private clinical laboratory
16 services, including—

17 (A) screening tests for metabolic diseases
18 in newborns,

19 (B) toxicology assessments of blood lead
20 levels and other environmental toxins,

21 (C) tuberculosis and other disease requir-
22 ing partner notification, and

23 (D) testing for infectious and food-borne
24 diseases.

1 (6) Training and education for the public
2 health professions.

3 (7) Research on effective and cost-effective pub-
4 lic health practices. This function includes the devel-
5 opment, testing, evaluation, and publication of re-
6 sults of new prevention and public health control
7 interventions.

8 (8) Integration and coordination of the preven-
9 tion programs and services of community-based pro-
10 viders, local and State health departments, and
11 other sectors of State and local government that af-
12 fect health.

13 **SEC. 712. SETASIDE FOR PRIMARY HEALTH CARE DELIV-**
14 **ERY.**

15 (a) TRANSFERS TO PUBLIC HEALTH SERVICE.—
16 From the amounts provided under subsection (c), the
17 Board shall make transfers from the American Health Se-
18 curity Trust Fund to the Public Health Service for the
19 program of primary care service expansion grants under
20 subpart V of part D of title III of the Public Health
21 Service Act (as added by section 713 of this Act).

22 (b) RANGE OF FUNDS.—The amount of transfers
23 under subsection (a) for any fiscal year shall be an amount
24 (specified by the Board each year) not less than $\frac{6}{100}$ per-
25 cent and not to exceed $\frac{1}{10}$ percent of the amounts the

1 Board estimates will be expended from the Trust Fund
2 in the fiscal year.

3 (c) FUNDS SUPPLEMENTAL TO OTHER FUNDS.—The
4 funds provided under this section with respect to provision
5 of services are in addition to, and not in replacement of,
6 funds made available under the sections 329, 330, 340,
7 340A, 1001, and 2655 of the Public Health Service Act.
8 The Board shall make no transfer of funds under this sec-
9 tion for any fiscal year for which the total appropriations
10 for such sections are less than the total amount appro-
11 priated under such sections in fiscal year 1994.

12 **SEC. 713. PRIMARY CARE SERVICE EXPANSION GRANTS.**

13 Part D of title III of the Public Health Service Act
14 (42 U.S.C. 254b et seq.) is amended by adding at the end
15 thereof the following new subpart:

16 “Subpart IX—Primary Care Expansion
17 **“SEC. 340E. EXPANDING PRIMARY CARE DELIVERY CAPAC-
18 ITY IN URBAN AND RURAL AREAS.**

19 “(a) GRANTS FOR PRIMARY CARE CENTERS.—From
20 the amounts described in subsection (c), the American
21 Health Security Standards Board shall make grants to
22 public and nonprofit private entities for projects to plan
23 and develop primary care centers which will serve medi-
24 cally underserved populations (as defined in section
25 330(b)(3)) in urban and rural areas and to deliver primary

1 care services to such populations in such areas. The funds
2 provided under such a grant may be used for the same
3 purposes for which a grant may be made under subsection
4 (c) or (d) of section 330.

5 “(b) PROCESS OF AWARDING GRANTS.—The provi-
6 sions of subsection (e)(1) of section 330 shall apply to a
7 grant under this section in the same manner as they apply
8 to a grant under subsection (c) of such section. The provi-
9 sions of subsection (g)(3) of such section shall apply to
10 grants for projects to plan and develop primary care cen-
11 ters under this section in the same manner as they apply
12 to grants under such section.

13 “(c) FUNDING AS SET-ASIDE FROM TRUST FUND.—
14 Funding to carry out this section is provided from the
15 American Health Security Trust Fund in accordance with
16 section 912 of the American Health Security Act.

17 “(d) PRIMARY CARE CENTER DEFINED.—In this sec-
18 tion, the term ‘primary care center’ means—

19 “(1) a migrant health center (as defined in sec-
20 tion 329(a)(1)),

21 “(2) a community health center (as defined in
22 section 330(a)),

23 “(3) an entity qualified to receive a grant under
24 section 340, 340A, 1001, or 2655, or

1 “(4) a Federally-qualified health center (as de-
2 fined in section 1905(l)(2)(B) of the Social Security
3 Act).”.

4 **Subtitle C—Primary Care and**
5 **Outcomes Research**

6 **SEC. 721. SET-ASIDE FOR OUTCOMES RESEARCH.**

7 (a) GRANTS FOR OUTCOMES RESEARCH.—The
8 Board shall make transfers from the American Health Se-
9 curity Trust Fund to the Agency for Health Care Policy
10 and Research under title IX of the Public Health Service
11 Act for the purpose of carrying out activities under such
12 title. The Secretary shall assure that there is a special em-
13 phasis placed on pediatric outcomes research.

14 (b) RANGE OF FUNDS.—The amount of transfers
15 under subsection (a) for any fiscal year shall be an amount
16 (specified by the Board each year) not less than $\frac{1}{100}$ per-
17 cent and not to exceed $\frac{2}{100}$ percent of the amounts the
18 Board estimates will be expended from the Trust Fund
19 in the fiscal year.

20 (c) FUNDS SUPPLEMENTAL TO OTHER FUNDS.—The
21 funds provided under this section with respect to provision
22 of services are in addition to, and not in replacement of,
23 funds made available to the Agency for Health Care Policy
24 and Research under section 926 of the Public Health
25 Service Act. The Board shall make no transfer of funds

1 under this section for any fiscal year for which the total
2 appropriations under such section are less than the total
3 amount appropriated under such section and title in fiscal
4 year 1994.

5 (d) CONFORMING AMENDMENT.—Section 926(a) of
6 the Public Health Service Act (42 U.S.C. 299c–5(a)) is
7 amended by striking “\$115,000,000” and all that follows
8 and inserting “for each fiscal year (beginning with fiscal
9 year 1996) such sums as may be necessary.”.

10 **SEC. 722. OFFICE OF PRIMARY CARE AND PREVENTION RE-**
11 **SEARCH.**

12 (a) IN GENERAL.—Title IV of the Public Health
13 Service Act, as amended by section 141 of Public Law
14 103–43 (107 Stat. 136), is amended—

15 (1) by redesignating parts G through I as parts
16 H through J, respectively; and

17 (2) by inserting after part F the following new
18 part:

19 “PART G—RESEARCH ON PRIMARY CARE AND
20 PREVENTION

21 **“SEC. 486E. OFFICE OF PRIMARY CARE AND PREVENTION**
22 **RESEARCH.**

23 “(a) ESTABLISHMENT.—There is established within
24 the Office of the Director of NIH an office to be known
25 as the Office of Primary Care and Prevention Research

1 (in this part referred to as the ‘Office’). The Office shall
2 be headed by a director, who shall be appointed by the
3 Director of NIH.

4 “(b) PURPOSE.—The Director of the Office shall—

5 “(1) identify projects of research on primary
6 care and prevention, for children as well as adults,
7 that should be conducted or supported by the na-
8 tional research institutes, with particular emphasis
9 on—

10 “(A) clinical patient care, with special em-
11 phasis on pediatric clinical care and diagnosis,

12 “(B) diagnostic effectiveness,

13 “(C) primary care education,

14 “(D) health and family planning services,

15 “(E) medical effectiveness outcomes of pri-
16 mary care procedures and interventions,

17 “(F) the use of multidisciplinary teams of
18 health care practitioners.

19 “(2) identify multidisciplinary research related
20 to primary care and prevention that should be so
21 conducted;

22 “(3) promote coordination and collaboration
23 among entities conducting research identified under
24 any of paragraphs (1) and (2);

1 “(4) encourage the conduct of such research by
2 entities receiving funds from the national research
3 institutes;

4 “(5) recommend an agenda for conducting and
5 supporting such research;

6 “(6) promote the sufficient allocation of the re-
7 sources of the national research institutes for con-
8 ducting and supporting such research; and

9 “(7) prepare the report required in section
10 486G.

11 “(c) PRIMARY CARE AND PREVENTION RESEARCH
12 DEFINED.—For purposes of this part, the term ‘primary
13 care and prevention research’ means research on improve-
14 ment of the practice of family medicine, general internal
15 medicine, and general pediatrics, and includes research
16 relating to—

17 “(1) obstetrics and gynecology, dentistry, or
18 mental health or substance abuse treatment when
19 provided by a primary care physician or other
20 primary care practitioner, and

21 “(2) primary care provided by multidisciplinary
22 teams.

1 **“SEC. 486F. NATIONAL DATA SYSTEM AND CLEARINGHOUSE**
2 **ON PRIMARY CARE AND PREVENTION RE-**
3 **SEARCH.**

4 “(a) DATA SYSTEM.—The Director of NIH, in con-
5 sultation with the Director of the Office, shall establish
6 a data system for the collection, storage, analysis, re-
7 trieval, and dissemination of information regarding pri-
8 mary care and prevention research that is conducted or
9 supported by the national research institutes. Information
10 from the data system shall be available through informa-
11 tion systems available to health care professionals and pro-
12 viders, researchers, and members of the public.

13 “(b) CLEARINGHOUSE.—The Director of NIH, in
14 consultation with the Director of the Office and with the
15 National Library of Medicine, shall establish, maintain,
16 and operate a program to provide, and encourage the use
17 of, information on research and prevention activities of the
18 national research institutes that relate to primary care
19 and prevention research.

20 **“SEC. 486G. BIENNIAL REPORT.**

21 “(a) IN GENERAL.—With respect to primary care
22 and prevention research, the Director of the Office shall,
23 not later than one year after the date of the enactment
24 of this part, and biennially thereafter, prepare a report—

25 “(1) describing and evaluating the progress
26 made during the preceding two fiscal years in re-

1 search and treatment conducted or supported by the
2 National Institutes of Health;

3 “(2) summarizing and analyzing expenditures
4 made by the agencies of such Institutes (and by
5 such Office) during the preceding two fiscal years;
6 and

7 “(3) making such recommendations for legisla-
8 tive and administrative initiatives as the Director of
9 the Office determines to be appropriate.

10 “(b) INCLUSION IN BIENNIAL REPORT OF DIRECTOR
11 OF NIH.—The Director of the Office shall submit each
12 report prepared under subsection (a) to the Director of
13 NIH for inclusion in the report submitted to the President
14 and the Congress under section 403.

15 **“SEC. 486H. AUTHORIZATION OF APPROPRIATIONS.**

16 “For the Office of Primary Care and Prevention Re-
17 search, there are authorized to be appropriated
18 \$150,000,000 for fiscal year 1996, \$180,000,000 for fis-
19 cal year 1997, and \$216,000,000 for fiscal year 1998.”.

20 (b) REQUIREMENT OF SUFFICIENT ALLOCATION OF
21 RESOURCES OF INSTITUTES.—Section 402(b) of the Pub-
22 lic Health Service Act (42 U.S.C. 282(b)) is amended—

23 (1) in paragraph (11), by striking “and” after
24 the semicolon at the end;

1 (2) in paragraph (12), by striking the period at
2 the end and inserting “; and”; and

3 (3) by inserting after paragraph (12) the fol-
4 lowing new paragraph:

5 “(13) after consultation with the Director of
6 the Office of Primary Care and Prevention Re-
7 search, shall ensure that resources of the National
8 Institutes of Health are sufficiently allocated for
9 projects on primary care and prevention research
10 that are identified under section 486E(b).”.

11 **Subtitle D—School-Related Health** 12 **Services**

13 **SEC. 731. AUTHORIZATIONS OF APPROPRIATIONS.**

14 (a) FUNDING FOR SCHOOL-RELATED HEALTH SERV-
15 ICES.—For the purpose of carrying out this subtitle, there
16 are authorized to be appropriated \$100,000,000 for fiscal
17 year 1998, \$275,000,000 for fiscal year 1999,
18 \$350,000,000 for fiscal year 2000, and \$400,000,000 for
19 each of the fiscal years 2001 and 2002.

20 (b) RELATION TO OTHER FUNDS.—The authoriza-
21 tions of appropriations established in subsection (a) are
22 in addition to any other authorizations of appropriations
23 that are available for the purpose described in such sub-
24 section.

1 **SEC. 732. ELIGIBILITY FOR DEVELOPMENT AND OPER-**
2 **ATION GRANTS.**

3 (a) IN GENERAL.—Entities eligible to apply for and
4 receive grants under section 734 or 735 are the following:

5 (1) State health agencies that apply on behalf
6 of local community partnerships and other commu-
7 nities in need of health services for school-aged chil-
8 dren within the State.

9 (2) Local community partnerships in States in
10 which health agencies have not applied.

11 (b) LOCAL COMMUNITY PARTNERSHIPS.—

12 (1) IN GENERAL.—A local community partner-
13 ship under subsection (a)(2) is an entity that, at a
14 minimum, includes—

15 (A) a local health care provider with expe-
16 rience in delivering services to school-aged chil-
17 dren;

18 (B) one or more local public schools; and

19 (C) at least one community based organi-
20 zation located in the community to be served
21 that has a history of providing services to
22 school-aged children in the community who are
23 at-risk.

24 (2) PARTICIPATION.—A partnership described
25 in paragraph (1) shall, to the maximum extent fea-
26 sible, involve broad based community participation

1 from parents and adolescent children to be served,
2 health and social service providers, teachers and
3 other public school and school board personnel, de-
4 velopment and service organizations for adolescent
5 children, and interested business leaders. Such par-
6 ticipation may be evidenced through an expanded
7 partnership, or an advisory board to such partner-
8 ship.

9 (c) DEFINITIONS REGARDING CHILDREN.—For pur-
10 poses of this subtitle:

11 (1) The term “adolescent children” means
12 school-aged children who are adolescents.

13 (2) The term “school-aged children” means in-
14 dividuals who are between the ages of 4 and 19 (in-
15 clusive).

16 **SEC. 733. PREFERENCES.**

17 (a) IN GENERAL.—In making grants under sections
18 734 and 735, the Secretary shall give preference to appli-
19 cants whose communities to be served show the most sub-
20 stantial level of need for such services among school-aged
21 children, as measured by indicators of community health
22 including the following:

23 (1) High levels of poverty.

24 (2) The presence of a medically underserved
25 population.

1 (3) The presence of a health professional short-
2 age area.

3 (4) High rates of indicators of health risk
4 among school-aged children, including a high propor-
5 tion of such children receiving services through the
6 Individuals with Disabilities Education Act, adoles-
7 cent pregnancy, sexually transmitted disease (includ-
8 ing infection with the human immunodeficiency
9 virus), preventable disease, communicable disease,
10 intentional and unintentional injuries, community
11 and gang violence, unemployment among adolescent
12 children, juvenile justice involvement, and high rates
13 of drug and alcohol exposure.

14 (b) LINKAGE TO COMMUNITY HEALTH CENTERS.—
15 In making grants under sections 734 and 735, the Sec-
16 retary shall give preference to applicants that demonstrate
17 a linkage to community health centers.

18 **SEC. 734. GRANTS FOR DEVELOPMENT OF PROJECTS.**

19 (a) IN GENERAL.—The Secretary may make grants
20 to State health agencies or to local community partner-
21 ships to develop school health service sites.

22 (b) USE OF FUNDS.—A project for which a grant
23 may be made under subsection (a) may include but not
24 be limited to the cost of the following:

1 (1) Planning for the provision of school health
2 services.

3 (2) Recruitment, compensation, and training of
4 health and administrative staff.

5 (3) The development of agreements, and the ac-
6 quisition and development of equipment and infor-
7 mation services, necessary to support information
8 exchange between school health service sites and
9 health plans, health providers, and other entities au-
10 thORIZED to collect information under this Act.

11 (4) Other activities necessary to assume oper-
12 ational status.

13 (c) APPLICATION FOR GRANT.—

14 (1) IN GENERAL.—Applicants shall submit ap-
15 plications in a form and manner prescribed by the
16 Secretary.

17 (2) APPLICATIONS BY STATE HEALTH AGEN-
18 CIES.—

19 (A) In the case of applicants that are State
20 health agencies, the application shall contain
21 assurances that the State health agency is ap-
22 plying for funds—

23 (i) on behalf of at least one local com-
24 munity partnership; and

1 (ii) on behalf of at least one other
2 community identified by the State as in
3 need of the services funded under this sub-
4 title but without a local community part-
5 nership.

6 (B) In the case of the communities identi-
7 fied in applications submitted by State health
8 agencies that do not yet have local community
9 partnerships (including the community identi-
10 fied under subparagraph (A)(ii)), the State
11 shall describe the steps that will be taken to aid
12 the communities in developing a local commu-
13 nity partnership.

14 (C) A State applying on behalf of local
15 community partnerships and other communities
16 may retain not more than 10 percent of grants
17 awarded under this subtitle for administrative
18 costs.

19 (d) CONTENTS OF APPLICATION.—In order to receive
20 a grant under this section, an applicant must include in
21 the application the following information:

22 (1) An assessment of the need for school health
23 services in the communities to be served, using the
24 latest available health data and health goals and ob-
25 jectives established by the Secretary.

1 (2) A description of how the applicant will de-
2 sign the proposed school health services to reach the
3 maximum number of school-aged children who are at
4 risk.

5 (3) An explanation of how the applicant will in-
6 tegrate its services with those of other health and
7 social service programs within the community.

8 (4) A description of a quality assurance pro-
9 gram which complies with standards that the Sec-
10 retary may prescribe.

11 (e) NUMBER OF GRANTS.—Not more than one plan-
12 ning grant may be made to a single applicant. A planning
13 grant may not exceed two years in duration.

14 **SEC. 735. GRANTS FOR OPERATION OF PROJECTS.**

15 (a) IN GENERAL.—The Secretary may make grants
16 to State health agencies or to local community partner-
17 ships for the cost of operating school health service sites.

18 (b) USE OF GRANT.—The costs for which a grant
19 may be made under this section include but are not limited
20 to the following:

21 (1) The cost of furnishing health services that
22 are not otherwise covered under this Act or by any
23 other public or private insurer.

24 (2) The cost of furnishing services whose pur-
25 pose is to increase the capacity of individuals to uti-

1 lize available health services, including transpor-
2 tation, community and patient outreach, patient
3 education, translation services, and such other serv-
4 ices as the Secretary determines to be appropriate in
5 carrying out such purpose.

6 (3) Training, recruitment and compensation of
7 health professionals and other staff.

8 (4) Outreach services to school-aged children
9 who are at risk and to the parents of such children.

10 (5) Linkage of individuals to health plans, com-
11 munity health services and social services.

12 (6) Other activities deemed necessary by the
13 Secretary.

14 (c) APPLICATION FOR GRANT.—Applicants shall sub-
15 mit applications in a form and manner prescribed by the
16 Secretary. In order to receive a grant under this section,
17 an applicant must include in the application the following
18 information:

19 (1) A description of the services to be furnished
20 by the applicant.

21 (2) The amounts and sources of funding that
22 the applicant will expend, including estimates of the
23 amount of payments the applicant will receive from
24 sources other than the grant.

1 (3) Such other information as the Secretary de-
2 termines to be appropriate.

3 (d) ADDITIONAL CONTENTS OF APPLICATION.—In
4 order to receive a grant under this section, an applicant
5 must meet the following conditions:

6 (1) The applicant furnishes the following serv-
7 ices:

8 (A) Diagnosis and treatment of simple ill-
9 nesses and minor injuries.

10 (B) Preventive health services, including
11 health screenings.

12 (C) Services provided for the purpose de-
13 scribed in subsection (b)(2).

14 (D) Referrals and followups in situations
15 involving illness or injury.

16 (E) Health and social services, counseling
17 services, and necessary referrals, including re-
18 ferrals regarding mental health and substance
19 abuse.

20 (F) Such other services as the Secretary
21 determines to be appropriate.

22 (2) The applicant is a participating provider in
23 the State's program for medical assistance under
24 title XIX of the Social Security Act.

1 (3) The applicant does not impose charges on
2 students or their families for services (including col-
3 lection of any cost-sharing for services under the
4 comprehensive benefit package that otherwise would
5 be required).

6 (4) The applicant has reviewed and will periodi-
7 cally review the needs of the population served by
8 the applicant in order to ensure that its services are
9 accessible to the maximum number of school-aged
10 children in the area, and that, to the maximum ex-
11 tent possible, barriers to access to services of the ap-
12 plicant are removed (including barriers resulting
13 from the area's physical characteristics, its eco-
14 nomic, social and cultural grouping, the health care
15 utilization patterns of such children, and available
16 transportation).

17 (5) In the case of an applicant which serves a
18 population that includes a substantial proportion of
19 individuals of limited English speaking ability, the
20 applicant has developed a plan to meet the needs of
21 such population to the extent practicable in the lan-
22 guage and cultural context most appropriate to such
23 individuals.

1 (6) The applicant will provide non-Federal con-
2 tributions toward the cost of the project in an
3 amount determined by the Secretary.

4 (7) The applicant will operate a quality assur-
5 ance program consistent with section 734(d).

6 (e) DURATION OF GRANT.—A grant under this sec-
7 tion shall be for a period determined by the Secretary.

8 (f) REPORTS.—A recipient of funding under this sec-
9 tion shall provide such reports and information as are re-
10 quired in regulations of the Secretary.

11 **SEC. 736. FEDERAL ADMINISTRATIVE COSTS.**

12 Of the amounts made available under section 731, the
13 Secretary may reserve not more than 5 percent for admin-
14 istrative expenses regarding this subtitle.

15 **SEC. 737. DEFINITIONS.**

16 For purposes of this subtitle:

17 (1) The term “adolescent children” has the
18 meaning given such term in section 732(c).

19 (2) The term “at risk” means at-risk with re-
20 spect to health.

21 (3) The term “community health center” has
22 the meaning given such term in section 330 of the
23 Public Health Service Act.

24 (4) The term “health professional shortage
25 area” means a health professional shortage area des-

1 **Subtitle A—American Health**
2 **Security Trust Fund**

3 **SEC. 801. AMERICAN HEALTH SECURITY TRUST FUND.**

4 (a) IN GENERAL.—There is hereby created on the
5 books of the Treasury of the United States a trust fund
6 to be known as the American Health Security Trust Fund
7 (in this section referred to as the “Trust Fund”). The
8 Trust Fund shall consist of such gifts and bequests as
9 may be made and such amounts as may be deposited in,
10 or appropriated to, such Trust Fund as provided in this
11 Act.

12 (b) APPROPRIATIONS INTO TRUST FUND.—

13 (1) TAXES.—There are hereby appropriated to
14 the Trust Fund for each fiscal year (beginning with
15 fiscal year 1996), out of any moneys in the Treasury
16 not otherwise appropriated, amounts equivalent to
17 100 percent of the aggregate increase in tax liabil-
18 ities under the Internal Revenue Code of 1986 which
19 is attributable to the application of the amendments
20 made by this title. The amounts appropriated by the
21 preceding sentence shall be transferred from time to
22 time (but not less frequently than monthly) from the
23 general fund in the Treasury to the Trust Fund,
24 such amounts to be determined on the basis of esti-
25 mates by the Secretary of the Treasury of the taxes

1 paid to or deposited into the Treasury; and proper
2 adjustments shall be made in amounts subsequently
3 transferred to the extent prior estimates were in ex-
4 cess of or were less than the amounts that should
5 have been so transferred.

6 (2) CURRENT PROGRAM RECEIPTS.—Notwith-
7 standing any other provision of law, there are hereby
8 appropriated to the Trust Fund for each fiscal year
9 (beginning with fiscal year 1996) the amounts that
10 would otherwise have been appropriated to carry out
11 the following programs:

12 (A) The medicare program, under parts A
13 and B of title XVIII of the Social Security Act
14 (other than amounts attributable to any pre-
15 miums under such parts).

16 (B) The medicaid program, under State
17 plans approved under title XIX of such Act.

18 (C) The Federal employees health benefit
19 program, under chapter 89 of title 5, United
20 States Code.

21 (D) The CHAMPUS program, under chap-
22 ter 55 of title 10, United States Code.

23 (E) The maternal and child health pro-
24 gram (under title V of the Social Security Act),
25 vocational rehabilitation programs, programs

1 for drug abuse and mental health services
2 under the Public Health Service Act, programs
3 providing general hospital or medical assistance,
4 and any other Federal program identified by
5 the Board, in consultation with the Secretary of
6 the Treasury, to the extent the programs pro-
7 vide for payment for health services the pay-
8 ment of which may be made under this Act.

9 (c) INCORPORATION OF PROVISIONS.—The provisions
10 of subsections (b) through (i) of section 1817 of the Social
11 Security Act shall apply to the Trust Fund under this Act
12 in the same manner as they applied to the Federal Hos-
13 pital Insurance Trust Fund under part A of title XVIII
14 of such Act, except that the American Health Security
15 Standards Board shall constitute the Board of Trustees
16 of the Trust Fund.

17 (d) TRANSFER OF FUNDS.—Any amounts remaining
18 in the Federal Hospital Insurance Trust Fund or the Fed-
19 eral Supplementary Medical Insurance Trust Fund after
20 the settlement of claims for payments under title XVIII
21 have been completed, shall be transferred into the Amer-
22 ican Health Security Trust Fund.

1 **Subtitle B—Taxes Based on Income**
2 **and Wages**

3 **SEC. 811. PAYROLL TAX ON EMPLOYERS.**

4 (a) IN GENERAL.—Section 3111 (relating to tax on
5 employers) is amended by redesignating subsection (c) as
6 subsection (d) and by inserting after subsection (b) the
7 following new subsection:

8 “(c) HEALTH CARE.—In addition to other taxes,
9 there is hereby imposed on every employer an excise tax,
10 with respect to having individuals in his employ, equal to
11 8.7 percent of the wages (as defined in section 3121(a))
12 paid by him with respect to employment (as defined in
13 section 3121(b)).”

14 (b) SELF-EMPLOYMENT INCOME.—Section 1401 (re-
15 lating to rate of tax on self-employment income) is amend-
16 ed by redesignating subsection (c) as subsection (d) and
17 by inserting after subsection (b) the following new sub-
18 section:

19 “(c) HEALTH CARE.—In addition to other taxes,
20 there shall be imposed for each taxable year, on the self-
21 employment income of every individual, a tax equal to 8.7
22 percent of the amount of the self-employment income for
23 such taxable year.”

24 (c) COMPARABLE TAXES FOR RAILROAD SERV-
25 ICES.—

1 (1) TAX ON EMPLOYERS.—Section 3221 is
2 amended by redesignating subsections (c), (d), and
3 (e) as subsections (d), (e), and (f), respectively, and
4 by inserting after subsection (b) the following new
5 subsection:

6 “(c) HEALTH CARE.—In addition to other taxes,
7 there is hereby imposed on every employer an excise tax,
8 with respect to having individuals in his employ, equal to
9 8.7 percent of the compensation paid by such employer
10 for services rendered to such employer.”

11 (2) TAX ON EMPLOYEE REPRESENTATIVES.—
12 Subsection (a) of section 3211 (relating to tax on
13 employee representatives) is amended by redesignat-
14 ing paragraph (3) as paragraph (4) and by inserting
15 after paragraph (2) the following new paragraph:

16 “(3) HEALTH CARE.—In addition to other
17 taxes, there is hereby imposed on the income of each
18 employee representative a tax equal to 8.7 percent of
19 the compensation received during the calendar year
20 by such employee representative for services ren-
21 dered by such employee representative.

22 (3) NO APPLICABLE BASE.—Subparagraph (A)
23 of section 3231(e)(2) is amended by adding at the
24 end thereof the following new clause:

1 “(iv) HEALTH CARE TAXES.—Clause
2 (i) shall not apply to the taxes imposed by
3 sections 3221(c) and 3211(a)(3).”

4 (4) TECHNICAL AMENDMENTS.—

5 (A) Paragraph (4) of section 3211, as re-
6 designated by paragraph (2), is amended by
7 striking “and (2)” and inserting “, (2), and
8 (3)”.

9 (B) Subsection (f) of section 3221, as re-
10 designated by paragraph (1), is amended by
11 striking “and (b)” and inserting “, (b), and
12 (c)”.

13 (d) EFFECTIVE DATE.—The amendments made by
14 this section shall apply to remuneration paid after Decem-
15 ber 31, 1996.

16 **SEC. 812. HEALTH CARE INCOME TAX.**

17 (a) GENERAL RULE.—Subchapter A of chapter 1 (re-
18 lating to determination of tax liability) is amended by add-
19 ing at the end thereof the following new part:

20 **“PART VIII—HEALTH CARE INCOME TAX ON**
21 **INDIVIDUALS**

 “Sec. 59B. Health care income tax.

22 **“SEC. 59B. HEALTH CARE INCOME TAX.**

23 “(a) IMPOSITION OF TAX.—In the case of an individ-
24 ual, there is hereby imposed a tax (in addition to any other

1 tax imposed by this subtitle) equal to 2.2 percent of the
2 taxable income of the taxpayer for the taxable year.

3 “(b) NO CREDITS AGAINST TAX; NO EFFECT ON
4 MINIMUM TAX.—The tax imposed by this section shall not
5 be treated as a tax imposed by this chapter for purposes
6 of determining—

7 “(1) the amount of any credit allowable under
8 this chapter, or

9 “(2) the amount of the minimum tax imposed
10 by section 55.

11 “(c) SPECIAL RULES.—

12 “(1) TAX TO BE WITHHELD, ETC.—For pur-
13 poses of this title, the tax imposed by this section
14 shall be treated as imposed by section 1.

15 “(2) REIMBURSEMENT OF TAX BY EMPLOYER
16 NOT INCLUDIBLE IN GROSS INCOME.—The gross in-
17 come of an employee shall not include any payment
18 by his employer to reimburse the employee for the
19 tax paid by the employee under this section.

20 “(3) OTHER RULES.—The rules of section
21 59A(d) shall apply to the tax imposed by this sec-
22 tion.”

23 (b) CLERICAL AMENDMENT.—The table of parts for
24 subchapter A of chapter 1 is amended by adding at the
25 end the following new item:

“Part VIII. Health care income tax on individuals.”

1 (c) EFFECTIVE DATE.—The amendments made by
2 this section shall apply to taxable years beginning after
3 December 31, 1996.

4 **Subtitle C—Increase in Excise**
5 **Taxes on Tobacco Products**

6 **SEC. 821. INCREASE IN EXCISE TAXES ON TOBACCO PROD-**
7 **UCTS.**

8 (a) CIGARETTES.—Subsection (b) of section 5701 is
9 amended—

10 (1) by striking “\$12 per thousand (\$10 per
11 thousand on cigarettes removed during 1991 or
12 1992)” in paragraph (1) and inserting “\$22.50 per
13 thousand”, and

14 (2) by striking “\$25.20 per thousand (\$21 per
15 thousand on cigarettes removed during 1991 or
16 1992)” in paragraph (2) and inserting “\$47.25 per
17 thousand”.

18 (b) CIGARS.—Subsection (a) of section 5701 is
19 amended—

20 (1) by striking “\$1.125 cents per thousand
21 (93.75 cents per thousand on cigars removed during
22 1991 or 1992)” in paragraph (1) and inserting
23 “\$2.11 per thousand”, and

24 (2) by striking “equal to” and all that follows
25 in paragraph (2) and inserting “equal to 23.91 per-

1 cent of the price for which sold but not more than
2 \$56.25 per thousand.”

3 (c) CIGARETTE PAPERS.—Subsection (c) of section
4 5701 is amended by striking “0.75 cent (0.625 cent on
5 cigarette papers removed during 1991 or 1992)” and in-
6 serting “1.41 cents”.

7 (d) CIGARETTE TUBES.—Subsection (d) of section
8 5701 is amended by striking “1.5 cents (1.25 cents on
9 cigarette tubes removed during 1991 or 1992)” and in-
10 serting “2.81 cents”.

11 (e) SMOKELESS TOBACCO.—Subsection (e) of section
12 5701 is amended—

13 (1) by striking “36 cents (30 cents on snuff re-
14 moved during 1991 or 1992)” in paragraph (1) and
15 inserting “67.5 cents”, and

16 (2) by striking “12 cents (10 cents on chewing
17 tobacco removed during 1991 or 1992)” in para-
18 graph (2) and inserting “22.5 cents”.

19 (f) PIPE TOBACCO.—Subsection (f) of section 5701
20 is amended by striking “67.5 cents (56.25 cents on pipe
21 tobacco removed during 1991 or 1992)” and inserting
22 “\$1.27”.

23 (g) EFFECTIVE DATE.—The amendments made by
24 this section shall apply to articles removed (as defined in

1 section 5702(k) of the Internal Revenue Code of 1986)
2 after December 31, 1996.

3 (h) FLOOR STOCKS TAXES.—

4 (1) IMPOSITION OF TAX.—On tobacco products
5 and cigarette papers and tubes manufactured in or
6 imported into the United States which are removed
7 before January 1, 1997, and held on such date for
8 sale by any person, there is hereby imposed a tax in
9 an amount equal to the excess of—

10 (A) the tax which would be imposed under
11 section 5701 of the Internal Revenue Code of
12 1986 on the article if the article had been re-
13 moved on such date, over

14 (B) the prior tax (if any) imposed under
15 section 5701 or 7652 of such Code on such ar-
16 ticle.

17 (2) AUTHORITY TO EXEMPT CIGARETTES HELD
18 IN VENDING MACHINES.—To the extent provided in
19 regulations prescribed by the Secretary, no tax shall
20 be imposed by paragraph (1) on cigarettes held for
21 retail sale on January 1, 1997, by any person in any
22 vending machine. If the Secretary provides such a
23 benefit with respect to any person, the Secretary
24 may reduce the \$500 amount in paragraph (3) with
25 respect to such person.

1 (3) CREDIT AGAINST TAX.—Each person shall
2 be allowed as a credit against the taxes imposed by
3 paragraph (1) an amount equal to \$500. Such credit
4 shall not exceed the amount of taxes imposed by
5 paragraph (1) for which such person is liable.

6 (4) LIABILITY FOR TAX AND METHOD OF PAY-
7 MENT.—

8 (A) LIABILITY FOR TAX.—A person hold-
9 ing any article on January 1, 1997, to which
10 any tax imposed by paragraph (1) applies shall
11 be liable for such tax.

12 (B) METHOD OF PAYMENT.—The tax im-
13 posed by paragraph (1) shall be paid in such
14 manner as the Secretary shall prescribe by reg-
15 ulations.

16 (C) TIME FOR PAYMENT.—The tax im-
17 posed by paragraph (1) shall be paid on or be-
18 fore July 31, 1997.

19 (5) ARTICLES IN FOREIGN TRADE ZONES.—
20 Notwithstanding the Act of June 18, 1934 (48 Stat.
21 998, 19 U.S.C. 81a) and any other provision of law,
22 any article which is located in a foreign trade zone
23 on January 1, 1997, shall be subject to the tax im-
24 posed by paragraph (1) if—

1 (A) internal revenue taxes have been deter-
2 mined, or customs duties liquidated, with re-
3 spect to such article before such date pursuant
4 to a request made under the 1st proviso of sec-
5 tion 3(a) of such Act, or

6 (B) such article is held on such date under
7 the supervision of a customs officer pursuant to
8 the 2d proviso of such section 3(a).

9 (6) DEFINITIONS.—For purposes of this sub-
10 section—

11 (A) IN GENERAL.—Terms used in this sub-
12 section which are also used in section 5702 of
13 the Internal Revenue Code of 1986 shall have
14 the respective meanings such terms have in
15 such section.

16 (B) SECRETARY.—The term “Secretary”
17 means the Secretary of the Treasury or his del-
18 egate.

19 (7) CONTROLLED GROUPS.—Rules similar to
20 the rules of section 5061(e)(3) of such Code shall
21 apply for purposes of this subsection.

22 (8) OTHER LAWS APPLICABLE.—All provisions
23 of law, including penalties, applicable with respect to
24 the taxes imposed by section 5701 of such Code
25 shall, insofar as applicable and not inconsistent with

1 the provisions of this subsection, apply to the floor
2 stocks taxes imposed by paragraph (1), to the same
3 extent as if such taxes were imposed by such section
4 5701. The Secretary may treat any person who bore
5 the ultimate burden of the tax imposed by para-
6 graph (1) as the person to whom a credit or refund
7 under such provisions may be allowed or made.

8 **TITLE IX—CONFORMING AMEND-**
9 **MENTS TO THE EMPLOYEE**
10 **RETIREMENT INCOME SECU-**
11 **RITY ACT OF 1974**

12 **SEC. 901. ERISA INAPPLICABLE TO HEALTH COVERAGE AR-**
13 **RANGEMENTS UNDER STATE HEALTH SECU-**
14 **RITY PROGRAMS.**

15 Section 4 of the Employee Retirement Income Secu-
16 rity Act of 1974 (29 U.S.C. 1003) is amended—

17 (1) in subsection (a), by striking “subsection
18 (b)” and inserting “subsections (b) and (c)”; and

19 (2) by adding at the end the following new sub-
20 section:

21 “(c) The provisions of this title shall not apply to any
22 arrangement forming a part of a State health security pro-
23 gram established pursuant to section 101(b) of the Amer-
24 ican Health Security Act of 1995.”.

1 **SEC. 902. EXEMPTION OF STATE HEALTH SECURITY PRO-**
2 **GRAMS FROM ERISA PREEMPTION.**

3 Section 514(b) of the Employee Retirement Income
4 Security Act of 1974 (29 U.S.C. 1144(b)) is amended by
5 adding at the end the following new paragraph:

6 “(9) Subsection (a) of this section shall not apply to
7 State health security programs established pursuant to
8 section 101(b) of the American Health Security Act of
9 1995.”.

10 **SEC. 903. PROHIBITION OF EMPLOYEE BENEFITS DUPLICA-**
11 **TIVE OF BENEFITS UNDER STATE HEALTH**
12 **SECURITY PROGRAMS; COORDINATION IN**
13 **CASE OF WORKERS’ COMPENSATION.**

14 (a) IN GENERAL.—Part 5 of subtitle B of title I of
15 the Employee Retirement Income Security Act of 1974 is
16 amended by adding at the end the following new section:

17 “PROHIBITION OF EMPLOYEE BENEFITS DUPLICATIVE OF
18 STATE HEALTH SECURITY PROGRAM BENEFITS; CO-
19 ORDINATION IN CASE OF WORKERS’ COMPENSATION

20 “SEC. 516. (a) Subject to subsection (b), no employee
21 benefit plan may provide benefits which duplicate payment
22 for any items or services for which payment may be made
23 under a State health security program established pursu-
24 ant to section 101(b) of the American Health Security Act
25 of 1995.

1 “(b)(1) Each workers compensation carrier that is
2 liable (or would be liable but for the enactment of the
3 American Health Security Act) for payment for workers
4 compensation services furnished in a State shall reimburse
5 the State health security plan for the State in which the
6 services are furnished for the cost of such services.

7 “(2) In this subsection:

8 “(A) The term ‘workers compensation carrier’
9 means an insurance company that underwrites work-
10 ers compensation medical benefits with respect to
11 one or more employers and includes an employer or
12 fund that is financially at risk for the provision of
13 workers compensation medical benefits.

14 “(B) The term ‘workers compensation medical
15 benefits’ means, with respect to an enrollee who is
16 an employee subject to the workers compensation
17 laws of a State, the comprehensive medical benefits
18 for work-related injuries and illnesses provided for
19 under such laws with respect to such an employee.

20 “(C) The term ‘workers compensation services’
21 means items and services included in workers com-
22 pensation medical benefits and includes items and
23 services (including rehabilitation services and long-
24 term-care services) commonly used for treatment of
25 work-related injuries and illnesses.”.

1 (b) CLERICAL AMENDMENT.—The table of contents
2 in section 1 of such Act is amended by inserting after the
3 item relating to section 514 the following new items:

“Sec. 515. Delinquent contributions.

“Sec. 516. Prohibition of employee benefits duplicative of State health security program benefits.”.

4 **SEC. 904. REPEAL OF CONTINUATION COVERAGE REQUIRE-**
5 **MENTS UNDER ERISA AND CERTAIN OTHER**
6 **REQUIREMENTS RELATING TO GROUP**
7 **HEALTH PLANS.**

8 (a) IN GENERAL.—Part 6 of subtitle B of title I of
9 the Employee Retirement Income Security Act of 1974
10 (29 U.S.C. 1161 et seq.) is repealed.

11 (b) CONFORMING AMENDMENTS.—

12 (1) Section 502(a) of such Act (29 U.S.C.
13 1132(a)) is amended—

14 (A) by striking paragraph (7); and

15 (B) by redesignating paragraph (8) as
16 paragraph (7).

17 (2) Section 502(c)(1) of such Act (29 U.S.C.
18 1132(c)(1)) is amended by striking “paragraph (1)
19 or (4) of section 606 or”.

20 (3) Section 4301(c)(4) of the Omnibus Budget
21 Reconciliation Act of 1993 (Public Law 103–66; 107
22 Stat. 377) and the amendments made thereby are
23 repealed.

1 (4) The table of contents in section 1 of the
2 Employee Retirement Income Security Act of 1974
3 is amended by striking the items relating to part 6
4 of subtitle B of title I of such Act.

5 **SEC. 905. EFFECTIVE DATE OF TITLE.**

6 The amendments made by this title shall take effect
7 January 1, 1997.

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