/* Title IV, part two of the proposed health security act follows. */

Section 4046 EFFECTIVE DATE.

The amendments made by this part shall take effect January 1, 1995.

Part 6 FUNDING OF GRADUATE MEDICAL EDUCATION AND ACADEMIC HEALTH CENTERS

Section 4051 TRANSFERS FROM MEDICARE TRUST FUNDS FOR GRADUATE MEDICAL EDUCATION.

(a) In General. For purposes of complying with section 3034(a), there shall be transferred to the Secretary from the Federal Hospital Insurance Trust Fund (established under section 1817 of the Social Security Act) and the Federal Supplementary Medical Insurance Trust Fund (established under section 1841 of such Act) the following amount (in the aggregate), as applicable to a fiscal year:

(1) In the case of fiscal year 1996, $1,500,000,000.

(2) In the case of each of the fiscal years 1997 and 1998, $1,600,000,000.

(3) In the case of each subsequent fiscal year, the amount specified in paragraph (2) increased by the Secretary's estimate of the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with the midpoint of the previous fiscal year.

(b) Allocation of Amount Among Funds. With respect to the amount required under subsection (a) to be transferred for a year from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, the Secretary shall determine an equitable allocation of such amount among the funds.

(c) Termination of Graduate Medical Education Payments Under Medicare.

(1) In General. Section 1886(h) (42 U.S.C. 1395ww(h)) is amended by adding at the end the following new paragraph:

"(6) Termination of payments attributable to costs of training physicians. Notwithstanding any other provision of this section or section 1861(v), no payment may be made under this

title for direct graduate medical education costs attributable to an approved medical residency training program for any cost reporting period (or portion thereof) beginning on or after October 1, 1995.".

(2) Prohibition against recognition of costs. Section 1861(v)(1) (42 U.S.C. 1395x(v)(1)) is amended by adding at the end the following new subparagraph:

"(T) Such regulations shall not include any provision for specific recognition of the costs of graduate medical education for hospitals for any cost reporting period (or portion thereof) beginning on or after October 1, 1995. Nothing in the previous sentence shall be construed to affect in any way payments to hospitals for the costs of any approved educational activities that not described in such sentence.".

Section 4052 TRANSFERS FROM HOSPITAL INSURANCE TRUST FUND FOR ACADEMIC HEALTH CENTERS.

(a) In General. For purposes of complying with section 3104(a), there shall be transferred to the Secretary from the Federal Hospital Insurance Trust Fund (established under section 1817 of the Social Security Act) the following amount (in the aggregate), as applicable to a fiscal year:

(1) In the case of fiscal year 1996, $2,100,000,000.

(2) In the case of each of the fiscal years 1997 and 1998, $2,000,000,000.

(3) In the case of each subsequent fiscal year, the amount specified in paragraph (2) increased by the Secretary's estimate of the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with the midpoint of the previous fiscal year.

(b) Termination of Payments Under Medicare.

(1) In general. Section 1886(d)(5)(B) (42 U.S.C. 1395ww(d)(5)(B)) is amended in the matter preceding clause (i) by striking "The Secretary" and inserting "For discharges occurring before October 1, 1995, the Secretary".

(2) Adjustment to standardized amounts. Section 1886(d)(2)(C)(i) (42 U.S.C. 1395ww(d)(2)(C)(i)) is amended by striking "excluding" and inserting "for discharges occurring before

October 1, 1995, excluding".

Part 7 COVERAGE OF SERVICES PROVIDED BY FACILITIES AND PLANS OF DEPARTMENTS OF DEFENSE AND VETERANS AFFAIRS

Section 4061 TREATMENT OF UNIFORMED SERVICES HEALTH PLAN AS ELIGIBLE ORGANIZATION UNDER MEDICARE.

(a) In General. Section 1876 (42 U.S.C. 1395mm), as amended by section 4002(a), is further amended by adding at the end the following new subsection:

"(l) Notwithstanding any other provision of this section, a Uniformed Services Health Plan of the Department of Defense under chapter 55 of title 10, United States Code, shall be considered an eligible organization under this section, and the Secretary shall make payments to such Plan during a year on behalf of any individuals entitled to benefits under this title who are enrolled with such a Plan during the year in the same amounts and under the same terms and conditions under which the Secretary makes payments to eligible organizations with risk-sharing contracts under section 1876.".

(b) Effective Date. The amendment made by subsection (a) shall apply to items and services furnished under title XVIII of the Social Security Act on or after October 1, 1995.

Section 4062 COVERAGE OF SERVICES PROVIDED TO MEDICARE BENEFICIARIES BY PLANS AND FACILITIES OF DEPARTMENT OF VETERANS AFFAIRS.

(a) In General. Title XVIII, as amended by sections 4001 and 4003, is further amended by adding at the end the following new section:

"treatment of plans and facilities of department of veterans affairs as providers

"Sec. 1895. (a) In General. Notwithstanding any other provision of this title

"(1) a VA health plan (as defined in section 1801(2) of title 38, United States Code) shall be considered an eligible organization for purposes of section 1876; and

"(2) a health care facility of the Department of Veterans Affairs shall be considered a provider of services under section

1861(u).

"(b) Eligibility for Payments.

"(1) VA health plans. The Secretary shall make payments to a VA health plan during a year on behalf of any veteran, other than a veteran described in section 1831(b) during the year (other than any individuals described in section 1831(b) of title 38, United States Code) in the same amounts and under the same terms and conditions under which the Secretary makes payments to eligible organizations with a risk-sharing contract under section 1876.

"(2) Health care facilities. The Secretary shall make payments to a health care facility of the Department of Veterans Affairs for services provided to an individual entitled to benefits under this title in the same amounts and under the same terms and conditions under which the Secretary makes payments to provider of services under this title.".

(b) Effective Date. The amendment made by subsection (a) shall apply to items and services furnished under title XVIII of the Social Security Act on or after January 1, 1998.

Section 4063 CONFORMING AMENDMENTS.

(a) Part A. Section 1814 (42 U.S.C. 1395f) is amended by striking subsection (c).

(b) Part B. Section 1835 (42 U.S.C. 1395n) is amended by striking subsection (d).

(c) Additional Conforming Amendment. Section 1880(a) (42 U.S.C. 1395qq(a)) is amended by striking ", notwithstanding sections 1814(c) and 1835(d),".

(d) Effective Date. The amendments made by this section shall take effect

January 1, 1998. Title IV, Subtitle B

Subtitle B Savings in Medicare Program

Part 1 SAVINGS RELATING TO PART A

Section 4101 REDUCTION IN UPDATE FOR INPATIENT HOSPITAL SERVICES.

Section 1886(b)(3)(B)(i) (42 U.S.C. 1395ww(b)(3)(B)(i)), as amended by section 13501(a)(1) of OBRA091993, is amended

(1) in subclause (XII)

(A) by striking "fiscal year 1997" and inserting "for each of the fiscal years 1997 through 2000", and

(B) by striking "0.5 percentage point" and inserting "2.0 percentage points"; and

(2) in subclause (XIII), by striking "fiscal year 1998" and inserting "fiscal year 2003".

Section 4102 REDUCTION IN ADJUSTMENT FOR INDIRECT MEDICAL EDUCATION.

(a) In General. Section 1886(d)(5)(B)(ii) (42 U.S.C. 1395ww(d)(5)(B)(ii)) is amended to read as follows:

"(ii) For purposes of clause (i)(II), the indirect teaching adjustment factor is equal to c * (((1+r) to the nth power) - 1), where `r' is the ratio of the hospital's full-time equivalent interns and residents to beds and `n' equals .405. For discharges occurring on or after

"(I) May 1, 1986, and before October 1, 1995, `c' is equal to 1.89, and

"(II) October 1, 1995, `c' is equal to 0.74.".

(b) No Restandardization of Payment Amounts Required. Section 1886(d)(2)(C)(i) (42 U.S.C. 1395ww(d)(2)(C)(i)) is amended by striking "of 1985" and inserting "of 1985, but not taking into account the amendments made by section 4102(a) of the Health Security Act".

Section 4103 REDUCTION IN PAYMENTS FOR CAPITAL-RELATED COSTS FOR INPATIENT HOSPITAL SERVICES.

(a) PPS Hospitals.

(1) Reduction in base payment rates. Section 1886(g)(1)(A) (42 U.S.C. 1395ww(g)(1)(A)), as amended by section 13501(a)(3) of OBRA091993, is amended by adding at the end the following new sentence: "In addition to the reduction described in the

preceding sentence, for discharges occurring after September 30, 1995, the Secretary shall reduce by 7.31 percent the unadjusted standard Federal capital payment rate (as described in 42 CFR 412.308(c), as in effect on the date of the enactment of the Health Security Act) and shall reduce by 10.41 percent the unadjusted hospital-specific rate (as described in 42 CFR 412.328(e)(1), as in effect on the date of the enactment of the Health Security Act).".

(2) Reduction in update. Section 1886(g)(1) (42 U.S.C. 1395ww(g)(1)) is amended

(A) in subparagraph (B)(i)

(i) by striking "and (II)" and inserting "(II)", and

(ii) by striking the semicolon at the end and inserting the following: ", and (III) an annual update factor established for the prospective payment rates applicable to discharges in a fiscal year which (subject to reduction under subparagraph (C)) will be based upon such factor as the Secretary determines appropriate to take into account amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality;";

(B) by redesignating subparagraph (C) as subparagraph (D); and

(C) by inserting after subparagraph (B) the following new subparagraph:

"(C)(i) With respect to payments attributable to portions of cost reporting periods or discharges occurring during each of the fiscal years 1996 through 2003, the Secretary shall include a reduction in the annual update factor established under subparagraph (B)(i)(III) for discharges in the year equal to the applicable update reduction described in clause (ii) to adjust for excessive increases in capital costs per discharge for fiscal years prior to fiscal year 1992 (but in no event may such reduction result in an annual update factor less than zero).

"(ii) In clause (i), the term `applicable update reduction' means, with respect to the update factor for a fiscal year

"(I) 4.9 percentage points; or

"(II) if the annual update factor for the previous fiscal

year was less than the applicable update reduction for the previous year, the sum of 4.9 percentage points and the difference between the annual update factor for the previous year and the applicable update reduction for the previous year.".

(b) PPS-Exempt Hospitals. Section 1861(v)(1) (42 U.S.C. 1395x(v)(1)), as amended by section 4051(c)(2), is further amended by adding at the end the following new subparagraph:

"(U) Such regulations shall provide that, in determining the amount of the payments that may be made under this title with respect to the capital-related costs of inpatient hospital services furnished by a hospital that is not a subsection (d) hospital (as defined in section 1886(d)(1)(B)) or a subsection (d) Puerto Rico hospital (as defined in section 1886(d)(9)(A)), the Secretary shall reduce the amounts of such payments otherwise established under this title by 15 percent for payments attributable to portions of cost reporting periods occurring during each of the fiscal years 1996 through 2003.".

Section 4104 REVISIONS TO PAYMENT ADJUSTMENTS FOR DISPROPORTIONATE SHARE HOSPITALS IN PARTICIPATING STATES.

(a) Application of Alternative Adjustments. Section 1886(d)(5) (42 U.S.C. 1395ww(d)(5)) is amended

(1) by redesignating subparagraphs (H) and (I) as subparagraphs (I) and (J); and

(2) by inserting after subparagraph (G) the following new subparagraph:

"(H)(i) In accordance with this subparagraph, the Secretary shall provide for an additional payment for each subsection (d) hospital that is located in a participating State under the Health Security Act during a cost reporting period and that meets the eligibility requirements described in clause (iii).

"(ii) The amount of the additional payment made under clause (i) for each discharge shall be determined by multiplying

"(I) the sum of the amount determined under paragraph (1)(A)(ii)(II) (or, if applicable, the amount determined under paragraph (1)(A)(iii)) and the amount paid to the hospital under subparagraph (A) for the discharge, by

"(II) the SSI adjustment percentage for the cost reporting

period in which the discharge occurs (as defined in clause (iv)).

"(iii) A hospital meets the eligibility requirements described in this clause with respect to a cost reporting period if

"(I) in the case of a hospital that is located in an urban area and that has more than 100 beds, the hospital's SSI patient percentage (as defined in clause (v)) for the cost reporting period is not less than 5.5 percent;

"(II) in the case of a hospital that is located in an urban area and that has less than 100 beds, the hospital's SSI patient percentage is not less than 17 percent;

"(III) in the case of a hospital that is classified as a rural referral center under subparagraph (C) or a sole community hospital under subparagraph (D), the hospital's SSI patient percentage for the cost reporting period is not less than 23 percent; and

"(IV) in the case of any other hospital, the hospital's SSI patient percentage is not less than 23 percent.

"(iv) For purposes of clause (ii), the `SSI adjustment percentage' applicable to a hospital for a cost reporting period is equal to

"(I) in the case of a hospital described in clause (iii)(I), the percentage determined in accordance with the following formula: e to the nth power - 1, where `e' is the natural antilog of 1 and where `n' is equal to (.5642 * (the hospital's SSI patient percentage for the cost reporting period - .055));

"(II) in the case of a hospital described in clause (iii)(II) or clause (iii)(IV), 2 percent; and

"(III) in the case of a hospital described in clause (iii) (III), the sum of 2 percent and .30 percent of the difference between the hospital's SSI patient percentage for the cost reporting period and 23 percent.

"(v) In this subparagraph, a hospital's `SSI patient percentage' with respect to a cost reporting period is equal to the fraction (expressed as a percentage)

"(I) the numerator of which is the number of the hospital's

patient days for such period which were made up of patients who (for such days) were entitled to benefits under part A and were entitled to supplementary security income benefits (excluding State supplementation) under title XVI; and

"(II) the denominator of which is the number of the hospital's patient days for such period which were made up of patients who (for such days) were entitled to benefits under part A.".

(b) No Standardization Resulting From Reduction. Section 1886(d)(2)(C)(iv) (42 U.S.C. 1395ww(d)(2)(C)(iv)) is amended

(1) by striking "exclude additional payments" and inserting "adjust such estimate for changes in payments";

(2) by striking "1989 or" and inserting "1989,"; and

(3) by striking the period at the end and inserting the following: ", or the enactment of section 4104 of the Health Security Act.".

(c) Conforming Amendment.Section 1886(d)(5)(F)(i) (42 U.S.C. 1395ww(d)(5)(F)(i)) is amended in the matter preceding subclause (I) by inserting after "hospital" the following: "that is not located in a State that is a participating State under the Health Security Act".

Section 4105 MORATORIUM ON DESIGNATION OF ADDITIONAL LONG-TERM CARE HOSPITALS.

Notwithstanding clause (iv) of section 1886(d)(1)(B) of the Social Security Act, a hospital which has an average inpatient length of stay (as determined by the Secretary of Health and Human Services) of greater than 25 days shall not be treated as a hospital described in such clause for purposes of title XVIII of such Act unless the hospital was treated as a hospital described in such clause for purposes of such title as of the date of the enactment of this Act.

Section 4106 EXTENSION OF FREEZE ON UPDATES TO ROUTINE SERVICE COSTS OF SKILLED NURSING FACILITIES.

(a) Payments Based on Cost Limits.Section 1888(a) (42 U.S.C. 1395yy(a)) is amended by striking "112 percent" each place it appears and inserting "100 percent (adjusted by such amount as the Secretary determines to be necessary to preserve the savings

resulting from the enactment of section 13503(a)(1) of the Omnibus Budget Reconciliation Act of 1993)".

(b) Payments Determined on Prospective Basis. Section 1888(d)(2)(B) (42 U.S.C. 1395yy(d)(2)(B)) is amended by striking "105 percent" and inserting "100 percent (adjusted by such amount as the Secretary determines to be necessary to preserve the savings resulting from the enactment of section 13503(b) of the Omnibus Budget Reconciliation Act of 1993)".

(c) Effective Date. The amendments made by subsections (a) and(b) shall apply to cost reporting periods beginning on or after October 1, 1995.

Part 2 SAVINGS RELATING TO PART B

Section 4111 ESTABLISHMENT OF CUMULATIVE EXPENDITURE GOALS FOR PHYSICIAN SERVICES.

(a) Use of Cumulative Performance Standard. Section 1848(f)(2) (42 U.S.C. 1395w0@4(f)(2)) is amended

(1) in subparagraph (A)

(A) in the heading, by striking "In general" and inserting "Fiscal years 1991 through 1994.--",

(B) in the matter preceding clause (i), by striking "a fiscal year (beginning with fiscal year 1991)" and inserting "fiscal years 1991, 1992, 1993, and 1994", and

(C) in the matter following clause (iv), by striking "subparagraph (B)" and inserting "subparagraph (C)";

(2) in subparagraph (B), by striking "subparagraph (A)" and inserting "subparagraphs (A) and (B)";

(3) by redesignating subparagraphs (B) and (C) as subparagraphs (C) and (D); and

(4) by inserting after subparagraph (A) the following new subparagraph:

"(B) Fiscal years beginning with fiscal year 1995. Unless Congress otherwise provides, the performance standard rate of increase, for all physicians' services and for each category of physicians' services, for a fiscal year beginning with fiscal

year 1995 shall be equal to the performance standard rate of increase determined under this paragraph for the previous fiscal year, increased by the product of

"(i) 1 plus the Secretary's estimate of the weighted average percentage increase (divided by 100) in the fees for all physicians' services or for the category of physicians' services, respectively, under this part for portions of calendar years included in the fiscal year involved,

"(ii) 1 plus the Secretary's estimate of the percentage increase or decrease (divided by 100) in the average number of individuals enrolled under this part (other than HMO enrollees) from the previous fiscal year to the fiscal year involved,

"(iii) 1 plus the Secretary's estimate of the average annual percentage growth (divided by 100) in volume and intensity of all physicians' services or of the category of physicians' services, respectively, under this part for the 5-fiscal-year period ending with the preceding fiscal year (based upon information contained in the most recent annual report made pursuant to section 1841(b)(2)), and

"(iv) 1 plus the Secretary's estimate of the percentage increase or decrease (divided by 100) in expenditures for all physicians' services or of the category of physicians' services, respectively, in the fiscal year (compared with the previous fiscal year) which are estimated to result from changes in law or regulations affecting the percentage increase described in clause (i) and which is not taken into account in the percentage increase described in clause (i), minus 1, multiplied by 100, and reduced by the performance standard factor (specified in subparagraph (C))."

(b) Treatment of Default Update.

(1) In general. Section 1848(d)(3)(B) (42 U.S.C. 1395 (d)(3)(B)) is amended

(A) in clause (i)

(i) in the heading, by striking "In general" and inserting "1992 through 1996", and

(ii) by striking "for a year" and inserting "for 1992, 1993, 1994, 1995, and 1996"; and

(B) by adding after clause (ii) the following new clause:

"(iii) Years beginning with 1997.

"(I) In general. The update for a category of physicians' services for a year beginning with 1997 provided under subparagraph (A) shall be increased or decreased by the same percentage by which the cumulative percentage increase in actual expenditures for such category of physicians' services for such year was less or greater, respectively, than the performance standard rate of increase (established under subsection (f)) for such category of services for such year.

"(II) Cumulative percentage increase defined. In subclause (I), the `cumulative percentage increase in actual expenditures' for a year shall be equal to the product of the adjusted increases for each year beginning with 1995 up to and including the year involved, minus 1 and multiplied by 100. In the previous sentence, the `adjusted increase' for a year is equal to 1 plus the percentage increase in actual expenditures for the year.".

(2) Conforming amendment. Section 1848(d)(3)(A)(i) (42 U.S.C. 1395(d)(3)(A)(i)) is amended by striking "subparagraph (B)" and inserting "subparagraphs (B) and (C)".

Section 4112 USE OF REAL GDP TO ADJUST FOR VOLUME AND INTENSITY; REPEAL OF RESTRICTION ON MAXIMUM REDUCTION PERMITTED IN DEFAULT UPDATE.

(a) Use of Real GDP to Adjust for Volume and Intensity. Section 1848(f)(2)(B)(iii) (42 U.S.C. 1395 4(f)(2)(B)(iii)), as added by section 4111(a), is amended to read as follows:

"(iii) 1 plus the average per capita growth in the real gross domestic product (divided by 100) for the 5-fiscal-year period ending with the previous fiscal year (increased by 1.5 percentage points for the category of services consisting of primary care services), and".

(b) Repeal of Restriction on Maximum Reduction.Section 1848(d)(3)(B)(ii) (42 U.S.C. 1395 4(d)(3)(B)(ii)), as amended by section 13512(b) of OBRA091993, is amended

(1) in the heading, by inserting "in certain years" after "adjustment";

(2) in the matter preceding subclause (I), by striking "for a year";

(3) in subclause (I), by adding "and" at the end;

(4) in subclause (II), by striking ", and" and inserting a period; and

(5) by striking subclause (III).

(c) Repeal of Performance Standard Factor.

(1) In general. Section 1842(f)(2), as amended by section 4111(a)(3), is amended by striking subparagraph (C) and redesignating subparagraph (D) as subparagraph (C).

(2) Conforming amendment.Section 1842(f)(2)(B), as added by section 4111(a), is amended in the matter following clause (iv) by striking "1, multiplied by 100" and all that follows through "subparagraph (C))" and inserting "1 and multiplied by 100".

Section 4113 REDUCTION IN CONVERSION FACTOR FOR PHYSICIAN FEE SCHEDULE FOR 1995.

Section 1848(d)(1) (42 U.S.C. 1395 4(d)(1)) is amended

(1) in subparagraph (A), by inserting after "subparagraph (B)" the following: ", and, in the case of 1995, specified in subparagraph (C)";

(2) by redesignating subparagraph (C) as subparagraph (D); and

(3) by inserting after subparagraph (B) the following new subparagraph:

"(C) Special provision for 1995. For purposes of subparagraph (A), the conversion factor specified in this subparagraph for 1995 is

"(i) in the case of physicians' services included in the category of primary care services (as defined in subsection (j)(1)), the conversion factor established under this subsection for 1994 adjusted by the update established under paragraph (3) for 1995; and

"(ii) in the case of any other physicians' services, the conversion factor established under this subsection for 1994 reduced by 3 percent and adjusted by the update established under paragraph (3) for 1995.".

Section 4114 LIMITATIONS ON PAYMENT FOR PHYSICIANS' SERVICES FURNISHED BY HIGH-COST HOSPITAL MEDICAL STAFFS.

(a) In General.

(1) Limitations described. Part B of title XVIII, as amended by section 2003(a), is amended by inserting after section 1848 the following new section:

"limitations on payment for physicians' services furnished by high-cost hospital medical staffs

"Sec. 1849. (a) Services Subject to Reduction.

"(1) Determination of hospital-specific per admission relative value. Not later than October 1 of each year (beginning with 1997), the Secretary shall determine for each hospital

"(A) the hospital-specific per admission relative value under subsection (b)(2) for the following year; and

"(B) whether such hospital-specific relative value is projected to exceed the allowable average per admission relative value applicable to the hospital for the following year under subsection (b)(1).

"(2) Reduction for services at hospitals exceeding allowable average per admission relative value. If the Secretary determines (under paragraph (1)) that a medical staff's hospital-specific per admission relative value for a year (beginning with 1998) is projected to exceed the allowable average per admission relative value applicable to the medical staff for the year, the Secretary shall reduce (in accordance with subsection (c)) the amount of payment otherwise determined under this part for each physician's service furnished during the year to an inpatient of the hospital by an individual who is a member of the hospital's medical staff.

"(3) Timing of determination; notice to hospitals and carriers. Not later than October 1 of each year (beginning with 1997), the Secretary shall notify the medical executive committee of each hospital (as set forth in the Standards of the Joint Commission on the Accreditation of Health Organizations) of the

determinations made with respect to the medical staff under paragraph (1).

"(b) Determination of Allowable Average Per Admission Relative Value and Hospital-Specific Per Admission Relative Values.

"(1) Allowable average per admission relative value.

"(A) Urban hospitals. In the case of a hospital located in an urban area, the allowable average per admission relative value established under this subsection for a year is equal to 125 percent (or 120 percent for years after 1999) of the median of 1996 hospital-specific per admission relative values determined under paragraph (2) for all hospital medical staffs.

"(B) Rural hospitals. In the case of a hospital located in a rural area, the allowable average per admission relative value established under this subsection for 1998 and each succeeding year, is equal to 140 percent of the median of the 1996 hospital-specific per admission relative values determined under paragraph (2) for all hospital medical staffs.

"(2) Hospital-specific per admission relative value.

"(A) In general. The hospital-specific per admission relative value projected for a hospital (other than a teaching hospital) for a calendar year, shall be equal to the average per admission relative value (as determined under section 1848(c)(2)) for physicians' services furnished to inpatients of the hospital by the hospital's medical staff (excluding interns and residents) during the second year preceding such calendar year, adjusted for variations in case-mix and disproportionate share status among hospitals (as determined by the Secretary under subparagraph (C)).

"(B) Special rule for teaching hospitals. The hospital-specific relative value projected for a teaching hospital in a calendar year shall be equal to the sum of

"(i) the average per admission relative value (as determined under section 1848(c)(2)) for physicians' services furnished to inpatients of the hospital by the hospital's medical staff (excluding interns and residents) during the second year preceding such calendar year; and

"(ii) the equivalent per admission relative value (as

determined under section 1848(c)(2)) for physicians' services furnished to inpatients of the hospital by interns and residents of the hospital during the second year preceding such calendar year, adjusted for variations in case-mix, disproportionate share status, and teaching status among hospitals (as determined by the Secretary under subparagraph (C)). The Secretary shall determine such equivalent relative value unit per admission for interns and residents based on the best available data for teaching hospitals and may make such adjustment in the aggregate.

"(C) Adjustment for teaching and disproportionate share hospitals. The Secretary shall adjust the allowable per admission relative values otherwise determined under this paragraph to take into account the needs of teaching hospitals and hospitals receiving additional payments under subparagraphs (F) and (G) of section 1886(d)(5). The adjustment for teaching status or disproportionate share shall not be less than zero.

"(c) Amount of Reduction. The amount of payment otherwise made under this part for a physician's service that is subject to a reduction under subsection (a) during a year shall be reduced 15 percent, in the case of a service furnished by a member of the medical staff of the hospital for which the Secretary determines under subsection (a)(1) that the hospital medical staff's projected relative value per admission exceeds the allowable average per admission relative value.

"(d) Reconciliation of Reductions Based on Hospital-Specific Relative Value Per Admission With Actual Relative Values.

"(1) Determination of actual average per admission relative value. Not later than October 1 of each year (beginning with 1999), the Secretary shall determine the actual average per admission relative value (as determined pursuant to section 1848(c)(2)) for the physicians' services furnished by members of a hospital's medical staff to inpatients of the hospital during the previous year, on the basis of claims for payment for such services that are submitted to the Secretary not later than 90 days after the last day of such previous year. The actual average per admission shall be adjusted by the appropriate case-mix, disproportionate share factor, and teaching factor for the hospital medical staff (as determined by the Secretary under subsection (b)(2)(C)). Notwithstanding any other provision of this title, no payment may be made under this part for any physician's service furnished by a member of a hospital's medical staff to an inpatient of the hospital during a year unless the hospital submits a claim to the Secretary for payment for such

service not later than 90 days after the last day of the year.

"(2) Reconciliation with reductions taken. In the case of a hospital for which the payment amounts for physicians' services furnished by members of the hospital's medical staff to inpatients of the hospital were reduced under this section for a year

"(A) if the actual average per admission relative value for such hospital's medical staff during the year (as determined by the Secretary under paragraph (1)) did not exceed the allowable average per admission relative value applicable to the hospital's medical staff under subsection (b)(1) for the year, the Secretary shall reimburse the fiduciary agent for the medical staff by the amount by which payments for such services were reduced for the year under subsection (c), including interest at an appropriate rate determined by the Secretary;

"(B) if the actual average per admission relative value for such hospital's medical staff during the year is less than 15 percentage points above the allowable average per admission relative value applicable to the hospital's medical staff under subsection (b)(1) for the year, the Secretary shall reimburse the fiduciary agent for the medical staff, as a percent of the total allowed charges for physicians' services performed in such hospital (prior to the withhold), the difference between 15 percentage points and the actual number of percentage points that the staff exceeds the limit allowable average per admission relative value, including interest at an appropriate rate determined by the Secretary; and

"(C) if the actual average per admission relative value for such hospital's medical staff during the year exceeded the allowable average per admission relative value applicable to the hospital's medical staff by 15 percentage points or more, none of the withhold is paid to the fiduciary agent for the medical staff.

"(3) Medical executive committee of a hospital.Each medical executive committee of a hospital whose medical staff is projected to exceed the allowable relative value per admission for a year, shall have one year from the date of notification that such medical staff is projected to exceed the allowable relative value per admission to designate a fiduciary agent for the medical staff to receive and disburse any appropriate withhold amount made by the carrier.

"(4) Alternative reimbursement to members of staff. At the request of a fiduciary agent for the medical staff, if the fiduciary agent for the medical staff is owed the reimbursement described in paragraph (2)(B) for excess reductions in payments during a year, the Secretary shall make such reimbursement to the members of the hospital's medical staff, on a pro-rata basis according to the proportion of physicians' services furnished to inpatients of the hospital during the year that were furnished by each member of the medical staff.

"(e) Definitions. In this section, the following definitions apply:

"(1) Medical staff. An individual furnishing a physician's service is considered to be on the medical staff of a hospital

"(A) if (in accordance with requirements for hospitals established by the Joint Commission on Accreditation of Health Organizations)

"(i) the individual is subject to bylaws, rules, and regulations established by the hospital to provide a framework for the self-governance of medical staff activities;

"(ii) subject to such bylaws, rules, and regulations, the individual has clinical privileges granted by the hospital's governing body; and

"(iii) under such clinical privileges, the individual may provide physicians' services independently within the scope of the individual's clinical privileges, or

"(B) if such physician provides at least one service to a medicare beneficiary in such hospital.

"(2) Rural area; urban area. The terms `rural area' and `urban area' have the meaning given such terms under section 1886(d)(2)(D).

"(3) Teaching hospital. The term `teaching hospital' means a hospital which has a teaching program approved as specified in section 1861(b)(6).".

(2) Conforming amendments. (A) Section 1833(a)(1)(N) (42 U.S.C. 1395l(a)(1)(N)) is amended by inserting "(subject to reduction under section 1849)" after "1848(a)(1)".

(B) Section 1848(a)(1)(B) (42 U.S.C. 1395w0@4(a)(1)(B)) is amended by striking "this subsection," and inserting "this subsection and section 1849,".

(b) Requiring Physicians to Identify Hospital at Which Service Furnished. Section 1848(g)(4)(A)(i) (42 U.S.C. 1395w0@4(g)(4)(A)(i)) is amended by striking "beneficiary," and inserting "beneficiary (and, in the case of a service furnished to an inpatient of a hospital, report the hospital identification number on such claim form),".

(c) Effective Date. The amendments made by this section shall apply to services furnished on or after January 1, 1998.

Section 4115 MEDICARE INCENTIVES FOR PHYSICIANS TO PROVIDE PRIMARY CARE.

(a) Resource-Based Practice Expense Relative Value Units.

(1) Increase in practice expense relative value units for certain services. Section 1848(c)(2) (42 U.S.C. 1395w0@4(c)(2)), as amended by sections 13513 and 13514 of OBRA0993, is amended by adding at the end the following new subparagraph:

"(G) Increase in practice expense relative value units for certain services. The Secretary shall increase the practice expense relative value units applied in primary care services, as defined in section 1842(i)(4), by 10 percent, beginning with 1996.".

(2) Assuring budget neutrality. Section 1842(c)(2)(F) (42 U.S.C. 1395u(c)(2)(F)), as added by section 13513 and amended by section 13514 of OBRA0993, is amended by adding at the end the following new clause:

"(iii) shall reduce the relative values for all services (other than anesthesia services and primary care services, as defined in section 1842(i)(4)) established under this paragraph (and, in the case of anesthesia services, the conversion factor established by the Secretary for such services) by such percentage as the Secretary determines to be necessary so that, beginning in 1996, the amendment made by section 4115(a)(1) of the Health Security Act would not result in expenditures under this section that exceed the amount of such expenditures that would have been made if such amendment had not been made.".

(3) Study. The Secretary of Health and Human Services

shall

(A) develop a methodology for implementing in 1997 a resource-based system for determining practice expense relative values unit for each physician's service, and

(B) transmit a report by June 30, 1996, on the methodology developed under paragraph (1) to the Committees on Ways and Means and Energy and Commerce of the House of Representatives and the Committee on Fiance of the Senate. The reported shall include a presentation of the data utilized in developing the methodology and an explanation of the methodology.

(b) Office Visit Pre- and Post-Time.

(1) Increase in work relative value units for office visits. Section 1848(c)(2) (42 U.S.C. 1395w0@4(c)(2)), as amended by subsection (a)(1), is amended by adding at the end the following new subparagraph:

"(H) Increase in work relative value units for certain services. The Secretary shall increase the work relative value units applied to office visits by 10 percent, beginning with 1996.".

(2) Assuring budget neutrality. Section 1842(c)(2)(F)(iii) (42 U.S.C. 1395u(c)(2)(F)(iii)), as added by subsection (a)(2), is amended by striking "section 4115(a)(1)" and substituting "sections 4115(a)(1) and (b)(1)".

(c) Office Consultations. Section 1848(c)(2) (42 U.S.C. 1395w0@4(c)(2)), as amended by subsections (a)(1) and (b)(1), is amended by adding at the end the following new subparagraph:

"(I) Amendment in relative values for office consultations. The Secretary shall reduce the work, practice expense and malpractice relative value components of office consultations to be equal to the work, practice expense and malpractice relative value components for comparable office visits beginning with 1996. In making such adjustment, the Secretary shall apply the savings from such reduction to increase each of the relative value components for office visits in a manner that would not result in expenditures under this section that exceed the amount of such expenditures that would have been made if such amendment had not been made.".

(d) Outlier Intensity Relative Value Adjustments.

(1) Adjustment of outlier intensity of relative values. Section 1848(c)(2) (42 U.S.C. 1395w0@4(c)(2)), as amended by subsections (a)(1), (b)(1), and (c), is amended by adding at the end the following new subparagraph:

"(J) Adjustment of outlier intensity of relative values. Beginning with 1996, the Secretary shall reduce the work relative value components of procedures, or classes of procedures, where the intensity exceeds thresholds established by the Secretary. In the previous sentence, intensity shall mean the work relative value units for the procedure divided by the time for the procedure. The Secretary shall apply the savings from such reductions to increase the work relative value components of primary care services, as defined in section 1842(i)(4), such that the changes made by this subsection would not result in expenditures under this section that exceed the amount of such expenditures that would have been made if such amendment had not been made.".

(e) Changes In Underserved Area Bonus Payments.

(1) In general. Section 1833(m) (42 U.S.C. 1395l(m)) is amended

(A) by striking "10 percent" and inserting "a percent",

(B) by striking "service" the last place it appears and inserting "services", and

(C) by adding the following new sentence: "The percent referred to in the previous sentence is 20 percent in the case of primary care services, as defined in section 1842(i)(4), and 10 percent for services other than primary care services furnished in health professional shortage areas located in rural areas as defined in section 1886(d)(2)(D).".

(2) The amendments made by paragraph (1) are effective for services furnished on or after January 1, 1996.

Section 4116 ELIMINATION OF FORMULA-DRIVEN OVERPAYMENTS FOR CERTAIN OUTPATIENT HOSPITAL SERVICES.

(a) Ambulatory Surgical Center Procedures. Section 1833(i)(3)(B)(i)(II) (42 U.S.C. 1395l(i)(3)(B)(i)(II)) is amended

(1) by striking "of 80 percent"; and

(2) by striking the period at the end and inserting the following: ", less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A).".

(b) Radiology Services and Diagnostic Procedures. Section 1833(n)(1)(B)(i)(II) (42 U.S.C. 1395l(n)(1)(B)(i)(II)) is amended

(1) by striking "of 80 percent"; and

(2) by striking the period at the end and inserting the following: ", less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A).".

(c) Effective Date. The amendments made by this section shall apply to services furnished during portions of cost reporting periods occurring on or after July 1, 1994.

Section 4117 IMPOSITION OF COINSURANCE ON LABORATORY SERVICES.

(a) In General. Paragraphs (1)(D) and (2)(D) of section 1833(a) (42 U.S.C. 1395l(a)) are each amended

(1) by striking "(or 100 percent" and all that follows through "the first opinion))"; and

(2) by striking "100 percent of such negotiated rate" and inserting "80 percent of such negotiated rate".

(b) Effective Date. The amendments made by subsection (a) shall apply to tests furnished on or after January 1, 1995.

SEC. 4118. APPLICATION OF COMPETITIVE ACQUISITION PROCESS FOR PART B ITEMS AND SERVICES.

(a) General Rule. Part B of title XVIII of the Social Security Act is amended by inserting after section 1846 the following: "competition acquisition for items and services

"Sec. 1847. (a) Establishment of Bidding Areas.

"(1) In general. The Secretary shall establish competitive acquisition areas for the purpose of awarding a contract or contracts for the furnishing under this part of the items and services described in subsection (c) on or after January 1, 1995.

The Secretary may establish different competitive acquisition areas under this subsection for different classes of items and services under this part.

"(2) Criteria for establishment. The competitive acquisition areas
established under paragraph (1) shall

"(A) initially be, or be within, metropolitan statistical areas; and

"(B) be chosen based on the availability and accessibility of suppliers and the probable savings to be realized by the use of competitive bidding in the furnishing of items and services in the area.

"(b) Awarding of Contracts in Areas.

"(1) In general. The Secretary shall conduct a competition among individuals and entities supplying items and services under this part for each competitive acquisition area established under subsection (a) for each class of items and services.

"(2) Conditions for awarding contract. The Secretary may not award a contract to any individual or entity under the competition conducted pursuant to paragraph (1) to furnish an item or service under this part unless the Secretary finds that the individual or entity

"(A) meets quality standards specified by the Secretary for the furnishing of such item or service; and

"(B) offers to furnish a total quantity of such item or service that is sufficient to meet the expected need within the competitive acquisition area.

"(3) Contents of contract. A contract entered into with an individual or entity under the competition conducted pursuant to paragraph (1) shall specify (for all of the items and services within a class)

"(A) the quantity of items and services the entity shall provide; and

"(B) such other terms and conditions as the Secretary may require.

"(c) Services Described. The items and services to which the provisions of this section shall apply are as follows:

"(1) Magnetic resonance imaging tests and computerized axial tomography scans, including a physician's interpretation of the results of such tests and scans.

"(2) Oxygen and oxygen equipment.

"(3) Such other items and services for which the Secretary determines that the use of competitive acquisition under this section will be appropriate and cost-effective.".

(b) Items and Services To Be Furnished Only Through Competitive Acquisition. Section 1862(a) (42 U.S.C. 1395y(a)), as amended by section 4034(b)(4), is amended

(1) by striking "or" at the end of paragraph (14);

(2) by striking the period at the end of paragraph (15) and inserting "; or"; and

(3) by inserting after paragraph (15) the following new paragraph:

"(16) where such expenses are for an item or service furnished in a competitive acquisition area (as established by the Secretary under section 1847(a)) by an individual or entity other than the supplier with whom the Secretary has entered into a contract under section 1847(b) for the furnishing of such item or service in that area, unless the Secretary finds that such expenses were incurred in a case of urgent need.".

(c) Reduction in Payment Amounts if Competitive Acquisition Fails to Achieve Minimum Reduction in Payments. Notwithstanding any other provision of title XVIII of the Social Security Act, if the establishment of competitive acquisition areas under section 1847 of such Act (as added by subsection (a)) and the limitation of coverage for items and services under part B of such title to items and services furnished by providers with competitive acquisition contracts under such section does not result in a reduction of at least 10 percent in the projected payment amount that would have applied to the item or service under part B if the item or service had not been furnished through competitive acquisition under such section, the Secretary shall reduce the payment amount by such percentage as the Secretary determines necessary to result in such a reduction.

(d) Effective Date. The amendments made by this section shall apply to items and services furnished under part B of title XVIII of the Social Security Act on or after January 1, 1995.

Section 4119 APPLICATION OF COMPETITIVE ACQUISITION PROCEDURES FOR LABORATORY SERVICES.

(a) In General. Section 1847(c), as added by section 4118, is amended

(1) by redesignating paragraph (4) as paragraph (5); and

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

"(4) Clinical diagnostic laboratory tests.".

(b) Reduction in Fee Schedule Amounts if Competitive Acquisition Fails to Achieve Savings. Section 1833(h) (42 U.S.C. 1395l(h)) is amended by adding at the end the following new paragraph:

"(7) Notwithstanding any other provision of this subsection, if the Secretary applies the authority provided under section 1847 to establish competitive acquisition areas for the furnishing of clinical diagnostic laboratory tests in a year and the application of such authority does not result in a reduction of at least 10 percent in the projected payment amount that would have applied to such tests under this section if the tests had not been furnished through competitive acquisition under section 1847, the Secretary shall reduce each payment amount otherwise determined under the fee schedules and negotiated rates established under this subsection by such percentage as the Secretary determines necessary to result in such a reduction.".

Part 3 SAVINGS RELATING TO PARTS A AND B

Section 4131 MEDICARE SECONDARY PAYER CHANGES.

(a) Extension of Data Match.

(1) Section 1862(b)(5)(C) (42 U.S.C. 1395y(b)(5)(C)) is amended by striking clause (iii).

(2) Section 6103(l)(12) of the Internal Revenue Code of 1986 is amended by striking subparagraph (F).

(b) Repeal of Sunset on Application to Disabled Employees of Employers with More than 100 Employees. Section 1862(b)(1)(B)(iii) (42 U.S.C. 1395y(b)(1)(B)(iii)), as amended by section 13561(b) of OBRA091993, is amended

(1) in the heading, by striking "Sunset" and inserting "Effective date"; and

(2) by striking ", and before October 1, 1998".

(c) Extension of Period for End Stage Renal Disease Beneficiaries. Section 1862(b)(1)(C) (42 U.S.C. 1395y(b)(1)(C)), as amended by section 13561(c) of OBRA091993, is amended in the second sentence by striking "and on or before October 1, 1998,".

Section 4132 PAYMENT LIMITS FOR HMOS AND CMPS WITH RISK-SHARING CONTRACTS.

(a) In General. Section 1876(a)(1)(C) (42 U.S.C. 1395mm(a)(1)(C)) is amended

(1) by inserting ", subject to adjustment to take into account the provisions of the succeeding clauses" before the period,

(2) by striking "(C)" and inserting "(C)(i)", and

(3) by adding at the end the following new clauses:

"(ii) The portion of the annual per capita rate of payment for each such class attributable to payments made from the Federal Supplementary Medical Insurance Trust Fund may not exceed 95 percent of the following amount (unless the portion of the annual per capita rate of payment for each such class attributable to payments made from the Federal Hospital Insurance Trust Fund is less than 95 percent of the weighted national average of all adjusted average per capita costs determined under paragraph (4) for that class that are attributable to payments made from the Federal Hospital Insurance Trust Fund):

"(I) For 1995, 150 percent of the weighted national average of all adjusted average per capita costs determined under paragraph (4) for that class that are attributable to payments made from such Trust Fund, plus 80 percent of the amount by which (if any) the adjusted average per capita cost for that class

exceeds 150 percent of that weighted national average.

"(II) For 1996, 150 percent of the weighted national average of all adjusted average per capita costs determined under paragraph (4) for that class that are attributable to payments made from such Trust Fund, plus 60 percent of the amount by which (if any) the adjusted average per capita cost for that class exceeds 150 percent of that weighted national average.

"(III) For 1997, 150 percent of the weighted national average of all adjusted average per capita costs determined under paragraph (4) for that class that are attributable to payments made from such Trust Fund, plus 40 percent of the amount by which (if any) the adjusted average per capita cost for that class exceeds 150 percent of that weighted national average.

"(IV) For 1998, 150 percent of the weighted national average of all adjusted average per capita costs determined under paragraph (4) for that class that are attributable to payments made from such Trust Fund, plus 20 percent of the amount by which (if any) the adjusted average per capita cost for that class exceeds 150 percent of that weighted national average.

"(V) For 1999 and each succeeding year (subject to the establishment by the Secretary of alternative limits under clause (vi)), 150 percent of the weighted national average of all adjusted average per capita costs determined under paragraph (4) for that class that are attributable to payments made from such Trust Fund.

"(iii) The portion of the annual per capita rate of payment for each such class attributable to payments made from the Federal Hospital Insurance Trust Fund may not exceed 95 percent of the following amount (unless the portion of the annual per capita rate of payment for each such class attributable to payments made from the Federal Supplementary Medical Insurance Trust Fund is less than 95 percent of the weighted national average of all adjusted average per capita costs determined under paragraph (4) for that class that are attributable to payments made from the Federal Supplementary Medical Insurance Trust Fund):

"(I) For 1995, 170 percent of the weighted national average of all adjusted average per capita costs determined under paragraph (4) for that class that are attributable to payments made from such Trust Fund, plus 80 percent of the amount by which (if any) the adjusted average per capita cost for that class

exceeds 170 percent of that weighted national average.

"(II) For 1996, 170 percent of the weighted national average of all adjusted average per capita costs determined under paragraph (4) for that class that are attributable to payments made from such Trust Fund, plus 60 percent of the amount by which (if any) the adjusted average per capita cost for that class exceeds 170 percent of that weighted national average.

"(III) For 1997, 170 percent of the weighted national average of all adjusted average per capita costs determined under paragraph (4) for that class that are attributable to payments made from such Trust Fund, plus 40 percent of the amount by which (if any) the adjusted average per capita cost for that class exceeds 170 percent of that weighted national average.

"(IV) For 1998, 170 percent of the weighted national average of all adjusted average per capita costs determined under paragraph (4) for that class that are attributable to payments made from such Trust Fund, plus 20 percent of the amount by which (if any) the adjusted average per capita cost for that class exceeds 170 percent of that weighted national average.

"(V) For 1999 and each succeeding year (subject to the establishment by the Secretary of alternative limits under clause (vi)), 170 percent of the weighted national average of all adjusted average per capita costs determined under paragraph (4) for that class that are attributable to payments made from such Trust Fund.

"(iv) For 1995 and succeeding years, the portion of the annual per capita rate of payment for each such class attributable to payments made from the Federal Supplementary Medical Insurance Trust Fund may not be less than 80 percent of 95 percent of the weighted national average of all adjusted average per capita costs determined under paragraph (4) for that class that are attributable to payments made from such Trust Fund, unless the portion of the annual per capita rate of payment for each such class attributable to payments made from the Federal Hospital Insurance Trust Fund is greater than 95 percent of the weighted national average of all adjusted average per capita costs determined under paragraph (4) for that class that are attributable to payments made from the Federal Hospital Insurance Trust Fund.

"(v) For 1995 and succeeding years, the portion of the annual per capita rate of payment for each such class attributable to

payments made from the Federal Hospital Insurance Trust Fund may not be less than 80 percent of 95 percent of the weighted national average of all adjusted average per capita costs determined under paragraph (4) for that class that are attributable to payments made from such Trust Fund, unless the portion of the annual per capita rate of payment for each such class attributable to payments made from the Federal Supplementary Medical Insurance Trust Fund is greater than 95 percent of the weighted national average of all adjusted average per capita costs determined under paragraph (4) for that class that are attributable to payments made from the Federal Supplementary Medical Insurance Trust Fund.

"(vi) For 2000 and succeeding years, the Secretary may revise any of the percentages otherwise applicable during a year under the preceding clauses (other than clause (i)), but only if the aggregate payments made under this title to eligible organizations under risk-sharing contracts during the year is not greater than the aggregate payments that would have been made under this title to such organizations during the year if the Secretary had not revised the percentages.

"(vii) For purposes of clauses (ii) through (v), in determining the weighed average of all adjusted average per capita costs determined under paragraph (4) for a class, the Secretary shall not take into account any costs associated with individuals entitled to benefits under this title under section 226A.".

(b) Conforming Amendment. Section 1876(a)(5)(A) (42 U.S.C. 1395mm(a)(5)(A)) is amended by inserting ", adjusted to take into account the limitations imposed by clauses (ii) through (vi) of paragraph (1)(C)" before the period.

Section 4133 REDUCTION IN ROUTINE COST LIMITS FOR HOME HEALTH SERVICES.

(a) Reduction in Update to Maintain Freeze in 1996. Section 1861(v)(1)(L)(i) (42 U.S.C. 1395x(v)(1)(L)(i)) is amended

(1) in subclause (II), by striking "or" at the end;

(2) in subclause (III), by striking "112 percent," and inserting "and before July 1, 1996, 112 percent, or"; and

(3) by inserting after subclause (III) the following new subclause:

"(IV) July 1, 1996, 100 percent (adjusted by such amount as the Secretary determines to be necessary to preserve the savings resulting from the enactment of section 13564(a)(1) of the Omnibus Budget Reconciliation Act of 1993),".

(b) Basing Limits in Subsequent Years on Median of Costs.

(1) In general. Section 1861(v)(1)(L)(i) (U.S.C. 1395x(v)(1)(L)(i)), as amended by subsection (a), is amended in the matter following subclause (IV) by striking "the mean" and inserting "the median".

(2) Effective date. The amendment made by paragraph (1) shall apply to cost reporting periods beginning on or after July 1, 1997.

Section 4134 IMPOSITION OF COPAYMENT FOR CERTAIN HOME HEALTH VISITS.

(a) In General.

(1) Part a. Section 1813(a) (42 U.S.C. 1395e(a)) is amended by adding at the end the following new paragraph:

"(5) The amount payable for home health services furnished to an individual under this part shall be reduced by a copayment amount equal to 10 percent of the average of all per visit costs for home health services furnished under this title determined under section 1861(v)(1)(L) (as determined by the Secretary on a prospective basis for services furnished during a calendar year), unless such services were furnished to the individual during the 30-day period that begins on the date the individual is discharged as an inpatient from a hospital.".

(2) Part b. Section 1833(a)(2) (42 U.S.C. 1395l(a)(2)) is amended

(A) in subparagraph (A), by striking "to home health services," and by striking the comma after "opinion)";

(B) in subparagraph (D), by striking "and" at the end;

(C) in subparagraph (E), by striking the semicolon at the end and inserting "; and"; and

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

"(F) with respect to home health services

"(i) the lesser of

"(I) the reasonable cost of such services, as determined under section 1861(v), or

"(II) the customary charges with respect to such services, less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A),

"(ii) if such services are furnished by a public provider of services, or by another provider which demonstrates to the satisfaction of the Secretary that a significant portion of its patients are low-income (and requests that payment be made under this clause), free of charge or at nominal charges to the public, the amount determined in accordance with section 1814(b)(2), or

"(iii) if (and for so long as) the conditions described in section 1814(b)(3) are met, the amounts determined under the reimbursement system described in such section, less a copayment amount equal to 10 percent of the average of all per visit costs for home health services furnished under this title determined under section 1861(v)(1)(L) (as determined by the Secretary on a prospective basis for services furnished during a calendar year), unless such services were furnished to the individual during the 30-day period that begins on the date the individual is discharged as an inpatient from a hospital;".

(3) Provider charges. Section 1866(a)(2)(A)(i) (42 U.S.C. 1395cc(a)(2)(A)(i)) is amended

(A) by striking "deduction or coinsurance" and inserting "deduction, coinsurance, or copayment"; and

(B) by striking "or (a)(4)" and inserting "(a)(4), or (a)(5)".

(b) Effective Date. The amendments made by subsection (a) shall apply to home health services furnished on or after July 1, 1995.

Section 4135 EXPANSION OF CENTERS OF EXCELLENCE.

(a) In General.The Secretary of Health and Human Services shall use a competitive process to contract with centers of excellence for cataract surgery, coronary artery by-pass surgery, and such other services as the Secretary determines to be appropriate. Payment under title XVIII of the Social Security Act will be made for services subject to such contracts on the basis of negotiated or all-inclusive rates as follows:

(1) The center shall cover services provided in an urban area (as defined in section 1886(d)(2)(D) of the Social Security Act) for years beginning with fiscal year 1995.

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

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

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

(B) Coronary artery bypass surgery and related services.

(C) Such other services as the Secretary and the center may agree to cover under the agreement.

(b) Rebate of Portion of Savings. In the case of any services provided under a demonstration project conducted under subsection (a), the Secretary shall make a payment to each individual to whom such services are furnished (at such time and in such manner as the Secretary may provide) in an amount equal to 10 percent of the amount by which

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

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

Part 4 PART B PREMIUM

Section 4141 GENERAL PART B PREMIUM.

Section 1839(e) (42 U.S.C. 1395r(e)), as amended by section 13571 of OBRA091993, is amended

(1) in paragraph (1)(A), by striking "and prior to January 1999"; and

(2) in paragraph (2), by striking "prior to January 1998".

Part 5 REPORT ON MEDICARE SAVINGS FOR FISCAL YEARS 2000 THROUGH 2003

Section 4151 REPORT ON SAVINGS.

(a) In General. The Secretary shall submit to Congress, by January 30, 1999, a report that contains

(1) a determination of whether the average, annual rate of growth in spending under the medicare program (taking into account savings under this subtitle) in the 4-fiscal-year period beginning with fiscal year 2000 will exceed the rate of growth described in subsection (b); and

(2) if so, recommendations as to how to achieve the rate of growth specified in subsection (b).

(b) Rate of Growth Described. The rate of growth described in this subsection is the sum of the following:

(1) CPI. The average annual percentage change in the CPI.

(2) Medicare population. The average, annual percentage change in the number of medicare-eligible individuals.

(3) Real gdp per capita. The average, annual percentage change in the real, per capita gross domestic product of the United States, and

(4) 1 percent. 1 percentage point.

Title IV, Subtitle C Subtitle C Medicaid

Part 1 COMPREHENSIVE BENEFIT PACKAGE

Section 4201 LIMITING COVERAGE UNDER MEDICAID OF ITEMS AND SERVICES COVERED UNDER COMPREHENSIVE BENEFIT PACKAGE.

(a) Removal of Comprehensive Benefits Package from State Plan. Title XIX is amended by redesignating section 1931 as section 1932 and by inserting after section 1930 the following new section:

"treatment of comprehensive benefit package under health security act

"Sec. 1931. (a) Items and Services Covered Under Comprehensive Benefit Package. If a State plan for medical assistance under this title provides for payment in accordance with section 1902(a)(63) for a year, notwithstanding any other provision of this title, the State plan under this title is not required to provide medical assistance consisting of payment for items and services in the comprehensive benefit package under subtitle B of title I of the Health Security Act for alliance eligible individuals (as defined in section 1902(5) of such Act).

"(b) Construction. (1) Payment under section 1902(a)(63) shall not constitute medical assistance for purposes of section 1903(a).

"(2) This section shall not be construed as affecting the provision of
medical assistance under this title for items and services included in the
comprehensive benefit package for

"(A) medicare-eligible individuals, or

"(B) certain emergency services to certain aliens under section 1903(v)(2).".

(b) Substitute Requirement of State Payment. Section 1902(a) (42 U.S.C. 1396a(a)), as amended by section 13631(a)(3) of OBRA091993, is amended

(1) by striking "and" at the end of paragraph (61),

(2) by striking the period at the end of paragraph (62) and inserting "; and", and

(3) by inserting after paragraph (62) the following new paragraph:

"(63) provide for payment to regional alliances of the amounts required under subtitle A of title IX of the Health Security Act.".

(c) No Federal Financial Participation. Section 1903(i) (42 U.S.C. 1396b(i)), as amended by section 13631(h)(1)(C) of OBRA091993, is amended

(1) by striking "or" at the end of paragraph (14),

(2) by striking the period at the end of paragraph (15) and inserting "; or", and

(3) by inserting after paragraph (15) the following new paragraph:

"(16) with respect to items and services covered under the comprehensive benefit package under subtitle B of title I of the Health Security Act for alliance eligible individuals (as defined in section 1902(5) of such Act).".

(d) Effective Date.The amendments made by this section shall apply with respect to items or services furnished in a State on or after January 1 of the first year (as defined in section 1902(17)) for the State.

Part 2 EXPANDING ELIGIBILITY FOR NURSING FACILITY SERVICES; LONG-TERM CARE INTEGRATION OPTION

Section 4211 SPENDDOWN ELIGIBILITY FOR NURSING FACILITY RESIDENTS.

(a) In General. Section 1902(a)(10)(A)(i) (42 U.S.C. 1396a(a)(10)(A)(i)) is amended

(1) by striking "or" at the end of subclause (VI);

(2) by striking the semicolon at the end of subclause (VII) and inserting ", or"; and

(3) by inserting after subclause (VII) the following new subclause:

"(VIII) who are individuals who would meet the income and

resource requirements of the appropriate State plan described in subclause (I) or the supplemental security income program (as the case may be), if incurred expenses for medical care as recognized under State law were deducted from income;".

(b) Limitation to Benefits for Nursing Facility Services. Section 1902(a)(10) of such Act (42 U.S.C. 1396a(a)(10)), as amended by section 13603(c)(1) of OBRA091993, is amended in the matter following subparagraph (F)

(1) by striking "and (XIII)" and inserting "(XIII)"; and

(2) by inserting before the semicolon at the end the following:

", and (XIV) the medical assistance made available to an individual described in subparagraph (A)(i)(VIII) shall be limited to medical assistance for nursing facility services, except to the extent that assistance is provided in accordance with the election described in section 1932 in the case of a State making such election".

(c) Effective Date. The amendments made by subsections (a) and (b) shall apply with respect to a State as of January 1, 1996.

Section 4212 INCREASED INCOME AND RESOURCE DISREGARDS FOR NURSING FACILITY RESIDENTS.

(a) Increased Disregards for Personal Needs Allowance; Resources. Section 1902(a)(10) (42 U.S.C. 1396a(a)(1)) is amended

(1) by striking "and" at the end of paragraph (F); and

(2) by adding at the end the following new paragraph:

"(G) that, in determining the eligibility of any individual who is an inpatient in a nursing facility or intermediate care facility for the mentally retarded

"(i) the first $50 of income for each month shall be disregarded; and

"(ii) in the case of an unmarried individual, the first $12,000 of resources may, at the option of the State, be disregarded;".

(b) Conforming SSI Personal Needs Allowance. For provision increasing SSI personal needs allowance, see section 4301.

(c) Federal Reimbursement for Reductions in State Funds Attributable to Increased Disregard. Section 1903(a) (42 U.S.C. 1396b(a)) is amended

(1) by striking "plus" at the end of paragraph (6);

(2) by striking the period at the end of paragraph (7) and inserting "; plus"; and

(3) by adding at the end the following new paragraph:

"(8) an amount equal to 100 percent of the difference between the amount of expenditures made by the State for nursing facility services and services in an intermediate care facility for the mentally retarded during the quarter and the amount of expenditures that would have been made by the State for such services during the quarter based on the personal needs allowance in effect in the State as of September 30, 1993.".

(d) Effective Date. The amendments made by subsection (a) shall apply with respect to months beginning with January 1996.

Section 4213 INFORMING NURSING HOME RESIDENTS ABOUT AVAILABILITY OF ASSISTANCE FOR HOME AND COMMUNITY-BASED SERVICES.

(a) In General. Section 1902(a) (42 U.S.C. 1396a(a)), as amended by section 4201(b), is amended

(1) by striking "and" at the end of paragraph (62),

(2) by striking the period at the end of paragraph (63) and inserting "; and", and

(3) by inserting after paragraph (63) the following new paragraph:

"(64) provide, in the case of an individual who is a resident (or who is applying to become a resident) of a nursing facility or intermediate care facility for the mentally retarded, at the time of application for medical assistance and periodically thereafter, the individual (or a designated representative) with information on the range of home and community-based services for which assistance is available in the State either under the plan under this title, under the program under part 1 of subtitle B of

title II of the Health Security Act, or any other public program.".

(b) Effective Date. The amendments made by this section shall apply to quarters beginning on or after January 1, 1996.

Part 3 OTHER BENEFITS

Section 4221 TREATMENT OF ITEMS AND SERVICES NOT COVERED UNDER THE COMPREHENSIVE BENEFIT PACKAGE.

(a) Continuation of Eligibility for Assistance for AFDC and SSI Recipients. With respect to an individual who is described in section 1933(b) of the Social Security Act (as added by subsection (b)(1)), nothing in this Act shall be construed as

(1) changing the eligibility of the individual for medical assistance under title XIX of the Social Security Act for items and services not covered under the comprehensive benefit package, or

(2) subject to the amendments made by this subtitle, changing the amount, duration, or scope of medical assistance required (or permitted) to be provided to the individual under such title.

(b) Limitation on Scope of Assistance for Other Medicaid Beneficiaries.

(1) In general. Title XIX, as amended by sections 4201(a) and 4213, is amended by redesignating section 1933 as section 1934 and by inserting after section 1932 the following new section:

"limitation on scope of assistance for most non-cash beneficiaries

"Sec 1933. (a) Limitation. Notwithstanding any other provision of this title, the medical assistance made available under section 1902(a) to an individual not described in subsection (b) shall be limited to medical assistance for

"(1) long-term care services (as defined in subsection (c)); and

"(2) medicare cost-sharing (as defined in section 1905(p)(3)), in accordance with the requirements of section 1902(a)(10)

(E).

"(b) Individuals Exempt from Limitation. The individuals described in this subsection are the following:

"(1) AFDC recipients (as defined in section 1902(3) of the Health Security Act).

"(2) SSI recipients (as defined in section 1902(33) of the Health Security Act).

"(3) Individuals entitled to benefits under title XVIII.

"(4) Children under 18 years of age (or, at the option of the State, under age 19, 20, or 21).

"(c) Long-Term Care Services Defined. In subsection (a), the term `long-term care services' means the following items and services, but only to the extent they are not included as an item or service under the comprehensive benefit package under the Health Security Act:

"(1) Nursing facility services and intermediate care facility services for the mentally retarded (including items and services that may be included in such services pursuant to regulations in effect as of October 26, 1993).

"(2) Personal care services.

"(3) Home or community-based services provided under a waiver granted under subsection (c), (d), or (e) of section 1915.

"(4) Home and community care provided to functionally disabled elderly individuals under section 1929.

"(5) Community supported living arrangements services provided under section 1930.

"(6) Case-management services (as described in section 1915(g)(2)).

"(7) Home health care services, clinic services, and rehabilitation services that are furnished to an individual who has a condition or disability that qualifies the individual to receive any of the services described in paragraphs (1) through (6).".

(2) Conforming amendment. Section 1902(a)(10) of such Act (42 U.S.C. 1396a(a)(10)), as amended by section 13603(c)(1) of OBRA091993 and section 4211(b), is amended in the matter following subparagraph

(G) (as inserted by section 4212(a))

(A) by striking "and (XIV)" and inserting "(XIV)"; and

(B) by inserting before the semicolon at the end the following:

", and (XV) the medical assistance made available to an individual who is not described in section 1933(b) shall be limited in accordance with section 1933".

(c) Conforming Amendments Relating to Secondary Payer. (1) Section 1902(a)(25)(A) (42 U.S.C. 1396a(a)(25)(A)), as amended by section 13622(a) of OBRA091993, is amended by inserting "health plans (as defined in section 1400 of the Health Security Act)," after "of 1974),".

(2) Section 1903(o) (42 U.S.C. 1396b(o)), as so amended, is amended by inserting "and a health plan (as defined in section 1400 of the Health Security Act)" after "of 1974)".

(d) Effective Date. The amendments made by this section shall apply to items and services furnished in a State on or after January 1 of the first year for which the State is a participating State under the Health Security Act.

Section 4222 ESTABLISHMENT OF PROGRAM FOR POVERTY-LEVEL CHILDREN WITH SPECIAL NEEDS.

(a) Establishment of Program. Title XIX, as amended by sections 4201, 4213, and 4221(b), is amended by redesignating section 1934 as section 1935 and by inserting after section 1933 the following new section:

"services for poverty-level children with special needs

"Sec 1934. (a) Establishment of Program. There is hereby established a program under which the Secretary shall provide for payment on behalf of each qualified child (as defined in subsection (b)) during a year for all medically necessary or appropriate items and services described in section 1905(a)

(including items and services described in section 1905(r) but excluding long-term care services described in section 1933(c)) that are not included in the comprehensive benefit package under subtitle B of title I of the Health Security Act.

"(b) Qualified Child Defined.

"(1) In general. In this section, a `qualified child' is an eligible individual (as defined in section 1001(c) of the Health Security Act) who

"(A) for years prior to 1998, is a resident of a participating State under the Health Security Act;

"(B) is under the age of 19; and

"(C) meets the requirements relating to financial eligibility described in paragraph (2).

"(2) Requirements relating to financial eligibility. An individual meets the requirements of this paragraph if

"(A) the individual is an AFDC recipient or an SSI recipient (as such terms are defined in section 1902 of the Health Security Act);

"(B) the individual is eligible to receive medical assistance under the State plan under section 1902(a)(10)(C); or

"(C) the individual is

"(i) under one year of age and has adjusted family income at or below 133 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981, applicable to a family of the size involved) (or, in the case of a State that established an income level greater than 133 percent for individuals under 1 year of age for purposes of section 1902(l)(2)(A) as of October 1, 1993, an income level which is a percentage of such level not greater than 185 percent),

"(ii) the individual has attained 1 year of age but is under 6 years of age and has adjusted family income at or below 133 percent of such income official poverty line, or

"(iii) the individual was born after September 30, 1983, has

attained 6 years of age, and has adjusted family income at or below 100 percent of such income official poverty line.

"(3) Enrollment procedures.

"(A) In general. Not later than July 1, 1995, the Secretary shall establish procedures for the enrollment of qualified children in the program under this section under which

"(i) essential community providers certified by the Secretary under subpart B of part 2 of subtitle F of title I of the Health Security Act serve as enrollment sites for the program; and

"(ii) any forms used for enrollment purposes are designed to make the enrollment as simple as practicable.

"(B) Individuals under alliance plans automatically enrolled. The Secretary shall establish a process under which an individual who is a qualified child under paragraph (1) and is enrolled in a health plan (as defined in section 1400(a) of the Health Security Act) shall automatically be deemed to have met any enrollment requirements established under paragraph (1).

"(c) Additional Responsibilities of Secretary. Not later than July 1, 1995, the Secretary shall promulgate such regulations as are necessary to establish and operate the program under this section, including regulations with respect to the following:

"(1) The benefits to be provided and the circumstances under which such benefits shall be considered medically necessary.

"(2) Procedures for the periodic redetermination of an individual's eligibility for benefits.

"(3) Qualification criteria for providers participating in the program.

"(4) Payment amounts for services provided under the program, the methodology used to determine such payment amounts, and the procedures for making payments to providers.

"(5) Standards to ensure the quality of services and the coordination of services under the program with services under the comprehensive benefit package, as well as services under parts B and H of the Individuals With Disabilities Education Act, title V, and any other program providing health care, remedial, educational, and social services to qualified children as the

Secretary may identify.

"(6) Hearing and appeals for individuals adversely affected by any determination by the Secretary under the program.

"(7) Such other requirements as the Secretary determines to be necessary for the proper and efficient administration of the program.

"(d) Federal Payment for Program.

"(1) In general. Subject to paragraph (2), the Secretary shall pay 100 percent of the costs of providing benefits under this program in a year, including all administrative expenses.

"(2) Annual limit on expenditures. The total amount of Federal expenditures that may be made under this section in a year may not exceed

"(A) for a year prior to 1998, an amount equal to total expenditures for medical assistance under State plans under this title during fiscal year 1993 for services described in subsection (a) furnished to qualified children that are attributable to States in which the program is in operation during the year (adjusted to take into account the operation of the program under this section on a calendar year basis)

"(i) adjusted to take into account any increases or decreases in the number of qualified children under the most recent decennial census, as adjusted by the most recent current population survey for the year in question, and

"(ii) adjusted by the applicable percentage applied to the State non-cash, non-DSH baseline amount for the year under section 9003(a) of the Health Security Act;

"(B) for 1998, the total expenditures for medical assistance under State plans under this title during 1993 for services described in subsection (a) furnished to qualified children (adjusted to take into account the operation of the program under this section on a calendar year basis)

"(i) adjusted to take into account any increases or decreases in the number of qualified children under the most recent decennial census, as adjusted by the most recent current population survey for the year in question, and

"(ii) adjusted by the update applied to the State non-cash, non-DSH baseline amount for the year under section 9003(b) of the Health Security Act; and

"(C) for each succeeding year, the limit established under this paragraph for the previous year (adjusted to take into account the operation of the program under this section on a calendar year basis), adjusted by the update applied to the State non-cash baseline amount for the year under section 9003(b) of the Health Security Act.".

(b) Repeal of Alternative Eligibility Standards for Children in Participating States. Section 1902(r)(2) (42 U.S.C. 1396a(r)(2)) is amended by adding at the end the following new subparagraph:

"(C) Subparagraph (A) shall not apply with respect to the determination of income and resources for children under age 18 under the State plan of a State (other than under the State plan of a State that utilized an alternative methodology pursuant to such subparagraph as of October 1, 1993)

"(i) in the case of a State that is a participating State under the Health Security Act for a year prior to 1998, for quarters beginning on or after January 1 of the first year for which the State is such a participating State; and

"(ii) in the case of any State not described in clause (i), for quarters beginning on or after January 1, 1998.".

Part 4 DISCONTINUATION OF CERTAIN PAYMENT POLICIES

Section 4231 DISCONTINUATION OF MEDICAID DSH PAYMENTS.

(a) Elimination of Specific Obligation. Section 1923(a) (42 U.S.C. 1396r094(a)) is amended by adding at the end the following new paragraph:

"(5) Notwithstanding any other provision of this title, the requirement of this subsection shall not apply

"(A) with respect to a State for any portion of a fiscal year during which the State is a participating State under the Health Security Act; or

"(B) with respect to any State for any months beginning on or

after January 1, 1998.".

(b) Elimination of State Plan Requirement. Section 1902(a)(13)(A) (42 U.S.C. 1396a(a)(13)(A)) is amended by inserting after "special needs" the following: "(but only with respect to any quarters during which the State is not a participating State under the Health Security Act or with respect to any quarters ending on or before December 31, 1997)".

(c) Elimination of State DSH Allotments and Federal Financial Participation .Section 1923(f) (42 U.S.C. 1396r094(f)) is amended

(1) in paragraph (2), by inserting "and paragraph (5)" after "subparagraph (B)", and

(2) by adding at the end the following new paragraph:

"(5) Elimination of allotments for participating States and sunset for all States.

"(A) In general. Notwithstanding any other provision of this section, the State DSH allotment shall be zero with respect to

"(i) any participating State under the Health Security Act; and

"(ii) any State for any portion of a fiscal year that occurs on or after January 1, 1998.

"(B) No redistribution of reductions.In the computation of State supplemental amounts under paragraph (3), the State DSH allotments shall be determined under subparagraph (A)(ii) of such paragraph as if this paragraph did not apply.".

Section 4232 DISCONTINUATION OF REIMBURSEMENT STANDARDS FOR INPATIENT HOSPITAL SERVICES.

Section 1902(a)(13)(A) (42 U.S.C. 1396a(a)(13)(A)), as amended by section 4231(b), is amended by inserting "(in the case of services other than hospital services in a State that is a participating State under the Health Security Act)" before "are reasonable and adequate".

Part 5 COORDINATION WITH ADMINISTRATIVE SIMPLIFICATION AND QUALITY MANAGEMENT INITIATIVES

Section 4241 REQUIREMENTS FOR CHANGES IN BILLING PROCEDURES.

(a) Limitation on Frequency of System Changes; Advance Notification to Providers. Section 1902(a) (42 U.S.C. 1396a(a)), as amended by sections 4201(b) and 4214(a), is amended

(1) by striking "and" at the end of paragraph (63),

(2) by striking the period at the end of paragraph (64) and inserting "; and", and

(3) by inserting after paragraph (64) the following new paragraph:

"(65) provide that the State

"(A) will not implement any change in the system used for the billing and processing of claims for payment for items and services furnished under the State plan within 6 months of implementing any previous change in such system; and

"(B) shall notify individuals and entities providing medical assistance under the State plan of any major change in the procedures for billing for services furnished under the plan at least 120 days before such change is to take effect.".

(b) Effective Date. The amendments made by subsection (a) shall apply to a State as of January 1 of the first year for which the State is a participating State.

Part 6 MEDICAID COMMISSION

Section 4251 MEDICAID COMMISSION.

(a) Establishment. There is established a commission to be known as the "Medicaid Commission" (in this section referred to as the "Commission").

(b) Membership. (1) The Commission shall be composed of 15 members appointed by the Secretary for the life of the Commission.

(2) Members shall include representatives of the Federal Government and State Governments.

(3) The Administrator of the Health Care Financing

Administration shall be an ex officio member of the Commission.

(4) Individuals, while serving as members of the Commission, shall not be entitled to compensation, other than travel expenses, including per diem in lieu of subsistence, in accordance with sections 5702 and 5703 of title 5, United States Code.

(c) Study. The Commission shall study options with respect to each of the following in relation to the medicaid program under title XIX of the Social Security Act:

(1) Use of block grant. Whether, and (if so) how, to convert payments for services not covered in the comprehensive benefit package (for all recipients, including AFDC and SSI recipients defined in section 1902) into new financing mechanisms that give the States greater flexibility in targeting and delivering needed services.

(2) Integration of acute and long-term care services for health plans. Whether, and (if so) how, to integrate long-term care services and the home and community-based services program under part 1 of subtitle B of title II with the services covered under the comprehensive benefit package offered by health plans.

(3) Consolidating institutional and home and community-based long-term care. Whether, and (if so) how, to offer States an option to combine together expenditures under the home and community-based services program (under part 1 of subtitle B of title II) with continuing home and community-based services and institutional care under the medicaid program into a global budget for long-term care services, and how such a combined program could be implemented.

(d) Report and Recommendations. The Commission shall submit to the Secretary and the National Health Board, not later than 1 year after the date of the enactment of this Act, a report on its study under subsection (c). The Commission shall include in such report such recommendations for changes in the medicaid program, and the programs under this Act, as it deems appropriate.

(e) Operations. (1) The Commission shall appoint a chair from among its members.

(2) Upon request of the Chair of the Commission, the head of any Federal department or agency may detail, on a reimbursable basis, any of the personnel of that department or

agency to the Commission to assist it in carrying out its duties under this section.

(3) The Commission may secure directly from any department or agency of the United States information necessary to enable it to carry out this section. Upon request of the Chair of the Commission, the head of that department or agency shall furnish that information to the Commission.

(4) Upon the request of the Commission, the Administrator of General Services shall provide to the Commission, on a reimbursable basis, the administrative support services necessary for the Commission to carry out its responsibilities under this section.

(e) Termination. The Commission shall terminate 90 days after the date of submission of its report under subsection (d).

(f) Authorization of Appropriations. There are authorized to be appropriate such sums as may be necessary to carry out this section.

Title IV,
Subtitle D

Subtitle D Increase in SSI Personal Needs Allowance

Section 4301 INCREASE IN SSI PERSONAL NEEDS ALLOWANCE.

(a) In General. Section 1611(e)(1)(B) (42 U.S.C. 1382(e)(1)(B)) is amended

(1) in clauses (i) and (ii)(I), by striking "$360" and inserting "$600"; and

(2) in clause (iii), by striking "$720" and inserting "$1,200".

(b) Effective Date. The amendments made by subsection (a) shall apply with respect to months beginning with January 1996.