AMERICAN NURSES ASSOCIATION

600 Maryland Avenue SW
Suite 100 West
Washington, DC 20024-2571
202 651-7000 • Fax: 202 651-7001

Virginia Trotter Betts, JD, MSN, RN
President

Geri Marullo, MSN, RN
Executive Director

To Jen Klein ASAP

TO: Melanne Verveer
Deputy Chief of Staff to the First Lady

FROM: Virginia Trotter Betts, JD, MSN, RN VTB
President
American Nurses Association

DATE: December 18, 1995

RE: Administration's Medicare and Medicaid Proposal

The American Nurses Association (ANA) is very concerned about several provisions contained in the Medicare and Medicaid sections of the Administration's budget proposal. A statement outlining those concerns, as well as acceptable remedies, is attached.

It is imperative that these concerns be remedied immediately. We look forward to hearing from you in this regard at your earliest convenience.

Attachments

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12/18/95

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THE PRESIDENT'S MEDICARE AND MEDICAID PROPOSALS MUST INCLUDE REIMBURSEMENT FOR ADVANCED PRACTICE NURSES

The American Nurses Association (ANA) is deeply concerned by the failure of the White House proposals on Medicare and Medicaid to include coverage for services of nurse practitioners (NPs) and clinical nurse specialists (CNSs).

Medicare and Medicaid reimbursement for NPs and CNSs has been a key part of ANA's legislative agenda for many years. ***Incredibly, the White House proposal is actually worse on this issue than the Republican budget bill.***

* **The *Republican bill* would have extended Medicare Part B coverage to services of nurse practitioners in all outpatient settings. The *White House proposal* includes no such provision.**

* **Currently, states are mandated by federal Medicaid law to cover the services of Family and Pediatric NPs and of Certified Nurse-Midwives in state Medicaid programs. The White House bill *fails* to extend this mandate to all NPs and t: CNSs.**

The White House proposal would also allow states to move to Medicaid Primary Care Case Management programs without applying for a federal waiver, and to include NPs and CNMs as case managers "at state option"--meaning states can effectively circumvent requirements to cover NP and CNM services.

In addition, while the Republican proposal's provisions on Provider Sponsored Organizations would have included all appropriately licensed health care practitioners, the White House proposal would limit eligibility to physicians only. This is unacceptable to nursing, as well as to the broader non-physician community, which has already been vocal on this issue.

Nurses applauded the President's veto of the Republican budget bill, despite its inclusion of a provision for which nursing has worked hard for years--reimbursement for NPs in all geographic settings. We strongly and actively opposed the bill because we knew it would spell disaster for the entire health care system. Now that the President has decided to offer an alternative budget proposal, we are alarmed to learn that it actually does **worse** for nursing on this key issue than the Republican plan did.

We are astounded in light of the minimal cost of reimbursement for NPs and CNSs, as well as nursing's longstanding record of visible and continuing support for the President's health care initiatives. Congressional Budget Office estimates of the cost of the reimbursement provision in the Republican bill (which covered both NPs and physician assistants) were *$300 million over seven years*. ANA estimates that adding clinical nurse specialists (fewer of whom are in private practice settings than NPs) would cost another $60 million. This total of $360 million over seven years would add a mere six percent to the $5.9 billion in expansion of Medicare preventive services in the President's proposal (provisions we strongly support).

This distressing situation can be easily corrected--by including Medicare and Medicaid reimbursement for NPs and CNSs and provider status in PSOs in the White House's budget proposal.

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revised 12/18/95

Attachment 1

104TH CONGRESS
1ST SESSION

S. 864

To amend title XVIII of the Social Security Act to provide for increased medicare reimbursement for nurse practitioners and clinical nurse specialists to increase the delivery of health services in health professional shortage areas, and for other purposes.

IN THE SENATE OF THE UNITED STATES

MAY 25 (legislative day, MAY 15), 1995

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

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A BILL

To amend title XVIII of the Social Security Act to provide for increased medicare reimbursement for nurse practitioners and clinical nurse specialists to increase the delivery of health services in health professional shortage areas, and for other purposes.

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

SECTION 1. SHORT TITLE.

This Act may be cited as the "Primary Care Health Practitioner Incentive Act of 1995".

SEC. 2. INCREASED MEDICARE REIMBURSEMENT FOR NURSE PRACTITIONERS AND CLINICAL NURSE SPECIALISTS.

(a) REMOVAL OF RESTRICTIONS ON SETTINGS.—

(1) IN GENERAL.—Section 1861(s)(2)(K)(ii) of the Social Security Act (42 U.S.C. 1395x(s)(2)(K)(ii)) is amended to read as follows:

"(ii) services which would be physicians' services if furnished by a physician (as defined in subsection (r)(1)) and which are performed by a nurse practitioner or clinical nurse specialist (as defined in subsection (aa)(5)) working in collaboration (as defined in subsection (aa)(6)) with a physician (as so defined) which the nurse practitioner or clinical nurse specialist is legally authorized to perform by the State in which the services are performed, and such services and supplies furnished as an incident to such services as would be covered under subparagraph (A) if furnished incident to a physician's professional service;".

(2) CONFORMING AMENDMENTS.—

(A) Section 1861(s)(2)(K) of such Act (42 U.S.C. 1395x(s)(2)(K)), as amended by paragraph (1), is amended—

(i) in clause (i), by inserting "and such services and supplies furnished as in-

cident to such services as would be covered under subparagraph (A) if furnished as an incident to a physician's professional service." after "are performed, and"; and

(ii) by striking clauses (iii) and (iv).

(B) Section 1861(b)(4) of such Act (42 U.S.C. 1395x(b)(4)) is amended by striking "clauses (i) or (iii) of subsection (s)(2)(K)" and inserting "subsection (s)(2)(K)".

(C) Section 1862(a)(14) of such Act (42 U.S.C. 1395y(a)(14)) is amended by striking "section 1861(s)(2)(K)(i) or 1861(s)(2)(K)(iii)" and inserting "section 1861(s)(2)(K)".

(D) Section 1866(a)(1)(H) of such Act (42 U.S.C. 1395cc(a)(1)(H)) is amended by striking "section 1861(s)(2)(K)(i) or 1861(s)(2)(K)(iii)" and inserting "section 1861(s)(2)(K)".

(b) INCREASED PAYMENT.—

(1) FEE SCHEDULE AMOUNT.—Section 1833(a)(1)(O) of the Social Security Act (42 U.S.C. 1395*l*(a)(1)(O)) is amended to read as follows: "(O) with respect to services described in section 1861(s)(2)(K)(ii) (relating to nurse practitioner or clinical nurse specialist services), the amounts paid

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

(2) CONFORMING AMENDMENTS.—

(A) Section 1833(r) of such Act (42 U.S.C. 1395*l*(r)) is amended—

(i) in paragraph (1), by striking "section 1861(s)(2)(K)(iii) (relating to nurse practitioner or clinical nurse specialist services provided in a rural area)," and inserting "section 1861(s)(2)(K)(ii) (relating to nurse practitioner or clinical nurse specialist services),";

(ii) by striking paragraph (2);

(iii) in paragraph (3), by striking "section 1861(s)(2)(K)(iii)" and inserting "section 1861(s)(2)(K)(ii)"; and

(iv) by redesignating paragraph (3) as paragraph (2).

(E) Section 1842(b)(12)(A) of such Act (42 U.S.C. 1395u(b)(12)(A)) is amended in the matter preceding clause (i), by striking "clauses (i), (ii), or (iv) of section 1861(s)(2)(K) (relating to a physician assistants and nurse practitioners)" and inserting "section 1861(s)(2)(K)(i) (relating to physician assistants)".

(c) DIRECT PAYMENT FOR NURSE PRACTITIONERS AND CLINICAL NURSE SPECIALISTS.—

(1) IN GENERAL.—Section 1832(a)(2)(B)(iv) of the Social Security Act (42 U.S.C. 1395k(a)(2)(B)(iv)) is amended by striking "provided in a rural area (as defined in section 1886(d)(2)(D))".

(2) CONFORMING AMENDMENT.—Section 1842(b)(6)(C) of such Act (42 U.S.C. 1395u(b)(6)(C)) is amended—

(A) by striking "clauses (i), (ii), or (iv)" and inserting "clause (i)"; and

(B) by striking "or nurse practitioner".

(d) BONUS PAYMENT FOR SERVICES PROVIDED IN HEALTH PROFESSIONAL SHORTAGE AREAS.—Section 1833(m) of such Act (42 U.S.C. 1395*l*(m)) is amended—

(1) by inserting "(1)" after "(m)"; and

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

"(2) In the case of services of a nurse practitioner or clinical nurse specialist furnished to an individual, described in paragraph (1), in an area that is a health professional shortage area as described in such paragraph, in addition to the amount otherwise paid under this part, there shall also be paid to such service provider (on a monthly or quarterly basis) from the Federal Supplementary Medical Insurance Trust Fund an amount equal to 10 percent of the payment amount for the service under this part.".

(e) DEFINITION OF CLINICAL NURSE SPECIALIST CLARIFIED.—Section 1861(aa)(5) of such Act (42 U.S.C. 1395x(aa)(5)) is amended—

(1) by inserting "(A)" after "(5)";

(2) by striking "The term "'physician assistant'" and all that follows through "who performs" and inserting "The term 'physician assistant' and the term 'nurse practitioner' mean, for purposes of this title, a physician assistant or nurse practitioner who performs"; and

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

"(B) The term 'clinical nurse specialist' means, for purposes of this title, an individual who—

"(i) is a registered nurse and is licensed to practice nursing in the State in which the clinical nurse specialist services are performed; and

"(ii) holds a master's degree in a defined clinical area of nursing from an accredited educational institution.".

(f) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to services furnished and supplies provided on and after July 1, 1995.

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shall accept patients transferred to the hospital from the facility and receive data from and transmit data to the facility.

"(E) There is a practitioner who is qualified to provide advanced cardiac life support services (as determined by the State in which the facility is located) on-site at the facility on a 24-hour basis.

"(F) A physician is available on-call to provide emergency medical services on a 24-hour basis.

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

"(i) the facility need not meet hospital standards relating to the number of hours during a day, or days during a week, in which the facility must be open, except insofar as the facility is required to provide emergency care on a 24-hour basis under subparagraphs (E) and (F); and

"(ii) the facility may provide any services otherwise required to be provided by a full-time, on-site dietitian, pharmacist, laboratory technician, medical technologist, or radiological technologist on a part-time, off-site basis.

"(5) The facility meets the requirements applicable to clinics and facilities under subparagraphs (C) through (J) of paragraph (2) of section 1861(aa) and of clauses (ii) and (iv) of the second sentence of such paragraph (or, in the case of the requirements of subparagraph (E), (F), or (J) of such paragraph, would meet the requirements if any reference in such subparagraph to a 'nurse practitioner' or to 'nurse practitioners' were deemed to be a reference to a 'nurse practitioner or nurse' or to 'nurse practitioners or nurses'); except that in determining whether a facility meets the requirements of this subparagraph, subparagraphs (E) and (F) of that paragraph shall be applied as if any reference to a 'physician' is a reference to a physician as defined in section 1861(r)(1).

"(2) The term 'rural emergency access care hospital services' means the following services provided by a rural emergency access care hospital and furnished to an individual over a continuous period not to exceed 24 hours (except that such services may be furnished over a longer period in the case of an individual who is unable to leave the hospital because of inclement weather):

"(A) An appropriate medical screening examination (as described in section 1867(a)).

"(B) Necessary stabilizing examination and treatment services for an emergency medical condition and labor (as described in section 1867(b)).".

(b) REQUIRING RURAL EMERGENCY ACCESS CARE HOSPITALS TO MEET HOSPITAL ANTI-DUMPING REQUIREMENTS.—Section 1867(e)(5) (42 U.S.C. 1395dd(e)(5)) is amended by striking "1861(mm)(1))" and inserting "1861(mm)(1)) and a rural emergency access care hospital (as defined in section 1861(oo)(1))".

(c) COVERAGE AND PAYMENT FOR SERVICES.—

(1) COVERAGE.—Section 1832(a)(2) (42 U.S.C. 1395k(a)(2)) is amended—

(A) by striking "and" at the end of subparagraph (I);

(B) by striking the period at the end of subparagraph (J) and inserting "; and"; and

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

"(K) rural emergency access care hospital services (as defined in section 1861(oo)(2)).".

(2) PAYMENT BASED ON PAYMENT FOR OUTPATIENT CRITICAL ACCESS HOSPITAL SERVICES.—

(A) IN GENERAL.—Section 1833(a)(6) (42 U.S.C. 1395l(a)(6)), as amended by section 8702(f)(2), is amended by striking "services," and inserting "services and rural emergency access care hospital services,".

(B) PAYMENT METHODOLOGY DESCRIBED.—Section 1834(g) (42 U.S.C. 1395m(g)), as amended by section 8702(f)(2)(B), is amended—

(i) in the heading, by striking "SERVICES" and inserting "SERVICES AND RURAL EMERGENCY ACCESS CARE HOSPITAL SERVICES"; and

(ii) by adding at the end the following new sentence: "The amount of payment for rural emergency access care hospital services provided during a year shall be determined using the applicable method provided under this subsection for determining payment for outpatient rural primary care hospital services during the year.".

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

SEC. 8704. CLASSIFICATION OF RURAL REFERRAL CENTERS.

(a) PROHIBITING DENIAL OF REQUEST FOR RECLASSIFICATION ON BASIS OF COMPARABILITY OF WAGES.—

(1) IN GENERAL.—Section 1886(d)(10)(D) (42 U.S.C. 1395ww(d)(10)(D)) is amended—

(A) by redesignating clause (iii) as clause (iv); and

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

"(iii) Under the guidelines published by the Secretary under clause (i), in the case of a hospital which is classified by the Secretary as a rural referral center under paragraph (5)(C), the Board may not reject the application of the hospital under this paragraph on the basis of any comparison between the average hourly wage of the hospital and the average hourly wage of hospitals in the area in which it is located.".

(2) EFFECTIVE DATE.—Notwithstanding section 1886(d)(10)(C)(iii) of the Social Security Act, a hospital may submit an application to the Medicare Geographic Classification Review Board during the 30-day period beginning on the date of the enactment of this Act requesting a change in its classification for purposes of determining the area wage index applicable to the hospital under section 1886(d)(3)(D) of such Act for fiscal year 1997, if the hospital would be eligible for such a change in its classification under the standards described in section 1886(d)(10)(D) (as amended by paragraph (1)) but for its failure to meet the deadline for applications under section 1886(d)(10)(C)(iii).

(b) CONTINUING TREATMENT OF PREVIOUSLY DESIGNATED CENTERS.—Any hospital classified as a rural referral center by the Secretary of Health and Human Services under section 1886(d)(5)(C) of the Social Security Act for fiscal year 1994 shall be classified as such a rural referral center for fiscal year 1996 and each subsequent fiscal year.

SEC. 8705. FLOOR ON AREA WAGE INDEX.

(a) IN GENERAL.—For purposes of section 1886(d)(3)(E) of the Social Security Act for discharges occurring on or after October 1, 1995, the area wage index applicable under such section to any hospital which is not located in a rural area (as defined in section 1886(d)(2)(D) of such Act) may not be less than the average of the area wage indices applicable under such section to hospitals located in rural areas in the State in which the hospital is located.

(b) IMPLEMENTATION.—The Secretary of Health and Human Services shall adjust the area wage indices referred to in subsection (a) for hospitals not described in such subsection in a manner which assures that the aggregate payments made under section 1886(d) of the Social Security Act in a fiscal year for the operating costs of inpatient hospital services are not greater or less than those which would have been made in the year if this section did not apply.

SEC. 8706. ADDITIONAL PAYMENTS FOR PHYSICIANS' SERVICES FURNISHED IN SHORTAGE AREAS.

(a) INCREASE IN AMOUNT OF ADDITIONAL PAYMENT.—Section 1833(m) (42 U.S.C. 1395l(m)) is amended by striking "10 percent" and inserting "20 percent".

(b) RESTRICTION TO PRIMARY CARE SERVICES.—Section 1833(m) (42 U.S.C. 1395l(m)) is amended by inserting after "physicians' services" the following: "consisting of primary care services (as defined in section 1842(i)(4))".

(c) EXTENSION OF PAYMENT FOR FORM SHORTAGE AREAS.—

(1) IN GENERAL.—Section 1833(m) (42 U.S.C. 1395l(m)) is amended by striking "area," and inserting "area (or, in the case of an area in which the designation as a health profession shortage area under such section is withdrawn, in the case of physicians' services furnished such an individual during the 3-year period beginning with the effective date of the withdrawal of such designation),".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to physicians' services furnished in an area for which the designation as a health professional shortage area under section 332(a)(1)(A) of the Public Health Service Act is withdrawn on or after January 1, 1996.

(d) REQUIRING CARRIERS TO REPORT ON SERVICES PROVIDED.—Section 1842(b)(3) (42 U.S.C. 1395u(b)(3)) is amended—

(1) by striking "and" at the end of subparagraph (I);

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

"(J) will provide information to the Secretary (on such periodic basis as the Secretary may require) on the types of providers to whom the carrier makes additional payments for certain physicians' services pursuant to section 1833(m), together with a description of the services furnished by such providers; and".

(e) EFFECTIVE DATE.—The amendments made by subsections (a), (b), and (d) shall apply to physicians' services furnished on or after October 1, 1995.

SEC. 8707. PAYMENTS TO PHYSICIAN ASSISTANTS AND NURSE PRACTITIONERS FOR SERVICES FURNISHED IN OUTPATIENT OR HOME SETTINGS.

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

(1) in clause (i)—

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

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

(2) in clause (ii)—

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

(B) by inserting ", or (II) in an outpatient or home setting (as defined by the Secretary)," after "(as defined in section 1819(a))".

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

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

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

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

(2) CONFORMING AMENDMENT.—Section 1842(b)(6)(C) (42 U.S.C. 1395u(b)(6)(C)) is amended by striking "clauses (i), (ii), or (iv)" and inserting "subclauses (I), (II), or (III) of clause (i), clause (ii)(I), or clause (iv)".

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

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

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

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

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

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

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

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

SEC. 8708. EXPANDING ACCESS TO NURSE AIDE TRAINING IN UNDERSERVED AREAS.

(a) IN GENERAL.—Section 1819(f)(2)(B)(iii)(I) (42 U.S.C. 1396r(f)(2)(B)(iii)(I)) is amended in the matter preceding item (a), by striking "by or in a nursing facility" and inserting "by a nursing facility (or in such a facility, unless the State determines that there is no other such program offered within a reasonable distance, provides notice of the approval to the State long term care ombudsman, and assures, through an oversight effort, that an adequate environment exists for such a program)".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to nurse aide training and competency evaluation programs under section 1819 of the Social Security Act which are offered on or after October 1, 1995.

TITLE IX—TRANSPORTATION AND RELATED PROVISIONS

SEC. 9001. MINIMUM ALLOCATION FOR HIGHWAY PROGRAMS.

(a) TECHNICAL CORRECTION.—With respect to fiscal year 1996—

(1) the Secretary of Transportation shall determine, in accordance with the policies established by the Intermodal Surface Transportation Efficiency Act of 1991 (105 Stat. 1914)—

(A) which of the States will no longer require an apportionment under section 157(a)(4) of title 23, United States Code; and

(B) which of the States will require decreased funding under such section 157(a)(4);

as a result of the termination of the Interstate construction program; and

(2) as a result of the reduced number of States that may require an apportionment under such section 157(a)(4), and the decrease in the amount of funds some States will require under such section 157(a)(4), the maximum amount available for apportionment under such section 157(a)(4) shall be reduced from the amount apportioned under such section 157(a)(4) for fiscal year 1995 by 60.4 percent.

(b) EFFECT ON CERTAIN CALCULATIONS.—The correction made by subsection (a) shall be made after the reduction required under section 1003(c) of the Intermodal Surface Transportation Efficiency Act of 1991 (105 Stat. 1921) and shall not be taken into account in making the calculations under sections 1003(c), 1013(c), and 1015 of such Act (105 Stat. 1921, 1940, and 1943).

SEC. 9002. EXTENSION OF HIGHER VESSEL TONNAGE DUTIES.

(a) EXTENSION OF DUTIES.—Section 36 of the Act of August 5, 1909 (36 Stat. 111; 46 U.S.C. App. 121), is amended by striking "for fiscal years 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998," each place it appears and inserting "for fiscal years through fiscal year 2002,".

(b) CONFORMING AMENDMENT.—The Act entitled "An Act concerning tonnage duties on vessels entering otherwise than by sea", approved March 8, 1910 (36 Stat. 234; 46 U.S.C. App. 132), is amended by striking "for fiscal years 1991, 1992, 1993, 1994, 1995, 1996, 1997, and 1998," and inserting "for fiscal years through fiscal year 2002,".

SEC. 9003. FEMA RADIOLOGICAL EMERGENCY PREPAREDNESS FEES.

(a) IN GENERAL.—The Director of the Federal Emergency Management Agency may assess and collect fees applicable to persons subject to radiological emergency preparedness regulations issued by the Director.

(b) REQUIREMENTS.—The assessment and collection of fees by the Director under subsection (a) shall be fair and equitable and shall reflect the full amount of costs to the Agency of providing radiological emergency planning, preparedness, response, and associated services. Such fees shall be assessed by the Director in a manner that reflects the use of resources of the Agency for classes of regulated persons and the administrative costs of collecting such fees.

(c) AMOUNT OF FEES.—The aggregate amount of fees assessed under subsection (a) in a fiscal year shall approximate, but not be less than, 100 percent of the amounts anticipated by the Director to be obligated for the radiological emergency preparedness program of the Agency for such fiscal year.

(d) DEPOSIT OF FEES IN TREASURY.—Fees received pursuant to subsection (a) shall be deposited in the general fund of the Treasury as offsetting receipts.

(e) EXPIRATION OF AUTHORITY.—The authority of the Director to assess and collect fees under subsection (a) shall expire on September 30, 2002.

TITLE X—VETERANS AND RELATED PROVISIONS

SEC. 10001. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This title may be cited as the "Veterans Reconciliation Act of 1995".

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

Sec. 10001. Short title; table of contents.

Subtitle A—Extension of Temporary Authorities

Sec. 10011. Authority to require that certain veterans make copayments in exchange for receiving health-care benefits.

Sec. 10012. Medical care cost recovery authority.

Sec. 10013. Income verification authority.

Sec. 10014. Limitation on pension for certain recipients of medicaid-covered nursing home care.

Sec. 10015. Home loan fees.

Sec. 10016. Procedures applicable to liquidation sales on defaulted home loans guaranteed by the Department of Veterans Affairs.

Sec. 10017. Enhanced loan asset sale authority.

Subtitle B—Other Matters

Sec. 10021. Revision to prescription drug copayment.

Sec. 10022. Rounding down of cost-of-living adjustments in compensation and DIC rates.

Sec. 10023. Revised standard for liability for injuries resulting from Department of Veterans Affairs treatment.

Sec. 10024. Withholding of payments and benefits.

Subtitle A—Extension of Temporary Authorities

SEC. 10011. AUTHORITY TO REQUIRE THAT CERTAIN VETERANS MAKE COPAYMENTS IN EXCHANGE FOR RECEIVING HEALTH-CARE BENEFITS.

(a) HOSPITAL AND MEDICAL CARE.—Section 8013(c) of the Omnibus Budget Reconciliation Act of 1990 (38 U.S.C. 1710 note) is amended by striking out "September 30, 1998" and inserting in lieu thereof "September 30, 2002".

(b) OUTPATIENT MEDICATIONS.—Section 1722A(c) of title 38, United States Code, is amended by striking out "September 30, 199 and inserting in lieu thereof "September 2002".

SEC. 10012. MEDICAL CARE COST RECOVERY A THORITY.

Section 1729(a)(2)(E) of title 38, United Sta Code, is amended by striking out "before Oc ber 1, 1998," and inserting "before October 2002,".

SEC. 10013. INCOME VERIFICATION AUTHORITY.

Section 5317(g) of title 38, United States Co is amended by striking out "September 30, 19 and inserting in lieu thereof "September 2002".

SEC. 10014. LIMITATION ON PENSION FOR C TAIN RECIPIENTS OF MEDICAID-C ERED NURSING HOME CARE.

Section 5503(f)(7) of title 38, United Sta Code, is amended by striking out "September 1998" and inserting in lieu thereof "Septem 30, 2002".

SEC. 10015. HOME LOAN FEES.

Section 3729(a) of title 38, United States Co is amended—

(1) in paragraph (4), by striking out "Octo 1, 1998" and inserting in lieu thereof "Octobe 2002"; and

(2) in paragraph (5)(C), by striking out "Oc ber 1, 1998" and inserting in lieu thereof "Oc ber 1, 2002".

SEC. 10016. PROCEDURES APPLICABLE TO L UIDATION SALES ON DEFAULT HOME LOANS GUARANTEED BY T DEPARTMENT OF VETERANS FAIRS.

Section 3732(c)(11) of title 38, United Sta Code, is amended by striking out "October 1998" and inserting "October 1, 2002".

SEC. 10017. ENHANCED LOAN ASSET SALE A THORITY.

Section 3720(h)(2) of title 38, United Sta Code, is amended by striking out "December 1995" and inserting in lieu thereof "Septemb 30, 2002".

Subtitle B—Other Matters

SEC. 10021. REVISION TO PRESCRIPTION DRU COPAYMENT.

(a) INCREASE IN AMOUNT OF COPAYMENT. Section 1722A(a) of title 38, United States Cod is amended—

(1) in paragraph (1), by striking out "$2" a inserting in lieu thereof "$6";

(2) by striking out paragraph (2); and

(3) by redesignating paragraph (3) as par graph (2) and in that paragraph—

(A) striking out "or" at the end of subpar graph (A);

(B) striking out the period at the end of su paragraph (B) and inserting in lieu thereof or"; and

(C) adding at the end the following new su paragraph:

"(C) to a veteran who is a former prisoner war.".

(b) RECOVERY OF INDEBTEDNESS.—(1) Sectio 5302 of such title is amended by adding at t end the following new subsection:

"(f) The Secretary may not waive under th section the recovery of any payment or the co lection of any indebtedness owed under sectio 1722A of this title.".

(2) The amendment made by paragraph (shall apply with respect to amounts that becor due to the United States under section 1722A title 38, United States Code, on or after the da of the enactment of this Act.

SEC. 10022. ROUNDING DOWN OF COST-OF-LIVIN ADJUSTMENTS IN COMPENSATIO AND DIC RATES.

(a) FISCAL YEAR 1996 COLA.—(1) Effective of December 1, 1995, the Secretary of Veterans Affairs shall recompute any increase in an a justment that is otherwise provided by law to effective during fiscal year 1996 in the rates disability compensation and dependency and i demnity compensation paid by the Secretary such rates were in effect on November 30, 19

Attachment 3

CHART 2 -- MEDICARE

Medicare Proposal (based on specs through 9/24): Preliminary CBO Staff Estimates

By fiscal year, in billions of dollars	1996	1996	1997	1998	1999	2000	2001	2002	7-year savings Total
Medicare Part A:									
Provider Reimbursement Options									
PPS MB-2.5% thru 2002		-0.2	-1.3	-3.0	-4.8	-6.8	-8.9	-11.2	-36.1
Rebase Capital rates		-0.3	-0.4	-0.4	-0.4	-0.4	-0.4	-0.4	-2.7
Reduce PPS capital by 15%		-1.0	-1.2	-1.3	-1.3	-1.4	-1.4	-1.5	-9.9
Reduce Disproportionate Share to 25%		-0.1	-0.3	-0.5	-0.7	-0.9	-0.9	-1.0	-4.5
Reduce IME to 6.7, 5.6, 4.6%		-0.4	-0.9	-1.5	-1.7	-1.7	-1.8	-1.9	-9.9
Change PPS-exempt pmt ceilings and floors		-0.0	-0.1	-0.2	-0.4	-0.5	-0.7	-0.7	-2.7
NonPPS MB-2.5% thru 2002		-0.0	-0.1	-0.2	-0.3	-0.4	-0.5	-0.6	-2.0
Reduce NonPPS capital by 15%		-0.1	-0.2	-0.2	-0.2	-0.2	-0.3	-0.3	-1.5
SNFs		-0.2	-0.6	-1.0	-1.4	-1.9	-2.3	-2.9	-10.4
Home Health Prospective Payment /1		0.0	-1.4	-2.3	-2.8	-3.3	-3.7	-4.3	-17.8
Hospice		0.0	0.0	-0.1	-0.1	-0.1	-0.1	-0.1	-0.5
Critical Access Hospitals, Extend MDH		0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.5
AAPCC Interaction with DSH,IME,GME /2		0.0	0.8	1.5	1.8	2.0	2.2	2.5	10.7
Part A		-2.4	-6.6	-9.1	-12.2	-16.6	-18.9	-22.2	-85.8
Medicare Part B:									
Provider Reimbursement Options									
Eliminate Formula Driven Overpayment		-0.9	-1.2	-1.5	-2.0	-2.5	-3.3	-4.5	-15.9
Extend 5.8% Outpatient payment reduction		0.0	0.0	0.0	-0.3	-0.3	-0.4	-0.4	-1.4
Increase Outpatient capital reduction to 15%		-0.0	-0.0	-0.1	-0.2	-0.2	-0.2	-0.3	-1.0
Freeze Ambulatory Surgical Center updates		-0.0	-0.1	-0.1	-0.2	-0.2	-0.3	-0.4	-1.3
Revise MVPS (CF-3.65% in 96; GDP+2 thru 2002)		-0.4	-1.3	-2.3	-3.2	-4.1	-5.1	-6.2	-22.6
Freeze Clinical lab update, 66% of median		-0.1	-0.4	-0.7	-0.9	-1.1	-1.3	-1.6	-6.0
Freeze Dur Med Eqpt update, -40% on oxygen		-0.3	-0.6	-0.7	-0.9	-1.0	-1.3	-1.5	-6.2
Eliminate Ambulance Update		-0.0	-0.0	-0.1	-0.1	-0.1	-0.2	-0.3	-0.8
Increase bonus to rural prim care docs		0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.4
Direct payments to nurse prac/phys asstc.		0.0	0.0	0.0	0.0	- 0.1	- 0.1	- 0.1	- 0.3
REACH		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1
Interactions		-0.1	-0.1	-0.2	-0.2	-0.3	-0.3	-0.3	-1.4
Beneficiary Options /3									
Deductible to $150 in 96; +$10/year thereafter		-0.7	-1.1	-1.3	-1.5	-1.7	-2.0	-2.2	-10.5
31.5% Premium through 2002; rounded up		-3.1	-4.4	-4.4	-5.0	-8.5	-11.1	-14.1	-51.6
Income-related premiums		0.0	-0.5	-0.9	-1.4	-1.8	-2.1	-2.5	-9.1
Part B		-5.6	-9.4	-12.0	-16.5	-21.9	-27.6	-33.9	-126.9

DRAFT

DRAFT

Attachment 4

I

104TH CONGRESS
1ST SESSION

H. R. 1339

To amend title XIX of the Social Security Act to provide for mandatory coverage of services furnished by nurse practitioners and clinical nurse specialists under State medicaid plans.

IN THE HOUSE OF REPRESENTATIVES

MARCH 28, 1995

Mr. RICHARDSON (for himself, Ms. ESHOO, Mr. FROST, Mr. MCHALE, Ms. RIVERS, Mr. VENTO, Mr. MINGE, Mrs. LOWEY, Ms. PELOSI, Ms. LOFGREN, and Mr. DELLUMS) introduced the following bill; which was referred to the Committee on Commerce

---

A BILL

To amend title XIX of the Social Security Act to provide for mandatory coverage of services furnished by nurse practitioners and clinical nurse specialists under State medicaid plans.

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

SECTION 1. MEDICAID COVERAGE OF SERVICES FURNISHED BY CERTIFIED NURSE PRACTITIONERS AND CLINICAL NURSE SPECIALISTS.

(a) IN GENERAL.—Section 1905(a)(21) of the Social Security Act (42 U.S.C. 1396d(a)(21)) is amended to read as follows:

"(21) services furnished by a certified nurse practitioner (as defined by the Secretary) or a clinical nurse specialist (as defined in subsection (t)) which the certified nurse practitioner or clinical nurse specialist is legally authorized to perform under State law (or the State regulatory mechanism provided by State law), whether or not the certified nurse practitioner or clinical nurse specialist is under the supervision of, or associated with, a physician or other health care provider;".

(b) DEFINITION OF CLINICAL NURSE SPECIALIST.—Section 1905 of such Act (42 U.S.C. 1396d) is amended by adding at the end the following new subsection:

"(t) The term 'clinical nurse specialist' means an individual who has earned a master's degree in a clinical area of nursing from an accredited institution and who is a registered nurse licensed to practice nursing in the State in which the individual furnishes services.".

(c) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) shall apply to calendar quarters

beginning on or after January 1, 1996, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

○

"(iii) any provisions of State law which relate to the licensing of the organization and which prohibit the organization from providing coverage pursuant to a contract under this part shall be superseded.

Nothing in this subparagraph shall be construed as limiting the number of times such a waiver may be renewed.

"(D) CONSTRUCTION.—Nothing in this paragraph shall be construed as affecting the operation of section 514 of the Employee Retirement Income Security Act of 1974.

"(5) EXCEPTION IF REQUIRED TO OFFER MORE THAN MEDICARE PLUS PLANS.—Paragraph (1) shall not apply to a MedicarePlus organization in a State if the State requires the organization, as a condition of licensure, to offer any product or plan other than a MedicarePlus plan.

"(6) EXCEPTION IN CASES OF UNREASONABLE BARRIERS TO MARKET ENTRY.—

"(A) IN GENERAL.—A MedicarePlus organization that seeks to offer a MedicarePlus plan in a State may apply for a waiver of the requirement of paragraph (1) for that organization operating in that State.

"(B) STANDARD.—The Secretary shall act on such an application within 60 days after the date it is filed and shall grant such a waiver for an organization with respect to a State if the Secretary determines that—

"(i) the State (I) denied such a licensing application or (II) unreasonably delayed in acting upon the application, and

"(ii) the State's licensing standards or review process imposes unreasonable barriers to market entry, including through the imposition of any requirements, procedures, or other standards to such organizations that are not generally applicable to any other entities engaged in substantially similar business.

"(C) APPLICATION OF CERTAIN RULES.—The provisions of subparagraphs (C) and (D) of paragraph (4) shall apply to this paragraph in the same manner as they apply under such paragraph, except that for this purpose any reference in paragraph (4)(C)(i) to 36-month period is deemed a reference to a 24-month period.

"(b) PREPAID PAYMENT.—A MedicarePlus organization shall be compensated (except for deductibles, coinsurance, and copayments) for the provision of health care services to enrolled members by a payment which is paid on a periodic basis without regard to the date the health care services are provided and which is fixed without regard to the frequency, extent, or kind of health care service actually provided to a member.

"(c) ASSUMPTION OF FULL FINANCIAL RISK.—The MedicarePlus organization shall assume full financial risk on a prospective basis for the provision of the health care services (except, at the election of the organization, hospice care) for which benefits are required to be provided under section 1852(a)(1), except that the organization—

"(1) may obtain insurance or make other arrangements for the cost of providing to any enrolled member such services the aggregate value of which exceeds $5,000 in any year,

"(2) may obtain insurance or make other arrangements for the cost of such services provided to its enrolled members other than through the organization because medical necessity required their provision before they could be secured through the organization,

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

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

In the case of a MedicarePlus organization that is a union sponsor, Taft-Hartley sponsor, or a qualified association sponsor, this subsection shall not apply with respect to MedicarePlus plans offered by such organization and issued by an organization to which subsection (a)(1) applies or by a provider-sponsored organization (as defined in section 1851(a)).

"(d) PROVISION AGAINST RISK OF INSOLVENCY.—

"(1) IN GENERAL.—Each MedicarePlus organization shall meet standards under section 1855 relating to the financial solvency and capital adequacy of the organization and including provision to prevent enrollees from being held liable to any person or entity for the plan sponsor's debts in the event of the plan sponsor's insolvency. Such standards shall take into account the nature and type of MedicarePlus plans offered by the organization.

"(2) TREATMENT OF PROVIDER-SPONSORED ORGANIZATIONS.—

"(A) IN GENERAL.—In the case of an entity that is a provider-sponsored organization that is operating—

"(i) in a State approved under subparagraph (B), the organization shall meet the standards described in paragraph (1) through licensure by the State, or

"(ii) in a State that is not so approved, the organization shall meet the standards described in paragraph (1) through application and certification licensure by the Secretary.

"(B) APPROVED STATES.—

"(i) APPLICATION PROCESS.—For purposes of subparagraph (A), the Secretary shall establish a process under which a State may apply to the Secretary for a determination that the State is applying to provider-sponsored organizations, through its process for licensing provider-sponsored organizations, solvency standards that are identical with the solvency standards established under section 1856(c) for such organizations.

"(ii) DETERMINATION.—The Secretary shall approve such a State if the Secretary determines that the State is so applying such standards. If the Secretary denies such an approval, the State may reapply for such a determination.

"(iii) PUBLICATION.—The Secretary shall publish a list of States that are approved under this subparagraph.

"(3) TREATMENT OF UNION AND TAFT-HARTLEY SPONSORS.—An entity that is a union sponsor or a Taft-Hartley sponsor is deemed to meet the requirement of paragraph (1).

"(4) TREATMENT OF CERTAIN QUALIFIED ASSOCIATION SPONSORS.—An entity that is a qualified association sponsor is deemed to meet the requirement of paragraph (1) with respect to MedicarePlus plans offered by such association and issued by an organization to which subsection (b)(1) applies or by a provider-sponsored organization.

"(e) PROVIDER-SPONSORED ORGANIZATION DEFINED.—

"(1) IN GENERAL.—In this part, the term 'provider-sponsored organization' means a public or private entity—

"(A) that is established or organized by a health care provider, or group of affiliated health care providers,

"(B) that provides a substantial proportion (as defined by the Secretary) of the health care items and services under the contract under this part directly through the provider or affiliated group of providers, and

"(C) with respect to which those affiliated providers that share, directly or indirectly, substantial financial risk with respect to the provision of such items and services have at least a majority financial interest in the entity.

"(2) SUBSTANTIAL PROPORTION.—In defining what is a 'substantial proportion' for purposes of paragraph (1)(A), the Secretary—

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

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

"(3) AFFILIATION.—For purposes of this su
section, a provider is 'affiliated' with anoth
provider if, through contract, ownership, or oth
erwise—

"(A) one provider, directly or indirectly, co
trols, is controlled by, or is under common co
trol with the other,

"(B) both providers are part of a controlle
group of corporations under section 1563 of t
Internal Revenue Code of 1986, or

"(C) both providers are part of an affiliate
service group under section 414 of such Code.

"(4) CONTROL.—For purposes of paragra
(3), control is presumed to exist if one party, d
rectly or indirectly, owns, controls, or holds th
power to vote, or proxies for, not less than
percent of the voting rights or governance righ
of another.

"(5) HEALTH CARE PROVIDER DEFINED.—In th
subsection and subsection (f), the term 'healt
care provider' means—

"(A) any individual who is engaged in the d
livery of health care services in a State and wh
is required by State law or regulation to be
censed or certified by the State to engage in th
delivery of such services in the State, and

"(B) any entity that is engaged in the deli
ery of health care services in a State and tha
if it is required by State law or regulation to
licensed or certified by the State to engage
the delivery of such services in the State, is
licensed.

"(5) REGULATIONS.—The Secretary shall iss
regulations to carry out this subsection.

"(f) APPLICATION OF ANTITRUST RULE OF RE
SON TO PROVIDER-SPONSORED ORGANIZATIONS.—

"(1) RULE OF REASON STANDARD.—In any a
tion under the antitrust laws, or under any la
of a State (as defined in section 4G(2) of th
Clayton Act) similar to the antitrust laws, th
following conduct shall not be deemed illega
per se:

"(A) The conduct of a provider-sponsored o
ganization, and affiliated providers of the orga
nization, in negotiating, making, or performin
a contract (including the establishment an
modification of a fee schedule and the develop
ment of a panel of physicians), to the exten
such contract is for the purpose of providin
health care services to individuals under th
terms of a MedicarePlus plan offered by such o
organization.

"(B) The exchange of information amon
health care providers relating to costs, sale
profitability, marketing, prices, or fees of an
health care product or service if—

"(i) the exchange of such information wa
solely for the purpose of establishing a provide
sponsored organization and was reasonably re
quired for such purpose, and

"(ii) such information was not used for an
other purpose.

Such conduct shall be judged on the basis of it
reasonableness, taking into account all relevan
factors affecting competition, including the e
fects on competition in properly defined mar
kets.

"(C) The conduct of a group of health ca
providers, and provider members of such
group, in negotiating, making, or performing
contract (including the establishment and mod
fication of a fee schedule and the developmen
of a panel of physicians) with a provider-spon
sored organization, to the extent such contra
is for the purpose of providing health care ser
ices to individuals under the terms of
MedicarePlus plan of the organization, but onl
if the group meets the requirements of para
graph (2).

Such conduct shall be judged on the basis of it
reasonableness, taking into account all relevan
factors affecting competition, including the e
fects on competition in properly defined mar
kets.

"(2) REQUIREMENTS FOR GROUP.—A group of health care providers meets the requirements of this paragraph with respect to a MedicarePlus plan of a provider-sponsored organization if the group—

"(i) is not a provider-sponsored organization,

"(ii) is organized by, operated by, and composed only of members who are health care providers and for purposes that include providing health care services,

"(iii) is funded in part by capital contributions made by the members of such group,

"(iv) with respect to each contract made by such group for the purpose of providing a type of health care service to individuals under the terms of the plan—

"(I) requires all members of such group who engage in providing such type of health care service to agree to provide health care services of such type under such contract,

"(II) receives the compensation paid for the health care services of such type provided under such contract by such members, and

"(III) provides for the distribution of such compensation,

"(v) has established, consistent with the requirements of this part, a program to review, pursuant to written guidelines, the quality, efficiency, and appropriateness of treatment methods and setting of services for all health care providers and all patients participating in the plan, along with internal procedures to correct identified deficiencies relating to such methods and such services,

"(vi) has established, consistent with the requirements of this part, a program to monitor and control utilization of health care services provided under the plan, for the purpose of improving efficient, appropriate care and eliminating the provision of unnecessary health care services,

"(vii) has established a management program to coordinate the delivery of health care services for all health care providers and all patients participating in the plan, for the purpose of achieving efficiencies and enhancing the quality of health care services provided, and

"(viii) has established, consistent with the requirements of this part, a grievance and appeal process for such group designed to review and promptly resolve beneficiary or patient grievances and complaints.

"(3) DEFINITIONS.—For purposes of this subsection:

"(A) ANTITRUST LAWS.—The term 'antitrust laws' has the meaning given it in subsection (a) of the first section of the Clayton Act (15 U.S.C. 12), except that such term includes section 5 of the Federal Trade Commission Act (15 U.S.C. 45) to the extent that such section 5 applies to unfair methods of competition.

"(B) HEALTH CARE SERVICE.—The term 'health care service' means any service for which payment may be made under a MedicarePlus plan including services related to the delivery or administration of such service.

"(C) ISSUANCE OF GUIDELINES.—Not later than 120 days after the date of the enactment of this part, the Attorney General and the Federal Trade Commission shall issue jointly guidelines specifying the enforcement policies and analytical principles that will be applied by the Department of Justice and the Commission with respect to the operation of this subsection.

"(g) ORGANIZATIONS TREATED AS MEDICAREPLUS ORGANIZATIONS DURING TRANSITION.—Any of the following organizations shall be considered to qualify as a MedicarePlus organization for contract years beginning before January 1, 1998:

"(1) HEALTH MAINTENANCE ORGANIZATIONS.—An organization that is organized under the laws of any State and that is a qualified health maintenance organization (as defined in section 1310(d) of the Public Health Service Act), an organization recognized under State law as a health maintenance organization, or a similar organization regulated under State law for solvency in the same manner and to the same extent as such a health maintenance organization.

"(2) LICENSED INSURERS.—An organization that is organized under the laws of any State and—

"(A) is licensed by a State agency as an insurer for the offering of health benefit coverage, or

"(B) is licensed by a State agency as a service benefit plan,

but only for individuals residing in an area in which the organization is licensed to offer health insurance coverage.

"(3) CURRENT RISK-CONTRACTORS.—An organization that is an eligible organization (as defined in section 1876(b)) and that has a risk-sharing contract in effect under section 1876 as of the date of the enactment of this section.

"PAYMENTS TO MEDICAREPLUS ORGANIZATIONS

"SEC. 1854. (a) PAYMENTS TO ORGANIZATIONS.—

"(1) MONTHLY PAYMENTS.—

"(A) IN GENERAL.—Under a contract under section 1857 and subject to subsections (e) and (f), the Secretary shall make monthly payments under this section in advance to each MedicarePlus organization, with respect to coverage of an individual under this part in a MedicarePlus payment area for a month, in an amount equal to 1/12 of the annual MedicarePlus capitation rate (as calculated under subsection (c)) with respect to that individual for that area, adjusted for such risk factors as age, disability status, gender, institutional status, and such other factors as the Secretary determines to be appropriate, so as to ensure actuarial equivalence. The Secretary may add to, modify, or substitute for such factors, if such changes will improve the determination of actuarial equivalence.

"(B) SPECIAL RULE FOR END-STAGE RENAL DISEASE.—The Secretary shall establish a separate rate of payment to a MedicarePlus organization with respect to any individual determined to have end-stage renal disease and enrolled in a MedicarePlus plan of the organization. Such rate of payment shall be actuarially equivalent to rates paid to other enrollees in the MedicarePlus payment area for such other area as specified by the Secretary).

"(2) ADJUSTMENT TO REFLECT NUMBER OF ENROLLEES.—

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

"(B) SPECIAL RULE FOR CERTAIN ENROLLEES.—

"(i) IN GENERAL.—Subject to clause (ii), the Secretary may make retroactive adjustments under subparagraph (A) to take into account individuals enrolled during the period beginning on the date on which the individual enrolls with a MedicarePlus organization under a plan operated, sponsored, or contributed to by the individual's employer or former employer (or the employer or former employer of the individual's spouse) and ending on the date on which the individual is enrolled in the organization under this part, except that for purposes of making such retroactive adjustments under this subparagraph, such period may not exceed 90 days.

"(ii) EXCEPTION.—No adjustment may be made under clause (i) with respect to any individual who does not certify that the organization provided the individual with the disclosure statement described in section 1852(c) at the time the individual enrolled with the organization.

"(b) ANNUAL ANNOUNCEMENT OF PAYMENT RATES.—

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

"(A) the annual MedicarePlus capitation rate for each MedicarePlus payment area for the year, and

"(B) the risk and other factors to be used in adjusting such rates under subsection (a)(1)(A) for payments for months in that year.

"(2) ADVANCE NOTICE OF METHODOLOGICAL CHANGES.—At least 45 days before making the announcement under paragraph (2) for a year, the Secretary shall provide for notice to MedicarePlus organizations of proposed changes to be made in the methodology from the methodology and assumptions used in the previous announcement and shall provide such organizations an opportunity to comment on such proposed changes.

"(3) EXPLANATION OF ASSUMPTIONS.—In each announcement made under paragraph (1) for a year, the Secretary shall include an explanation of the assumptions and changes in methodology used in the announcement in sufficient detail so that MedicarePlus organizations can compute monthly adjusted MedicarePlus capitation rates for individuals in each MedicarePlus payment area which is in whole or in part within the service area of such an organization.

"(c) CALCULATION OF ANNUAL MEDICAREPLUS CAPITATION RATES.—

"(1) IN GENERAL.—For purposes of this part, the annual MedicarePlus capitation rate, for a MedicarePlus payment area for a contract year consisting of a calendar year, is equal to the greatest of the following:

"(A) BLENDED CAPITATION RATE.—The sum of—

"(i) area-specific percentage (for the year (as specified under paragraph (2) for the year) of the annual area-specific MedicarePlus capitation rate for the year for the MedicarePlus payment area, as determined under paragraph (3), and

"(ii) national percentage (as specified under paragraph (2) for the year) of the input-price-adjusted annual national MedicarePlus capitation rate for the year, as determined under paragraph (4),

multiplied by a budget neutrality adjustment factor determined under paragraph (5).

"(B) MINIMUM AMOUNT.—

"(i) For 1996, $300.

"(ii) For 1997, $350.

"(iii) For a succeeding year, is the minimum amount specified in this subparagraph for the preceding year increased by national average per capita growth percentage, specified under paragraph (6) for that succeeding year.

"(C) MINIMUM INCREASE OF 2 PERCENT OVER PREVIOUS YEAR'S RATE.—

"(i) For 1996, 102 percent of the annual per capita rate of payment for 1995 determined under section 1876(a)(1)(C) for the MedicarePlus payment area.

"(ii) For a subsequent year, 102 percent of the annual MedicarePlus capitation rate under this subsection for the area for the previous year.

"(2) AREA-SPECIFIC AND NATIONAL PERCENTAGES.—For purposes of paragraph (1)(A)—

"(A) for 1996 and 1997, the 'area-specific percentage' is 90 percent and the 'national percentage' is 10 percent,

"(B) for 1998, the 'area-specific percentage' is 85 percent and the 'national percentage' is 15 percent,

"(C) for 1999, the 'area-specific percentage' is 80 percent and the 'national percentage' is 20 percent,

"(D) for 2000, the 'area-specific percentage' is 75 percent and the 'national percentage' is 25 percent, and

"(E) for a year after 2000, the 'area-specific percentage' is 70 percent and the 'national percentage' is 30 percent.

"(3) ANNUAL AREA-SPECIFIC MEDICAREPLUS CAPITATION RATE.—For purposes of paragraph (1)(A), the annual area-specific MedicarePlus capitation rate for a MedicarePlus payment area—

"(A) for 1996 is the annual per capita rate of payment for 1995 determined under section

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Attachment 6

health center services (as defined in
ner ambulatory services offered by a
center and which are otherwise in-

ray services;
services (other than services in an
es) for individuals 21 years of age or
screening, diagnostic, and treatment
section (r)) for individuals who are
l are under the age of 21; and[270] (C)
and supplies furnished (directly or
thers) to individuals of child-bearing
) can be considered to be sexually
r the State plan and who desire such

furnished by a physician (as defined
er furnished in the office, the pa-
[271] nursing facility, or elsewhere, and
ervices furnished by a dentist (de-
to the extent such services may be
either by a doctor of medicine or by a
or dental medicine and would be
rnished by a physician (as defined in

her type of remedial care recognized
by licensed practitioners within the
ined by State law;
ces including personal care services
an for an individual in accordance
g)) provided by an individual who is
vices and who is not a member of the
rvised by a registered nurse, and (D)
ner location; but not including such
npatient or resident of a nursing

rvices;
ed by or under the direction of a
whether the clinic itself is adminis-
ling such services furnished outside
l to an eligible individual who does
dwelling or does not have a fixed

and" and subparagraph (C), effective as if included
nd redesignated P.L. 101-239, §6402(d).
and this second subparagraph (C). For the effecti

". For the effective date, see Vol. II, P.L. 100-2

ragraph (B) in its entirety, effective April 1, 19
ations to carry out this amendment have b
(B)) as if formerly read, see Vol. III, P.L. 101-239.
lied". For the effective date, see Vol. II, P.L. 100-2

personal care services (A) prescribed by a physici
of treatment, (B) provided by an individual wh
is not a member of the individual's family,
shed in a home or other location; but not inclu
dent of a nursing facility", effective with respe
ber 1, 1994.

(10) dental services;
(11) physical therapy and related services;
(12) prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select;
(13) other diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level[273];
(14) inpatient hospital services and nursing[274] facility services for individuals 65 years of age or over in an institution for mental diseases;
(15) services in an intermediate care facility for the mentally retarded (other than[275] in an institution for mental diseases) for individuals who are determined, in accordance with section 1902(a)(31)(A), to be in need of such care;
(16) effective January 1, 1973, inpatient psychiatric hospital services for individuals under age 21, as defined in subsection (h);
(17) services furnished by a nurse-midwife (as defined in section 1861(gg)) which the nurse-midwife is legally authorized to perform under State law (or the State regulatory mechanism provided by State law), whether or not the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider;
(18) hospice care (as defined in subsection (o));
(19) case-management services (as defined in section 1915(g)(2));
(20) respiratory care services (as defined in section 1902(e)(9)(C));[276]
(21) services furnished by a certified pediatric nurse practitioner or certified family nurse practitioner (as defined by the Secretary) which the certified pediatric nurse practitioner or certified family nurse practitioner is legally authorized to perform under State law (or the State regulatory mechanism provided by State law), whether or not the certified pediatric nurse practitioner or certified family nurse practitioner is under the supervision of, or associated with, a physician or other health care provider; and[277]
(22)[278] any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary;[279]

[273] P.L. 101-508, §4719(a), inserted ", including any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level", effective November 5, 1990.
[274] P.L. 100-203, §4211(h)(6)(B), struck out ", skilled nursing facility services, and intermediate care" and substituted "and nursing". For the effective date, see Vol. II, P.L. 100-203, §4214.
[275] P.L. 100-203, §4211(h)(6)(C), struck out "intermediate care facility services (other than such services" and substituted "services in an intermediate care facility for the mentally retarded (other than". For the effective date, see Vol. II, P.L. 100-203, §4214.
[276] P.L. 101-239, §6405(a)(1), struck out "and".
[277] P.L. 101-239, §6405(a)(3), added this paragraph (21), effective with respect to services furnished by a certified pediatric nurse practitioner or certified family nurse practitioner on or after July 1, 1990.
[278] P.L. 101-239, §6405(a)(2), redesignated paragraph (21) as paragraph (22).
[279] P.L. 101-508, §4711(a)(1), struck out "and". Impossible to execute.

ANA IMPERATIVES
Summary of Status

1. Take Action on threats to patient safety and quality.

a) Administration support for legislation that:

i) would require providers to make available to the public certain information regarding nurse staffing and patient outcomes;

Doubtful, given VP's regulatory reform.

ii) protect "whistleblowers" employed by a health plan, who point out dangerous or potentially dangerous conditions;

HCFA strongly supports protection for whistleblowers; ANA given HCFA contact: Judy Berrick, HCFA

iii) require HHS to review merger applications to determine impact on patient care

Would add extra layer of regulatory review to DOJ and FTC merger reviews. Spoke to Bob Potter, Head of DOJ Antitrust Policy Office (514-2512) about consideration given to patient care. ANA given Bob Potter to discuss their concerns further.

b) Nurse involvement in HCFA managed care quality initiatives

HCFA would welcome. ANA given contact: Barbara Gagel, Director of Health Standards and Quality Bureau (410/786-6841)

c) Hold firm on current health and safety regulations, including those issued under OBRA 87's nursing home reform provisions.

Molly checking w/ HCFA & ANA

HCFA conducting extensive monitoring of the implementation of nursing home enforcement regulation that was implemented 7/1/95. (holding firm?)

2. a) Support legislation (WH letters of support for HR 1750, S 864, HR 1339, S 972) to provide reimbursement for services of all advanced practice nurses,...

No.

Jennifer Boulanger checking with their leg. affairs.

b) Reject state Medicaid waiver applications that fail to ensure utilization of nurses as primary care providers.

No. (unlikely) HCFA does encourage reform that increases access and quality. While not mandated, availability of adv. practice nurses is part of access.

Molly to check. (KG suggestion/discussion with JB: look into how quality assurance standards that are already in place could encourage utilization of nurses)

3. Increase number of nurses appointed to visible federal positions.

Yes. Peg Clark: Next week sending Helen Maramontes name to POTUS for AIDS Commission (ANA requested). Pushing HHS, but very few hires. ANA should forward names to Peg Clark (6-7831).

4. HRSA should conduct National Sample Survey of Registered Nurses beginning in 1995. Costs $800,000. $200,000 appropriated from HRSA.

Molly Clarify whether being funded, why we shld or shldn't. Ciro Sumaya, head of HRSA, commited to fund and conduct the initial stage of survey (with 1% funds). Looking to outside sources for rest of funding. Marla believes preferable if entirely government funded. Mary Beth checking whether we can get entire study done.

Hopeful.

5. Reich should allow H-1A Visa Program to sunset.

Done. (INS may allow some nurses in under more restrictive reqts -- advanced practice degrees--but few)

6. USTR should initiate discussins with Canada and Mexico to remove registered nurses and other health professionals for mAppendix 1603.D.1 of the NAFTA.

Roger Kramer - DOL

Steve checking. If no, call ~~Mike Garrity~~

Commerce | USTR oppose raising this in November. But leaning toward it.

7. a) Provide vocal support for funding of nurse education, including full reauthorization and full funding of the Nurse Education Act (S 555).

↳ Title XIII

Molly checking status S.555 held up in Senate (Coats abortion amendment). If doesn't move, Marla hopes for CR allowing them to contuineu at current levels.

✓ b) Continuation and funding of the Division of Nursing at HRSA

✓ Originally zeroed. Last pass back has it in at Pres' level.

c) Continuation and funding for NINR.

✓ Dir. Pat Grady speaking with Sen. Kassebaum next week -- re: consolidation rumors (targeting small inst's, not just NINR). Hbudget has 7.5% decrease across all institutes; Pres 4.4% increase; H-5.7% increase?

d) Continuation of funding for AHCPR.

Mentioned inletter to Senate prior to the start of Subcommittee work (Senate Comm increased from House cut). Item of concern(attachment ot Senate letter). We are trying to get funding restored to Pres level. 97 budget request?

8. Revamp HCFA guidleines for "incident to" provision under Medicare B, to include removal of the requirement fo on-site presence of a physician in order for "incident to" services to be covered.

No.

HCFA doing cost estimates.

9. Support Reauthorization of Community Nursing Organization project (due to sunset at end of 1996)

Give ANA status report.

Preliminary descriptive information indicates that apporximately 95% of current demonstration enrollees have 0 to 1 ADL impairment. But not enough outcome data yet on costs and impacts. Interim evaluation report due in early 1996. Demonstration scheduled to end January 1997.

Follow up with Jennifer: can we get a rough idea?

10. Make Chiefs of military nursing services tow-star flaga officers instead of one-star. ACTUALLY -- Allow chiefs of the nurse corsp to compete for promotion to two-star.

Molly checking w/ army to see if possible -- navy and air force already doing

Meeting this week (leadership development at all levles; open competition to nurses). Optimistic

M E M O R A N D U M

To: Jennifer Klein

From: Karen Guss

Date: September 1, 1995

Re: The American Nurses Association's "Ten Imperatives"

As you know, I have been following up on the American Nurses Association's Ten Imperatives for Administration Action. (The ANA's Ten Imperatives are actually more like fifteen or sixteen imperatives). I have listed them below, described where we are on each, and suggested next steps.

1. **Take action on threats to patient safety and quality.**

- ANA wants:
  Administration support of legislation requiring hospitals and other institutions that receive Medicare funds to disclose nurse staffing and outcome data.

  contact:
  Debbie Chang, HCFA (there was no way around Debbie on several of these!), 690-7961

  HCFA has been resistant to data disclosure in the past, contending that the principles behind the Vice President's regulatory review argue against data disclosure. As you stated in your memo to Harold, your role as the head of the health industry reg review group puts you in a good position to push HCFA on this.

- ANA wants:
  Participation of the nursing profession in HCFA initiatives to address the issue of quality within managed care programs.

  contact:
  Jennifer Boulanger, HCFA, 690-8502

- ANA wants:
  The Administration to hold firm on current health and safety regulations.

  contact: Debbie Chang

2. **Support legislation to provide reimbursement for services of all advanced practice nurses, regardless of geographic location or practice setting, under Medicare and Medicaid. Reject state Medicaid waiver applications that fail to ensure utilization of nurses as primary care providers.**

- ANA wants:
  White House letters of support to the Congressional leadership about certain Medicaid and Medicare reimbursement bills (H.R. 1750, S. 864, H.R. 1339, S. 972).

  contact: Debbie Chang

- ANA wants:
  The Administration to reject any state Medicaid waiver proposals that fail to ensure the utilization of nurses as primary care providers.

  contact: Jennifer Boulanger

  You have discussed this with Jennifer before and determined that it would be difficult to effect this change because the ANA's problem here is really a problem with managed care more than a problem with the waiver process. To the extent that the waiver process could theoretically be used to address the ANA's concerns, it would be difficult to put in the kind of restrictions the ANA wants given the Administration's emphasis on flexibility. However, I talked to Jennifer about looking into how the quality assurance standards that are already in place could encourage the utilization of nurses.

3. **Increase the number of nurses appointed to visible federal positions that affect public policy to federal commissions.**

   Per our discussion, I have taken no action on this imperative.

4. **HRSA should conduct a National Sample Survey of Registered Nurses beginning in 1995.**

   contacts:
   Marla Salmon, HRSA, 301 443-5786
   Mary Beth Donohue, HHS (Kevin Thurm's Office), 690-6133

   The National Sample Survey is the only initiative currently available to determine what is going on in the nursing workforce. This is an important issue for the ANA because, as you can see from the list of ANA imperatives, the ANA believes that nurses are not doing very well in "the changing health care industry environment." The National

Sample Survey could establish whether the ANA is right (and bolster its claims that its agenda should be supported).

Ciro Sumaya, who heads HRSA, has made a commitment to fund and conduct the initial stage of the survey. He has not committed to fund the remainder of the study. Instead, he has agreed to work with the ANA and other groups to try to secure alternative funding -- for example, from the groups themselves. However, Marla believes that it is important for the government to conduct the survey itself -- acting as an "honest broker" -- because the groups have their own agendas. Marla believes that Sumaya is using the study as a bargaining chip with the ANA and other nursing groups because he wants the groups to do more to promote the status of Hispanics and other minorities in the nursing workforce. In fact, Sumaya and Phil Lee apparently had a showdown on this issue; Dr. Lee wanted the entire study done but Sumaya held firm and refused to commit to funding the second part of the study.

The first part of the study will be funded by "1% funds," which is money set aside to conduct research and program evaluation. According to Marla, if HRSA continues to receive the amount of 1% funds it has received in the past, there will be enough money there to complete the survey.

I discussed this matter (although not in the detail I have given you above) with Mary Beth Donohue in Kevin Thurm's office and asked her to check into whether we can get the entire study done. She has not yet been able to get an answer from Kevin about it but she seems very cooperative. (It seemed more diplomatic to me to go through the Department to get the survey done, if possible.) I think we should be able to get this one done.

5. **Secretary Reich should allow the H-1A Visa Program to sunset, as scheduled, in September, 1995 as recommended by the Minority Report of the Immigration Nursing Relief Advisory Committee.**

contact:
John Frazier, Wages & Standards, Dept. of Labor, 219-8305

The H-1A Visa Program allows nurses to enter the United States to work for a specific employer if they are licensed and if the employer meets seven specific criteria (e.g., that the employment the employer is offering is temporary; that the employer has not laid off any American citizens for a number of years). This program ended at midnight on August 31, 1995. There is no legislation pending that would

continue the H-1A program.

The Secretary of Labor has an opportunity to recommend to Congress whether to continue this program. According to John Frazier, the Secretary now has in front of him a decision memo dealing with the program. Even if the Secretary decides for some reason that he would like to recommend continuing the H-1A program, he must get approval from the White House to do so. Therefore, we should be able to handle this one.

6. **The U.S. Trade Representative should initiate discussions with Canada and Mexico to remove registered nurses and other health professionals from Appendix 1603.D.1 of the NAFTA.**

contacts:
Paul Dasher, NAFTA Desk, Commerce (not very helpful), 482-3636
Bernie Ascher, Mickey Kantor's office, U.S.T.R., x59581
Helen deThomas, Immigration and Naturalization Service, 616-0704

Appendix 1603.D.1 deals with the "cross-border movement of professionals." Members of professions that are listed in the Appendix are eligible for expedited entry into the other NAFTA countries to practice their profession. Their entry must be for a limited amount of time.

Canada was the country that pushed the inclusion of registered nurses on this list. Approximately 25% of the Canadians who enter the United States pursuant to Appendix 1603.D.1 are registered nurses. Very few registered nurses enter the United States from Mexico.

NAFTA establishes a Temporary Entry Working Group in which all three countries participate. The INS is trying to arrange a meeting of the group in early November. Adding or subtracting professions from the Appendix can be negotiated within the Working Group. Everyone agrees that it would be easier to add professions than to subtract them and that Canada would resist attempts to remove registered nurses from the list. However, all the ANA has asked for is that discussions be initiated. According to Ms. deThomas, it would be possible to bring up removing registered nurses from the list at the Working Group meeting; if the Canadians ask for more than the United States is prepared to give in return, the United States could stop pursuing the issue. Of course, this approach could backfire and make the ANA even more angry.

Politics and logistics aside, none of the people I spoke to knew whether we want to remove registered nurses from the list as a policy matter. The INS is the lead agency on the issue of cross-border movement of professionals, but the person at INS who dealt with the issue during the negotiations is now gone (Ms. deThomas is her replacement). Mike Garrety at the DOL Solicitor's Office may be able to shine some light on the policy issues. His number is 219-8626.

7. **Provide vocal support for funding of nursing education, including full reauthorization of the Nurse Education Act (S. 555) as well as full funding of the Nurse Education Act. Support for continuation and funding of the Division of Nursing at HRSA, National Institute for Nursing Research and the Agency for Health Care Policy and Research and public health programs under the Health Resources and Services Administration.**

- ANA wants:
  Strong support for reauthorization and full funding of the NEA.

  contact: Mary Beth Donohue

  In the past, the Administration has supported the NEA. However, in the last several months the groups have begun to worry. Apparently, Shalala has made comments at at least one meeting to the effect that the programs dealt with in the NEA might fall victim to "tough budget choices." Mary Beth Donohue was aware of this issue. She will discuss with Kevin what exactly HHS's position is on the NEA and how vocal our support can be.

- ANA wants:
  Continuation of funding for the Division of Nursing at HRSA.

  contact: Marla Salmon

  Red flag here. According to Marla, who heads this division, the budget request for FY 1997 that HHS will soon "pass back" to the White House zeroes out the Division of Nursing at HRSA.

- ANA wants:
Continuation of funding for the National Institute for Nursing Research (NINR).

contact:
Pat Grady, NINR Director, 301 496-8230
Suzanne Feetham, NINR Deputy Director, 301 402-1446
Linda Cook, NINR, 301 496-0207

NINR is the smallest institute at NIH. NIH has done relatively well in the President's 1996 budget as well as in the House Labor/HHS Approp. bill. (The Senate has not yet considered Labor/HHS (even in committee)). HHS will ask for a slight increase for NIH in 1997. Neither the 1996 or 1997 budgets are specific enough to allocate funds to the individual NIH Institutes. According to Suzanne Feetham, the NIH leadership has been very supportive of the NINR and the NINR is not concerned that NIH will underfund it.

The larger concern for NINR (and probably for the ANA) is consolidation. There has been some talk in the past about consolidating NINR and some of the other small institutes into the larger institutes. Feetham has heard that Kassebaum's staffers have some interest in consolidating NINR with other institutes. NINR is opposed to this because it believes that NINR will lose its unique identity; NINR it believes its work is complementary to the work going on at the other, larger Institutes. A one-pager prepared by NINR is attached to this memo. It is important to note that the Administration has not shown any interest in trying to consolidate or weaken NINR.

- ANA wants:
Continuation of funding for AHCPR.

contact: Barry Clendenon, OMB, x54922

The President's February FY 1996 budget slated AHCPR, like many agencies, for 3-5-7-9 reductions. However, the President asked for $194 million for AHCPR in FY 1996 in the February budget, up from $163 million in FY 1995. The President's June FY 1996 budget would likely keep AHCPR's funding constant.

The House budget resolution called for the elimination of AHCPR, and the House Labor/HHS bill allotted AHCPR only $65 million. The Administration protested this large reduction in the letter we sent to the Senate for its consideration before it takes up Labor/HHS Approps. However, our protest was fairly weak; the Administration stated that the AHCPR reduction caused "some concern" and could hurt AHCPR's

mission. In addition, this statement was actually made in an attachment to the letter, not the letter itself (the letter is for top priorities only). Also, the Administration had not said anything about AHCPR before the letter to the Senate, even though we knew from the budget resolution that it was going to be a target for major cuts. The Senate budget resolution called for a cut in AHCPR's budget of 75%.

We do not know how much HHS is going to ask for for AHCPR in FY 1997. HHS's request is due to the White House on September 8.

Barry Clendenon stated that AHCPR's budget grew very quickly and that he believes it is reasonable to make fairly substantial cuts in it. Then again, those OMB types never met a cut they didn't like.

8. **Revamp HCFA guidelines for the "incident to" provision under Medicare B, to include removal of the requirement for on-site presence of a physician in order for "incident to" services to be covered.**

contact: Jennifer Boulanger

To state the obvious, it seems that we would really upset the doctors if we did this. There may also be a policy argument against it.

9. **Support reauthorization of the Community Nursing Organization (CNO) project (due to sunset at end of 1996).**

contact: Jennifer Boulanger

The CNO project is one of the initiatives you previously identified for the ANA as a training opportunity for nurses that is offered by HHS.

10. **Make the Chiefs of the military nursing services two-star flag officers instead of one-star.**

contact:
General Nancy Adams, Chief of the Army Nurse Corps,
410 671 4311.

This is a very interesting situation. As the ANA states, the Chiefs of the Nurse Corps are one-star officers. According to Gen. Adams, it is not a good idea to make the Chief of the Nurse Corps into a two-star position instead of a one-star position. Gen. Adams stated that the difference between a two-star general and a one-star general is like the difference between a major league baseball player and a minor leaguer. Therefore, it is good management for each two-star general to have at least one one-star general below her so that when the two-star general leaves, a one-star general who has had an opportunity to learn the skills she needs to become a two-star will be able to replace the outgoing two-star. A colonel would not be able to step directly into the shoes of the departing two-star general. However, it is not feasible to give the Nurse Corps a two-star and a one-star because there downsizing in the general ranks. Even if the Nurse Corps won the battle to get at least two generals at this time, it would only be a matter of time before these gains were reversed.

According to Gen. Adams, what the Army nurses really want is the opportunity to compete for two-star generalships after they have been Corps Chiefs. Currently, Army nurses are not permitted to compete for two-star positions (although Navy and Air Force Nurse Corps Chiefs are). In the past, the duty of the Chief of the Nurse Corps was solely to run the Nurse Corps. Today, the Chiefs of the Nurse Corps have been given much greater responsibilities that integrate them into higher levels of the medical divisions and allow them to bring a nursing perspective to bear on a larger scale. However, Nurse Corps Chief is only a four year position, and after leaving the Nurse Corps as a one-star general, there is unlikely to be another slot for a one-star general available in the medical division. Therefore, the opportunity for Army nurses to influence the conduct of business in the medical division is limited. Because they cannot compete for two-star status (and jobs that require a two-star general), outgoing Nurse Corps Chiefs are often forced into retirement. It is somewhat like an "up or out" situation in a law firm.

Accordingly, the Army Nurse Corps has been trying to get the rules changed so that nurses can compete for two-star generalships. (According to Gen. Adams, the change is working out quite well in the Navy and the Air Force). Lt.

General Alcid LaNoue, the Surgeon General of the Army, is sympathetic to the nurses' situation. He is meeting next week with the new Army Chief of Staff, General Dennis Reimer, to ask him to make the rule change. Gen. Adams is optimistic that this meeting will result in the rule change. She believes that White House intervention could be useful, but that it is best to wait until after LaNoue's meeting with Reimer in order to avoid unnecessary friction and give the Army the opportunity to change itself.

Effecting this rule change in the Army would not be delivering exactly what the ANA wants. However, I think we could make the case that it is even better because it will help nursing become more influential in the medical division while preserving the quality of the Nurse Corps leadership. I think it would be a good idea to talk to the Chiefs of the Navy and Air Force Nurse Corps to see if they share the Gen. Adams's perspective on this issue.

FACT SHEET

NATIONAL INSTITUTE OF NURSING RESEARCH
NATIONAL INSTITUTES OF HEALTH

Research supported by the National Institute of Nursing Research (NINR) is a critical component of the nation's biomedical and behavioral research effort. NINR's mission is to:

- reduce the burden of illness and disability by understanding and easing the effects of acute and chronic illness,
- improve health-related quality of life by preventing or delaying the onset of disease or slowing its progression,
- establish better approaches to promoting health and preventing disease,
- improve clinical environments by testing interventions that influence patient health outcomes and reduce costs and demand for care.

RELEVANCE OF NURSING RESEARCH

Answers to many of the nation's most pressing health problems are being pursued by nursing research. For example:

- How can health professionals provide high quality care in a cost-effective way? One concern is that the recent trend to discharge patients from the hospital early might compromise their health. Studies indicate that transitional care from hospital to residence, provided by advanced practice nurses, can reduce the incidence and length of rehospitalizations, increase patients' satisfaction with their care, and lower costs, in some cases by as much as 38%. Another research emphasis is to test methods to provide care to underserved at-risk populations in rural areas. Health promotion and disease prevention strategies are stressed.

- How can premature delivery and low birth weight be prevented to avert developmental problems and infant mortality? The infant mortality rate in the United States remains high. Health-care costs for children weighing less than 5.5 pounds at birth can be at minimum $21,000 a year, compared to $2,800 for normal weight infants. Studies show that such factors as culturally sensitive prenatal care, availability of telephone contact for the mother with advanced practice nurses, adequate social support systems, and education programs that promote maternal and fetal health can result in significant reductions in premature births and low birth weight.

- How can patients, caregivers and families cope with devastating illnesses such as Alzheimer's disease? As more of the U.S. population live to an older age, the number of people with dementia will increase dramatically, escalating health care costs for institutionalization and compromising the health and quality of life for all concerned. Researchers are testing techniques to slow the progression of cognitive impairment through such methods as mental stimulation exercises and strategies that promote self sufficiency. Methods to encourage urinary continence and ease the burden on caregivers are also being developed. The goal is to forestall costly institutionalization while promoting ways to cope with the disease.

- How can the little understood health problems of women in midlife be addressed? Symptoms associated with physiological changes in midlife, coupled with difficult health-related choices concerning hormone replacement therapy, hysterectomy, and breast cancer screening and treatment, are issues faced by many middle-aged women. Studies are revealing ways to ease menopausal symptoms, such as insomnia, gastrointestinal problems, and hot flashes, and help women make important health decisions that can affect the rest of their lives. This research has the potential to reduce demand for health care and the loss of work time for treatment of symptoms.

- How can the management of symptoms of acute and chronic illness be improved? Treatment of disease is vital but can produce highly discomforting, possibly dangerous side effects, sometimes causing patients to avoid life-saving therapies. Researchers are revealing ways to control side effects of such treatments as chemotherapy and HIV medication, promote adherence to treatment for people with tuberculosis and other illnesses, and ease pain, which if undertreated can be life-threatening and compromise recovery.

These are but some of the directions of nursing research today. The NINR at the National Institutes of Health is the Federal Government's focal point for nursing research and research training. Funding support is provided for studies at universities, clinical sites such as hospitals, and research centers across the United States. The findings are applicable to the practice of all health care providers and to the health of all the American people.

AMERICAN NURSES ASSOCIATION

600 Maryland Avenue SW
Suite 100 West
Washington, DC 20024-2571
202 651-7000 • Fax: 202 651-7001

Virginia Trotter Betts, JD, MSN, RN
President

Geri Marullo, MSN, RN
Executive Director

DEC 18 1995

Jennifer —
Pls. review
& also call
Betts —
What is our
deal on
this?

TO: Carol Rasco
Assistant to the President for Domestic Policy
The White House

FROM: Virginia Trotter Betts, JD, MSN, RN VTB
President
American Nurses Association

DATE: December 15, 1995

RE: Administration's Medicare and Medicaid Proposal

The American Nurses Association (ANA) is very concerned about several provisions contained in the Medicare and Medicaid sections of the Administration's budget proposal. A statement outlining those concerns, as well as acceptable remedies, is attached.

It is imperative that these concerns be remedied immediately. We look forward to hearing from you in this regard at your earliest convenience.

Attachments

g:\grel\mwv\whmdremdcd.wpd
12/15/95

AMERICAN NURSES ASSOCIATION

600 Maryland Avenue SW
Suite 100 West
Washington, DC 20024-2571
202 651-7000 • Fax: 202 651-7001

Virginia Trotter Betts, JD, MSN, RN
President

Geri Marullo, MSN, RN
Executive Director

THE PRESIDENT'S MEDICARE AND MEDICAID PROPOSALS MUST INCLUDE REIMBURSEMENT FOR ADVANCED PRACTICE NURSES

The American Nurses Association (ANA) is deeply concerned by the failure of the White House proposals on Medicare and Medicaid to include coverage for services of nurse practitioners (NPs) and clinical nurse specialists (CNSs).

Medicare and Medicaid reimbursement for NPs and CNSs has been a key part of ANA's legislative agenda for many years. ***Incredibly, the White House proposal is actually worse on this issue than the Republican budget bill.***

* **The *Republican bill* would have extended Medicare Part B coverage to services of nurse practitioners in all outpatient settings. The *White House proposal* includes no such provision.**

* **Currently, states are mandated by federal Medicaid law to cover the services of Family and Pediatric NPs and of Certified Nurse-Midwives in state Medicaid programs. The White House bill *fails* to extend this mandate to all NPs and to CNSs.**

The White House proposal would also allow states to move to Medicaid Primary Care Case Management programs without applying for a federal waiver, and to include NPs and CNMs as case managers "at state option"--meaning states can effectively circumvent requirements to cover NP and CNM services.

In addition, while the Republican proposal's provisions on Provider Sponsored Organizations would have included all appropriately licensed health care practitioners, the White House proposal would limit eligibility to physicians only. This is unacceptable to nursing, as well as to the broader non-physician community, which has already been vocal on this issue.

Nurses applauded the President's veto of the Republican budget bill, despite its inclusion of a provision for which nursing has worked hard for years--reimbursement for NPs in all geographic settings. We strongly and actively opposed the bill because we knew it would spell disaster for the entire health care system. Now that the President has decided to offer an alternative budget proposal, we are alarmed to learn that it actually does **worse** for nursing on this key issue than the Republican plan did.

We are astounded in light of the minimal cost of reimbursement for NPs and CNSs, as well as nursing's longstanding record of visible and continuing support for the President's health care initiatives. Congressional Budget Office estimates of the cost of the reimbursement provision in the Republican bill (which covered NPs and physician assistants) were a mere *$3 million over seven years*. ANA estimates that adding clinical nurse specialists (fewer of whom are in private practice settings than NPs) would cost another $0.6 million. This total of $3.6 million would add a minuscule six hundredths of one percent to the $5.9 billion in expansion of Medicare preventive services in the President's proposal (provisions we strongly support).

This distressing situation can be easily corrected--by including Medicare and Medicaid reimbursement for NPs and CNSs and provider status in PSOs in the White House's budget proposal.

Attachments: (1) S 864 (Grassley-Conrad bill for Medicare reimbursement for NPs and CNSs); (2) language on Medicare reimbursement from budget reconciliation conference report; (3) CBO figures on NP provisions in Republican budget bill; (4) HR 13339 (proposal for extending Medicaid reimbursement to all NPs and CNSs); (5) existing statutory requirement for Medicaid reimbursement coverage of Family NP, Pediatric NP and CNM services; (6) language from on Provider Sponsored Organizations from budget reconciliation report.

104TH CONGRESS
1ST SESSION

S. 864

To amend title XVIII of the Social Security Act to provide for increased medicare reimbursement for nurse practitioners and clinical nurse specialists to increase the delivery of health services in health professional shortage areas, and for other purposes.

IN THE SENATE OF THE UNITED STATES

MAY 25 (legislative day, MAY 15), 1995

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

---

A BILL

To amend title XVIII of the Social Security Act to provide for increased medicare reimbursement for nurse practitioners and clinical nurse specialists to increase the delivery of health services in health professional shortage areas, and for other purposes.

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

SECTION 1. SHORT TITLE.

This Act may be cited as the "Primary Care Health Practitioner Incentive Act of 1995".

SEC. 2. INCREASED MEDICARE REIMBURSEMENT FOR NURSE PRACTITIONERS AND CLINICAL NURSE SPECIALISTS.

(a) REMOVAL OF RESTRICTIONS ON SETTINGS.—

(1) IN GENERAL.—Section 1861(s)(2)(K)(ii) of the Social Security Act (42 U.S.C. 1395x(s)(2)(K)(ii)) is amended to read as follows:

"(ii) services which would be physicians' services if furnished by a physician (as defined in subsection (r)(1)) and which are performed by a nurse practitioner or clinical nurse specialist (as defined in subsection (aa)(5)) working in collaboration (as defined in subsection (aa)(6)) with a physician (as so defined) which the nurse practitioner or clinical nurse specialist is legally authorized to perform by the State in which the services are performed, and such services and supplies furnished as an incident to such services as would be covered under subparagraph (A) if furnished incident to a physician's professional service;".

(2) CONFORMING AMENDMENTS.—

(A) Section 1861(s)(2)(K) of such Act (42 U.S.C. 1395x(s)(2)(K)), as amended by paragraph (1), is amended—

(i) in clause (i), by inserting "and such services and supplies furnished as in-

cident to such services as would be covered under subparagraph (A) if furnished as an incident to a physician's professional service." after "are performed, and"; and

(ii) by striking clauses (iii) and (iv).

(B) Section 1861(b)(4) of such Act (42 U.S.C. 1395x(b)(4)) is amended by striking "clauses (i) or (iii) of subsection (s)(2)(K)" and inserting "subsection (s)(2)(K)".

(C) Section 1862(a)(14) of such Act (42 U.S.C. 1395y(a)(14)) is amended by striking "section 1861(s)(2)(K)(i) or 1861(s)(2)(K)(iii)" and inserting "section 1861(s)(2)(K)".

(D) Section 1866(a)(1)(H) of such Act (42 U.S.C. 1395cc(a)(1)(H)) is amended by striking "section 1861(s)(2)(K)(i) or 1861(s)(2)(K)(iii)" and inserting "section 1861(s)(2)(K)".

(b) INCREASED PAYMENT.—

(1) FEE SCHEDULE AMOUNT.—Section 1833(a)(1)(O) of the Social Security Act (42 U.S.C. 1395*l*(a)(1)(O)) is amended to read as follows: "(O) with respect to services described in section 1861(s)(2)(K)(ii) (relating to nurse practitioner or clinical nurse specialist services), the amounts paid

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

(2) CONFORMING AMENDMENTS.—

(A) Section 1833(r) of such Act (42 U.S.C. 1395*l*(r)) is amended—

(i) in paragraph (1), by striking "section 1861(s)(2)(K)(iii) (relating to nurse practitioner or clinical nurse specialist services provided in a rural area)," and inserting "section 1861(s)(2)(K)(ii) (relating to nurse practitioner or clinical nurse specialist services),";

(ii) by striking paragraph (2);

(iii) in paragraph (3), by striking "section 1861(s)(2)(K)(iii)" and inserting "section 1861(s)(2)(K)(ii)"; and

(iv) by redesignating paragraph (3) as paragraph (2).

(B) Section 1842(b)(12)(A) of such Act (42 U.S.C. 1395u(b)(12)(A)) is amended in the matter preceding clause (i), by striking "clauses (i), (ii), or (iv) of section 1861(s)(2)(K) (relating to a physician assistants and nurse practitioners)" and inserting "section 1861(s)(2)(K)(i) (relating to physician assistants)".

(c) DIRECT PAYMENT FOR NURSE PRACTITIONERS AND CLINICAL NURSE SPECIALISTS.—

(1) IN GENERAL.—Section 1832(a)(2)(B)(iv) of the Social Security Act (42 U.S.C. 1395k(a)(2)(B)(iv)) is amended by striking "provided in a rural area (as defined in section 1886(d)(2)(D))".

(2) CONFORMING AMENDMENT.—Section 1842(b)(6)(C) of such Act (42 U.S.C. 1395u(b)(6)(C)) is amended—

(A) by striking "clauses (i), (ii), or (iv)" and inserting "clause (i)"; and

(B) by striking "or nurse practitioner".

(d) BONUS PAYMENT FOR SERVICES PROVIDED IN HEALTH PROFESSIONAL SHORTAGE AREAS.—Section 1833(m) of such Act (42 U.S.C. 1395*l*(m)) is amended—

(1) by inserting "(1)" after "(m)"; and

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

"(2) In the case of services of a nurse practitioner or clinical nurse specialist furnished to an individual, described in paragraph (1), in an area that is a health professional shortage area as described in such paragraph, in addition to the amount otherwise paid under this part, there shall also be paid to such service provider (on a monthly or quarterly basis) from the Federal Supplementary Medical Insurance Trust Fund an amount equal to 10 percent of the payment amount for the service under this part.".

(e) DEFINITION OF CLINICAL NURSE SPECIALIST CLARIFIED.—Section 1861(aa)(5) of such Act (42 U.S.C. 1395x(aa)(5)) is amended—

(1) by inserting "(A)" after "(5)";

(2) by striking "The term "'physician assistant'" and all that follows through "who performs" and inserting "The term 'physician assistant' and the term 'nurse practitioner' mean, for purposes of this title, a physician assistant or nurse practitioner who performs"; and

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

"(B) The term 'clinical nurse specialist' means, for purposes of this title, an individual who—

"(i) is a registered nurse and is licensed to practice nursing in the State in which the clinical nurse specialist services are performed; and

"(ii) holds a master's degree in a defined clinical area of nursing from an accredited educational institution.".

(f) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to services furnished and supplies provided on and after July 1, 1995.

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shall accept patients transferred to the hospital from the facility and receive data from and transmit data to the facility.

"(E) There is a practitioner who is qualified to provide advanced cardiac life support services (as determined by the State in which the facility is located) on-site at the facility on a 24-hour basis.

"(F) A physician is available on-call to provide emergency medical services on a 24-hour basis.

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

"(i) the facility need not meet hospital standards relating to the number of hours during a day, or days during a week, in which the facility must be open, except insofar as the facility is required to provide emergency care on a 24-hour basis under subparagraphs (E) and (F); and

"(ii) the facility may provide any services otherwise required to be provided by a full-time, on-site dietitian, pharmacist, laboratory technician, medical technologist, or radiological technologist on a part-time, off-site basis.

"(H) The facility meets the requirements applicable to clinics and facilities under subparagraphs (C) through (J) of paragraph (2) of section 1861(aa) and of clauses (ii) and (iv) of the second sentence of such paragraph (or, in the case of the requirements of subparagraph (E), (F), or (J) of such paragraph, would meet the requirements if any reference in such subparagraph to a 'nurse practitioner' or to 'nurse practitioners' were deemed to be a reference to a 'nurse practitioner or nurse' or to 'nurse practitioners or nurses'); except that in determining whether a facility meets the requirements of this subparagraph, subparagraphs (E) and (F) of that paragraph shall be applied as if any reference to a 'physician' is a reference to a physician as defined in section 1861(r)(1).

"(2) The term 'rural emergency access care hospital services' means the following services provided by a rural emergency access care hospital and furnished to an individual over a continuous period not to exceed 24 hours (except that such services may be furnished over a longer period in the case of an individual who is unable to leave the hospital because of inclement weather):

"(A) An appropriate medical screening examination (as described in section 1867(a)).

"(B) Necessary stabilizing examination and treatment services for an emergency medical condition and labor (as described in section 1867(b)).".

(b) REQUIRING RURAL EMERGENCY ACCESS CARE HOSPITALS TO MEET HOSPITAL ANTI-DUMPING REQUIREMENTS.—Section 1867(e)(5) (42 U.S.C. 1395dd(e)(5)) is amended by striking "1861(mm)(1))" and inserting "1861(mm)(1)) and a rural emergency access care hospital (as defined in section 1861(oo)(1))".

(c) COVERAGE AND PAYMENT FOR SERVICES.—

(1) COVERAGE.—Section 1832(a)(2) (42 U.S.C. 1395k(a)(2)) is amended—

(A) by striking "and" at the end of subparagraph (I);

(B) by striking the period at the end of subparagraph (J) and inserting "; and"; and

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

"(K) rural emergency access care hospital services (as defined in section 1861(oo)(2)).".

(2) PAYMENT BASED ON PAYMENT FOR OUTPATIENT CRITICAL ACCESS HOSPITAL SERVICES.—

(A) IN GENERAL.—Section 1833(a)(6) (42 U.S.C. 1395l(a)(6)), as amended by section 8702(f)(2), is amended by striking "services," and inserting "services and rural emergency access care hospital services,".

(B) PAYMENT METHODOLOGY DESCRIBED.—Section 1834(g) (42 U.S.C. 1395m(g)), as amended by section 8702(f)(2)(B), is amended—

(i) in the heading, by striking "SERVICES" and inserting "SERVICES AND RURAL EMERGENCY ACCESS CARE HOSPITAL SERVICES"; and

(ii) by adding at the end the following new sentence: "The amount of payment for rural emergency access care hospital services provided during a year shall be determined using the applicable method provided under this subsection for determining payment for outpatient rural primary care hospital services during the year.".

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

SEC. 8704. CLASSIFICATION OF RURAL REFERRAL CENTERS.

(a) PROHIBITING DENIAL OF REQUEST FOR RECLASSIFICATION ON BASIS OF COMPARABILITY OF WAGES.—

(1) IN GENERAL.—Section 1886(d)(10)(D) (42 U.S.C. 1395ww(d)(10)(D)) is amended—

(A) by redesignating clause (iii) as clause (iv); and

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

"(iii) Under the guidelines published by the Secretary under clause (i), in the case of a hospital which is classified by the Secretary as a rural referral center under paragraph (5)(C), the Board may not reject the application of the hospital under this paragraph on the basis of any comparison between the average hourly wage of the hospital and the average hourly wage of hospitals in the area in which it is located.".

(2) EFFECTIVE DATE.—Notwithstanding section 1886(d)(10)(C)(ii) of the Social Security Act, a hospital may submit an application to the Medicare Geographic Classification Review Board during the 30-day period beginning on the date of the enactment of this Act requesting a change in its classification for purposes of determining the area wage index applicable to the hospital under section 1886(d)(3)(D) of such Act for fiscal year 1997, if the hospital would be eligible for such a change in its classification under the standards described in section 1886(d)(10)(D) (as amended by paragraph (1)) but for its failure to meet the deadline for applications under section 1886(d)(10)(C)(ii).

(b) CONTINUING TREATMENT OF PREVIOUSLY DESIGNATED CENTERS.—Any hospital classified as a rural referral center by the Secretary of Health and Human Services under section 1886(d)(5)(C) of the Social Security Act for fiscal year 1994 shall be classified as such a rural referral center for fiscal year 1996 and each subsequent fiscal year.

SEC. 8705. FLOOR ON AREA WAGE INDEX.

(a) IN GENERAL.—For purposes of section 1886(d)(3)(E) of the Social Security Act for discharges occurring on or after October 1, 1995, the area wage index applicable under such section to any hospital which is not located in a rural area (as defined in section 1886(d)(2)(D) of such Act) may not be less than the average of the area wage indices applicable under such section to hospitals located in rural areas in the State in which the hospital is located.

(b) IMPLEMENTATION.—The Secretary of Health and Human Services shall adjust the area wage indices referred to in subsection (a) for hospitals not described in such subsection in a manner which assures that the aggregate payments made under section 1886(d) of the Social Security Act in a fiscal year for the operating costs of inpatient hospital services are not greater or less than those which would have been made in the year if this section did not apply.

SEC. 8706. ADDITIONAL PAYMENTS FOR PHYSICIANS' SERVICES FURNISHED IN SHORTAGE AREAS.

(a) INCREASE IN AMOUNT OF ADDITIONAL PAYMENT.—Section 1833(m) (42 U.S.C. 1395l(m)) is amended by striking "10 percent" and inserting "20 percent".

(b) RESTRICTION TO PRIMARY CARE SERVICES.—Section 1833(m) (42 U.S.C. 1395l(m)) is amended by inserting after "physicians' services" the following: "consisting of primary care services (as defined in section 1842(i)(4))".

(c) EXTENSION OF PAYMENT FOR FORMER SHORTAGE AREAS.—

(1) IN GENERAL.—Section 1833(m) (42 U.S.C. 1395l(m)) is amended by striking "area," and inserting "area (or, in the case of an area for which the designation as a health professional shortage area under such section is withdrawn, in the case of physicians' services furnished to such an individual during the 3-year period beginning on the effective date of the withdrawal of such designation),".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to physicians' services furnished in an area for which the designation as a health professional shortage area under section 332(a)(1)(A) of the Public Health Service Act is withdrawn on or after January 1, 1996.

(d) REQUIRING CARRIERS TO REPORT ON SERVICES PROVIDED.—Section 1842(b)(3) (42 U.S.C. 1395u(b)(3)) is amended—

(1) by striking "and" at the end of subparagraph (I); and

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

"(J) will provide information to the Secretary (on such periodic basis as the Secretary may require) on the types of providers to whom the carrier makes additional payments for certain physicians' services pursuant to section 1833(m), together with a description of the services furnished by such providers; and".

(e) EFFECTIVE DATE.—The amendments made by subsections (a), (b), and (d) shall apply to physicians' services furnished on or after October 1, 1995.

SEC. 8707. PAYMENTS TO PHYSICIAN ASSISTANTS AND NURSE PRACTITIONERS FOR SERVICES FURNISHED IN OUTPATIENT OR HOME SETTINGS.

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

(1) in clause (i)—

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

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

(2) in clause (ii)—

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

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

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

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

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

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

(2) CONFORMING AMENDMENT.—Section 1842(b)(6)(C) (42 U.S.C. 1395u(b)(6)(C)) is amended by striking "clauses (i), (ii), or (iv)" and inserting "subclauses (I), (II), or (III) of clause (i), clause (ii)(I), or clause (iv)".

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

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

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

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

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

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

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

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

SEC. 8708. EXPANDING ACCESS TO NURSE AIDE TRAINING IN UNDERSERVED AREAS.

(a) IN GENERAL.—Section 1819(f)(2)(B)(iii)(I) (42 U.S.C. 1396r(f)(2)(B)(iii)(I)) is amended in the matter preceding item (a), by striking "by or in a nursing facility" and inserting "by a nursing facility (or in such a facility, unless the State determines that there is no other such program offered within a reasonable distance, provides notice of the approval to the State long term care ombudsman, and assures, through an oversight effort, that an adequate environment exists for such a program)".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to nurse aide training and competency evaluation programs under section 1819 of the Social Security Act which are offered on or after October 1, 1995.

TITLE IX—TRANSPORTATION AND RELATED PROVISIONS

SEC. 9001. MINIMUM ALLOCATION FOR HIGHWAY PROGRAMS.

(a) TECHNICAL CORRECTION.—With respect to fiscal year 1996—

(1) the Secretary of Transportation shall determine, in accordance with the policies established by the Intermodal Surface Transportation Efficiency Act of 1991 (105 Stat. 1914)—

(A) which of the States will no longer require an apportionment under section 157(a)(4) of title 23, United States Code; and

(B) which of the States will require decreased funding under such section 157(a)(4);

as a result of the termination of the Interstate construction program; and

(2) as a result of the reduced number of States that may require an apportionment under such section 157(a)(4), and the decrease in the amount of funds some States will require under such section 157(a)(4), the maximum amount available for apportionment under such section 157(a)(4) shall be reduced from the amount apportioned under such section 157(a)(4) for fiscal year 1995 by 60.4 percent.

(b) EFFECT ON CERTAIN CALCULATIONS.—The correction made by subsection (a) shall be made after the reduction required under section 1003(c) of the Intermodal Surface Transportation Efficiency Act of 1991 (105 Stat. 1921) and shall not be taken into account in making the calculations under sections 1003(c), 1013(c), and 1015 of such Act (105 Stat. 1921, 1940, and 1943).

SEC. 9002. EXTENSION OF HIGHER VESSEL TONNAGE DUTIES.

(a) EXTENSION OF DUTIES.—Section 36 of the Act of August 5, 1909 (36 Stat. 111; 46 U.S.C. App. 121), is amended by striking "for fiscal years 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998," each place it appears and inserting "for fiscal years through fiscal year 2002,".

(b) CONFORMING AMENDMENT.—The Act entitled "An Act concerning tonnage duties on vessels entering otherwise than by sea", approved March 8, 1910 (36 Stat. 234; 46 U.S.C. App. 132), is amended by striking "for fiscal years 1991, 1992, 1993, 1994, 1995, 1996, 1997, and 1998," and inserting "for fiscal years through fiscal year 2002,".

SEC. 9003. FEMA RADIOLOGICAL EMERGENCY PREPAREDNESS FEES.

(a) IN GENERAL.—The Director of the Federal Emergency Management Agency may assess and collect fees applicable to persons subject to radiological emergency preparedness regulations issued by the Director.

(b) REQUIREMENTS.—The assessment and collection of fees by the Director under subsection (a) shall be fair and equitable and shall reflect the full amount of costs to the Agency of providing radiological emergency planning, preparedness, response, and associated services. Such fees shall be assessed by the Director in a manner that reflects the use of resources of the Agency for classes of regulated persons and the administrative costs of collecting such fees.

(c) AMOUNT OF FEES.—The aggregate amount of fees assessed under subsection (a) in a fiscal year shall approximate, but not be less than, 100 percent of the amounts anticipated by the Director to be obligated for the radiological emergency preparedness program of the Agency for such fiscal year.

(d) DEPOSIT OF FEES IN TREASURY.—Fees received pursuant to subsection (a) shall be deposited in the general fund of the Treasury as offsetting receipts.

(e) EXPIRATION OF AUTHORITY.—The authority of the Director to assess and collect fees under subsection (a) shall expire on September 30, 2002.

TITLE X—VETERANS AND RELATED PROVISIONS

SEC. 10001. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This title may be cited as the "Veterans Reconciliation Act of 1995".

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

Sec. 10001. Short title; table of contents.

Subtitle A—Extension of Temporary Authorities

Sec. 10011. Authority to require that certain veterans make copayments in exchange for receiving health-care benefits.

Sec. 10012. Medical care cost recovery authority.

Sec. 10013. Income verification authority.

Sec. 10014. Limitation on pension for certain recipients of medicaid-covered nursing home care.

Sec. 10015. Home loan fees.

Sec. 10016. Procedures applicable to liquidation sales on defaulted home loans guaranteed by the Department of Veterans Affairs.

Sec. 10017. Enhanced loan asset sale authority.

Subtitle B—Other Matters

Sec. 10021. Revision to prescription drug copayment.

Sec. 10022. Rounding down of cost-of-living adjustments in compensation and DIC rates.

Sec. 10023. Revised standard for liability for injuries resulting from Department of Veterans Affairs treatment.

Sec. 10024. Withholding of payments and benefits.

Subtitle A—Extension of Temporary Authorities

SEC. 10011. AUTHORITY TO REQUIRE THAT CERTAIN VETERANS MAKE COPAYMENTS IN EXCHANGE FOR RECEIVING HEALTH-CARE BENEFITS.

(a) HOSPITAL AND MEDICAL CARE.—Section 8013(e) of the Omnibus Budget Reconciliation Act of 1990 (38 U.S.C. 1710 note) is amended by striking out "September 30, 1998" and inserting in lieu thereof "September 30, 2002".

(b) OUTPATIENT MEDICATIONS.—Section 1722A(c) of title 38, United States Code, is amended by striking out "September 30, 199 and inserting in lieu thereof "September 2002".

SEC. 10012. MEDICAL CARE COST RECOVERY A THORITY.

Section 1729(a)(2)(E) of title 38, United Stat Code, is amended by striking out "before Oct ber 1, 1998," and inserting "before October 2002,".

SEC. 10013. INCOME VERIFICATION AUTHORITY.

Section 5317(g) of title 38, United States Coc is amended by striking out "September 30, 199 and inserting in lieu thereof "September 2002".

SEC. 10014. LIMITATION ON PENSION FOR CE TAIN RECIPIENTS OF MEDICAID-CO ERED NURSING HOME CARE.

Section 5503(f)(7) of title 38, United Sta Code, is amended by striking out "September 1998" and inserting in lieu thereof "Septemb 30, 2002".

SEC. 10015. HOME LOAN FEES.

Section 3729(a) of title 38, United States Coc is amended—

(1) in paragraph (4), by striking out "Octol 1, 1998" and inserting in lieu thereof "October 2002"; and

(2) in paragraph (5)(C), by striking out "Oct ber 1, 1998" and inserting in lieu thereof "Oct ber 1, 2002".

SEC. 10016. PROCEDURES APPLICABLE TO LI UIDATION SALES ON DEFAULTE HOME LOANS GUARANTEED BY TH DEPARTMENT OF VETERANS A FAIRS.

Section 3732(c)(11) of title 38, United Stat Code, is amended by striking out "October 1998" and inserting "October 1, 2002".

SEC. 10017. ENHANCED LOAN ASSET SALE A THORITY.

Section 3720(h)(2) of title 38, United Stat Code, is amended by striking out "December 3 1995" and inserting in lieu thereof "Septemb 30, 2002".

Subtitle B—Other Matters

SEC. 10021. REVISION TO PRESCRIPTION DRU COPAYMENT.

(a) INCREASE IN AMOUNT OF COPAYMENT.—Section 1722A(a) of title 38, United States Cod is amended—

(1) in paragraph (1), by striking out "$2" an inserting in lieu thereof "$4";

(2) by striking out paragraph (2); and

(3) by redesignating paragraph (3) as par graph (2) and in that paragraph—

(A) striking out "or" at the end of subpar graph (A);

(B) striking out the period at the end of su paragraph (B) and inserting in lieu thereof or"; and

(C) adding at the end the following new su paragraph:

"(C) to a veteran who is a former prisoner war.".

(b) RECOVERY OF INDEBTEDNESS.—(1) Sectio 5302 of such title is amended by adding at t end the following new subsection:

"(f) The Secretary may not waive under th section the recovery of any payment or the co lection of any indebtedness owed under sectio 1722A of this title.".

(2) The amendment made by paragraph (shall apply with respect to amounts that becon due to the United States under section 1722A title 38, United States Code, on or after the da of the enactment of this Act.

SEC. 10022. ROUNDING DOWN OF COST-OF-LIVIN ADJUSTMENTS IN COMPENSATIO AND DIC RATES.

(a) FISCAL YEAR 1996 COLA.—(1) Effective o of December 1, 1995, the Secretary of Veterar Affairs shall recompute any increase in an a justment that is otherwise provided by law to l effective during fiscal year 1996 in the rates disability compensation and dependency and in demnity compensation paid by the Secretary such rates were in effect on November 30, 199

Attachment 3

CHART 2 -- MEDICARE

Medicare Proposal (based on specs through 9/24): Preliminary CBO Staff Estimates

By fiscal year, in billions of dollars	1996	1996	1997	1998	1999	2000	2001	2002	7-year savings Total
Medicare Part A:									
Provider Reimbursement Options									
PPS MB-2.5% thru 2002		-0.2	-1.3	-3.0	-4.8	-6.8	-8.9	-11.2	-36.1
Rebase Capital rates		-0.3	-0.4	-0.4	-0.4	-0.4	-0.4	-0.4	-2.7
Reduce PPS capital by 15%		-1.0	-1.2	-1.3	-1.3	-1.4	-1.4	-1.5	-9.0
Reduce Disproportionate Share to 25%		-0.1	-0.3	-0.5	-0.7	-0.9	-0.9	-1.0	-4.5
Reduce IME to 6.7, 5.6, 4.6%		-0.4	-0.9	-1.5	-1.7	-1.7	-1.8	-1.9	-9.9
Change PPS-exempt pmt ceilings and floors		-0.0	-0.1	-0.2	-0.4	-0.5	-0.7	-0.7	-2.7
NonPPS MB-2.5% thru 2002		-0.0	-0.1	-0.2	-0.3	-0.4	-0.5	-0.6	-2.0
Reduce NonPPS capital by 15%		-0.1	-0.2	-0.2	-0.2	-0.2	-0.3	-0.3	-1.5
SNFs		-0.2	-0.6	-1.0	-1.4	-1.9	-2.3	-2.9	-10.4
Home Health Prospective Payment /1		0.0	-1.4	-2.3	-2.8	-3.3	-3.7	-4.3	-17.8
Hospice		0.0	0.0	-0.1	-0.1	-0.1	-0.1	-0.1	-0.5
Critical Access Hospitals, Extend MDH		0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.5
AAPCC Interaction with DSH,IME,GME /2		0.0	0.8	1.5	1.8	2.0	2.2	2.5	10.7
Part A		-2.4	-6.5	-9.1	-12.2	-16.6	-18.9	-22.2	-85.8
Medicare Part B:									
Provider Reimbursement Options									
Eliminate Formula Driven Overpayment		-0.9	-1.2	-1.5	-2.0	-2.5	-3.3	-4.5	-15.9
Extend 5.8% Outpatient payment reduction		0.0	0.0	0.0	-0.3	-0.3	-0.4	-0.4	-1.4
Increase Outpatient capital reduction to 15%		-0.0	-0.0	-0.1	-0.2	-0.2	-0.2	-0.3	-1.0
Freeze Ambulatory Surgical Center updates		-0.0	-0.1	-0.1	-0.2	-0.2	-0.3	-0.4	-1.3
Revise MVPS (CF-3.65% in 96; GDP+2 thru 2002)		-0.4	-1.3	-2.3	-3.2	-4.1	-5.1	-6.2	-22.6
Freeze Clinical lab update, 85% of median		-0.1	-0.4	-0.7	-0.9	-1.1	-1.3	-1.6	-6.0
Freeze Dur Med Eqpt update, -40% on oxygen		-0.3	-0.6	-0.7	-0.9	-1.0	-1.3	-1.5	-6.2
Eliminate Ambulance Update		-0.0	-0.0	-0.1	-0.1	-0.1	-0.2	-0.3	-0.8
Increase bonus to rural prim care docs		0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.4
Direct payments to nurse prac/phys assts.		0.0	0.0	0.0	0.0	-0.1	-0.1	-0.1	-0.3
REACH		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1
Interactions		-0.1	-0.1	-0.2	-0.2	-0.3	-0.3	-0.3	-1.4
Beneficiary Options /3									
Deductible to $150 in 96; +$10/year thereafter		-0.7	-1.1	-1.3	-1.5	-1.7	-2.0	-2.2	-10.5
31.5% Premium through 2002; rounded up		-3.4	-4.4	-4.4	-5.0	-8.5	-11.1	-14.1	-51.6
Income-related premiums		0.0	-0.5	-0.9	-1.4	-1.8	-2.1	-2.5	-9.1
Part B		-5.8	-9.4	-12.0	-16.5	-21.9	-27.8	-33.9	-126.9

DRAFT

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I

104TH CONGRESS
1ST SESSION

H. R. 1339

To amend title XIX of the Social Security Act to provide for mandatory coverage of services furnished by nurse practitioners and clinical nurse specialists under State medicaid plans.

IN THE HOUSE OF REPRESENTATIVES

MARCH 28, 1995

Mr. RICHARDSON (for himself, Ms. ESHOO, Mr. FROST, Mr. MCHALE, Ms. RIVERS, Mr. VENTO, Mr. MINGE, Mrs. LOWEY, Ms. PELOSI, Ms. LOFGREN, and Mr. DELLUMS) introduced the following bill; which was referred to the Committee on Commerce

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A BILL

To amend title XIX of the Social Security Act to provide for mandatory coverage of services furnished by nurse practitioners and clinical nurse specialists under State medicaid plans.

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

SECTION 1. MEDICAID COVERAGE OF SERVICES FURNISHED BY CERTIFIED NURSE PRACTITIONERS AND CLINICAL NURSE SPECIALISTS.

(a) IN GENERAL.—Section 1905(a)(21) of the Social Security Act (42 U.S.C. 1396d(a)(21)) is amended to read as follows:

"(21) services furnished by a certified nurse practitioner (as defined by the Secretary) or a clinical nurse specialist (as defined in subsection (t)) which the certified nurse practitioner or clinical nurse specialist is legally authorized to perform under State law (or the State regulatory mechanism provided by State law), whether or not the certified nurse practitioner or clinical nurse specialist is under the supervision of, or associated with, a physician or other health care provider;".

(b) DEFINITION OF CLINICAL NURSE SPECIALIST.—Section 1905 of such Act (42 U.S.C. 1396d) is amended by adding at the end the following new subsection:

"(t) The term 'clinical nurse specialist' means an individual who has earned a master's degree in a clinical area of nursing from an accredited institution and who is a registered nurse licensed to practice nursing in the State in which the individual furnishes services.".

(c) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) shall apply to calendar quarters

beginning on or after January 1, 1996, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

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"(iii) any provisions of State law which relate to the licensing of the organization and which prohibit the organization from providing coverage pursuant to a contract under this part shall be superseded.

Nothing in this subparagraph shall be construed as limiting the number of times such a waiver may be renewed.

"(D) CONSTRUCTION.—Nothing in this paragraph shall be construed as affecting the operation of section 514 of the Employee Retirement Income Security Act of 1974.

"(5) EXCEPTION IF REQUIRED TO OFFER MORE THAN MEDICAREPLUS PLANS.—Paragraph (1) shall not apply to a MedicarePlus organization in a State if the State requires the organization, as a condition of licensure, to offer any product or plan other than a MedicarePlus plan.

"(6) EXCEPTION IN CASES OF UNREASONABLE BARRIERS TO MARKET ENTRY.—

"(A) IN GENERAL.—A MedicarePlus organization that seeks to offer a MedicarePlus plan in a State may apply for a waiver of the requirement of paragraph (1) for that organization operating in that State.

"(B) STANDARD.—The Secretary shall act on such an application within 60 days after the date it is filed and shall grant such a waiver for an organization with respect to a State if the Secretary determines that—

"(i) the State (I) denied such a licensing application or (II) unreasonably delayed in acting upon the application, and

"(ii) the State's licensing standards or review process imposes unreasonable barriers to market entry, including through the imposition of any requirements, procedures, or other standards to such organizations that are not generally applicable to any other entities engaged in substantially similar business.

"(C) APPLICATION OF CERTAIN RULES.—The provisions of subparagraphs (C) and (D) of paragraph (4) shall apply to this paragraph in the same manner as they apply under such paragraph, except that for this purpose any reference in paragraph (4)(C)(i) to 36-month period is deemed a reference to a 24-month period.

"(b) PREPAID PAYMENT.—A MedicarePlus organization shall be compensated (except for deductibles, coinsurance, and copayments) for the provision of health care services to enrolled members by a payment which is paid on a periodic basis without regard to the date the health care services are provided and which is fixed without regard to the frequency, extent, or kind of health care service actually provided to a member.

"(c) ASSUMPTION OF FULL FINANCIAL RISK.—The MedicarePlus organization shall assume full financial risk on a prospective basis for the provision of the health care services (except, at the election of the organization, hospice care) for which benefits are required to be provided under section 1852(a)(1), except that the organization—

"(1) may obtain insurance or make other arrangements for the cost of providing to any enrolled member such services the aggregate value of which exceeds $5,000 in any year,

"(2) may obtain insurance or make other arrangements for the cost of such services provided to its enrolled members other than through the organization because medical necessity required their provision before they could be secured through the organization,

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

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

In the case of a MedicarePlus organization that is a union sponsor, Taft-Hartley sponsor, or a qualified association sponsor, this subsection shall not apply with respect to MedicarePlus plans offered by such organization and issued by an organization to which subsection (b)(1) applies or by a provider-sponsored organization (as defined in section 1854(a)).

"(d) PROVISION AGAINST RISK OF INSOLVENCY.—

"(1) IN GENERAL.—Each MedicarePlus organization shall meet standards under section 1856 relating to the financial solvency and capital adequacy of the organization and including provision to prevent enrollees from being held liable to any person or entity for the plan sponsor's debts in the event of the plan sponsor's insolvency. Such standards shall take into account the nature and type of MedicarePlus plans offered by the organization.

"(2) TREATMENT OF PROVIDER-SPONSORED ORGANIZATIONS.—

"(A) IN GENERAL.—In the case of an entity that is a provider-sponsored organization that is operating—

"(i) in a State approved under subparagraph (B), the organization shall meet the standards described in paragraph (1) through licensure by the State, or

"(ii) in a State that is not so approved, the organization shall meet the standards described in paragraph (1) through application and certification licensure by the Secretary.

"(B) APPROVED STATES.—

"(i) APPLICATION PROCESS.—For purposes of subparagraph (A), the Secretary shall establish a process under which a State may apply to the Secretary for a determination that the State is applying to provider-sponsored organizations, through its process for licensing provider-sponsored organizations, solvency standards that are identical with the solvency standards established under section 1856(c) for such organizations.

"(ii) DETERMINATION.—The Secretary shall approve such a State if the Secretary determines that the State is so applying such standards. If the Secretary denies such an approval, the State may reapply for such a determination.

"(iii) PUBLICATION.—The Secretary shall publish a list of States that are approved under this subparagraph.

"(3) TREATMENT OF UNION AND TAFT-HARTLEY SPONSORS.—An entity that is a union sponsor or a Taft-Hartley sponsor is deemed to meet the requirement of paragraph (1).

"(4) TREATMENT OF CERTAIN QUALIFIED ASSOCIATION SPONSORS.—An entity that is a qualified association sponsor is deemed to meet the requirement of paragraph (1) with respect to MedicarePlus plans offered by such association and issued by an organization to which subsection (b)(1) applies or by a provider-sponsored organization.

"(e) PROVIDER-SPONSORED ORGANIZATION DEFINED.—

"(1) IN GENERAL.—In this part, the term 'provider-sponsored organization' means a public or private entity—

"(A) that is established or organized by a health care provider, or group of affiliated health care providers,

"(B) that provides a substantial proportion (as defined by the Secretary) of the health care items and services under the contract under this part directly through the provider or affiliated group of providers, and

"(C) with respect to which those affiliated providers that share, directly or indirectly, substantial financial risk with respect to the provision of such items and services have at least a majority financial interest in the entity.

"(2) SUBSTANTIAL PROPORTION.—In defining what is a 'substantial proportion' for purposes of paragraph (1)(A), the Secretary—

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

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

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

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

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

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

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

"(5) HEALTH CARE PROVIDER DEFINED.—In this subsection and subsection (f), the term 'health care provider' means—

"(A) any individual who is engaged in the delivery of health care services in a State and who is required by State law or regulation to be licensed or certified by the State to engage in the delivery of such services in the State, and

"(B) any entity that is engaged in the delivery of health care services in a State and that, if it is required by State law or regulation to be licensed or certified by the State to engage in the delivery of such services in the State, is so licensed.

"(6) REGULATIONS.—The Secretary shall issue regulations to carry out this subsection.

"(f) APPLICATION OF ANTITRUST RULE OF REASON TO PROVIDER-SPONSORED ORGANIZATIONS.—

"(1) RULE OF REASON STANDARD.—In any action under the antitrust laws, or under any law of a State (as defined in section 4G(2) of the Clayton Act) similar to the antitrust laws, the following conduct shall not be deemed illegal per se:

"(A) The conduct of a provider-sponsored organization, and affiliated providers of the organization, in negotiating, making, or performing a contract (including the establishment and modification of a fee schedule and the development of a panel of physicians), to the extent such contract is for the purpose of providing health care services to individuals under the terms of a MedicarePlus plan offered by such an organization.

"(B) The exchange of information among health care providers relating to costs, sales, profitability, marketing, prices, or fees of any health care product or service if—

"(i) the exchange of such information was solely for the purpose of establishing a provider-sponsored organization and was reasonably required for such purpose, and

"(ii) such information was not used for any other purpose.

Such conduct shall be judged on the basis of its reasonableness, taking into account all relevant factors affecting competition, including the effects on competition in properly defined markets.

"(C) The conduct of a group of health care providers, and provider members of such a group, in negotiating, making, or performing a contract (including the establishment and modification of a fee schedule and the development of a panel of physicians) with a provider-sponsored organization, to the extent such contract is for the purpose of providing health care services to individuals under the terms of a MedicarePlus plan of the organization, but only if the group meets the requirements of paragraph (2).

Such conduct shall be judged on the basis of its reasonableness, taking into account all relevant factors affecting competition, including the effects on competition in properly defined markets.

"(2) REQUIREMENTS FOR GROUP.—A group of health care providers meets the requirements of this paragraph with respect to a MedicarePlus plan of a provider-sponsored organization if the group—

"(i) is not a provider-sponsored organization,

"(ii) is organized by, operated by, and composed only of members who are health care providers and for purposes that include providing health care services,

"(iii) is funded in part by capital contributions made by the members of such group,

"(iv) with respect to each contract made by such group for the purpose of providing a type of health care service to individuals under the terms of the plan—

"(I) requires all members of such group who engage in providing such type of health care service to agree to provide health care services of such type under such contract,

"(II) receives the compensation paid for the health care services of such type provided under such contract by such members, and

"(III) provides for the distribution of such compensation,

"(v) has established, consistent with the requirements of this part, a program to review, pursuant to written guidelines, the quality, efficiency, and appropriateness of treatment methods and setting of services for all health care providers and all patients participating in the plan, along with internal procedures to correct identified deficiencies relating to such methods and such services,

"(vi) has established, consistent with the requirements of this part, a program to monitor and control utilization of health care services provided under the plan, for the purpose of improving efficient, appropriate care and eliminating the provision of unnecessary health care services,

"(vii) has established a management program to coordinate the delivery of health care services for all health care providers and all patients participating in the plan, for the purpose of achieving efficiencies and enhancing the quality of health care services provided, and

"(viii) has established, consistent with the requirements of this part, a grievance and appeal process for such group designed to review and promptly resolve beneficiary or patient grievances and complaints.

"(3) DEFINITIONS.—For purposes of this subsection:

"(A) ANTITRUST LAWS.—The term 'antitrust laws' has the meaning given it in subsection (a) of the first section of the Clayton Act (15 U.S.C. 12), except that such term includes section 5 of the Federal Trade Commission Act (15 U.S.C. 45) to the extent that such section 5 applies to unfair methods of competition.

"(B) HEALTH CARE SERVICE.—The term 'health care service' means any service for which payment may be made under a MedicarePlus plan including services related to the delivery or administration of such service.

"(3) ISSUANCE OF GUIDELINES.—Not later than 120 days after the date of the enactment of this part, the Attorney General and the Federal Trade Commission shall issue jointly guidelines specifying the enforcement policies and analytical principles that will be applied by the Department of Justice and the Commission with respect to the operation of this subsection.

"(g) ORGANIZATIONS TREATED AS MEDICAREPLUS ORGANIZATIONS DURING TRANSITION.—Any of the following organizations shall be considered to qualify as a MedicarePlus organization for contract years beginning before January 1, 1998:

"(1) HEALTH MAINTENANCE ORGANIZATIONS.—An organization that is organized under the laws of any State and that is a qualified health maintenance organization (as defined in section 1310(d) of the Public Health Service Act), an organization recognized under State law as a health maintenance organization, or a similar organization regulated under State law for solvency in the same manner and to the same extent as such a health maintenance organization.

"(2) LICENSED INSURERS.—An organization that is organized under the laws of any State and—

"(A) is licensed by a State agency as an insurer for the offering of health benefit coverage, or

"(B) is licensed by a State agency as a service benefit plan,

but only for individuals residing in an area in which the organization is licensed to offer health insurance coverage.

"(3) CURRENT RISK-CONTRACTORS.—An organization that is an eligible organization (as defined in section 1876(b)) and that has a risk-sharing contract in effect under section 1876 as of the date of the enactment of this section.

"PAYMENTS TO MEDICAREPLUS ORGANIZATIONS

"SEC. 1854. (a) PAYMENTS TO ORGANIZATIONS.—

"(1) MONTHLY PAYMENTS.—

"(A) IN GENERAL.—Under a contract under section 1857 and subject to subsections (e) and (f), the Secretary shall make monthly payments under this section in advance to each MedicarePlus organization, with respect to coverage of an individual under this part in a MedicarePlus payment area for a month, in an amount equal to 1/12 of the annual MedicarePlus capitation rate (as calculated under subsection (c)) with respect to that individual for that area, adjusted for such risk factors as age, disability status, gender, institutional status, and such other factors as the Secretary determines to be appropriate, so as to ensure actuarial equivalence. The Secretary may add to, modify, or substitute for such factors, if such changes will improve the determination of actuarial equivalence.

"(B) SPECIAL RULE FOR END-STAGE RENAL DISEASE.—The Secretary shall establish a separate rate of payment to a MedicarePlus organization with respect to any individual determined to have end-stage renal disease and enrolled in a MedicarePlus plan of the organization. Such rate of payment shall be actuarially equivalent to rates paid to other enrollees in the MedicarePlus payment area (or such other area as specified by the Secretary).

"(2) ADJUSTMENT TO REFLECT NUMBER OF ENROLLEES.—

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

"(B) SPECIAL RULE FOR CERTAIN ENROLLEES.—

"(i) IN GENERAL.—Subject to clause (ii), the Secretary may make retroactive adjustments under subparagraph (A) to take into account individuals enrolled during the period beginning on the date on which the individual enrolls with a MedicarePlus organization under a plan operated, sponsored, or contributed to by the individual's employer or former employer (or the employer or former employer of the individual's spouse) and ending on the date on which the individual is enrolled in the organization under this part, except that for purposes of making such retroactive adjustments under this subparagraph, such period may not exceed 90 days.

"(ii) EXCEPTION.—No adjustment may be made under clause (i) with respect to any individual who does not certify that the organization provided the individual with the disclosure statement described in section 1852(c) at the time the individual enrolled with the organization.

"(b) ANNUAL ANNOUNCEMENT OF PAYMENT RATES.—

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

"(A) the annual MedicarePlus capitation rate for each MedicarePlus payment area for the year, and

"(B) the risk and other factors to be used in adjusting such rates under subsection (a)(1)(A) for payments for months in that year.

"(2) ADVANCE NOTICE OF METHODOLOGICAL CHANGES.—At least 45 days before making the announcement under paragraph (2) for a year, the Secretary shall provide for notice to MedicarePlus organizations of proposed changes to be made in the methodology from the methodology and assumptions used in the previous announcement and shall provide such organizations an opportunity to comment on such proposed changes.

"(3) EXPLANATION OF ASSUMPTIONS.—In each announcement made under paragraph (1) for a year, the Secretary shall include an explanation of the assumptions and changes in methodology used in the announcement in sufficient detail so that MedicarePlus organizations can compute monthly adjusted MedicarePlus capitation rates for individuals in each MedicarePlus payment area which is in whole or in part within the service area of such an organization.

"(c) CALCULATION OF ANNUAL MEDICAREPLUS CAPITATION RATES.—

"(1) IN GENERAL.—For purposes of this part, the annual MedicarePlus capitation rate, for a MedicarePlus payment area for a contract year consisting of a calendar year, is equal to the greatest of the following:

"(A) BLENDED CAPITATION RATE.—The sum of—

"(i) area-specific percentage for the year (as specified under paragraph (2) for the year) of the annual area-specific MedicarePlus capitation rate for the year for the MedicarePlus payment area, as determined under paragraph (3), and

"(ii) national percentage (as specified under paragraph (2) for the year) of the input-price-adjusted annual national MedicarePlus capitation rate for the year, as determined under paragraph (4),

multiplied by a budget neutrality adjustment factor determined under paragraph (5).

"(B) MINIMUM AMOUNT.—

"(i) For 1996, $300.

"(ii) For 1997, $350.

"(iii) For a succeeding year, is the minimum amount specified in this subparagraph for the preceding year increased by national average per capita growth percentage, specified under paragraph (6) for that succeeding year.

"(C) MINIMUM INCREASE OF 2 PERCENT OVER PREVIOUS YEAR'S RATE.—

"(i) For 1996, 102 percent of the annual per capita rate of payment for 1995 determined under section 1876(a)(1)(C) for the MedicarePlus payment area.

"(ii) For a subsequent year, 102 percent of the annual MedicarePlus capitation rate under this subsection for the area for the previous year.

"(2) AREA-SPECIFIC AND NATIONAL PERCENTAGES.—For purposes of paragraph (1)(A)—

"(A) for 1996 and 1997, the 'area-specific percentage' is 90 percent and the 'national percentage' is 10 percent,

"(B) for 1998, the 'area-specific percentage' is 85 percent and the 'national percentage' is 15 percent,

"(C) for 1999, the 'area-specific percentage' is 80 percent and the 'national percentage' is 20 percent,

"(D) for 2000, the 'area-specific percentage' is 75 percent and the 'national percentage' is 25 percent, and

"(E) for a year after 2000, the 'area-specific percentage' is 70 percent and the 'national percentage' is 30 percent.

"(3) ANNUAL AREA-SPECIFIC MEDICAREPLUS CAPITATION RATE.—For purposes of paragraph (1)(A), the annual area-specific MedicarePlus capitation rate for a MedicarePlus payment area—

"(A) for 1996 is the annual per capita rate of payment for 1995 determined under section

th center services (as defined in
ambulatory services offered by a
er and which are otherwise in-

services;
vices (other than services in an
for individuals 21 years of age or
eening, diagnostic, and treatment
tion (r)) for individuals who are
e under the age of 21; and[270] (C)
supplies furnished (directly or
rs) to individuals of child-bearing
an be considered to be sexually
he State plan and who desire such

rnished by a physician (as defined
furnished in the office, the pa-
nursing facility, or elsewhere, and
vices furnished by a dentist (de-
the extent such services may be
her by a doctor of medicine or by a
dental medicine and would be
ished by a physician (as defined in

er type of remedial care recognized
y licensed practitioners within the
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) provided by an individual who is
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vised by a registered nurse, and (D)
er location; but not including such
patient or resident of a nursing

vices;
ed by or under the direction of a
whether the clinic itself is adminis-
ing such services furnished outside
l to an eligible individual who does
dwelling or does not have a fixed

and" and subparagraph (C), effective as if included
d redesignated P.L. 101-239, §6402(d).
and this second subparagraph (C). For the effecti
". For the effective date, see Vol. II, P.L. 100-2
agraph (B) in its entirety, effective April 1, 199
ulations to carry out this amendment have be
(B) as if formerly read, see Vol. III, P.L. 101-239.
lled". For the effective date, see Vol. II, P.L. 100-2

personal care services (A) prescribed by a physici
of treatment, (B) provided by an individual wh
is not a member of the individual's family,
ished in a home or other location; but not includi
dent of a nursing facility", effective with respe
ber 1, 1994.

(10) dental services;
(11) physical therapy and related services;
(12) prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select;
(13) other diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level[273];
(14) inpatient hospital services and nursing[274] facility services for individuals 65 years of age or over in an institution for mental diseases;
(15) services in an intermediate care facility for the mentally retarded (other than[275] in an institution for mental diseases) for individuals who are determined, in accordance with section 1902(a)(31)(A), to be in need of such care;
(16) effective January 1, 1973, inpatient psychiatric hospital services for individuals under age 21, as defined in subsection (h);
(17) services furnished by a nurse-midwife (as defined in section 1861(gg)) which the nurse-midwife is legally authorized to perform under State law (or the State regulatory mechanism provided by State law), whether or not the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider;
(18) hospice care (as defined in subsection (o));
(19) case-management services (as defined in section 1915(g)(2));
(20) respiratory care services (as defined in section 1902(e)(9)(C));[276]
(21) services furnished by a certified pediatric nurse practitioner or certified family nurse practitioner (as defined by the Secretary) which the certified pediatric nurse practitioner or certified family nurse practitioner is legally authorized to perform under State law (or the State regulatory mechanism provided by State law), whether or not the certified pediatric nurse practitioner or certified family nurse practitioner is under the supervision of, or associated with, a physician or other health care provider; and[277]
(22)[278] any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary;[279]

[273] P.L. 101-508, §4719(a), inserted ", including any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level", effective November 5, 1990.
[274] P.L. 100-203, §4211(h)(6)(B), struck out ", skilled nursing facility services, and intermediate care" and substituted "and nursing". For the effective date, see Vol. II, P.L. 100-203, §4214.
[275] P.L. 100-203, §4211(h)(6)(C), struck out "intermediate care facility services (other than such services" and substituted "services in an intermediate care facility for the mentally retarded (other than". For the effective date, see Vol. II, P.L. 100-203, §4214.
[276] P.L. 101-239, §6405(a)(1), struck out "and".
[277] P.L. 101-239, §6405(a)(3), added this paragraph (21), effective with respect to services furnished by a certified pediatric nurse practitioner or certified family nurse practitioner on or after July 1, 1990.
[278] P.L. 101-239, §6405(a)(2), redesignated paragraph (21) as paragraph (22).
[279] P.L. 101-508, §4711(a)(1), struck out "and". Impossible to execute.

THE WHITE HOUSE
OFFICE OF DOMESTIC POLICY

CAROL H. RASCO
Assistant to the President for Domestic Policy

To: _____ _____

_____ _____

Draft response for POTUS
and forward to CHR by: _____

Draft response for CHR by: _____

Please reply directly to the writer
(copy to CHR) by: _____

Please advise by: _____

Let's discuss: _____

For your information: _____

Reply using form code: _____

File: _____

Send copy to (original to CHR): _____

Schedule ? : ☐ Accept ☐ Pending ☐ Regret

Designee to attend: _____

Remarks: _____

_____

_____

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_____

AMERICAN NURSES ASSOCIATION

600 Maryland Avenue SW
Suite 100 West
Washington, DC 20024-2571
202 651-7000 • Fax: 202 651-7001

Virginia Trotter Betts, JD, MSN, RN
President

Geri Marullo, MSN, RN
Executive Director

DEC 18 [illegible]

TO: Carol Rasco
Assistant to the President for Domestic Policy
The White House

FROM: Marjorie W. Vanderbilt
Director
Department of Federal Government Relations

DATE: December 18, 1995

RE: Correction - Reimbursement for Advanced Practice Nurses

The document that we messengered to you on Friday, December 15, 1995 contained a computation error. Attached is a corrected version. We apologize for any inconvenience.

REPLACE ANA'S MEMO AND ATTACHMENTS DATED DECEMBER 15, 1995 WITH THE ATTACHED.

The issue of direct Medicare and Medicaid Reimbursement for all advanced practice nurses is critical to the American Nurses Association. If you would like to discuss this issue in more detail, please feel free to contact me at 202-651-7085.

G:\grel\mwv\reimbmemcor.wpd
Corrected 12/18/95

AMERICAN NURSES ASSOCIATION

600 Maryland Avenue SW
Suite 100 West
Washington, DC 20024-2571
202 651-7000 • Fax: 202 651-7001

Virginia Trotter Betts, JD, MSN, RN
President

Geri Marullo, MSN, RN
Executive Director

THE PRESIDENT'S MEDICARE AND MEDICAID PROPOSALS MUST INCLUDE REIMBURSEMENT FOR ADVANCED PRACTICE NURSES

The American Nurses Association (ANA) is deeply concerned by the failure of the White House proposals on Medicare and Medicaid to include coverage for services of nurse practitioners (NPs) and clinical nurse specialists (CNSs).

Medicare and Medicaid reimbursement for NPs and CNSs has been a key part of ANA's legislative agenda for many years. ***Incredibly, the White House proposal is actually worse on this issue than the Republican budget bill.***

* **The *Republican bill* would have extended Medicare Part B coverage to services of nurse practitioners in all outpatient settings. The *White House proposal* includes no such provision.**

* **Currently, states are mandated by federal Medicaid law to cover the services of Family and Pediatric NPs and of Certified Nurse-Midwives in state Medicaid programs. The White House bill *fails* to extend this mandate to all NPs and to CNSs.**

The White House proposal would also allow states to move to Medicaid Primary Care Case Management programs without applying for a federal waiver, and to include NPs and CNMs as case managers "at state option"--meaning states can effectively circumvent requirements to cover NP and CNM services.

In addition, while the Republican proposal's provisions on Provider Sponsored Organizations would have included all appropriately licensed health care practitioners, the White House proposal would limit eligibility to physicians only. This is unacceptable to nursing, as well as to the broader non-physician community, which has already been vocal on this issue.

Nurses applauded the President's veto of the Republican budget bill, despite its inclusion of a provision for which nursing has worked hard for years--reimbursement for NPs in all geographic settings. We strongly and actively opposed the bill because we knew it would spell disaster for the entire health care system. Now that the President has decided to offer an alternative budget proposal, we are alarmed to learn that it actually does **worse** for nursing on this key issue than the Republican plan did.

We are astounded in light of the minimal cost of reimbursement for NPs and CNSs, as well as nursing's longstanding record of visible and continuing support for the President's health care initiatives. Congressional Budget Office estimates of the cost of the reimbursement provision in the Republican bill (which covered both NPs and physician assistants) were *$300 million over seven years*. ANA estimates that adding clinical nurse specialists (fewer of whom are in private practice settings than NPs) would cost another $60 million. This total of $360 million over seven years would add a mere six percent to the $5.9 billion in expansion of Medicare preventive services in the President's proposal (provisions we strongly support).

This distressing situation can be easily corrected--by including Medicare and Medicaid reimbursement for NPs and CNSs and provider status in PSOs in the White House's budget proposal.

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revised 12/18/95

104TH CONGRESS
1ST SESSION

S. 864

To amend title XVIII of the Social Security Act to provide for increased medicare reimbursement for nurse practitioners and clinical nurse specialists to increase the delivery of health services in health professional shortage areas, and for other purposes.

IN THE SENATE OF THE UNITED STATES

MAY 25 (legislative day, MAY 15), 1995

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

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A BILL

To amend title XVIII of the Social Security Act to provide for increased medicare reimbursement for nurse practitioners and clinical nurse specialists to increase the delivery of health services in health professional shortage areas, and for other purposes.

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

SECTION 1. SHORT TITLE.

This Act may be cited as the "Primary Care Health Practitioner Incentive Act of 1995".

SEC. 2. INCREASED MEDICARE REIMBURSEMENT FOR NURSE PRACTITIONERS AND CLINICAL NURSE SPECIALISTS.

(a) REMOVAL OF RESTRICTIONS ON SETTINGS.—

(1) IN GENERAL.—Section 1861(s)(2)(K)(ii) of the Social Security Act (42 U.S.C. 1395x(s)(2)(K)(ii)) is amended to read as follows:

"(ii) services which would be physicians' services if furnished by a physician (as defined in subsection (r)(1)) and which are performed by a nurse practitioner or clinical nurse specialist (as defined in subsection (aa)(5)) working in collaboration (as defined in subsection (aa)(6)) with a physician (as so defined) which the nurse practitioner or clinical nurse specialist is legally authorized to perform by the State in which the services are performed, and such services and supplies furnished as an incident to such services as would be covered under subparagraph (A) if furnished incident to a physician's professional service;".

(2) CONFORMING AMENDMENTS.—

(A) Section 1861(s)(2)(K) of such Act (42 U.S.C. 1395x(s)(2)(K)), as amended by paragraph (1), is amended—

(i) in clause (i), by inserting "and such services and supplies furnished as in-

cident to such services as would be covered under subparagraph (A) if furnished as an incident to a physician's professional service." after "are performed, and"; and

(ii) by striking clauses (iii) and (iv).

(B) Section 1861(b)(4) of such Act (42 U.S.C. 1395x(b)(4)) is amended by striking "clauses (i) or (iii) of subsection (s)(2)(K)" and inserting "subsection (s)(2)(K)".

(C) Section 1862(a)(14) of such Act (42 U.S.C. 1395y(a)(14)) is amended by striking "section 1861(s)(2)(K)(i) or 1861(s)(2)(K)(iii)" and inserting "section 1861(s)(2)(K)".

(D) Section 1866(a)(1)(H) of such Act (42 U.S.C. 1395cc(a)(1)(H)) is amended by striking "section 1861(s)(2)(K)(i) or 1861(s)(2)(K)(iii)" and inserting "section 1861(s)(2)(K)".

(b) INCREASED PAYMENT.—

(1) FEE SCHEDULE AMOUNT.—Section 1833(a)(1)(O) of the Social Security Act (42 U.S.C. 1395*l*(a)(1)(O)) is amended to read as follows: "(O) with respect to services described in section 1861(s)(2)(K)(ii) (relating to nurse practitioner or clinical nurse specialist services), the amounts paid

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

(2) CONFORMING AMENDMENTS.—

(A) Section 1833(r) of such Act (42 U.S.C. 1395*l*(r)) is amended—

(i) in paragraph (1), by striking "section 1861(s)(2)(K)(iii) (relating to nurse practitioner or clinical nurse specialist services provided in a rural area)," and inserting "section 1861(s)(2)(K)(ii) (relating to nurse practitioner or clinical nurse specialist services),";

(ii) by striking paragraph (2);

(iii) in paragraph (3), by striking "section 1861(s)(2)(K)(iii)" and inserting "section 1861(s)(2)(K)(ii)"; and

(iv) by redesignating paragraph (3) as paragraph (2).

(B) Section 1842(b)(12)(A) of such Act (42 U.S.C. 1395u(b)(12)(A)) is amended in the matter preceding clause (i), by striking "clauses (i), (ii), or (iv) of section 1861(s)(2)(K) (relating to a physician assistants and nurse practitioners)" and inserting "section 1861(s)(2)(K)(i) (relating to physician assistants)".

(c) DIRECT PAYMENT FOR NURSE PRACTITIONERS AND CLINICAL NURSE SPECIALISTS.—

(1) IN GENERAL.—Section 1832(a)(2)(B)(iv) of the Social Security Act (42 U.S.C. 1395k(a)(2)(B)(iv)) is amended by striking "provided in a rural area (as defined in section 1886(d)(2)(D))".

(2) CONFORMING AMENDMENT.—Section 1842(b)(6)(C) of such Act (42 U.S.C. 1395u(b)(6)(C)) is amended—

(A) by striking "clauses (i), (ii), or (iv)" and inserting "clause (i)"; and

(B) by striking "or nurse practitioner".

(d) BONUS PAYMENT FOR SERVICES PROVIDED IN HEALTH PROFESSIONAL SHORTAGE AREAS.—Section 1833(m) of such Act (42 U.S.C. 1395*l*(m)) is amended—

(1) by inserting "(1)" after "(m)"; and

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

"(2) In the case of services of a nurse practitioner or clinical nurse specialist furnished to an individual, described in paragraph (1), in an area that is a health professional shortage area as described in such paragraph, in addition to the amount otherwise paid under this part, there shall also be paid to such service provider (on a monthly or quarterly basis) from the Federal Supplementary Medical Insurance Trust Fund an amount equal to 10 percent of the payment amount for the service under this part.".

(e) DEFINITION OF CLINICAL NURSE SPECIALIST CLARIFIED.—Section 1861(aa)(5) of such Act (42 U.S.C. 1395x(aa)(5)) is amended—

(1) by inserting "(A)" after "(5)";

(2) by striking "The term "'physician assistant'" and all that follows through "who performs" and inserting "The term 'physician assistant' and the term 'nurse practitioner' mean, for purposes of this title, a physician assistant or nurse practitioner who performs"; and

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

"(B) The term 'clinical nurse specialist' means, for purposes of this title, an individual who—

"(i) is a registered nurse and is licensed to practice nursing in the State in which the clinical nurse specialist services are performed; and

"(ii) holds a master's degree in a defined clinical area of nursing from an accredited educational institution.".

(f) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to services furnished and supplies provided on and after July 1, 1995.

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shall accept patients transferred to the hospital from the facility and receive data from and transmit data to the facility.

"(E) There is a practitioner who is qualified to provide advanced cardiac life support services (as determined by the State in which the facility is located) on-site at the facility on a 24-hour basis.

"(F) A physician is available on-call to provide emergency medical services on a 24-hour basis.

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

"(i) the facility need not meet hospital standards relating to the number of hours during a day, or days during a week, in which the facility must be open, except insofar as the facility is required to provide emergency care on a 24-hour basis under subparagraphs (E) and (F); and

"(ii) the facility may provide any services otherwise required to be provided by a full-time, on-site dietitian, pharmacist, laboratory technician, medical technologist, or radiological technologist on a part-time, off-site basis.

"(H) The facility meets the requirements applicable to clinics and facilities under subparagraphs (C) through (J) of paragraph (2) of section 1861(aa) and of clauses (ii) and (iv) of the second sentence of such paragraph (or, in the case of the requirements of subparagraph (E), (F), or (J) of such paragraph, would meet the requirements if any reference in such subparagraph to a 'nurse practitioner' or to 'nurse practitioners' were deemed to be a reference to a 'nurse practitioner or nurse' or to 'nurse practitioners or nurses'); except that in determining whether a facility meets the requirements of this subparagraph, subparagraphs (E) and (F) of that paragraph shall be applied as if any reference to a 'physician' is a reference to a physician as defined in section 1861(r)(1).

"(2) The term 'rural emergency access care hospital services' means the following services provided by a rural emergency access care hospital and furnished to an individual over a continuous period not to exceed 24 hours (except that such services may be furnished over a longer period in the case of an individual who is unable to leave the hospital because of inclement weather):

"(A) An appropriate medical screening examination (as described in section 1867(a)).

"(B) Necessary stabilizing examination and treatment services for an emergency medical condition and labor (as described in section 1867(b)).".

(b) REQUIRING RURAL EMERGENCY ACCESS CARE HOSPITALS TO MEET HOSPITAL ANTI-DUMPING REQUIREMENTS.—Section 1867(e)(5) (42 U.S.C. 1395dd(e)(5)) is amended by striking "1861(mm)(1))" and inserting "1861(mm)(1)) and a rural emergency access care hospital (as defined in section 1861(oo)(1))".

(c) COVERAGE AND PAYMENT FOR SERVICES.—

(1) COVERAGE.—Section 1832(a)(2) (42 U.S.C. 1395k(a)(2)) is amended—

(A) by striking "and" at the end of subparagraph (I);

(B) by striking the period at the end of subparagraph (J) and inserting "; and"; and

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

"(K) rural emergency access care hospital services (as defined in section 1861(oo)(2)).".

(2) PAYMENT BASED ON PAYMENT FOR OUTPATIENT CRITICAL ACCESS HOSPITAL SERVICES.—

(A) IN GENERAL.—Section 1833(a)(6) (42 U.S.C. 1395l(a)(6)), as amended by section 8702(f)(2), is amended by striking "services," and inserting "services and rural emergency access care hospital services,".

(B) PAYMENT METHODOLOGY DESCRIBED.—Section 1834(g) (42 U.S.C. 1395m(g)), as amended by section 8702(f)(2)(B), is amended—

(i) in the heading, by striking "SERVICES" and inserting "SERVICES AND RURAL EMERGENCY ACCESS CARE HOSPITAL SERVICES"; and

(ii) by adding at the end the following new sentence: "The amount of payment for rural emergency access care hospital services provided during a year shall be determined using the applicable method provided under this subsection for determining payment for outpatient rural primary care hospital services during the year.".

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

SEC. 8704. CLASSIFICATION OF RURAL REFERRAL CENTERS.

(a) PROHIBITING DENIAL OF REQUEST FOR RECLASSIFICATION ON BASIS OF COMPARABILITY OF WAGES.—

(1) IN GENERAL.—Section 1886(d)(10)(D) (42 U.S.C. 1395ww(d)(10)(D)) is amended—

(A) by redesignating clause (iii) as clause (iv); and

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

"(iii) Under the guidelines published by the Secretary under clause (i), in the case of a hospital which is classified by the Secretary as a rural referral center under paragraph (5)(C), the Board may not reject the application of the hospital under this paragraph on the basis of any comparison between the average hourly wage of the hospital and the average hourly wage of hospitals in the area in which it is located.".

(2) EFFECTIVE DATE.—Notwithstanding section 1886(d)(10)(C)(ii) of the Social Security Act, a hospital may submit an application to the Medicare Geographic Classification Review Board during the 30-day period beginning on the date of the enactment of this Act requesting a change in its classification for purposes of determining the area wage index applicable to the hospital under section 1886(d)(3)(D) of such Act for fiscal year 1997, if the hospital would be eligible for such a change in its classification under the standards described in section 1886(d)(10)(D) (as amended by paragraph (1)) but for its failure to meet the deadline for applications under section 1886(d)(10)(C)(ii).

(b) CONTINUING TREATMENT OF PREVIOUSLY DESIGNATED CENTERS.—Any hospital classified as a rural referral center by the Secretary of Health and Human Services under section 1886(d)(5)(C) of the Social Security Act for fiscal year 1994 shall be classified as such a rural referral center for fiscal year 1996 and each subsequent fiscal year.

SEC. 8705. FLOOR ON AREA WAGE INDEX.

(a) IN GENERAL.—For purposes of section 1886(d)(3)(E) of the Social Security Act for discharges occurring on or after October 1, 1995, the area wage index applicable under such section to any hospital which is not located in a rural area (as defined in section 1886(d)(2)(D) of such Act) may not be less than the average of the area wage indices applicable under such section to hospitals located in rural areas in the State in which the hospital is located.

(b) IMPLEMENTATION.—The Secretary of Health and Human Services shall adjust the area wage indices referred to in subsection (a) for hospitals not described in such subsection in a manner which assures that the aggregate payments made under section 1886(d) of the Social Security Act in a fiscal year for the operating costs of inpatient hospital services are not greater or less than those which would have been made in the year if this section did not apply.

SEC. 8706. ADDITIONAL PAYMENTS FOR PHYSICIANS' SERVICES FURNISHED IN SHORTAGE AREAS.

(a) INCREASE IN AMOUNT OF ADDITIONAL PAYMENT.—Section 1833(m) (42 U.S.C. 1395l(m)) is amended by striking "10 percent" and inserting "20 percent".

(b) RESTRICTION TO PRIMARY CARE SERVICES.—Section 1833(m) (42 U.S.C. 1395l(m)) is amended by inserting after "physicians' services" the following: "consisting of primary care services (as defined in section 1842(i)(4))".

(c) EXTENSION OF PAYMENT FOR FORM SHORTAGE AREAS.—

(1) IN GENERAL.—Section 1833(m) (42 U.S. 1395l(m)) is amended by striking "area," and i serting "area (or, in the case of an area f which the designation as a health profession shortage area under such section is withdraw in the case of physicians' services furnished such an individual during the 3-year period b ginning on the effective date of the withdraw of such designation),".

(2) EFFECTIVE DATE.—The amendment ma by paragraph (1) shall apply to physician services furnished in an area for which the de ignation as a health professional shortage ar under section 332(a)(1)(A) of the Public Heal Service Act is withdrawn on or after January 1996.

(d) REQUIRING CARRIERS TO REPORT ON SER ICES PROVIDED.—Section 1842(b)(3) (42 U.S.C 1395u(b)(3)) is amended—

(1) by striking "and" at the end of subpara graph (I); and

(2) by inserting after subparagraph (I) the fo lowing new subparagraph:

"(J) will provide information to the Secreta (on such periodic basis as the Secretary may re quire) on the types of providers to whom th carrier makes additional payments for certai physicians' services pursuant to section 1833(m together with a description of the services fu nished by such providers; and".

(e) EFFECTIVE DATE.—The amendments mad by subsections (a), (b), and (d) shall apply t physicians' services furnished on or after Octo ber 1, 1995.

SEC. 8707. PAYMENTS TO PHYSICIAN ASSISTANTS AND NURSE PRACTITIONERS FOR SERVICES FURNISHED IN OUTPATIENT OR HOME SETTINGS.

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

(1) in clause (i)—

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

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

(2) in clause (ii)—

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

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

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

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

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

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

(2) CONFORMING AMENDMENT.—Section 1842(b)(6)(C) (42 U.S.C. 1395u(b)(6)(C)) is amended by striking "clauses (i), (ii), or (iv)" and inserting "subclauses (I), (II), or (III) of clause (i), clause (ii)(I), or clause (iv)".

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

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

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

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

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

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

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

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

SEC. 8708. EXPANDING ACCESS TO NURSE AIDE TRAINING IN UNDERSERVED AREAS.

(a) IN GENERAL.—Section 1819(f)(2)(B)(iii)(I) (42 U.S.C. 1396r(f)(2)(B)(iii)(I)) is amended in the matter preceding item (a), by striking "by or in a nursing facility" and inserting "by a nursing facility (or in such a facility, unless the State determines that there is no other such program offered within a reasonable distance, provides notice of the approval to the State long term care ombudsman, and assures, through an oversight effort, that an adequate environment exists for such a program)".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to nurse aide training and competency evaluation programs under section 1819 of the Social Security Act which are offered on or after October 1, 1995.

TITLE IX—TRANSPORTATION AND RELATED PROVISIONS

SEC. 9001. MINIMUM ALLOCATION FOR HIGHWAY PROGRAMS.

(a) TECHNICAL CORRECTION.—With respect to fiscal year 1996—

(1) the Secretary of Transportation shall determine, in accordance with the policies established by the Intermodal Surface Transportation Efficiency Act of 1991 (105 Stat. 1914)—

(A) which of the States will no longer require an apportionment under section 157(a)(4) of title 23, United States Code; and

(B) which of the States will require decreased funding under such section 157(a)(4);

as a result of the termination of the Interstate construction program; and

(2) as a result of the reduced number of States that may require an apportionment under such section 157(a)(4), and the decrease in the amount of funds some States will require under such section 157(a)(4), the maximum amount available for apportionment under such section 157(a)(4) shall be reduced from the amount apportioned under such section 157(a)(4) for fiscal year 1995 by 60.4 percent.

(b) EFFECT ON CERTAIN CALCULATIONS.—The correction made by subsection (a) shall be made after the reduction required under section 1003(c) of the Intermodal Surface Transportation Efficiency Act of 1991 (105 Stat. 1921) and shall not be taken into account in making the calculations under sections 1003(c), 1013(c), and 1015 of such Act (105 Stat. 1921, 1940, and 1943).

SEC. 9002. EXTENSION OF HIGHER VESSEL TONNAGE DUTIES.

(a) EXTENSION OF DUTIES.—Section 36 of the Act of August 5, 1909 (36 Stat. 111; 46 U.S.C. App. 121), is amended by striking "for fiscal years 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998," each place it appears and inserting "for fiscal years through fiscal year 2002,".

(b) CONFORMING AMENDMENT.—The Act entitled "An Act concerning tonnage duties on vessels entering otherwise than by sea", approved March 8, 1910 (36 Stat. 234; 46 U.S.C. App. 132), is amended by striking "for fiscal years 1991, 1992, 1993, 1994, 1995, 1996, 1997, and 1998," and inserting "for fiscal years through fiscal year 2002,".

SEC. 9003. FEMA RADIOLOGICAL EMERGENCY PREPAREDNESS FEES.

(a) IN GENERAL.—The Director of the Federal Emergency Management Agency may assess and collect fees applicable to persons subject to radiological emergency preparedness regulations issued by the Director.

(b) REQUIREMENTS.—The assessment and collection of fees by the Director under subsection (a) shall be fair and equitable and shall reflect the full amount of costs to the Agency of providing radiological emergency planning, preparedness, response, and associated services. Such fees shall be assessed by the Director in a manner that reflects the use of resources of the Agency for classes of regulated persons and the administrative costs of collecting such fees.

(c) AMOUNT OF FEES.—The aggregate amount of fees assessed under subsection (a) in a fiscal year shall approximate, but not be less than, 100 percent of the amounts anticipated by the Director to be obligated for the radiological emergency preparedness program of the Agency for such fiscal year.

(d) DEPOSIT OF FEES IN TREASURY.—Fees received pursuant to subsection (a) shall be deposited in the general fund of the Treasury as offsetting receipts.

(e) EXPIRATION OF AUTHORITY.—The authority of the Director to assess and collect fees under subsection (a) shall expire on September 30, 2002.

TITLE X—VETERANS AND RELATED PROVISIONS

SEC. 10001. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This title may be cited as the "Veterans Reconciliation Act of 1995".

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

Sec. 10001. Short title; table of contents.
Subtitle A—Extension of Temporary Authorities
Sec. 10011. Authority to require that certain veterans make copayments in exchange for receiving health-care benefits.
Sec. 10012. Medical care cost recovery authority.
Sec. 10013. Income verification authority.
Sec. 10014. Limitation on pension for certain recipients of medicaid-covered nursing home care.
Sec. 10015. Home loan fees.
Sec. 10016. Procedures applicable to liquidation sales on defaulted home loans guaranteed by the Department of Veterans Affairs.
Sec. 10017. Enhanced loan asset sale authority.
Subtitle B—Other Matters
Sec. 10021. Revision to prescription drug copayment.
Sec. 10022. Rounding down of cost-of-living adjustments in compensation and DIC rates.
Sec. 10023. Revised standard for liability for injuries resulting from Department of Veterans Affairs treatment.
Sec. 10024. Withholding of payments and benefits.

Subtitle A—Extension of Temporary Authorities

SEC. 10011. AUTHORITY TO REQUIRE THAT CERTAIN VETERANS MAKE COPAYMENTS IN EXCHANGE FOR RECEIVING HEALTH-CARE BENEFITS.

(a) HOSPITAL AND MEDICAL CARE.—Section 8013(e) of the Omnibus Budget Reconciliation Act of 1990 (38 U.S.C. 1710 note) is amended by striking out "September 30, 1998" and inserting in lieu thereof "September 30, 2002".

(b) OUTPATIENT MEDICATIONS.—Section 1722A(c) of title 38, United States Code, is amended by striking out "September 30, 199 and inserting in lieu thereof "September 2002".

SEC. 10012. MEDICAL CARE COST RECOVERY A THORITY.

Section 1729(a)(2)(E) of title 38, United Sta Code, is amended by striking out "before Oct ber 1, 1998," and inserting "before October 2002,".

SEC. 10013. INCOME VERIFICATION AUTHORITY.

Section 5317(g) of title 38, United States Co is amended by striking out "September 30, 199 and inserting in lieu thereof "September 2002".

SEC. 10014. LIMITATION ON PENSION FOR CE TAIN RECIPIENTS OF MEDICAID-CO ERED NURSING HOME CARE.

Section 5503(f)(7) of title 38, United Sta Code, is amended by striking out "September 1998" and inserting in lieu thereof "Septemb 30, 2002".

SEC. 10015. HOME LOAN FEES.

Section 3729(a) of title 38, United States Co is amended—

(1) in paragraph (4), by striking out "Octol 1, 1998" and inserting in lieu thereof "October 2002"; and

(2) in paragraph (5)(C), by striking out "Oc ber 1, 1998" and inserting in lieu thereof "Oc ber 1, 2002".

SEC. 10016. PROCEDURES APPLICABLE TO LI UIDATION SALES ON DEFAULT HOME LOANS GUARANTEED BY T DEPARTMENT OF VETERANS A FAIRS.

Section 3732(c)(11) of title 38, United Sta Code, is amended by striking out "October 1998" and inserting "October 1, 2002".

SEC. 10017. ENHANCED LOAN ASSET SALE A THORITY.

Section 3720(h)(2) of title 38, United Sta Code, is amended by striking out "December 1995" and inserting in lieu thereof "Septemb 30, 2002".

Subtitle B—Other Matters

SEC. 10021. REVISION TO PRESCRIPTION DRU COPAYMENT.

(a) INCREASE IN AMOUNT OF COPAYMENT. Section 1722A(a) of title 38, United States Co is amended—

(1) in paragraph (1), by striking out "$2" a inserting in lieu thereof "$4";

(2) by striking out paragraph (2); and

(3) by redesignating paragraph (3) as par graph (2) and in that paragraph—

(A) striking out "or" at the end of subpar graph (A);

(B) striking out the period at the end of su paragraph (B) and inserting in lieu thereof or"; and

(C) adding at the end the following new su paragraph:

"(C) to a veteran who is a former prisoner war.".

(b) RECOVERY OF INDEBTEDNESS.—(1) Sectio 5302 of such title is amended by adding at t end the following new subsection:

"(f) The Secretary may not waive under th section the recovery of any payment or the co lection of any indebtedness owed under sectio 1722A of this title.".

(2) The amendment made by paragraph (shall apply with respect to amounts that becor due to the United States under section 1722A title 38, United States Code, on or after the da of the enactment of this Act.

SEC. 10022. ROUNDING DOWN OF COST-OF-LIVIN ADJUSTMENTS IN COMPENSATIO AND DIC RATES.

(a) FISCAL YEAR 1996 COLA.—(1) Effective of December 1, 1995, the Secretary of Vetera Affairs shall recompute any increase in an a justment that is otherwise provided by law to effective during fiscal year 1996 in the rates disability compensation and dependency and i demnity compensation paid by the Secretary such rates were in effect on November 30, 199

Attachment 3

CHART 2 -- MEDICARE

Medicare Proposal (based on specs through 9/24): Preliminary CBO Staff Estimates

By fiscal year, in billions of dollars

	1996	1996	1997	1998	1999	2000	2001	2002	7-year savings Total
Medicare Part A:									
Provider Reimbursement Options									
PPS MB-2.5% thru 2002	-0.2	-1.3	-3.0	-4.8	-6.8	-8.9	-11.2	-36.1	
Rebase Capital rates	-0.3	-0.4	-0.4	-0.4	-0.4	-0.4	-0.4	-2.7	
Reduce PPS capital by 15%	-1.0	-1.2	-1.3	-1.3	-1.4	-1.4	-1.5	-9.0	
Reduce Disproportionate Share to 25%	-0.1	-0.3	-0.5	-0.7	-0.9	-0.9	-1.0	-4.5	
Reduce IME to 6.7, 5.6, 4.6%	-0.4	-0.9	-1.5	-1.7	-1.7	-1.8	-1.9	-9.9	
Change PPS-exempt pmt ceilings and floors	-0.0	-0.1	-0.2	-0.4	-0.5	-0.7	-0.7	-2.7	
NonPPS MB-2.5% thru 2002	-0.0	-0.1	-0.2	-0.3	-0.4	-0.5	-0.6	-2.0	
Reduce NonPPS capital by 15%	-0.1	-0.2	-0.2	-0.2	-0.2	-0.3	-0.3	-1.5	
SNFs	-0.2	-0.6	-1.0	-1.4	-1.9	-2.3	-2.9	-10.4	
Home Health Prospective Payment /1	0.0	-1.4	-2.3	-2.8	-3.3	-3.7	-4.3	-17.8	
Hospice	0.0	0.0	-0.1	-0.1	-0.1	-0.1	-0.1	-0.5	
Critical Access Hospitals, Extend MDH	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.5	
AAPCC Interaction with DSH,IME,GME /2	0.0	0.8	1.5	1.8	2.0	2.2	2.5	10.7	
Part A	-2.4	-6.6	-9.1	-12.2	-16.6	-19.9	-22.2	-88.8	
Medicare Part B:									
Provider Reimbursement Options									
Eliminate Formula Driven Overpayment	-0.9	-1.2	-1.5	-2.0	-2.5	-3.3	-4.5	-15.9	
Extend 5.8% Outpatient payment reduction	0.0	0.0	0.0	-0.3	-0.3	-0.4	-0.4	-1.4	
Increase Outpatient capital reduction to 15%	-0.0	-0.0	-0.1	-0.2	-0.2	-0.2	-0.3	-1.0	
Freeze Ambulatory Surgical Center updates	-0.0	-0.1	-0.1	-0.2	-0.2	-0.3	-0.4	-1.3	
Revise MVPS (CF-3.65% in 96; GDP+2 thru 2002)	-0.4	-1.3	-2.3	-3.2	-4.1	-5.1	-6.2	-22.6	
Freeze Clinical lab update, 66% of median	-0.1	-0.4	-0.7	-0.9	-1.1	-1.3	-1.6	-6.0	
Freeze Dur Med Eqpt update, -40% on oxygen	-0.3	-0.6	-0.7	-0.9	-1.0	-1.3	-1.5	-6.2	
Eliminate Ambulance Update	-0.0	-0.0	-0.1	-0.1	-0.1	-0.2	-0.3	-0.8	
Increase bonus to rural prim care docs	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.4	
Direct payments to nurse prac/phys assts.	0.0	0.0	0.0	0.0	-0.1	-0.1	-0.1	-0.3	
REACH	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	
Interactions	-0.1	-0.1	-0.2	-0.2	-0.3	-0.3	-0.3	-1.4	
Beneficiary Options /3									
Deductible to $150 in 96; +$10/year thereafter	-0.7	-1.1	-1.3	-1.5	-1.7	-2.0	-2.2	-10.5	
31.5% Premium through 2002; rounded up	-3.4	-4.4	-4.4	-5.0	-8.5	-11.1	-14.1	-51.0	
Income-related premiums	0.0	-0.5	-0.9	-1.4	-1.8	-2.1	-2.5	-9.1	
Part B	-5.8	-9.4	-12.0	-16.5	-21.9	-27.8	-33.9	-126.9	

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104TH CONGRESS
1ST SESSION

H. R. 1339

To amend title XIX of the Social Security Act to provide for mandatory coverage of services furnished by nurse practitioners and clinical nurse specialists under State medicaid plans.

IN THE HOUSE OF REPRESENTATIVES

MARCH 28, 1995

Mr. RICHARDSON (for himself, Ms. ESHOO, Mr. FROST, Mr. MCHALE, Ms. RIVERS, Mr. VENTO, Mr. MINGE, Mrs. LOWEY, Ms. PELOSI, Ms. LOFGREN, and Mr. DELLUMS) introduced the following bill; which was referred to the Committee on Commerce

---

A BILL

To amend title XIX of the Social Security Act to provide for mandatory coverage of services furnished by nurse practitioners and clinical nurse specialists under State medicaid plans.

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

SECTION 1. MEDICAID COVERAGE OF SERVICES FURNISHED BY CERTIFIED NURSE PRACTITIONERS AND CLINICAL NURSE SPECIALISTS.

(a) IN GENERAL.—Section 1905(a)(21) of the Social Security Act (42 U.S.C. 1396d(a)(21)) is amended to read as follows:

"(21) services furnished by a certified nurse practitioner (as defined by the Secretary) or a clinical nurse specialist (as defined in subsection (t)) which the certified nurse practitioner or clinical nurse specialist is legally authorized to perform under State law (or the State regulatory mechanism provided by State law), whether or not the certified nurse practitioner or clinical nurse specialist is under the supervision of, or associated with, a physician or other health care provider;".

(b) DEFINITION OF CLINICAL NURSE SPECIALIST.—Section 1905 of such Act (42 U.S.C. 1396d) is amended by adding at the end the following new subsection:

"(t) The term 'clinical nurse specialist' means an individual who has earned a master's degree in a clinical area of nursing from an accredited institution and who is a registered nurse licensed to practice nursing in the State in which the individual furnishes services.".

(c) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) shall apply to calendar quarters

beginning on or after January 1, 1996, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

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"(iii) any provisions of State law which relate to the licensing of the organization and which prohibit the organization from providing coverage pursuant to a contract under this part shall be superseded.

Nothing in this subparagraph shall be construed as limiting the number of times such a waiver may be renewed.

"(D) CONSTRUCTION.—Nothing in this paragraph shall be construed as affecting the operation of section 514 of the Employee Retirement Income Security Act of 1974.

"(5) EXCEPTION IF REQUIRED TO OFFER MORE THAN MEDICAREPLUS PLANS.—Paragraph (1) shall not apply to a MedicarePlus organization in a State if the State requires the organization, as a condition of licensure, to offer any product or plan other than a MedicarePlus plan.

"(6) EXCEPTION IN CASES OF UNREASONABLE BARRIERS TO MARKET ENTRY.—

"(A) IN GENERAL.—A MedicarePlus organization that seeks to offer a MedicarePlus plan in a State may apply for a waiver of the requirement of paragraph (1) for that organization operating in that State.

"(B) STANDARD.—The Secretary shall act on such an application within 60 days after the date it is filed and shall grant such a waiver for an organization with respect to a State if the Secretary determines that—

"(i) the State (I) denied such a licensing application or (II) unreasonably delayed in acting upon the application, and

"(ii) the State's licensing standards or review process imposes unreasonable barriers to market entry, including through the imposition of any requirements, procedures, or other standards to such organizations that are not generally applicable to any other entities engaged in substantially similar business.

"(C) APPLICATION OF CERTAIN RULES.—The provisions of subparagraphs (C) and (D) of paragraph (4) shall apply to this paragraph in the same manner as they apply under such paragraph, except that for this purpose any reference in paragraph (4)(C)(i) to 36-month period is deemed a reference to a 24-month period.

"(b) PREPAID PAYMENT.—A MedicarePlus organization shall be compensated (except for deductibles, coinsurance, and copayments) for the provision of health care services to enrolled members by a payment which is paid on a periodic basis without regard to the date the health care services are provided and which is fixed without regard to the frequency, extent, or kind of health care service actually provided to a member.

"(c) ASSUMPTION OF FULL FINANCIAL RISK.—The MedicarePlus organization shall assume full financial risk on a prospective basis for the provision of the health care services (except, at the election of the organization, hospice care) for which benefits are required to be provided under section 1852(a)(1), except that the organization—

"(1) may obtain insurance or make other arrangements for the cost of providing to any enrolled member such services the aggregate value of which exceeds $5,000 in any year,

"(2) may obtain insurance or make other arrangements for the cost of such services provided to its enrolled members other than through the organization because medical necessity required their provision before they could be secured through the organization,

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

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

In the case of a MedicarePlus organization that is a union sponsor, Taft-Hartley sponsor, or a qualified association sponsor, this subsection shall not apply with respect to MedicarePlus plans offered by such organization and issued by an organization to which subsection (b)(1) applies or by a provider-sponsored organization (as defined in section 1854(a)).

"(d) PROVISION AGAINST RISK OF INSOLVENCY.—

"(1) IN GENERAL.—Each MedicarePlus organization shall meet standards under section 1856 relating to the financial solvency and capital adequacy of the organization and including provision to prevent enrollees from being held liable to any person or entity for the plan sponsor's debts in the event of the plan sponsor's insolvency. Such standards shall take into account the nature and type of MedicarePlus plans offered by the organization.

"(2) TREATMENT OF PROVIDER-SPONSORED ORGANIZATIONS.—

"(A) IN GENERAL.—In the case of an entity that is a provider-sponsored organization that is operating—

"(i) in a State approved under subparagraph (B), the organization shall meet the standards described in paragraph (1) through licensure by the State, or

"(ii) in a State that is not so approved, the organization shall meet the standards described in paragraph (1) through application and certification licensure by the Secretary.

"(B) APPROVED STATES.—

"(i) APPLICATION PROCESS.—For purposes of subparagraph (A), the Secretary shall establish a process under which a State may apply to the Secretary for a determination that the State is applying to provider-sponsored organizations, through its process for licensing provider-sponsored organizations, solvency standards that are identical with the solvency standards established under section 1856(c) for such organizations.

"(ii) DETERMINATION.—The Secretary shall approve such a State if the Secretary determines that the State is so applying such standards. If the Secretary denies such an approval, the State may reapply for such a determination.

"(iii) PUBLICATION.—The Secretary shall publish a list of States that are approved under this subparagraph.

"(3) TREATMENT OF UNION AND TAFT-HARTLEY SPONSORS.—An entity that is a union sponsor or a Taft-Hartley sponsor is deemed to meet the requirement of paragraph (1).

"(4) TREATMENT OF CERTAIN QUALIFIED ASSOCIATION SPONSORS.—An entity that is a qualified association sponsor is deemed to meet the requirement of paragraph (1) with respect to MedicarePlus plans offered by such association and issued by an organization to which subsection (b)(1) applies or by a provider-sponsored organization.

"(e) PROVIDER-SPONSORED ORGANIZATION DEFINED.—

"(1) IN GENERAL.—In this part, the term 'provider-sponsored organization' means a public or private entity—

"(A) that is established or organized by a health care provider, or group of affiliated health care providers,

"(B) that provides a substantial proportion (as defined by the Secretary) of the health care items and services under the contract under this part directly through the provider or affiliated group of providers, and

"(C) with respect to which those affiliated providers that share, directly or indirectly, substantial financial risk with respect to the provision of such items and services have at least a majority financial interest in the entity.

"(2) SUBSTANTIAL PROPORTION.—In defining what is a 'substantial proportion' for purposes of paragraph (1)(A), the Secretary—

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

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

"(3) AFFILIATION.—For purposes of this su section, a provider is 'affiliated' with anothe provider if, through contract, ownership, or oth erwise—

"(A) one provider, directly or indirectly, co trols, is controlled by, or is under common co trol with the other,

"(B) both providers are part of a controlle group of corporations under section 1563 of th Internal Revenue Code of 1986, or

"(C) both providers are part of an affiliate service group under section 414 of such Code.

"(4) CONTROL.—For purposes of paragrap (3), control is presumed to exist if one party, d rectly or indirectly, owns, controls, or holds th power to vote, or proxies for, not less than 5 percent of the voting rights or governance right of another.

"(5) HEALTH CARE PROVIDER DEFINED.—In th subsection and subsection (f), the term 'heal care provider' means—

"(A) any individual who is engaged in the d livery of health care services in a State and wh is required by State law or regulation to be l censed or certified by the State to engage in th delivery of such services in the State, and

"(B) any entity that is engaged in the deli ery of health care services in a State and tha if it is required by State law or regulation to b licensed or certified by the State to engage i the delivery of such services in the State, is licensed.

"(6) REGULATIONS.—The Secretary shall issu regulations to carry out this subsection.

"(f) APPLICATION OF ANTITRUST RULE OF RE SON TO PROVIDER-SPONSORED ORGANIZATIONS.—

"(1) RULE OF REASON STANDARD.—In any ca tion under the antitrust laws, or under any la of a State (as defined in section 4G(2) of th Clayton Act) similar to the antitrust laws, th following conduct shall not be deemed illega per se:

"(A) The conduct of a provider-sponsored or ganization, and affiliated providers of the orga nization, in negotiating, making, or performin a contract (including the establishment an modification of a fee schedule and the develop ment of a panel of physicians), to the exten such contract is for the purpose of providin health care services to individuals under th terms of a MedicarePlus plan offered by such a organization.

"(B) The exchange of information amon health care providers relating to costs, sale profitability, marketing, prices, or fees of an health care product or service if—

"(i) the exchange of such information wa solely for the purpose of establishing a provider sponsored organization and was reasonably re quired for such purpose, and

"(ii) such information was not used for an other purpose.

Such conduct shall be judged on the basis of i reasonableness, taking into account all relevan factors affecting competition, including the ef fects on competition in properly defined mar kets.

"(C) The conduct of a group of health car providers, and provider members of such group, in negotiating, making, or performing contract (including the establishment and modi fication of a fee schedule and the development of a panel of physicians) with a provider-spon sored organization, to the extent such contrac is for the purpose of providing health care ser ices to individuals under the terms of MedicarePlus plan of the organization, but only if the group meets the requirements of para graph (2).

Such conduct shall be judged on the basis of i reasonableness, taking into account all relevan factors affecting competition, including the ef fects on competition in properly defined mar kets.

"(2) REQUIREMENTS FOR GROUP.—A group of health care providers meets the requirements of this paragraph with respect to a MedicarePlus plan of a provider-sponsored organization if the group—

"(i) is not a provider-sponsored organization,

"(ii) is organized by, operated by, and composed only of members who are health care providers and for purposes that include providing health care services,

"(iii) is funded in part by capital contributions made by the members of such group,

"(iv) with respect to each contract made by such group for the purpose of providing a type of health care service to individuals under the terms of the plan—

"(I) requires all members of such group who engage in providing such type of health care service to agree to provide health care services of such type under such contract,

"(II) receives the compensation paid for the health care services of such type provided under such contract by such members, and

"(III) provides for the distribution of such compensation,

"(v) has established, consistent with the requirements of this part, a program to review, pursuant to written guidelines, the quality, efficiency, and appropriateness of treatment methods and setting of services for all health care providers and all patients participating in the plan, along with internal procedures to correct identified deficiencies relating to such methods and such services,

"(vi) has established, consistent with the requirements of this part, a program to monitor and control utilization of health care services provided under the plan, for the purpose of improving efficient, appropriate care and eliminating the provision of unnecessary health care services,

"(vii) has established a management program to coordinate the delivery of health care services for all health care providers and all patients participating in the plan, for the purpose of achieving efficiencies and enhancing the quality of health care services provided, and

"(viii) has established, consistent with the requirements of this part, a grievance and appeal process for such group designed to review and promptly resolve beneficiary or patient grievances and complaints.

"(3) DEFINITIONS.—For purposes of this subsection:

"(A) ANTITRUST LAWS.—The term 'antitrust laws' has the meaning given it in subsection (a) of the first section of the Clayton Act (15 U.S.C. 12), except that such term includes section 5 of the Federal Trade Commission Act (15 U.S.C. 45) to the extent that such section 5 applies to unfair methods of competition.

"(B) HEALTH CARE SERVICE.—The term 'health care service' means any service for which payment may be made under a MedicarePlus plan including services related to the delivery or administration of such service.

"(3) ISSUANCE OF GUIDELINES.—Not later than 120 days after the date of the enactment of this part, the Attorney General and the Federal Trade Commission shall issue jointly guidelines specifying the enforcement policies and analytical principles that will be applied by the Department of Justice and the Commission with respect to the operation of this subsection.

"(g) ORGANIZATIONS TREATED AS MEDICAREPLUS ORGANIZATIONS DURING TRANSITION.—Any of the following organizations shall be considered to qualify as a MedicarePlus organization for contract years beginning before January 1, 1998:

"(1) HEALTH MAINTENANCE ORGANIZATIONS.—An organization that is organized under the laws of any State and that is a qualified health maintenance organization (as defined in section 1310(d) of the Public Health Service Act), an organization recognized under State law as a health maintenance organization, or a similar organization regulated under State law for solvency in the same manner and to the same extent as such a health maintenance organization.

"(2) LICENSED INSURERS.—An organization that is organized under the laws of any State and—

"(A) is licensed by a State agency as an insurer for the offering of health benefit coverage, or

"(B) is licensed by a State agency as a service benefit plan,

but only for individuals residing in an area in which the organization is licensed to offer health insurance coverage.

"(3) CURRENT RISK-CONTRACTORS.—An organization that is an eligible organization (as defined in section 1876(b)) and that has a risk-sharing contract in effect under section 1876 as of the date of the enactment of this section.

"PAYMENTS TO MEDICAREPLUS ORGANIZATIONS

"SEC. 1854. (a) PAYMENTS TO ORGANIZATIONS.—

"(1) MONTHLY PAYMENTS.—

"(A) IN GENERAL.—Under a contract under section 1857 and subject to subsections (e) and (f), the Secretary shall make monthly payments under this section in advance to each MedicarePlus organization, with respect to coverage of an individual under this part in a MedicarePlus payment area for a month, in an amount equal to 1/12 of the annual MedicarePlus capitation rate (as calculated under subsection (c)) with respect to that individual for that area, adjusted for such risk factors as age, disability status, gender, institutional status, and such other factors as the Secretary determines to be appropriate, so as to ensure actuarial equivalence. The Secretary may add to, modify, or substitute for such factors, if such changes will improve the determination of actuarial equivalence.

"(B) SPECIAL RULE FOR END-STAGE RENAL DISEASE.—The Secretary shall establish a separate rate of payment to a MedicarePlus organization with respect to any individual determined to have end-stage renal disease and enrolled in a MedicarePlus plan of the organization. Such rate of payment shall be actuarially equivalent to rates paid to other enrollees in the MedicarePlus payment area (or such other area as specified by the Secretary).

"(2) ADJUSTMENT TO REFLECT NUMBER OF ENROLLEES.—

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

"(B) SPECIAL RULE FOR CERTAIN ENROLLEES.—

"(i) IN GENERAL.—Subject to clause (ii), the Secretary may make retroactive adjustments under subparagraph (A) to take into account individuals enrolled during the period beginning on the date on which the individual enrolls with a MedicarePlus organization under a plan operated, sponsored, or contributed to by the individual's employer or former employer (or the employer or former employer of the individual's spouse) and ending on the date on which the individual is enrolled in the organization under this part, except that for purposes of making such retroactive adjustments under this subparagraph, such period may not exceed 90 days.

"(ii) EXCEPTION.—No adjustment may be made under clause (i) with respect to any individual who does not certify that the organization provided the individual with the disclosure statement described in section 1852(c) at the time the individual enrolled with the organization.

"(b) ANNUAL ANNOUNCEMENT OF PAYMENT RATES.—

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

"(A) the annual MedicarePlus capitation rate for each MedicarePlus payment area for the year, and

"(B) the risk and other factors to be used in adjusting such rates under subsection (a)(1)(A) for payments for months in that year.

"(2) ADVANCE NOTICE OF METHODOLOGICAL CHANGES.—At least 45 days before making the announcement under paragraph (2) for a year, the Secretary shall provide for notice to MedicarePlus organizations of proposed changes to be made in the methodology from the methodology and assumptions used in the previous announcement and shall provide such organizations an opportunity to comment on such proposed changes.

"(3) EXPLANATION OF ASSUMPTIONS.—In each announcement made under paragraph (1) for a year, the Secretary shall include an explanation of the assumptions and changes in methodology used in the announcement in sufficient detail so that MedicarePlus organizations can compute monthly adjusted MedicarePlus capitation rates for individuals in each MedicarePlus payment area which is in whole or in part within the service area of such an organization.

"(c) CALCULATION OF ANNUAL MEDICAREPLUS CAPITATION RATES.—

"(1) IN GENERAL.—For purposes of this part, the annual MedicarePlus capitation rate, for a MedicarePlus payment area for a contract year consisting of a calendar year, is equal to the greatest of the following:

"(A) BLENDED CAPITATION RATE.—The sum of—

"(i) area-specific percentage for the year (as specified under paragraph (2) for the year) of the annual area-specific MedicarePlus capitation rate for the year for the MedicarePlus payment area, as determined under paragraph (3), and

"(ii) national percentage (as specified under paragraph (2) for the year) of the input-price-adjusted annual national MedicarePlus capitation rate for the year, as determined under paragraph (4),

multiplied by a budget neutrality adjustment factor determined under paragraph (5).

"(B) MINIMUM AMOUNT.—

"(i) For 1996, $300.

"(ii) For 1997, $350.

"(iii) For a succeeding year, is the minimum amount specified in this subparagraph for the preceding year increased by national average per capita growth percentage, specified under paragraph (6) for that succeeding year.

"(C) MINIMUM INCREASE OF 2 PERCENT OVER PREVIOUS YEAR'S RATE.—

"(i) For 1996, 102 percent of the annual per capita rate of payment for 1995 determined under section 1876(a)(1)(C) for the MedicarePlus payment area.

"(ii) For a subsequent year, 102 percent of the annual MedicarePlus capitation rate under this subsection for the area for the previous year.

"(2) AREA-SPECIFIC AND NATIONAL PERCENTAGES.—For purposes of paragraph (1)(A)—

"(A) for 1996 and 1997, the 'area-specific percentage' is 90 percent and the 'national percentage' is 10 percent,

"(B) for 1998, the 'area-specific percentage' is 85 percent and the 'national percentage' is 15 percent,

"(C) for 1999, the 'area-specific percentage' is 80 percent and the 'national percentage' is 20 percent,

"(D) for 2000, the 'area-specific percentage' is 75 percent and the 'national percentage' is 25 percent, and

"(E) for a year after 2000, the 'area-specific percentage' is 70 percent and the 'national percentage' is 30 percent.

"(3) ANNUAL AREA-SPECIFIC MEDICAREPLUS CAPITATION RATE.—For purposes of paragraph (1)(A), the annual area-specific MedicarePlus capitation rate for a MedicarePlus payment area—

"(A) for 1996 is the annual per capita rate of payment for 1995 determined under section

Attachment 6

health center services (as defined in
her ambulatory services offered by a
center and which are otherwise in-

-ray services;
services (other than services in an
ses) for individuals 21 years of age or
screening, diagnostic, and treatment
section (r)) for individuals who are
l are under the age of 21; and[270] (C)
and supplies furnished (directly or
thers) to individuals of child-bearing
) can be considered to be sexually
er the State plan and who desire such

furnished by a physician (as defined
ner furnished in the office, the pa-
[271] nursing facility, or elsewhere, and
ervices furnished by a dentist (de-
to the extent such services may be
either by a doctor of medicine or by a
or dental medicine and would be
rnished by a physician (as defined in

her type of remedial care recognized
by licensed practitioners within the
ined by State law;
ices including personal care services
an for an individual in accordance
B) provided by an individual who is
vices and who is not a member of the
rvised by a registered nurse, and (D)
ner location; but not including such
npatient or resident of a nursing

rvices;
ed by or under the direction of a
whether the clinic itself is adminis-
ling such services furnished outside
l to an eligible individual who does
dwelling or does not have a fixed

, and" and subparagraph (C), effective as if included
nd redesignated P.L. 101-239, §6402(d).
and this second subparagraph (C). For the effective

". For the effective date, see Vol. II, P.L. 100-20

agraph (B) in its entirety, effective April 1, 199
ulations to carry out this amendment have be
(B) as if formerly read, see Vol. III, P.L. 101-239.
lled". For the effective date, see Vol. II, P.L. 100-20

personal care services (A) prescribed by a physic
of treatment, (B) provided by an individual who
is not a member of the individual's family,
ished in a home or other location; but not includi
dent of a nursing facility", effective with respe
ber 1, 1994.

(10) dental services;
(11) physical therapy and related services;
(12) prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select;
(13) other diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level[273];
(14) inpatient hospital services and nursing[274] facility services for individuals 65 years of age or over in an institution for mental diseases;
(15) services in an intermediate care facility for the mentally retarded (other than[275] in an institution for mental diseases) for individuals who are determined, in accordance with section 1902(a)(31)(A), to be in need of such care;
(16) effective January 1, 1973, inpatient psychiatric hospital services for individuals under age 21, as defined in subsection (h);
(17) services furnished by a nurse-midwife (as defined in section 1861(gg)) which the nurse-midwife is legally authorized to perform under State law (or the State regulatory mechanism provided by State law), whether or not the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider;
(18) hospice care (as defined in subsection (o));
(19) case-management services (as defined in section 1915(g)(2));
(20) respiratory care services (as defined in section 1902(e)(9)(C));[276]
(21) services furnished by a certified pediatric nurse practitioner or certified family nurse practitioner (as defined by the Secretary) which the certified pediatric nurse practitioner or certified family nurse practitioner is legally authorized to perform under State law (or the State regulatory mechanism provided by State law), whether or not the certified pediatric nurse practitioner or certified family nurse practitioner is under the supervision of, or associated with, a physician or other health care provider; and[277]
(22)[278] any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary;[279]

[273] P.L. 101-508, §4719(a), inserted ", including any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level", effective November 5, 1990.
[274] P.L. 100-203, §4211(h)(6)(B), struck out ", skilled nursing facility services, and intermediate care" and substituted "and nursing". For the effective date, see Vol. II, P.L. 100-203, §4214.
[275] P.L. 100-203, §4211(h)(6)(C), struck out "intermediate care facility services (other than such services" and substituted "services in an intermediate care facility for the mentally retarded (other than". For the effective date, see Vol. II, P.L. 100-203, §4214.
[276] P.L. 101-239, §6405(a)(1), struck out "and".
[277] P.L. 101-239, §6405(a)(3), added this paragraph (21), effective with respect to services furnished by a certified pediatric nurse practitioner or certified family nurse practitioner on or after July 1, 1990.
[278] P.L. 101-239, §6405(a)(2), redesignated paragraph (21) as paragraph (22).
[279] P.L. 101-508, §4711(a)(1), struck out "and". Impossible to execute.

Question: Why doesn't your Medicare proposal provide for reimbursement for nurse practitioners and clinical nurse specialists?

Answer: I put a Medicare proposal on the table that will preserve the Medicare program and keep it financially secure, while not adding new costs for people on Medicare. I vetoed the Republican budget bill because it would threaten the Medicare program, beneficiaries access to care, and the quality of health care for everyone in this country. I very much appreciated your support for that veto and for all the work you have done to bring health care to all Americans.

As you pointed out, a provision to reimburse nurse practitioners and clinical nurse specialists would have some costs associated with it. At a time when we were trying to cut as little as possible from the Medicare program, we did not include the provision. However, we are more than happy to work with you on it.