

ENSURING REMOVAL OF TERMINATED PROVIDERS FROM
MEDICAID AND CHIP ACT

FEBRUARY 23, 2016.—Committed to the Committee of the Whole House on the State
of the Union and ordered to be printed

Mr. UPTON, from the Committee on Energy and Commerce,
submitted the following

R E P O R T

together with

ADDITIONAL VIEWS

[To accompany H.R. 3716]

[Including cost estimate of the Congressional Budget Office]

The Committee on Energy and Commerce, to whom was referred the bill (H.R. 3716) to amend title XIX of the Social Security Act to require States to provide to the Secretary of Health and Human Services certain information with respect to provider terminations, and for other purposes, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

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The amendment is as follows:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the “Ensuring Removal of Terminated Providers from Medicaid and CHIP Act”.

SEC. 2. INCREASING OVERSIGHT OF TERMINATION OF MEDICAID PROVIDERS.

(a) INCREASED OVERSIGHT AND REPORTING.—

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

(A) by redesignating paragraph (8) as paragraph (9); and

(B) by inserting after paragraph (7) the following new paragraph:

“(8) PROVIDER TERMINATIONS.—

“(A) IN GENERAL.—Beginning on January 1, 2017, in the case of a notification under subsection (a)(41) with respect to a termination for a reason specified in section 455.101 of title 42, Code of Federal Regulations (as in effect on November 1, 2015) or for any other reason specified by the Secretary, of the participation of a provider of services or any other person under the State plan, the State, not later than 21 business days after the effective date of such termination, submits to the Secretary with respect to any such provider or person, as appropriate—

“(i) the name of such provider or person;

“(ii) the provider type of such provider or person;

“(iii) the specialty of such provider’s or person’s practice;

“(iv) the date of birth, Social Security number, national provider identifier, Federal taxpayer identification number, and the State license or certification number of such provider or person;

“(v) the reason for the termination;

“(vi) a copy of the notice of termination sent to the provider or person;

“(vii) the effective date of such termination specified in such notice; and

“(viii) any other information required by the Secretary.

“(B) EFFECTIVE DATE DEFINED.—For purposes of this paragraph, the term ‘effective date’ means, with respect to a termination described in subparagraph (A), the later of—

“(i) the date on which such termination is effective, as specified in the notice of such termination; or

“(ii) the date on which all appeal rights applicable to such termination have been exhausted or the timeline for any such appeal has expired.”.

(2) REPORTING REQUIREMENTS FOR MANAGED CARE ENTITIES.—Section 1932(d) of the Social Security Act (42 U.S.C. 1396u–2(d)) is amended by adding at the end the following new paragraph:

“(5) STATE REPORTING REQUIREMENTS FOR MANAGED CARE ENTITIES.—

“(A) IN GENERAL.—With respect to any contract with a managed care entity under section 1903(m) or 1905(t)(3) (as applicable), beginning on the later of the first day of the first plan year for such managed care entity that begins after the date of the enactment of this paragraph or January 1, 2017, the State shall require that such contract include a provision that providers of services or persons terminated (as described in section 1902(kk)(8)) from participation under this title, title XVIII, or title XXI be terminated from participating under this title as a provider in any network of such entity that serves individuals eligible to receive medical assistance under this title.

“(B) NOTIFICATION OF TERMINATION.—For the period beginning on January 1, 2017, and ending on the date on which the enrollment of providers under paragraph (6) is complete for a State, the State shall provide for a system for notifying managed care entities (as defined in subsection (a)(1)) of the termination (as described in section 1902(kk)(8)) of providers of services or persons from participation under this title, title XVIII, or title XXI.”.

(3) **TERMINATION NOTIFICATION DATABASE.**—Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended by adding at the end the following new subsection:

“(ll) **TERMINATION NOTIFICATION DATABASE.**—In the case of a provider of services or any other person whose participation under this title, title XVIII, or title XXI is terminated (as described in subsection (kk)(8)), the Secretary shall, not later than 21 business days after the date on which the Secretary terminates such participation under title XVIII or is notified of such termination under subsection (a)(41) (as applicable), review such termination and, if the Secretary determines appropriate, include such termination in any database or similar system developed pursuant to section 6401(b)(2) of the Patient Protection and Affordable Care Act (42 U.S.C. 1395cc note; Public Law 111–148).”

(4) **NO FEDERAL FUNDS FOR ITEMS AND SERVICES FURNISHED BY TERMINATED PROVIDERS.**—Section 1903 of the Social Security Act (42 U.S.C. 1396b) is amended—

(A) in subsection (i)(2)—

(i) in subparagraph (A), by striking the comma at the end and inserting a semicolon;

(ii) in subparagraph (B), by striking “or” at the end; and

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

“(D) beginning not later than January 1, 2018, under the plan by any provider of services or person whose participation in the State plan is terminated (as described in section 1902(kk)(8)) after the date that is 60 days after the date on which such termination is included in the database or other system under section 1902(ll); or”; and

(B) in subsection (m), by inserting after paragraph (2) the following new paragraph:

“(3) No payment shall be made under this title to a State with respect to expenditures incurred by the State for payment for services provided by a managed care entity (as defined under section 1932(a)(1)) under the State plan under this title (or under a waiver of the plan) unless the State—

“(A) beginning on the applicable date specified in subparagraph (A) of section 1932(d)(5), has a contract with such entity that complies with the requirement specified in such subparagraph; and

“(B)(i) for the period specified in subparagraph (B) of such section, has a system in effect that meets the requirement specified in such subparagraph; and

“(ii) after such period, complies with section 1932(d)(6).”

(5) **DEVELOPMENT OF UNIFORM TERMINOLOGY FOR REASONS FOR PROVIDER TERMINATION.**—Not later than January 1, 2017, the Secretary of Health and Human Services shall, in consultation with the heads of State agencies administering State Medicaid plans (or waivers of such plans), issue regulations establishing uniform terminology to be used with respect to specifying reasons under subparagraph (A)(v) of paragraph (8) of section 1902(kk) of the Social Security Act (42 U.S.C. 1396a(kk)), as amended by paragraph (1), for the termination (as described in such paragraph) of the participation of certain providers in the Medicaid program under title XIX of such Act or the Children’s Health Insurance Program under title XXI of such Act.

(6) **CONFORMING AMENDMENT.**—Section 1902(a)(41) of the Social Security Act (42 U.S.C. 1396a(a)(41)) is amended by striking “provide that whenever” and inserting “provide, in accordance with subsection (kk)(8) (as applicable), that whenever”.

(b) **INCREASING AVAILABILITY OF MEDICAID PROVIDER INFORMATION.**—

(1) **FFS PROVIDER ENROLLMENT.**—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended by inserting after paragraph (77) the following new paragraph:

“(78) provide that, not later than January 1, 2017, in the case of a State plan that provides medical assistance on a fee-for-service basis, the State shall require each provider furnishing items and services to individuals eligible to receive medical assistance under such plan to enroll with the State agency and provide to the State agency the provider’s identifying information, including the name, specialty, date of birth, Social Security number, national provider identifier, Federal taxpayer identification number, and the State license or certification number of the provider;”

(2) **MANAGED CARE PROVIDER ENROLLMENT.**—Section 1932(d) of the Social Security Act (42 U.S.C. 1396u–2(d)), as amended by subsection (a)(2), is amended by adding at the end the following new paragraph:

“(6) **ENROLLMENT OF PARTICIPATING PROVIDERS.**—

“(A) **IN GENERAL.**—Beginning not later than January 1, 2018, a State shall require that, in order to participate as a provider in the network of

a managed care entity that provides services to, or orders, prescribes, refers, or certifies eligibility for services for, individuals who are eligible for medical assistance under the State plan under this title and who are enrolled with the entity, the provider is enrolled with the State agency administering the State plan under this title. Such enrollment shall include providing to the State agency the provider's identifying information, including the name, specialty, date of birth, Social Security number, national provider identifier, Federal taxpayer identification number, and the State license or certification number of the provider.

“(B) RULE OF CONSTRUCTION.—Nothing in subparagraph (A) shall be construed as requiring a provider described in such subparagraph to provide services to individuals who are not enrolled with a managed care entity under this title.”.

(c) COORDINATION WITH CHIP.—

(1) IN GENERAL.—Section 2107(e)(1) of the Social Security Act (42 U.S.C. 1397gg(e)(1)) is amended—

(A) by redesignating subparagraphs (B), (C), (D), (E), (F), (G), (H), (I), (J), (K), (L), (M), (N), and (O) as subparagraphs (D), (E), (F), (G), (H), (I), (J), (K), (M), (N), (O), (P), (Q), and (R), respectively;

(B) by inserting after subparagraph (A) the following new subparagraphs:

“(B) Section 1902(a)(39) (relating to termination of participation of certain providers).

“(C) Section 1902(a)(78) (relating to enrollment of providers participating in State plans providing medical assistance on a fee-for-service basis).”;

(C) by inserting after subparagraph (K) (as redesignated by paragraph (1)) the following new subparagraph:

“(L) Section 1903(m)(3) (relating to limitation on payment with respect to managed care).”; and

(D) in subparagraph (P) (as redesignated by paragraph (1)), by striking “(a)(2)(C) and (h)” and inserting “(a)(2)(C) (relating to Indian enrollment), (d)(5) (relating to reporting requirements for managed care entities), (d)(6) (relating to enrollment of providers participating with a managed care entity), and (h) (relating to special rules with respect to Indian enrollees, Indian health care providers, and Indian managed care entities)”.

(2) EXCLUDING FROM MEDICAID PROVIDERS EXCLUDED FROM CHIP.—Section 1902(a)(39) of the Social Security Act (42 U.S.C. 1396a(a)(39)) is amended by striking “title XVIII or any other State plan under this title” and inserting “title XVIII, any other State plan under this title, or any State child health plan under title XXI”.

(d) RULE OF CONSTRUCTION.—Nothing in this section shall be construed as changing or limiting the appeal rights of providers or the process for appeals of States under the Social Security Act.

PURPOSE AND SUMMARY

H.R. 3716, the Ensuring Terminated Providers are Removed from Medicaid and CHIP Act, would require States and Medicaid managed care plans to report identifying information for providers terminated for reasons related to fraud, integrity and quality from Medicare or one State's Medicaid or Children's Health Insurance Program (CHIP). The bill would, among other things, also require providers participating in Medicaid or CHIP managed care to be enrolled with the State; require CMS to include State reported provider terminations and Medicare provider terminations in its Termination Notification Database or equivalent system; and require States to pay back the federal portion of Medicaid and CHIP payments made to terminated providers for services performed more than 60 days after a provider's termination is included in the CMS Termination Notification Database.

BACKGROUND AND NEED FOR LEGISLATION

Prior to passage of the Patient Protection and Affordable Care Act (PPACA), a provider excluded from participation in one State's Medicaid program, could potentially participate in another State's

Medicaid program, leaving the second State's program vulnerable to fraud, waste, or abuse committed by that provider. To prevent this from happening, Section 6501 of PPACA amended Section 1902(a)(39) of the Social Security Act (SSA) so that a State not only must exclude a provider for engaging in activities articulated in Section 1128 and Section 1128A (engaging in fraud or other certain criminal activity related to patient care), but that other States also must terminate the participation of a provider from its Medicaid program if that provider's participation was terminated from Medicare or from another State Medicaid program. This requirement was intended to strengthen Medicaid program integrity across States, so that a specific provider found to warrant termination in one State cannot continue to provide services for Medicaid beneficiaries in another State and receive Medicaid payments for doing so.

Despite the PPACA requirement, the Department of Health and Human Services' Office of Inspector General (OIG) found continued participation from providers terminated "for reasons of fraud, integrity or quality" (referred to as "for cause" terminations) by one State Medicaid program in other States' programs. Specifically, the OIG found that 12 percent of providers terminated for cause from a State Medicaid program during 2011 (295 of the 2,539 providers) were participating in another State's Medicaid programs as of January 1, 2012. Further, 172 of the 295 providers continued their participation in Medicaid as late as January 2014, more than 2 years after they were terminated for cause from another State program. These Medicaid programs paid \$7.4 million to 94 providers for services performed after each provider's termination for cause by the initial State. Furthermore, a review of public records conducted by Reuters found that more than one in five providers excluded from Medicare were still able to bill State Medicaid programs.

The OIG report noted several challenges faced by States in implementing the PPACA requirement, including the lack of a comprehensive centralized data source that identifies providers terminated for cause; the lack of uniform terminology in existing data sources regarding the reasons for provider terminations; and challenges related to excluding providers participating in managed care since those providers may not be enrolled with the State Medicaid agency. H.R. 3716 would address the challenges and concerns raised by the OIG.

HEARINGS

The Subcommittee on Health held a hearing on H.R. 3716 on September 11, 2015. The Subcommittee received testimony from:

- John Hagg, Director of Medicaid Audits, Office of Inspector General, U.S. Department of Health and Human Services;
- Nico Gomez, Chief Executive Officer, Oklahoma Health Care Authority; and
- Trish Riley, Executive Director, National Academy for State Health Policy; Commissioner, Medicaid and CHIP Payment and Access Commission.

COMMITTEE CONSIDERATION

On November 3, 2015, the Subcommittee on Health met in open markup session and forwarded H.R. 3716 to the full Committee, as amended, by a voice vote. On November 17, 2015, the full Committee on Energy and Commerce met in open markup session and ordered H.R. 3716 reported to the House, as amended, by a voice vote.

COMMITTEE VOTES

Clause 3(b) of rule XIII of the Rules of the House of Representatives requires the Committee to list the record votes on the motion to report legislation and amendments thereto. There were no record votes taken in connection with ordering H.R. 3716 reported.

COMMITTEE OVERSIGHT FINDINGS

Pursuant to clause 3(c)(1) of rule XIII of the Rules of the House of Representatives, the Committee held a hearing and made findings that are reflected in this report.

STATEMENT OF GENERAL PERFORMANCE GOALS AND OBJECTIVES

The objective of H.R. 3716 is to ensure that providers terminated for cause from one State's Medicaid program or Medicare are also removed from other States' programs.

NEW BUDGET AUTHORITY, ENTITLEMENT AUTHORITY, AND TAX EXPENDITURES

In compliance with clause 3(c)(2) of rule XIII of the Rules of the House of Representatives, the Committee finds that H.R. 3716, would result in no new or increased budget authority, entitlement authority, or tax expenditures or revenues.

EARMARK, LIMITED TAX BENEFITS, AND LIMITED TARIFF BENEFITS

In compliance with clause 9(e), 9(f), and 9(g) of rule XXI of the Rules of the House of Representatives, the Committee finds that H.R. 3716 contains no earmarks, limited tax benefits, or limited tariff benefits.

COMMITTEE COST ESTIMATE

The Committee adopts as its own the cost estimate prepared by the Director of the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974.

CONGRESSIONAL BUDGET OFFICE ESTIMATE

Pursuant to clause 3(c)(3) of rule XIII of the Rules of the House of Representatives, the following is the cost estimate provided by the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974:

H.R. 3716—Ensuring Removal of Terminated Providers from Medicaid and CHIP Act

Summary: H.R. 3716 would assist states in identifying health care providers who are ineligible to participate in their state Med-

icaid or Children's Health Insurance Program (CHIP) programs because the provider was terminated from participating in another state's programs or in the Medicare program.

CBO estimates that the bill would reduce direct spending by \$28 million over the 2016–2026 period. Because the legislation would affect direct spending; pay-as-you-go procedures apply. Enacting the bill would not affect revenues.

CBO estimates that enacting H.R. 3716 would not increase net direct spending or on-budget deficits in any of the four consecutive 10-year periods beginning in 2027.

H.R. 3716 contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA).

Estimated cost to the Federal Government: The estimated budgetary effects of H.R. 3716 are shown in the following table. The costs of this legislation fall within budget function 550 (health).

	By fiscal year, in millions of dollars—													2016– 2021	2016– 2026
	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026				
CHANGES IN DIRECT SPENDING															
Medicaid:															
Estimated Budget Authority	0	0	-1	-2	-3	-3	-3	-4	-4	-4	-4	-9	-28		
Estimated Outlays	0	0	-1	-2	-3	-3	-3	-4	-4	-4	-4	-9	-28		
CHIP:															
Estimated Budget Authority	0	0	*	*	*	*	*	*	*	*	*	*	*		
Estimated Outlays	0	0	*	*	*	*	*	*	*	*	*	*	*		
Total Changes:															
Estimated Budget Authority	0	0	-1	-2	-3	-3	-3	-4	-4	-4	-4	-9	-28		
Estimated Outlays	0	0	-1	-2	-3	-3	-3	-4	-4	-4	-4	-9	-28		

Notes: Components may not add to totals because of rounding; CHIP = Children's Health Insurance Program; * = between \$0 and -\$500,000.

Basis of estimate: The Affordable Care Act required states to terminate the participation of health care providers under Medicaid if they have been terminated under the Medicare program or another state Medicaid program. The Secretary of Health and Human Services (HHS), under regulatory authority, required states to comply with similar standards in CHIP. H.R. 3716 would codify the requirements in CHIP and also require states and managed care organizations that participate in Medicaid or CHIP to collect information about all participating health care providers and report information about terminated providers to the Secretary. The Secretary would be required to review the termination and, if the Secretary determines appropriate, include such information in any database intended for sharing data on terminated providers among states. The bill would also require the Secretary to issue regulations that establish uniform terminology to document the reasons for terminating a health care provider's eligibility to participate in Medicaid or CHIP.

CBO expects the additional requirements in H.R. 3716 for states and managed care organizations to collect and report information regarding terminated health care providers will reduce the likelihood of such providers receiving federal payments under Medicaid and CHIP. Based on information from a 2015 report from the HHS Office of Inspector General, CBO estimates that providers operating under managed care contracts receive, on average, \$3 million per year in federal payments from Medicaid and CHIP even though they have been terminated from the Medicare program or Medicaid

programs in other states. Once fully implemented, CBO estimates that the bill would reduce improper payments by \$3 million to \$4 million annually and reduce direct spending by \$28 million over the 2016–2026 period.

Pay-As-You-Go considerations: The Statutory Pay-As-You-Go Act of 2010 establishes budget-reporting and enforcement procedures for legislation affecting direct spending or revenues. The net changes in outlays that are subject to those pay-as-you-go procedures are shown in the following table.

	By fiscal year, in millions of dollars—														2016– 2021	2016– 2026
	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026					
	NET INCREASE OR DECREASE (–) IN THE DEFICIT															
Statutory Pay-As-You-Go Impact	–0	–0	–1	–2	–3	–3	–3	–4	–4	–4	–4	–4	–9	–28		

Increase in long term direct spending and deficits: CBO estimates that enacting H.R. 3716 would not increase net direct spending or on-budget deficits by more than \$5 billion in any of the four consecutive 10-year periods beginning in 2027.

Intergovernmental and private-sector impact: H.R. 3716 contains no intergovernmental or private-sector mandates as defined in UMRA and would impose no costs on state, local, or tribal governments. CBO estimates that provisions in the bill that would decrease federal spending in Medicaid and CHIP would similarly result in a reduction of \$18 million in state spending for Medicaid and CHIP (combined) over the 2016–2026 period.

The bill also would place new conditions on states. It would require them to provide information about Medicaid and CHIP providers who are terminated for cause and to prevent terminated providers from receiving payments by updating their contracts with managed care providers. For large entitlement programs like Medicaid and CHIP, UMRA defines an increase in the stringency of conditions or a cap on federal funding as an intergovernmental mandate if the affected governments lack authority to offset those costs while continuing to provide required services. Because states have flexibility within the Medicaid and CHIP programs to offset their financial and programmatic responsibilities to reduce costs, the costs of complying with the new conditions would not result from an intergovernmental mandate.

Estimate prepared by: Federal costs: Lisa Ramirez-Branum; Impact on state, local, and tribal governments: J’nell Blanco Suchy; Impact on the private sector: Amy Petz.

Estimate approved by: Holly Harvey; Deputy Assistant Director for Budget Analysis.

FEDERAL MANDATES STATEMENT

The Committee adopts as its own the estimate of Federal mandates prepared by the Director of the Congressional Budget Office pursuant to section 423 of the Unfunded Mandates Reform Act.

DUPLICATION OF FEDERAL PROGRAMS

No provision of H.R. 3716 establishes or reauthorizes a program of the Federal Government known to be duplicative of another Fed-

eral program, a program that was included in any report from the Government Accountability Office to Congress pursuant to section 21 of Public Law 111–139, or a program related to a program identified in the most recent Catalog of Federal Domestic Assistance.

DISCLOSURE OF DIRECTED RULE MAKINGS

The Committee estimates that enacting H.R. 3716 specifically directs to be completed 1 rule making within the meaning of 5 U.S.C. 551.

ADVISORY COMMITTEE STATEMENT

No advisory committees within the meaning of section 5(b) of the Federal Advisory Committee Act were created by this legislation.

APPLICABILITY TO LEGISLATIVE BRANCH

The Committee finds that the legislation does not relate to the terms and conditions of employment or access to public services or accommodations within the meaning of section 102(b)(3) of the Congressional Accountability Act.

SECTION-BY-SECTION ANALYSIS OF THE LEGISLATION

Section 1. Short title

This section provides the short title of the “Ensuring Removal of Terminated Providers from Medicaid and CHIP Act”.

Section 2. Increasing oversight of termination of Medicaid providers

Subsection (a) would require States to report to the Secretary of Health and Human Services identifying information about a specific provider or person terminated for cause pursuant to 42 CFR 455.101 or other reasons specified by the Secretary from participating in the State’s Medicaid program. The subsection would also require State Medicaid programs to include in their contract with managed care entities a provision that providers of services or persons terminated from participation in Medicaid, Medicare or CHIP also be terminated as a provider in the managed care entity’s network serving Medicaid beneficiaries. States would also be required to provide for a system for notifying managed care entities of any such provider terminations and would not be eligible for federal funds for managed care expenditures if they did not comply with these requirements. The subsection would require the Secretary of HHS to include providers terminated from participation in Medicare or Medicaid in a termination database or similar system within 21 days of notification of the termination and would prohibit federal Medicaid funds for expenditures to providers listed in the termination database after 60 days. Finally, the subsection would require the Secretary of HHS to issue regulations establishing uniform terminology regarding the reasons for provider terminations.

Subsection (b) would require States to enroll all providers participating in Medicaid to enroll with the State, regardless of whether the provider services Medicaid beneficiaries on a fee-for-service basis or through a managed care entity.

Subsection (c) would make the requirements in this bill applicable to CHIP.

Subsection (d) is a rule of construction that specifies that providers appeals rights and processes are not changed or limited by this legislation.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, and existing law in which no change is proposed is shown in roman):

SOCIAL SECURITY ACT

* * * * *

TITLE XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

* * * * *

STATE PLANS FOR MEDICAL ASSISTANCE

SEC. 1902. (a) A State plan for medical assistance must—

(1) provide that it shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them;

(2) provide for financial participation by the State equal to not less than 40 per centum of the non-Federal share of the expenditures under the plan with respect to which payments under section 1903 are authorized by this title; and, effective July 1, 1969, provide for financial participation by the State equal to all of such non-Federal share or provide for distribution of funds from Federal or State sources, for carrying out the State plan, on an equalization or other basis which will assure that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan;

(3) provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness;

(4) provide (A) such methods of administration (including methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Secretary shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods, and including provision for utilization of professional medical personnel in the administration and, where administered locally, supervision of administration of the plan) as are found by the Secretary to be necessary for the proper and efficient operation of the plan, (B) for the training and effective use of paid subprofessional staff, with particular emphasis on the full-time or part-time employment of recipients and other persons of low income, as community service aides, in the administration of the plan and for the use of

nonpaid or partially paid volunteers in a social service volunteer program in providing services to applicants and recipients and in assisting any advisory committees established by the State agency, (C) that each State or local officer, employee, or independent contractor who is responsible for the expenditure of substantial amounts of funds under the State plan, each individual who formerly was such an officer, employee, or contractor, and each partner of such an officer, employee, or contractor shall be prohibited from committing any act, in relation to any activity under the plan, the commission of which, in connection with any activity concerning the United States Government, by an officer or employee of the United States Government, an individual who was such an officer or employee, or a partner of such an officer or employee is prohibited by section 207 or 208 of title 18, United States Code, and (D) that each State or local officer, employee, or independent contractor who is responsible for selecting, awarding, or otherwise obtaining items and services under the State plan shall be subject to safeguards against conflicts of interest that are at least as stringent as the safeguards that apply under section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423) to persons described in subsection (a)(2) of such section of that Act;

(5) either provide for the establishment or designation of a single State agency to administer or to supervise the administration of the plan; or provide for the establishment or designation of a single State agency to administer or to supervise the administration of the plan, except that the determination of eligibility for medical assistance under the plan shall be made by the State or local agency administering the State plan approved under title I or XVI (insofar as it relates to the aged) if the State is eligible to participate in the State plan program established under title XVI, or by the agency or agencies administering the supplemental security income program established under title XVI or the State plan approved under part A of title IV if the State is not eligible to participate in the State plan program established under title XVI;

(6) provide that the State agency will make such reports, in such form and containing such information, as the Secretary may from time to time require, and comply with such provisions as the Secretary may from time to time find necessary to assure the correctness and verification of such reports;

(7) provide—

(A) safeguards which restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with—

- (i) the administration of the plan; and
- (ii) the exchange of information necessary to certify or verify the certification of eligibility of children for free or reduced price breakfasts under the Child Nutrition Act of 1966 and free or reduced price lunches under the Richard B. Russell National School Lunch Act, in accordance with section 9(b) of that Act, using data standards and formats established by the State agency; and

(B) that, notwithstanding the Express Lane option under subsection (e)(13), the State may enter into an agreement with the State agency administering the school lunch program established under the Richard B. Russell National School Lunch Act under which the State shall establish procedures to ensure that—

(i) a child receiving medical assistance under the State plan under this title whose family income does not exceed 133 percent of the poverty line (as defined in section 673(2) of the Community Services Block Grant Act, including any revision required by such section), as determined without regard to any expense, block, or other income disregard, applicable to a family of the size involved, may be certified as eligible for free lunches under the Richard B. Russell National School Lunch Act and free breakfasts under the Child Nutrition Act of 1966 without further application; and

(ii) the State agencies responsible for administering the State plan under this title, and for carrying out the school lunch program established under the Richard B. Russell National School Lunch Act (42 U.S.C. 1751 et seq.) or the school breakfast program established by section 4 of the Child Nutrition Act of 1966 (42 U.S.C. 1773), cooperate in carrying out paragraphs (3)(F) and (15) of section 9(b) of that Act;

(8) provide that all individuals wishing to make application for medical assistance under the plan shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals;

(9) provide—

(A) that the State health agency, or other appropriate State medical agency (whichever is utilized by the Secretary for the purpose specified in the first sentence of section 1864(a)), shall be responsible for establishing and maintaining health standards for private or public institutions in which recipients of medical assistance under the plan may receive care or services,

(B) for the establishment or designation of a State authority or authorities which shall be responsible for establishing and maintaining standards, other than those relating to health, for such institutions,

(C) that any laboratory services paid for under such plan must be provided by a laboratory which meets the applicable requirements of section 1861(e)(9) or paragraphs (16) and (17) of section 1861(s), or, in the case of a laboratory which is in a rural health clinic, of section 1861(aa)(2)(G), and

(D) that the State maintain a consumer-oriented website providing useful information to consumers regarding all skilled nursing facilities and all nursing facilities in the State, including for each facility, Form 2567 State inspection reports (or a successor form), complaint investigation reports, the facility's plan of correction, and such other information that the State or the Secretary considers useful in assisting the public to assess the quality of long term

care options and the quality of care provided by individual facilities;
 (10) provide—

(A) for making medical assistance available, including at least the care and services listed in paragraphs (1) through (5), (17), (21), and (28) of section 1905(a), to—

(i) all individuals—

(I) who are receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A or part E of title IV (including individuals eligible under this title by reason of section 402(a)(37), 406(h), or 473(b), or considered by the State to be receiving such aid as authorized under section 482(e)(6)),

(II)(aa) with respect to whom supplemental security income benefits are being paid under title XVI (or were being paid as of the date of the enactment of section 211(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104–193) and would continue to be paid but for the enactment of that section), (bb) who are qualified severely impaired individuals (as defined in section 1905(q)), or (cc) who are under 21 years of age and with respect to whom supplemental security income benefits would be paid under title XVI if subparagraphs (A) and (B) of section 1611(c)(7) were applied without regard to the phrase “the first day of the month following”,

(III) who are qualified pregnant women or children as defined in section 1905(n),

(IV) who are described in subparagraph (A) or (B) of subsection (1)(1) and whose family income does not exceed the minimum income level the State is required to establish under subsection (1)(2)(A) for such a family;

(V) who are qualified family members as defined in section 1905(m)(1),

(VI) who are described in subparagraph (C) of subsection (1)(1) and whose family income does not exceed the income level the State is required to establish under subsection (1)(2)(B) for such a family,

(VII) who are described in subparagraph (D) of subsection (1)(1) and whose family income does not exceed the income level the State is required to establish under subsection (1)(2)(C) for such a family;

(VIII) beginning January 1, 2014, who are under 65 years of age, not pregnant, not entitled to, or enrolled for, benefits under part A of title XVIII, or enrolled for benefits under part B of title XVIII, and are not described in a previous subclause of this clause, and whose income (as determined under subsection (e)(14)) does not exceed

133 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved, subject to subsection (k); or

(IX) who—

(aa) are under 26 years of age;

(bb) are not described in or enrolled under any of subclauses (I) through (VII) of this clause or are described in any of such subclauses but have income that exceeds the level of income applicable under the State plan for eligibility to enroll for medical assistance under such subclause;

(cc) were in foster care under the responsibility of the State on the date of attaining 18 years of age or such higher age as the State has elected under section 475(8)(B)(iii); and

(dd) were enrolled in the State plan under this title or under a waiver of the plan while in such foster care;

(ii) at the option of the State, to any group or groups of individuals described in section 1905(a) (or, in the case of individuals described in section 1905(a)(i), to any reasonable categories of such individuals) who are not individuals described in clause (i) of this subparagraph but—

(I) who meet the income and resources requirements of the appropriate State plan described in clause (i) or the supplemental security income program (as the case may be),

(II) who would meet the income and resources requirements of the appropriate State plan described in clause (i) if their work-related child care costs were paid from their earnings rather than by a State agency as a service expenditure,

(III) who would be eligible to receive aid under the appropriate State plan described in clause (i) if coverage under such plan was as broad as allowed under Federal law,

(IV) with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, aid or assistance under the appropriate State plan described in clause (i), supplemental security income benefits under title XVI, or a State supplementary payment;

(V) who are in a medical institution for a period of not less than 30 consecutive days (with eligibility by reason of this subclause beginning on the first day of such period), who meet the resource requirements of the appropriate State plan described in clause (i) or the supplemental security income program, and whose income does not exceed a separate income standard established by the State which is consistent with the limit established under section 1903(f)(4)(C),

(VI) who would be eligible under the State plan under this title if they were in a medical institution, with respect to whom there has been a determination that but for the provision of home or community-based services described in subsection (c), (d), or (e) of section 1915 they would require the level of care provided in a hospital, nursing facility or intermediate care facility for the mentally retarded the cost of which could be reimbursed under the State plan, and who will receive home or community-based services pursuant to a waiver granted by the Secretary under subsection (c), (d), or (e) of section 1915,

(VII) who would be eligible under the State plan under this title if they were in a medical institution, who are terminally ill, and who will receive hospice care pursuant to a voluntary election described in section 1905(o);

(VIII) who is a child described in section 1905(a)(i)—

(aa) for whom there is in effect an adoption assistance agreement (other than an agreement under part E of title IV) between the State and an adoptive parent or parents,

(bb) who the State agency responsible for adoption assistance has determined cannot be placed with adoptive parents without medical assistance because such child has special needs for medical or rehabilitative care, and

(cc) who was eligible for medical assistance under the State plan prior to the adoption assistance agreement being entered into, or who would have been eligible for medical assistance at such time if the eligibility standards and methodologies of the State's foster care program under part E of title IV were applied rather than the eligibility standards and methodologies of the State's aid to families with dependent children program under part A of title IV;

(IX) who are described in subsection (l)(1) and are not described in clause (i)(IV), clause (i)(VI), or clause (i)(VII);

(X) who are described in subsection (m)(1);

(XI) who receive only an optional State supplementary payment based on need and paid on a regular basis, equal to the difference between the individual's countable income and the income standard used to determine eligibility for such supplementary payment (with countable income being the income remaining after deductions as established by the State pursuant to standards that may be more restrictive than the standards for supplementary security income benefits under title XVI), which are available to all individuals in

the State (but which may be based on different income standards by political subdivision according to cost of living differences), and which are paid by a State that does not have an agreement with the Commissioner of Social Security under section 1616 or 1634;

(XII) who are described in subsection (z)(1) (relating to certain TB-infected individuals);

(XIII) who are in families whose income is less than 250 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved, and who but for earnings in excess of the limit established under section 1905(q)(2)(B), would be considered to be receiving supplemental security income (subject, notwithstanding section 1916, to payment of premiums or other cost-sharing charges (set on a sliding scale based on income) that the State may determine);

(XIV) who are optional targeted low-income children described in section 1905(u)(2)(B);

(XV) who, but for earnings in excess of the limit established under section 1905(q)(2)(B), would be considered to be receiving supplemental security income, who is at least 16, but less than 65, years of age, and whose assets, resources, and earned or unearned income (or both) do not exceed such limitations (if any) as the State may establish;

(XVI) who are employed individuals with a medically improved disability described in section 1905(v)(1) and whose assets, resources, and earned or unearned income (or both) do not exceed such limitations (if any) as the State may establish, but only if the State provides medical assistance to individuals described in subclause (XV);

(XVII) who are independent foster care adolescents (as defined in section 1905(w)(1)), or who are within any reasonable categories of such adolescents specified by the State;

(XVIII) who are described in subsection (aa) (relating to certain breast or cervical cancer patients);

(XIX) who are disabled children described in subsection (cc)(1);

(XX) beginning January 1, 2014, who are under 65 years of age and are not described in or enrolled under a previous subclause of this clause, and whose income (as determined under subsection (e)(14)) exceeds 133 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved but does not exceed the highest income eligibility level established

under the State plan or under a waiver of the plan, subject to subsection (hh);

(XXI) who are described in subsection (ii) (relating to individuals who meet certain income standards); or

(XXII) who are eligible for home and community-based services under needs-based criteria established under paragraph (1)(A) of section 1915(i), or who are eligible for home and community-based services under paragraph (6) of such section, and who will receive home and community-based services pursuant to a State plan amendment under such subsection;

(B) that the medical assistance made available to any individual described in subparagraph (A)—

(i) shall not be less in amount, duration, or scope than the medical assistance made available to any other such individual, and

(ii) shall not be less in amount, duration, or scope than the medical assistance made available to individuals not described in subparagraph (A);

(C) that if medical assistance is included for any group of individuals described in section 1905(a) who are not described in subparagraph (A) or (E), then—

(i) the plan must include a description of (I) the criteria for determining eligibility of individuals in the group for such medical assistance, (II) the amount, duration, and scope of medical assistance made available to individuals in the group, and (III) the single standard to be employed in determining income and resource eligibility for all such groups, and the methodology to be employed in determining such eligibility, which shall be no more restrictive than the methodology which would be employed under the supplemental security income program in the case of groups consisting of aged, blind, or disabled individuals in a State in which such program is in effect, and which shall be no more restrictive than the methodology which would be employed under the appropriate State plan (described in subparagraph (A)(i)) to which such group is most closely categorically related in the case of other groups;

(ii) the plan must make available medical assistance—

(I) to individuals under the age of 18 who (but for income and resources) would be eligible for medical assistance as an individual described in subparagraph (A)(i), and

(II) to pregnant women, during the course of their pregnancy, who (but for income and resources) would be eligible for medical assistance as an individual described in subparagraph (A);

(iii) such medical assistance must include (I) with respect to children under 18 and individuals entitled to institutional services, ambulatory services, and (II)

with respect to pregnant women, prenatal care and delivery services; and

(iv) if such medical assistance includes services in institutions for mental diseases or in an intermediate care facility for the mentally retarded (or both) for any such group, it also must include for all groups covered at least the care and services listed in paragraphs (1) through (5) and (17) of section 1905(a) or the care and services listed in any 7 of the paragraphs numbered (1) through (24) of such section;

(D) for the inclusion of home health services for any individual who, under the State plan, is entitled to nursing facility services;

(E)(i) for making medical assistance available for medicare cost-sharing (as defined in section 1905(p)(3)) for qualified medicare beneficiaries described in section 1905(p)(1);

(ii) for making medical assistance available for payment of medicare cost-sharing described in section 1905(p)(3)(A)(i) for qualified disabled and working individuals described in section 1905(s);

(iii) for making medical assistance available for medicare cost sharing described in section 1905(p)(3)(A)(ii) subject to section 1905(p)(4), for individuals who would be qualified medicare beneficiaries described in section 1905(p)(1) but for the fact that their income exceeds the income level established by the State under section 1905(p)(2) but is less than 110 percent in 1993 and 1994, and 120 percent in 1995 and years thereafter of the official poverty line (referred to in such section) for a family of the size involved; and

(iv) subject to sections 1933 and 1905(p)(4), for making medical assistance available for medicare cost-sharing described in section 1905(p)(3)(A)(ii) for individuals who would be qualified medicare beneficiaries described in section 1905(p)(1) but for the fact that their income exceeds the income level established by the State under section 1905(p)(2) and is at least 120 percent, but less than 135 percent, of the official poverty line (referred to in such section) for a family of the size involved and who are not otherwise eligible for medical assistance under the State plan;

(F) at the option of a State, for making medical assistance available for COBRA premiums (as defined in subsection (u)(2)) for qualified COBRA continuation beneficiaries described in section 1902(u)(1); and

(G) that, in applying eligibility criteria of the supplemental security income program under title XVI for purposes of determining eligibility for medical assistance under the State plan of an individual who is not receiving supplemental security income, the State will disregard the provisions of subsections (c) and (e) of section 1613;

except that (I) the making available of the services described in paragraph (4), (14), or (16) of section 1905(a) to individuals meeting the age requirements prescribed therein shall not, by reason of this paragraph (10), require the making available of

any such services, or the making available of such services of the same amount, duration, and scope, to individuals of any other ages, (II) the making available of supplementary medical insurance benefits under part B of title XVIII to individuals eligible therefor (either pursuant to an agreement entered into under section 1843 or by reason of the payment of premiums under such title by the State agency on behalf of such individuals), or provision for meeting part or all of the cost of deductibles, cost sharing, or similar charges under part B of title XVIII for individuals eligible for benefits under such part, shall not, by reason of this paragraph (10), require the making available of any such benefits, or the making available of services of the same amount, duration, and scope, to any other individuals, (III) the making available of medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in clause (A) to any classification of individuals approved by the Secretary with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, a State supplementary payment shall not, by reason of this paragraph (10), require the making available of any such assistance, or the making available of such assistance of the same amount, duration, and scope, to any other individuals not described in clause (A), (IV) the imposition of a deductible, cost sharing, or similar charge for any item or service furnished to an individual not eligible for the exemption under section 1916(a)(2) or (b)(2) shall not require the imposition of a deductible, cost sharing, or similar charge for the same item or service furnished to an individual who is eligible for such exemption, (V) the making available to pregnant women covered under the plan of services relating to pregnancy (including prenatal, delivery, and postpartum services) or to any other condition which may complicate pregnancy shall not, by reason of this paragraph (10), require the making available of such services, or the making available of such services of the same amount, duration, and scope, to any other individuals, provided such services are made available (in the same amount, duration, and scope) to all pregnant women covered under the State plan, (VI) with respect to the making available of medical assistance for hospice care to terminally ill individuals who have made a voluntary election described in section 1905(o) to receive hospice care instead of medical assistance for certain other services, such assistance may not be made available in an amount, duration, or scope less than that provided under title XVIII, and the making available of such assistance shall not, by reason of this paragraph (10), require the making available of medical assistance for hospice care to other individuals or the making available of medical assistance for services waived by such terminally ill individuals, (VII) the medical assistance made available to an individual described in subsection (1)(1)(A) who is eligible for medical assistance only because of subparagraph (A)(i)(IV) or (A)(ii)(IX) shall be limited to medical assistance for services related to pregnancy (including prenatal, delivery, postpartum, and family planning services) and to other conditions which may complicate pregnancy,

(VIII) the medical assistance made available to a qualified medicare beneficiary described in section 1905(p)(1) who is only entitled to medical assistance because the individual is such a beneficiary shall be limited to medical assistance for medicare cost-sharing (described in section 1905(p)(3)), subject to the provisions of subsection (n) and section 1916(b), (IX) the making available of respiratory care services in accordance with subsection (e)(9) shall not, by reason of this paragraph (10), require the making available of such services, or the making available of such services of the same amount, duration, and scope, to any individuals not included under subsection (e)(9)(A), provided such services are made available (in the same amount, duration, and scope) to all individuals described in such subsection, (X) if the plan provides for any fixed durational limit on medical assistance for inpatient hospital services (whether or not such a limit varies by medical condition or diagnosis), the plan must establish exceptions to such a limit for medically necessary inpatient hospital services furnished with respect to individuals under one year of age in a hospital defined under the State plan, pursuant to section 1923(a)(1)(A), as a disproportionate share hospital and subparagraph (B) (relating to comparability) shall not be construed as requiring such an exception for other individuals, services, or hospitals, (XI) the making available of medical assistance to cover the costs of premiums, deductibles, coinsurance, and other cost-sharing obligations for certain individuals for private health coverage as described in section 1906 shall not, by reason of paragraph (10), require the making available of any such benefits or the making available of services of the same amount, duration, and scope of such private coverage to any other individuals, (XII) the medical assistance made available to an individual described in subsection (u)(1) who is eligible for medical assistance only because of subparagraph (F) shall be limited to medical assistance for COBRA continuation premiums (as defined in subsection (u)(2)), (XIII) the medical assistance made available to an individual described in subsection (z)(1) who is eligible for medical assistance only because of subparagraph (A)(ii)(XII) shall be limited to medical assistance for TB-related services (described in subsection (z)(2)), (XIV) the medical assistance made available to an individual described in subsection (aa) who is eligible for medical assistance only because of subparagraph (A)(10)(ii)(XVIII) shall be limited to medical assistance provided during the period in which such an individual requires treatment for breast or cervical cancer (XV) the medical assistance made available to an individual described in subparagraph (A)(i)(VIII) shall be limited to medical assistance described in subsection (k)(1), (XVI) the medical assistance made available to an individual described in subsection (ii) shall be limited to family planning services and supplies described in section 1905(a)(4)(C) including medical diagnosis and treatment services that are provided pursuant to a family planning service in a family planning setting and (XVII) if an individual is described in subclause (IX) of subparagraph (A)(i) and is also described in subclause (VIII) of that subparagraph, the medical assistance shall be made

available to the individual through subclause (IX) instead of through subclause (VIII);

(11)(A) provide for entering into cooperative arrangements with the State agencies responsible for administering or supervising the administration of health services and vocational rehabilitation services in the State looking toward maximum utilization of such services in the provision of medical assistance under the plan, (B) provide, to the extent prescribed by the Secretary, for entering into agreements, with any agency, institution, or organization receiving payments under (or through an allotment under) title V, (i) providing for utilizing such agency, institution, or organization in furnishing care and services which are available under such title or allotment and which are included in the State plan approved under this section (ii) making such provision as may be appropriate for reimbursing such agency, institution, or organization for the cost of any such care and services furnished any individual for which payment would otherwise be made to the State with respect to the individual under section 1903, and (iii) providing for coordination of information and education on pediatric vaccinations and delivery of immunization services, and (C) provide for coordination of the operations under this title, including the provision of information and education on pediatric vaccinations and the delivery of immunization services, with the State's operations under the special supplemental nutrition program for women, infants, and children under section 17 of the Child Nutrition Act of 1966;

(12) provide that, in determining whether an individual is blind, there shall be an examination by a physician skilled in the diseases of the eye or by an optometrist, whichever the individual may select;

(13) provide—

(A) for a public process for determination of rates of payment under the plan for hospital services, nursing facility services, and services of intermediate care facilities for the mentally retarded under which—

(i) proposed rates, the methodologies underlying the establishment of such rates, and justifications for the proposed rates are published,

(ii) providers, beneficiaries and their representatives, and other concerned State residents are given a reasonable opportunity for review and comment on the proposed rates, methodologies, and justifications,

(iii) final rates, the methodologies underlying the establishment of such rates, and justifications for such final rates are published, and

(iv) in the case of hospitals, such rates take into account (in a manner consistent with section 1923) the situation of hospitals which serve a disproportionate number of low-income patients with special needs;

(B) for payment for hospice care in amounts no lower than the amounts, using the same methodology, used under part A of title XVIII and for payment of amounts under section 1905(o)(3); except that in the case of hospice care which is furnished to an individual who is a resident

of a nursing facility or intermediate care facility for the mentally retarded, and who would be eligible under the plan for nursing facility services or services in an intermediate care facility for the mentally retarded if he had not elected to receive hospice care, there shall be paid an additional amount, to take into account the room and board furnished by the facility, equal to at least 95 percent of the rate that would have been paid by the State under the plan for facility services in that facility for that individual; and

(C) payment for primary care services (as defined in subsection (jj)) furnished in 2013 and 2014 by a physician with a primary specialty designation of family medicine, general internal medicine, or pediatric medicine at a rate not less than 100 percent of the payment rate that applies to such services and physician under part B of title XVIII (or, if greater, the payment rate that would be applicable under such part if the conversion factor under section 1848(d) for the year involved were the conversion factor under such section for 2009);

(14) provide that enrollment fees, premiums, or similar charges, and deductions, cost sharing, or similar charges, may be imposed only as provided in section 1916;

(15) provide for payment for services described in clause (B) or (C) of section 1905(a)(2) under the plan in accordance with subsection (bb);

(16) provide for inclusion, to the extent required by regulations prescribed by the Secretary, of provisions (conforming to such regulations) with respect to the furnishing of medical assistance under the plan to individuals who are residents of the State but are absent therefrom;

(17) except as provided in subsections (e)(14), (l)(3), (m)(3), and (m)(4), include reasonable standards (which shall be comparable for all groups and may, in accordance with standards prescribed by the Secretary, differ with respect to income levels, but only in the case of applicants or recipients of assistance under the plan who are not receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, and with respect to whom supplemental security income benefits are not being paid under title XVI, based on the variations between shelter costs in urban areas and in rural areas) for determining eligibility for and the extent of medical assistance under the plan which (A) are consistent with the objectives of this title, (B) provide for taking into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient and (in the case of any applicant or recipient who would, except for income and resources, be eligible for aid or assistance in the form of money payments under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, or to have paid with respect to him supplemental security income benefits under title XVI) as would not be disregarded (or set aside for future needs) in determining his eligibility for such aid, assistance, or benefits, (C) provide for reasonable evaluation of any such in-

come or resources, and (D) do not take into account the financial responsibility of any individual for any applicant or recipient of assistance under the plan unless such applicant or recipient is such individual's spouse or such individual's child who is under age 21 or (with respect to States eligible to participate in the State program established under title XVI), is blind or permanently and totally disabled, or is blind or disabled as defined in section 1614 (with respect to States which are not eligible to participate in such program); and provide for flexibility in the application of such standards with respect to income by taking into account, except to the extent prescribed by the Secretary, the costs (whether in the form of insurance premiums, payments made to the State under section 1903(f)(2)(B), or otherwise and regardless of whether such costs are reimbursed under another public program of the State or political subdivision thereof) incurred for medical care or for any other type of remedial care recognized under State law;

(18) comply with the provisions of section 1917 with respect to liens, adjustments and recoveries of medical assistance correctly paid, transfers of assets, and treatment of certain trusts;

(19) provide such safeguards as may be necessary to assure that eligibility for care and services under the plan will be determined, and such care and services will be provided, in a manner consistent with simplicity of administration and the best interests of the recipients;

(20) if the State plan includes medical assistance in behalf of individuals 65 years of age or older who are patients in institutions for mental diseases—

(A) provide for having in effect such agreements or other arrangements with State authorities concerned with mental diseases, and, where appropriate, with such institutions, as may be necessary for carrying out the State plan, including arrangements for joint planning and for development of alternate methods of care, arrangements providing assurance of immediate readmittance to institutions where needed for individuals under alternate plans of care, and arrangements providing for access to patients and facilities, for furnishing information, and for making reports;

(B) provide for an individual plan for each such patient to assure that the institutional care provided to him is in his best interests, including, to that end, assurances that there will be initial and periodic review of his medical and other needs, that he will be given appropriate medical treatment within the institution, and that there will be a periodic determination of his need for continued treatment in the institution; and

(C) provide for the development of alternate plans of care, making maximum utilization of available resources, for recipients 65 years of age or older who would otherwise need care in such institutions, including appropriate medical treatment and other aid or assistance; for services referred to in section 3(a)(4)(A)(i) and (ii) or section 1603(a)(4)(A)(i) and (ii) which are appropriate for such recipients and for such patients; and for methods of administration necessary to assure that the responsibilities of the

State agency under the State plan with respect to such recipients and such patients will be effectively carried out;

(21) if the State plan includes medical assistance in behalf of individuals 65 years of age or older who are patients in public institutions for mental diseases, show that the State is making satisfactory progress toward developing and implementing a comprehensive mental health program, including provision for utilization of community mental health centers, nursing facilities, and other alternatives to care in public institutions for mental diseases;

(22) include descriptions of (A) the kinds and numbers of professional medical personnel and supporting staff that will be used in the administration of the plan and of the responsibilities they will have, (B) the standards, for private or public institutions in which recipients of medical assistance under the plan may receive care or services, that will be utilized by the State authority or authorities responsible for establishing and maintaining such standards, (C) the cooperative arrangements with State health agencies and State vocational rehabilitation agencies entered into with a view to maximum utilization of and coordination of the provision of medical assistance with the services administered or supervised by such agencies, and (D) other standards and methods that the State will use to assure that medical or remedial care and services provided to recipients of medical assistance are of high quality;

(23) provide that (A) any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required (including an organization which provides such services, or arranges for their availability, on a prepayment basis), who undertakes to provide him such services, and (B) an enrollment of an individual eligible for medical assistance in a primary care case-management system (described in section 1915(b)(1)), a medicaid managed care organization, or a similar entity shall not restrict the choice of the qualified person from whom the individual may receive services under section 1905(a)(4)(C), except as provided in subsection (g) and in section 1915, except that this paragraph shall not apply in the case of Puerto Rico, the Virgin Islands, and Guam, and except that nothing in this paragraph shall be construed as requiring a State to provide medical assistance for such services furnished by a person or entity convicted of a felony under Federal or State law for an offense which the State agency determines is inconsistent with the best interests of beneficiaries under the State plan or by a provider or supplier to which a moratorium under subsection (kk)(4) is applied during the period of such moratorium’;

(24) effective July 1, 1969, provide for consultative services by health agencies and other appropriate agencies of the State to hospitals, nursing facilities, home health agencies, clinics, laboratories, and such other institutions as the Secretary may specify in order to assist them (A) to qualify for payments under this Act, (B) to establish and maintain such fiscal records as may be necessary for the proper and efficient administration of this Act, and (C) to provide information needed

to determine payments due under this Act on account of care and services furnished to individuals;

(25) provide—

(A) that the State or local agency administering such plan will take all reasonable measures to ascertain the legal liability of third parties (including health insurers, self-insured plans, group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974), service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service) to pay for care and services available under the plan, including—

(i) the collection of sufficient information (as specified by the Secretary in regulations) to enable the State to pursue claims against such third parties, with such information being collected at the time of any determination or redetermination of eligibility for medical assistance, and

(ii) the submission to the Secretary of a plan (subject to approval by the Secretary) for pursuing claims against such third parties, which plan shall be integrated with, and be monitored as a part of the Secretary's review of, the State's mechanized claims processing and information retrieval systems required under section 1903(r);

(B) that in any case where such a legal liability is found to exist after medical assistance has been made available on behalf of the individual and where the amount of reimbursement the State can reasonably expect to recover exceeds the costs of such recovery, the State or local agency will seek reimbursement for such assistance to the extent of such legal liability;

(C) that in the case of an individual who is entitled to medical assistance under the State plan with respect to a service for which a third party is liable for payment, the person furnishing the service may not seek to collect from the individual (or any financially responsible relative or representative of that individual) payment of an amount for that service (i) if the total of the amount of the liabilities of third parties for that service is at least equal to the amount payable for that service under the plan (disregarding section 1916), or (ii) in an amount which exceeds the lesser of (I) the amount which may be collected under section 1916, or (II) the amount by which the amount payable for that service under the plan (disregarding section 1916) exceeds the total of the amount of the liabilities of third parties for that service;

(D) that a person who furnishes services and is participating under the plan may not refuse to furnish services to an individual (who is entitled to have payment made under the plan for the services the person furnishes) because of a third party's potential liability for payment for the service;

(E) that in the case of prenatal or preventive pediatric care (including early and periodic screening and diagnosis services under section 1905(a)(4)(B)) covered under the State plan, the State shall—

(i) make payment for such service in accordance with the usual payment schedule under such plan for such services without regard to the liability of a third party for payment for such services; and

(ii) seek reimbursement from such third party in accordance with subparagraph (B);

(F) that in the case of any services covered under such plan which are provided to an individual on whose behalf child support enforcement is being carried out by the State agency under part D of title IV of this Act, the State shall—

(i) make payment for such service in accordance with the usual payment schedule under such plan for such services without regard to any third-party liability for payment for such services, if such third-party liability is derived (through insurance or otherwise) from the parent whose obligation to pay support is being enforced by such agency, if payment has not been made by such third party within 30 days after such services are furnished;

(ii) seek reimbursement from such third party in accordance with subparagraph (B);

(G) that the State prohibits any health insurer (including a group health plan, as defined in section 607(1) of the Employee Retirement Income Security Act of 1974, a self-insured plan, a service benefit plan, a managed care organization, a pharmacy benefit manager, or other party that is, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service), in enrolling an individual or in making any payments for benefits to the individual or on the individual's behalf, from taking into account that the individual is eligible for or is provided medical assistance under a plan under this title for such State, or any other State;

(H) that to the extent that payment has been made under the State plan for medical assistance in any case where a third party has a legal liability to make payment for such assistance, the State has in effect laws under which, to the extent that payment has been made under the State plan for medical assistance for health care items or services furnished to an individual, the State is considered to have acquired the rights of such individual to payment by any other party for such health care items or services; and

(I) that the State shall provide assurances satisfactory to the Secretary that the State has in effect laws requiring health insurers, including self-insured plans, group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974), service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agree-

ment, legally responsible for payment of a claim for a health care item or service, as a condition of doing business in the State, to—

(i) provide, with respect to individuals who are eligible (and, at State option, individuals who apply or whose eligibility for medical assistance is being evaluated in accordance with section 1902(e)(13)(D)) for, or are provided, medical assistance under the State plan under this title (and, at State option, child health assistance under title XXI), upon the request of the State, information to determine during what period the individual or their spouses or their dependents may be (or may have been) covered by a health insurer and the nature of the coverage that is or was provided by the health insurer (including the name, address, and identifying number of the plan) in a manner prescribed by the Secretary;

(ii) accept the State's right of recovery and the assignment to the State of any right of an individual or other entity to payment from the party for an item or service for which payment has been made under the State plan;

(iii) respond to any inquiry by the State regarding a claim for payment for any health care item or service that is submitted not later than 3 years after the date of the provision of such health care item or service; and

(iv) agree not to deny a claim submitted by the State solely on the basis of the date of submission of the claim, the type or format of the claim form, or a failure to present proper documentation at the point-of-sale that is the basis of the claim, if—

(I) the claim is submitted by the State within the 3-year period beginning on the date on which the item or service was furnished; and

(II) any action by the State to enforce its rights with respect to such claim is commenced within 6 years of the State's submission of such claim;

(26) if the State plan includes medical assistance for inpatient mental hospital services, provide, with respect to each patient receiving such services, for a regular program of medical review (including medical evaluation) of his need for such services, and for a written plan of care;

(27) provide for agreements with every person or institution providing services under the State plan under which such person or institution agrees (A) to keep such records as are necessary fully to disclose the extent of the services provided to individuals receiving assistance under the State plan, and (B) to furnish the State agency or the Secretary with such information, regarding any payments claimed by such person or institution for providing services under the State plan, as the State agency or the Secretary may from time to time request;

(28) provide—

(A) that any nursing facility receiving payments under such plan must satisfy all the requirements of subsections

(b) through (d) of section 1919 as they apply to such facilities;

(B) for including in “nursing facility services” at least the items and services specified (or deemed to be specified) by the Secretary under section 1919(f)(7) and making available upon request a description of the items and services so included;

(C) for procedures to make available to the public the data and methodology used in establishing payment rates for nursing facilities under this title; and

(D) for compliance (by the date specified in the respective sections) with the requirements of—

(i) section 1919(e);

(ii) section 1919(g) (relating to responsibility for survey and certification of nursing facilities); and

(iii) sections 1919(h)(2)(B) and 1919(h)(2)(D) (relating to establishment and application of remedies);

(29) include a State program which meets the requirements set forth in section 1908, for the licensing of administrators of nursing homes;

(30)(A) provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1903(i)(4)) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area; and

(B) provide, under the program described in subparagraph (A), that—

(i) each admission to a hospital, intermediate care facility for the mentally retarded, or hospital for mental diseases is reviewed or screened in accordance with criteria established by medical and other professional personnel who are not themselves directly responsible for the care of the patient involved, and who do not have a significant financial interest in any such institution and are not, except in the case of a hospital, employed by the institution providing the care involved, and

(ii) the information developed from such review or screening, along with the data obtained from prior reviews of the necessity for admission and continued stay of patients by such professional personnel, shall be used as the basis for establishing the size and composition of the sample of admissions to be subject to review and evaluation by such personnel, and any such sample may be of any size up to 100 percent of all admissions and must be of sufficient size to serve the purpose of (I) identifying the patterns of care being provided and the changes occurring over time in such patterns so that the need for modification may be ascertained, and (II) subjecting admissions to early or more extensive review where information indicates that such consideration is warranted to a hospital,

intermediate care facility for the mentally retarded, or hospital for mental diseases;

(31) with respect to services in an intermediate care facility for the mentally retarded (where the State plan includes medical assistance for such services) provide, with respect to each patient receiving such services, for a written plan of care, prior to admission to or authorization of benefits in such facility, in accordance with regulations of the Secretary, and for a regular program of independent professional review (including medical evaluation) which shall periodically review his need for such services;

(32) provide that no payment under the plan for any care or service provided to an individual shall be made to anyone other than such individual or the person or institution providing such care or service, under an assignment or power of attorney or otherwise; except that—

(A) in the case of any care or service provided by a physician, dentist, or other individual practitioner, such payment may be made (i) to the employer of such physician, dentist, or other practitioner if such physician, dentist, or practitioner is required as a condition of his employment to turn over his fee for such care or service to his employer, or (ii) (where the care or service was provided in a hospital, clinic, or other facility) to the facility in which the care or service was provided if there is a contractual arrangement between such physician, dentist, or practitioner and such facility under which such facility submits the bill for such care or service;

(B) nothing in this paragraph shall be construed (i) to prevent the making of such a payment in accordance with an assignment from the person or institution providing the care or service involved if such assignment is made to a governmental agency or entity or is established by or pursuant to the order of a court of competent jurisdiction, or (ii) to preclude an agent of such person or institution from receiving any such payment if (but only if) such agent does so pursuant to an agency agreement under which the compensation to be paid to the agent for his services for or in connection with the billing or collection of payments due such person or institution under the plan is unrelated (directly or indirectly) to the amount of such payments or the billings therefor, and is not dependent upon the actual collection of any such payment;

(C) in the case of services furnished (during a period that does not exceed 14 continuous days in the case of an informal reciprocal arrangement or 90 continuous days (or such longer period as the Secretary may provide) in the case of an arrangement involving per diem or other fee-for-time compensation) by, or incident to the services of, one physician to the patients of another physician who submits the claim for such services, payment shall be made to the physician submitting the claim (as if the services were furnished by, or incident to, the physician's services), but only if the claim identifies (in a manner specified by the Secretary) the physician who furnished the services; and

(D) in the case of payment for a childhood vaccine administered before October 1, 1994, to individuals entitled to medical assistance under the State plan, the State plan may make payment directly to the manufacturer of the vaccine under a voluntary replacement program agreed to by the State pursuant to which the manufacturer (i) supplies doses of the vaccine to providers administering the vaccine, (ii) periodically replaces the supply of the vaccine, and (iii) charges the State the manufacturer's price to the Centers for Disease Control and Prevention for the vaccine so administered (which price includes a reasonable amount to cover shipping and the handling of returns);

(33) provide—

(A) that the State health agency, or other appropriate State medical agency, shall be responsible for establishing a plan, consistent with regulations prescribed by the Secretary, for the review by appropriate professional health personnel of the appropriateness and quality of care and services furnished to recipients of medical assistance under the plan in order to provide guidance with respect thereto in the administration of the plan to the State agency established or designated pursuant to paragraph (5) and, where applicable, to the State agency described in the second sentence of this subsection; and

(B) that, except as provided in section 1919(g), the State or local agency utilized by the Secretary for the purpose specified in the first sentence of section 1864(a), or, if such agency is not the State agency which is responsible for licensing health institutions, the State agency responsible for such licensing, will perform for the State agency administering or supervising the administration of the plan approved under this title the function of determining whether institutions and agencies meet the requirements for participation in the program under such plan, except that, if the Secretary has cause to question the adequacy of such determinations, the Secretary is authorized to validate State determinations and, on that basis, make independent and binding determinations concerning the extent to which individual institutions and agencies meet the requirements for participation;

(34) provide that in the case of any individual who has been determined to be eligible for medical assistance under the plan, such assistance will be made available to him for care and services included under the plan and furnished in or after the third month before the month in which he made application (or application was made on his behalf in the case of a deceased individual) for such assistance if such individual was (or upon application would have been) eligible for such assistance at the time such care and services were furnished;

(35) provide that any disclosing entity (as defined in section 1124(a)(2)) receiving payments under such plan complies with the requirements of section 1124;

(36) provide that within 90 days following the completion of each survey of any health care facility, laboratory, agency, clinic, or organization, by the appropriate State agency described

in paragraph (9), such agency shall (in accordance with regulations of the Secretary) make public in readily available form and place the pertinent findings of each such survey relating to the compliance of each such health care facility, laboratory, clinic, agency, or organization with (A) the statutory conditions of participation imposed under this title, and (B) the major additional conditions which the Secretary finds necessary in the interest of health and safety of individuals who are furnished care or services by any such facility, laboratory, clinic, agency, or organization;

(37) provide for claims payment procedures which (A) ensure that 90 per centum of claims for payment (for which no further written information or substantiation is required in order to make payment) made for services covered under the plan and furnished by health care practitioners through individual or group practices or through shared health facilities are paid within 30 days of the date of receipt of such claims and that 99 per centum of such claims are paid within 90 days of the date of receipt of such claims, and (B) provide for procedures of prepayment and postpayment claims review, including review of appropriate data with respect to the recipient and provider of a service and the nature of the service for which payment is claimed, to ensure the proper and efficient payment of claims and management of the program;

(38) require that an entity (other than an individual practitioner or a group of practitioners) that furnishes, or arranges for the furnishing of, items or services under the plan, shall supply (within such period as may be specified in regulations by the Secretary or by the single State agency which administers or supervises the administration of the plan) upon request specifically addressed to such entity by the Secretary or such State agency, the information described in section 1128(b)(9);

(39) provide that the State agency shall exclude any specified individual or entity from participation in the program under the State plan for the period specified by the Secretary, when required by him to do so pursuant to section 1128 or section 1128A, terminate the participation of any individual or entity in such program if (subject to such exceptions as are permitted with respect to exclusion under sections 1128(c)(3)(B) and 1128(d)(3)(B)) participation of such individual or entity is terminated under [title XVIII or any other State plan under this title] *title XVIII, any other State plan under this title, or any State child health plan under title XXI*, and provide that no payment may be made under the plan with respect to any item or service furnished by such individual or entity during such period;

(40) require each health services facility or organization which receives payments under the plan and of a type for which a uniform reporting system has been established under section 1121(a) to make reports to the Secretary of information described in such section in accordance with the uniform reporting system (established under such section) for that type of facility or organization;

(41) ~~provide that whenever~~ *provide, in accordance with subsection (kk)(8) (as applicable), that whenever* a provider of services or any other person is terminated, suspended, or otherwise sanctioned or prohibited from participating under the State plan, the State agency shall promptly notify the Secretary and, in the case of a physician and notwithstanding paragraph (7), the State medical licensing board of such action;

(42) provide that—

(A) the records of any entity participating in the plan and providing services reimbursable on a cost-related basis will be audited as the Secretary determines to be necessary to insure that proper payments are made under the plan; and

(B) not later than December 31, 2010, the State shall—

(i) establish a program under which the State contracts (consistent with State law and in the same manner as the Secretary enters into contracts with recovery audit contractors under section 1893(h), subject to such exceptions or requirements as the Secretary may require for purposes of this title or a particular State) with 1 or more recovery audit contractors for the purpose of identifying underpayments and overpayments and recouping overpayments under the State plan and under any waiver of the State plan with respect to all services for which payment is made to any entity under such plan or waiver; and

(ii) provide assurances satisfactory to the Secretary that—

(I) under such contracts, payment shall be made to such a contractor only from amounts recovered;

(II) from such amounts recovered, payment—

(aa) shall be made on a contingent basis for collecting overpayments; and

(bb) may be made in such amounts as the State may specify for identifying underpayments;

(III) the State has an adequate process for entities to appeal any adverse determination made by such contractors; and

(IV) such program is carried out in accordance with such requirements as the Secretary shall specify, including—

(aa) for purposes of section 1903(a)(7), that amounts expended by the State to carry out the program shall be considered amounts expended as necessary for the proper and efficient administration of the State plan or a waiver of the plan;

(bb) that section 1903(d) shall apply to amounts recovered under the program; and

(cc) that the State and any such contractors under contract with the State shall coordinate such recovery audit efforts with other contractors or entities performing audits of entities receiving payments under the State plan or

waiver in the State, including efforts with Federal and State law enforcement with respect to the Department of Justice, including the Federal Bureau of Investigations, the Inspector General of the Department of Health and Human Services, and the State medicaid fraud control unit; and

(43) provide for—

(A) informing all persons in the State who are under the age of 21 and who have been determined to be eligible for medical assistance including services described in section 1905(a)(4)(B), of the availability of early and periodic screening, diagnostic, and treatment services as described in section 1905(r) and the need for age-appropriate immunizations against vaccine-preventable diseases,

(B) providing or arranging for the provision of such screening services in all cases where they are requested,

(C) arranging for (directly or through referral to appropriate agencies, organizations, or individuals) corrective treatment the need for which is disclosed by such child health screening services, and

(D) reporting to the Secretary (in a uniform form and manner established by the Secretary, by age group and by basis of eligibility for medical assistance, and by not later than April 1 after the end of each fiscal year, beginning with fiscal year 1990) the following information relating to early and periodic screening, diagnostic, and treatment services provided under the plan during each fiscal year:

(i) the number of children provided child health screening services,

(ii) the number of children referred for corrective treatment (the need for which is disclosed by such child health screening services),

(iii) the number of children receiving dental services, and other information relating to the provision of dental services to such children described in section 2108(e) and

(iv) the State's results in attaining the participation goals set for the State under section 1905(r);

(44) in each case for which payment for inpatient hospital services, services in an intermediate care facility for the mentally retarded, or inpatient mental hospital services is made under the State plan—

(A) a physician (or, in the case of skilled nursing facility services or intermediate care facility services, a physician, or a nurse practitioner or clinical nurse specialist who is not an employee of the facility but is working in collaboration with a physician) certifies at the time of admission, or, if later, the time the individual applies for medical assistance under the State plan (and a physician, a physician assistant under the supervision of a physician, or, in the case of skilled nursing facility services or intermediate care facility services, a physician, or a nurse practitioner or clinical nurse specialist who is not an employee of the facility but is working in collaboration with a physician,

recertifies, where such services are furnished over a period of time, in such cases, at least as often as required under section 1903(g)(6) (or, in the case of services that are services provided in an intermediate care facility for the mentally retarded, every year), and accompanied by such supporting material, appropriate to the case involved, as may be provided in regulations of the Secretary), that such services are or were required to be given on an inpatient basis because the individual needs or needed such services, and

(B) such services were furnished under a plan established and periodically reviewed and evaluated by a physician, or, in the case of skilled nursing facility services or intermediate care facility services, a physician, or a nurse practitioner or clinical nurse specialist who is not an employee of the facility but is working in collaboration with a physician;

(45) provide for mandatory assignment of rights of payment for medical support and other medical care owed to recipients, in accordance with section 1912;

(46)(A) provide that information is requested and exchanged for purposes of income and eligibility verification in accordance with a State system which meets the requirements of section 1137 of this Act; and

(B) provide, with respect to an individual declaring to be a citizen or national of the United States for purposes of establishing eligibility under this title, that the State shall satisfy the requirements of—

- (i) section 1903(x); or
- (ii) subsection (ee);

(47) provide—

(A) at the option of the State, for making ambulatory prenatal care available to pregnant women during a presumptive eligibility period in accordance with section 1920 and provide for making medical assistance for items and services described in subsection (a) of section 1920A available to children during a presumptive eligibility period in accordance with such section and provide for making medical assistance available to individuals described in subsection (a) of section 1920B during a presumptive eligibility period in accordance with such section and provide for making medical assistance available to individuals described in subsection (a) of section 1920C during a presumptive eligibility period in accordance with such section; and

(B) that any hospital that is a participating provider under the State plan may elect to be a qualified entity for purposes of determining, on the basis of preliminary information, whether any individual is eligible for medical assistance under the State plan or under a waiver of the plan for purposes of providing the individual with medical assistance during a presumptive eligibility period, in the same manner, and subject to the same requirements, as apply to the State options with respect to populations described in section 1920, 1920A, 1920B, or 1920C (but with-

- out regard to whether the State has elected to provide for a presumptive eligibility period under any such sections), subject to such guidance as the Secretary shall establish;
- (48) provide a method of making cards evidencing eligibility for medical assistance available to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address;
- (49) provide that the State will provide information and access to certain information respecting sanctions taken against health care practitioners and providers by State licensing authorities in accordance with section 1921;
- (50) provide, in accordance with subsection (q), for a monthly personal needs allowance for certain institutionalized individuals and couples;
- (51) meet the requirements of section 1924 (relating to protection of community spouses);
- (52) meet the requirements of section 1925 (relating to extension of eligibility for medical assistance);
- (53) provide—
- (A) for notifying in a timely manner all individuals in the State who are determined to be eligible for medical assistance and who are pregnant women, breastfeeding or postpartum women (as defined in section 17 of the Child Nutrition Act of 1966), or children below the age of 5, of the availability of benefits furnished by the special supplemental nutrition program under such section, and
- (B) for referring any such individual to the State agency responsible for administering such program;
- (54) in the case of a State plan that provides medical assistance for covered outpatient drugs (as defined in section 1927(k)), comply with the applicable requirements of section 1927;
- (55) provide for receipt and initial processing of applications of individuals for medical assistance under subsection (a)(10)(A)(i)(IV), (a)(10)(A)(i)(VI), (a)(10)(A)(i)(VII), or (a)(10)(A)(ii)(IX)—
- (A) at locations which are other than those used for the receipt and processing of applications for aid under part A of title IV and which include facilities defined as disproportionate share hospitals under section 1923(a)(1)(A) and Federally-qualified health centers described in section 1905(1)(2)(B), and
- (B) using applications which are other than those used for applications for aid under such part;
- (56) provide, in accordance with subsection (s), for adjusted payments for certain inpatient hospital services;
- (57) provide that each hospital, nursing facility, provider of home health care or personal care services, hospice program, or medicaid managed care organization (as defined in section 1903(m)(1)(A)) receiving funds under the plan shall comply with the requirements of subsection (w);
- (58) provide that the State, acting through a State agency, association, or other private nonprofit entity, develop a written description of the law of the State (whether statutory or as recognized by the courts of the State) concerning advance direc-

tives that would be distributed by providers or organizations under the requirements of subsection (w);

(59) maintain a list (updated not less often than monthly, and containing each physician's unique identifier provided under the system established under subsection (x)) of all physicians who are certified to participate under the State plan;

(60) provide that the State agency shall provide assurances satisfactory to the Secretary that the State has in effect the laws relating to medical child support required under section 1908A;

(61) provide that the State must demonstrate that it operates a medicaid fraud and abuse control unit described in section 1903(q) that effectively carries out the functions and requirements described in such section, as determined in accordance with standards established by the Secretary, unless the State demonstrates to the satisfaction of the Secretary that the effective operation of such a unit in the State would not be cost-effective because minimal fraud exists in connection with the provision of covered services to eligible individuals under the State plan, and that beneficiaries under the plan will be protected from abuse and neglect in connection with the provision of medical assistance under the plan without the existence of such a unit;

(62) provide for a program for the distribution of pediatric vaccines to program-registered providers for the immunization of vaccine-eligible children in accordance with section 1928;

(63) provide for administration and determinations of eligibility with respect to individuals who are (or seek to be) eligible for medical assistance based on the application of section 1931;

(64) provide, not later than 1 year after the date of the enactment of this paragraph, a mechanism to receive reports from beneficiaries and others and compile data concerning alleged instances of waste, fraud, and abuse relating to the operation of this title;

(65) provide that the State shall issue provider numbers for all suppliers of medical assistance consisting of durable medical equipment, as defined in section 1861(n), and the State shall not issue or renew such a supplier number for any such supplier unless—

(A)(i) full and complete information as to the identity of each person with an ownership or control interest (as defined in section 1124(a)(3)) in the supplier or in any subcontractor (as defined by the Secretary in regulations) in which the supplier directly or indirectly has a 5 percent or more ownership interest; and

(ii) to the extent determined to be feasible under regulations of the Secretary, the name of any disclosing entity (as defined in section 1124(a)(2)) with respect to which a person with such an ownership or control interest in the supplier is a person with such an ownership or control interest in the disclosing entity; and

(B) a surety bond in a form specified by the Secretary under section 1834(a)(16)(B) and in an amount that is not less than \$50,000 or such comparable surety bond as the

Secretary may permit under the second sentence of such section;

(66) provide for making eligibility determinations under section 1935(a);

(67) provide, with respect to services covered under the State plan (but not under title XVIII) that are furnished to a PACE program eligible individual enrolled with a PACE provider by a provider participating under the State plan that does not have a contract or other agreement with the PACE provider that establishes payment amounts for such services, that such participating provider may not require the PACE provider to pay the participating provider an amount greater than the amount that would otherwise be payable for the service to the participating provider under the State plan for the State where the PACE provider is located (in accordance with regulations issued by the Secretary);

(68) provide that any entity that receives or makes annual payments under the State plan of at least \$5,000,000, as a condition of receiving such payments, shall—

(A) establish written policies for all employees of the entity (including management), and of any contractor or agent of the entity, that provide detailed information about the False Claims Act established under sections 3729 through 3733 of title 31, United States Code, administrative remedies for false claims and statements established under chapter 38 of title 31, United States Code, any State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs (as defined in section 1128B(f));

(B) include as part of such written policies, detailed provisions regarding the entity's policies and procedures for detecting and preventing fraud, waste, and abuse; and

(C) include in any employee handbook for the entity, a specific discussion of the laws described in subparagraph (A), the rights of employees to be protected as whistleblowers, and the entity's policies and procedures for detecting and preventing fraud, waste, and abuse;

(69) provide that the State must comply with any requirements determined by the Secretary to be necessary for carrying out the Medicaid Integrity Program established under section 1936;

(70) at the option of the State and notwithstanding paragraphs (1), (10)(B), and (23), provide for the establishment of a non-emergency medical transportation brokerage program in order to more cost-effectively provide transportation for individuals eligible for medical assistance under the State plan who need access to medical care or services and have no other means of transportation which—

(A) may include a wheelchair van, taxi, stretcher car, bus passes and tickets, secured transportation, and such other transportation as the Secretary determines appropriate; and

- (B) may be conducted under contract with a broker who—
- (i) is selected through a competitive bidding process based on the State's evaluation of the broker's experience, performance, references, resources, qualifications, and costs;
 - (ii) has oversight procedures to monitor beneficiary access and complaints and ensure that transport personnel are licensed, qualified, competent, and courteous;
 - (iii) is subject to regular auditing and oversight by the State in order to ensure the quality of the transportation services provided and the adequacy of beneficiary access to medical care and services; and
 - (iv) complies with such requirements related to prohibitions on referrals and conflict of interest as the Secretary shall establish (based on the prohibitions on physician referrals under section 1877 and such other prohibitions and requirements as the Secretary determines to be appropriate);
- (71) provide that the State will implement an asset verification program as required under section 1940;
- (72) provide that the State will not prevent a Federally-qualified health center from entering into contractual relationships with private practice dental providers in the provision of Federally-qualified health center services;
- (73) in the case of any State in which 1 or more Indian Health Programs or Urban Indian Organizations furnishes health care services, provide for a process under which the State seeks advice on a regular, ongoing basis from designees of such Indian Health Programs and Urban Indian Organizations on matters relating to the application of this title that are likely to have a direct effect on such Indian Health Programs and Urban Indian Organizations and that—
- (A) shall include solicitation of advice prior to submission of any plan amendments, waiver requests, and proposals for demonstration projects likely to have a direct effect on Indians, Indian Health Programs, or Urban Indian Organizations; and
 - (B) may include appointment of an advisory committee and of a designee of such Indian Health Programs and Urban Indian Organizations to the medical care advisory committee advising the State on its State plan under this title;
- (74) provide for maintenance of effort under the State plan or under any waiver of the plan in accordance with subsection (gg); and
- (75) provide that, beginning January 2015, and annually thereafter, the State shall submit a report to the Secretary that contains—
- (A) the total number of enrolled and newly enrolled individuals in the State plan or under a waiver of the plan for the fiscal year ending on September 30 of the preceding calendar year, disaggregated by population, including children, parents, nonpregnant childless adults, disabled indi-

viduals, elderly individuals, and such other categories or sub-categories of individuals eligible for medical assistance under the State plan or under a waiver of the plan as the Secretary may require;

(B) a description, which may be specified by population, of the outreach and enrollment processes used by the State during such fiscal year; and

(C) any other data reporting determined necessary by the Secretary to monitor enrollment and retention of individuals eligible for medical assistance under the State plan or under a waiver of the plan;

(76) provide that any data collected under the State plan meets the requirements of section 3101 of the Public Health Service Act;

(77) provide that the State shall comply with provider and supplier screening, oversight, and reporting requirements in accordance with subsection (kk);

(78) provide that, not later than January 1, 2017, in the case of a State plan that provides medical assistance on a fee-for-service basis, the State shall require each provider furnishing items and services to individuals eligible to receive medical assistance under such plan to enroll with the State agency and provide to the State agency the provider's identifying information, including the name, specialty, date of birth, Social Security number, national provider identifier, Federal taxpayer identification number, and the State license or certification number of the provider;

(79) provide that any agent, clearinghouse, or other alternate payee (as defined by the Secretary) that submits claims on behalf of a health care provider must register with the State and the Secretary in a form and manner specified by the Secretary;

(80) provide that the State shall not provide any payments for items or services provided under the State plan or under a waiver to any financial institution or entity located outside of the United States; and

(81) provide for implementation of the payment models specified by the Secretary under section 1115A(c) for implementation on a nationwide basis unless the State demonstrates to the satisfaction of the Secretary that implementation would not be administratively feasible or appropriate to the health care delivery system of the State.

Notwithstanding paragraph (5), if on January 1, 1965, and on the date on which a State submits its plan for approval under this title, the State agency which administered or supervised the administration of the plan of such State approved under title X (or title XVI, insofar as it relates to the blind) was different from the State agency which administered or supervised the administration of the State plan approved under title I (or title XVI, insofar as it relates to the aged), the State agency which administered or supervised the administration of such plan approved under title X (or title XVI, insofar as it relates to the blind) may be designated to administer or supervise the administration of the portion of the State plan for medical assistance which relates to blind individuals and a different State agency may be established or designated to administer or supervise the administration of the rest of the State

plan for medical assistance; and in such case the part of the plan which each such agency administers, or the administration of which each such agency supervises, shall be regarded as a separate plan for purposes of this title (except for purposes of paragraph (10)). The provisions of paragraphs (9)(A), (31), and (33) and of section 1903(i)(4) shall not apply to a religious nonmedical health care institution (as defined in section 1861(ss)(1)).

For purposes of paragraph (10) any individual who, for the month of August 1972, was eligible for or receiving aid or assistance under a State plan approved under title I, X, XIV, or XVI, or part A of title IV and who for such month was entitled to monthly insurance benefits under title II shall for purposes of this title only be deemed to be eligible for financial aid or assistance for any month thereafter if such individual would have been eligible for financial aid or assistance for such month had the increase in monthly insurance benefits under title II resulting from enactment of Public Law 92-336 not been applicable to such individual.

The requirement of clause (A) of paragraph (37) with respect to a State plan may be waived by the Secretary if he finds that the State has exercised good faith in trying to meet such requirement. For purposes of this title, any child who meets the requirements of paragraph (1) or (2) of section 473(b) shall be deemed to be a dependent child as defined in section 406 and shall be deemed to be a recipient of aid to families with dependent children under part A of title IV in the State where such child resides. Notwithstanding paragraph (10)(B) or any other provision of this subsection, a State plan shall provide medical assistance with respect to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law only in accordance with section 1903(v).

(b) The Secretary shall approve any plan which fulfills the conditions specified in subsection (a) of this section, except that he shall not approve any plan which imposes, as a condition of eligibility for medical assistance under the plan—

- (1) an age requirement of more than 65 years; or
- (2) any residence requirement which excludes any individual who resides in the State, regardless of whether or not the residence is maintained permanently or at a fixed address; or
- (3) any citizenship requirement which excludes any citizen of the United States.

(c) Notwithstanding subsection (b), the Secretary shall not approve any State plan for medical assistance if the State requires individuals described in subsection (1)(1) to apply for assistance under the State program funded under part A of title IV as a condition of applying for or receiving medical assistance under this title.

(d) If a State contracts with an entity which meets the requirements of section 1152, as determined by the Secretary, or a utilization and quality control peer review organization having a contract with the Secretary under part B of title XI for the performance of medical or utilization review functions (including quality review functions described in subsection (a)(30)(C)) required under this title of a State plan with respect to specific services or providers (or services or providers in a geographic area of the State), such requirements shall be deemed to be met for those services or providers (or services or providers in that area) by delegation to such

an entity or organization under the contract of the State's authority to conduct such review activities if the contract provides for the performance of activities not inconsistent with part B of title XI and provides for such assurances of satisfactory performance by such an entity or organization as the Secretary may prescribe.

(e)

(1) Beginning April 1, 1990, for provisions relating to the extension of eligibility for medical assistance for certain families who have received aid pursuant to a State plan approved under part A of title IV and have earned income, see section 1925.

(2)(A) In the case of an individual who is enrolled with a medicaid managed care organization (as defined in section 1903(m)(1)(A)), with a primary care case manager (as defined in section 1905(t)), or with an eligible organization with a contract under section 1876 and who would (but for this paragraph) lose eligibility for benefits under this title before the end of the minimum enrollment period (defined in subparagraph (B)), the State plan may provide, notwithstanding any other provision of this title, that the individual shall be deemed to continue to be eligible for such benefits until the end of such minimum period, but, except for benefits furnished under section 1905(a)(4)(C), only with respect to such benefits provided to the individual as an enrollee of such organization or entity or by or through the case manager.

(B) For purposes of subparagraph (A), the term "minimum enrollment period" means, with respect to an individual's enrollment with an organization or entity under a State plan, a period, established by the State, of not more than six months beginning on the date the individual's enrollment with the organization or entity becomes effective.

(3) At the option of the State, any individual who—

(A) is 18 years of age or younger and qualifies as a disabled individual under section 1614(a);

(B) with respect to whom there has been a determination by the State that—

(i) the individual requires a level of care provided in a hospital, nursing facility, or intermediate care facility for the mentally retarded,

(ii) it is appropriate to provide such care for the individual outside such an institution, and

(iii) the estimated amount which would be expended for medical assistance for the individual for such care outside an institution is not greater than the estimated amount which would otherwise be expended for medical assistance for the individual within an appropriate institution; and

(C) if the individual were in a medical institution, would be eligible for medical assistance under the State plan under this title,

shall be deemed, for purposes of this title only, to be an individual with respect to whom a supplemental security income payment, or State supplemental payment, respectively, is being paid under title XVI.

(4) A child born to a woman eligible for and receiving medical assistance under a State plan on the date of the child's birth shall be deemed to have applied for medical assistance and to have been found eligible for such assistance under such plan on the date of

such birth and to remain eligible for such assistance for a period of one year. During the period in which a child is deemed under the preceding sentence to be eligible for medical assistance, the medical assistance eligibility identification number of the mother shall also serve as the identification number of the child, and all claims shall be submitted and paid under such number (unless the State issues a separate identification number for the child before such period expires). Notwithstanding the preceding sentence, in the case of a child who is born in the United States to an alien mother for whom medical assistance for the delivery of the child is made available pursuant to section 1903(v), the State immediately shall issue a separate identification number for the child upon notification by the facility at which such delivery occurred of the child's birth.

(5) A woman who, while pregnant, is eligible for, has applied for, and has received medical assistance under the State plan, shall continue to be eligible under the plan, as though she were pregnant, for all pregnancy-related and postpartum medical assistance under the plan, through the end of the month in which the 60-day period (beginning on the last day of her pregnancy) ends.

(6) In the case of a pregnant woman described in subsection (a)(10) who, because of a change in income of the family of which she is a member, would not otherwise continue to be described in such subsection, the woman shall be deemed to continue to be an individual described in subsection (a)(10)(A)(i)(IV) and subsection (l)(1)(A) without regard to such change of income through the end of the month in which the 60-day period (beginning on the last day of her pregnancy) ends. The preceding sentence shall not apply in the case of a woman who has been provided ambulatory prenatal care pursuant to section 1920 during a presumptive eligibility period and is then, in accordance with such section, determined to be ineligible for medical assistance under the State plan.

(7) In the case of an infant or child described in subparagraph (B), (C), or (D) of subsection (l)(1) or paragraph (2) of section 1905(n)—

(A) who is receiving inpatient services for which medical assistance is provided on the date the infant or child attains the maximum age with respect to which coverage is provided under the State plan for such individuals, and

(B) who, but for attaining such age, would remain eligible for medical assistance under such subsection, the infant or child shall continue to be treated as an individual described in such respective provision until the end of the stay for which the inpatient services are furnished.

(8) If an individual is determined to be a qualified medicare beneficiary (as defined in section 1905(p)(1)), such determination shall apply to services furnished after the end of the month in which the determination first occurs. For purposes of payment to a State under section 1903(a), such determination shall be considered to be valid for an individual for a period of 12 months, except that a State may provide for such determinations more frequently, but not more frequently than once every 6 months for an individual.

(9)(A) At the option of the State, the plan may include as medical assistance respiratory care services for any individual who—

(i) is medically dependent on a ventilator for life support at least six hours per day;

(ii) has been so dependent for at least 30 consecutive days (or the maximum number of days authorized under the State plan, whichever is less) as an inpatient;

(iii) but for the availability of respiratory care services, would require respiratory care as an inpatient in a hospital, nursing facility, or intermediate care facility for the mentally retarded and would be eligible to have payment made for such inpatient care under the State plan;

(iv) has adequate social support services to be cared for at home; and

(v) wishes to be cared for at home.

(B) The requirements of subparagraph (A)(ii) may be satisfied by a continuous stay in one or more hospitals, nursing facilities, or intermediate care facilities for the mentally retarded.

(C) For purposes of this paragraph, respiratory care services means services provided on a part-time basis in the home of the individual by a respiratory therapist or other health care professional trained in respiratory therapy (as determined by the State), payment for which is not otherwise included within other items and services furnished to such individual as medical assistance under the plan.

(10)(A) The fact that an individual, child, or pregnant woman may be denied aid under part A of title IV pursuant to section 402(a)(43) shall not be construed as denying (or permitting a State to deny) medical assistance under this title to such individual, child, or woman who is eligible for assistance under this title on a basis other than the receipt of aid under such part.

(B) If an individual, child, or pregnant woman is receiving aid under part A of title IV and such aid is terminated pursuant to section 402(a)(43), the State may not discontinue medical assistance under this title for the individual, child, or woman until the State has determined that the individual, child, or woman is not eligible for assistance under this title on a basis other than the receipt of aid under such part.

(11)(A) In the case of an individual who is enrolled with a group health plan under section 1906 and who would (but for this paragraph) lose eligibility for benefits under this title before the end of the minimum enrollment period (defined in subparagraph (B)), the State plan may provide, notwithstanding any other provision of this title, that the individual shall be deemed to continue to be eligible for such benefits until the end of such minimum period, but only with respect to such benefits provided to the individual as an enrollee of such plan.

(B) For purposes of subparagraph (A), the term “minimum enrollment period” means, with respect to an individual’s enrollment with a group health plan, a period established by the State, of not more than 6 months beginning on the date the individual’s enrollment under the plan becomes effective.

(12) At the option of the State, the plan may provide that an individual who is under an age specified by the State (not to exceed 19 years of age) and who is determined to be eligible for benefits under a State plan approved under this title under subsection

(a)(10)(A) shall remain eligible for those benefits until the earlier of—

(A) the end of a period (not to exceed 12 months) following the determination; or

(B) the time that the individual exceeds that age.

(13) EXPRESS LANE OPTION.—

(A) IN GENERAL.—

(i) OPTION TO USE A FINDING FROM AN EXPRESS LANE AGENCY.—At the option of the State, the State plan may provide that in determining eligibility under this title for a child (as defined in subparagraph (G)), the State may rely on a finding made within a reasonable period (as determined by the State) from an Express Lane agency (as defined in subparagraph (F)) when it determines whether a child satisfies one or more components of eligibility for medical assistance under this title. The State may rely on a finding from an Express Lane agency notwithstanding sections 1902(a)(46)(B) and 1137(d) or any differences in budget unit, disregard, deeming or other methodology, if the following requirements are met:

(I) PROHIBITION ON DETERMINING CHILDREN INELIGIBLE FOR COVERAGE.—If a finding from an Express Lane agency would result in a determination that a child does not satisfy an eligibility requirement for medical assistance under this title and for child health assistance under title XXI, the State shall determine eligibility for assistance using its regular procedures.

(II) NOTICE REQUIREMENT.—For any child who is found eligible for medical assistance under the State plan under this title or child health assistance under title XXI and who is subject to premiums based on an Express Lane agency's finding of such child's income level, the State shall provide notice that the child may qualify for lower premium payments if evaluated by the State using its regular policies and of the procedures for requesting such an evaluation.

(III) COMPLIANCE WITH SCREEN AND ENROLL REQUIREMENT.—The State shall satisfy the requirements under subparagraphs (A) and (B) of section 2102(b)(3) (relating to screen and enroll) before enrolling a child in child health assistance under title XXI. At its option, the State may fulfill such requirements in accordance with either option provided under subparagraph (C) of this paragraph.

(IV) VERIFICATION OF CITIZENSHIP OR NATIONALITY STATUS.—The State shall satisfy the requirements of section 1902(a)(46)(B) or 2105(c)(9), as applicable for verifications of citizenship or nationality status.

(V) CODING.—The State meets the requirements of subparagraph (E).

(ii) OPTION TO APPLY TO RENEWALS AND REDETERMINATIONS.—The State may apply the provisions of this paragraph when conducting initial determinations of eligibility, redeterminations of eligibility, or both, as described in the State plan.

(B) RULES OF CONSTRUCTION.—Nothing in this paragraph shall be construed—

(i) to limit or prohibit a State from taking any actions otherwise permitted under this title or title XXI in determining eligibility for or enrolling children into medical assistance under this title or child health assistance under title XXI; or

(ii) to modify the limitations in section 1902(a)(5) concerning the agencies that may make a determination of eligibility for medical assistance under this title.

(C) OPTIONS FOR SATISFYING THE SCREEN AND ENROLL REQUIREMENT.—

(i) IN GENERAL.—With respect to a child whose eligibility for medical assistance under this title or for child health assistance under title XXI has been evaluated by a State agency using an income finding from an Express Lane agency, a State may carry out its duties under subparagraphs (A) and (B) of section 2102(b)(3) (relating to screen and enroll) in accordance with either clause (ii) or clause (iii).

(ii) ESTABLISHING A SCREENING THRESHOLD.—

(I) IN GENERAL.—Under this clause, the State establishes a screening threshold set as a percentage of the Federal poverty level that exceeds the highest income threshold applicable under this title to the child by a minimum of 30 percentage points or, at State option, a higher number of percentage points that reflects the value (as determined by the State and described in the State plan) of any differences between income methodologies used by the program administered by the Express Lane agency and the methodologies used by the State in determining eligibility for medical assistance under this title.

(II) CHILDREN WITH INCOME NOT ABOVE THRESHOLD.—If the income of a child does not exceed the screening threshold, the child is deemed to satisfy the income eligibility criteria for medical assistance under this title regardless of whether such child would otherwise satisfy such criteria.

(III) CHILDREN WITH INCOME ABOVE THRESHOLD.—If the income of a child exceeds the screening threshold, the child shall be considered to have an income above the Medicaid applicable income level described in section 2110(b)(4) and to satisfy the requirement under section 2110(b)(1)(C) (relating to the requirement that CHIP matching funds be used only for children not eligible for Medicaid). If such a child is enrolled in child health assistance under title XXI, the State shall provide the parent, guardian, or custodial relative with the following:

(aa) Notice that the child may be eligible to receive medical assistance under the State plan under this title if evaluated for such assistance under the State's regular procedures and notice of the process through which a parent, guardian, or

custodial relative can request that the State evaluate the child's eligibility for medical assistance under this title using such regular procedures.

(bb) A description of differences between the medical assistance provided under this title and child health assistance under title XXI, including differences in cost-sharing requirements and covered benefits.

(iii) TEMPORARY ENROLLMENT IN CHIP PENDING SCREEN AND ENROLL.—

(I) IN GENERAL.—Under this clause, a State enrolls a child in child health assistance under title XXI for a temporary period if the child appears eligible for such assistance based on an income finding by an Express Lane agency.

(II) DETERMINATION OF ELIGIBILITY.—During such temporary enrollment period, the State shall determine the child's eligibility for child health assistance under title XXI or for medical assistance under this title in accordance with this clause.

(III) PROMPT FOLLOW UP.—In making such a determination, the State shall take prompt action to determine whether the child should be enrolled in medical assistance under this title or child health assistance under title XXI pursuant to subparagraphs (A) and (B) of section 2102(b)(3) (relating to screen and enroll).

(IV) REQUIREMENT FOR SIMPLIFIED DETERMINATION.—In making such a determination, the State shall use procedures that, to the maximum feasible extent, reduce the burden imposed on the individual of such determination. Such procedures may not require the child's parent, guardian, or custodial relative to provide or verify information that already has been provided to the State agency by an Express Lane agency or another source of information unless the State agency has reason to believe the information is erroneous.

(V) AVAILABILITY OF CHIP MATCHING FUNDS DURING TEMPORARY ENROLLMENT PERIOD.—Medical assistance for items and services that are provided to a child enrolled in title XXI during a temporary enrollment period under this clause shall be treated as child health assistance under such title.

(D) OPTION FOR AUTOMATIC ENROLLMENT.—

(i) IN GENERAL.—The State may initiate and determine eligibility for medical assistance under the State Medicaid plan or for child health assistance under the State CHIP plan without a program application from, or on behalf of, the child based on data obtained from sources other than the child (or the child's family), but a child can only be automatically enrolled in the State Medicaid plan or the State CHIP plan if the child or the family affirmatively consents to being enrolled through affirmation in writing, by telephone, orally, through electronic signature, or

through any other means specified by the Secretary or by signature on an Express Lane agency application, if the requirement of clause (ii) is met.

(ii) INFORMATION REQUIREMENT.—The requirement of this clause is that the State informs the parent, guardian, or custodial relative of the child of the services that will be covered, appropriate methods for using such services, premium or other cost sharing charges (if any) that apply, medical support obligations (under section 1912(a)) created by enrollment (if applicable), and the actions the parent, guardian, or relative must take to maintain enrollment and renew coverage.

(E) CODING; APPLICATION TO ENROLLMENT ERROR RATES.—

(i) IN GENERAL.—For purposes of subparagraph (A)(iv), the requirement of this subparagraph for a State is that the State agrees to—

(I) assign such codes as the Secretary shall require to the children who are enrolled in the State Medicaid plan or the State CHIP plan through reliance on a finding made by an Express Lane agency for the duration of the State's election under this paragraph;

(II) annually provide the Secretary with a statistically valid sample (that is approved by Secretary) of the children enrolled in such plans through reliance on such a finding by conducting a full Medicaid eligibility review of the children identified for such sample for purposes of determining an eligibility error rate (as described in clause (iv)) with respect to the enrollment of such children (and shall not include such children in any data or samples used for purposes of complying with a Medicaid Eligibility Quality Control (MEQC) review or a payment error rate measurement (PERM) requirement);

(III) submit the error rate determined under subclause (II) to the Secretary;

(IV) if such error rate exceeds 3 percent for either of the first 2 fiscal years in which the State elects to apply this paragraph, demonstrate to the satisfaction of the Secretary the specific corrective actions implemented by the State to improve upon such error rate; and

(V) if such error rate exceeds 3 percent for any fiscal year in which the State elects to apply this paragraph, a reduction in the amount otherwise payable to the State under section 1903(a) for quarters for that fiscal year, equal to the total amount of erroneous excess payments determined for the fiscal year only with respect to the children included in the sample for the fiscal year that are in excess of a 3 percent error rate with respect to such children.

(ii) NO PUNITIVE ACTION BASED ON ERROR RATE.—The Secretary shall not apply the error rate derived from the sample under clause (i) to the entire population of children enrolled in the State Medicaid plan or the State CHIP plan through reliance on a finding made by an Express

Lane agency, or to the population of children enrolled in such plans on the basis of the State's regular procedures for determining eligibility, or penalize the State on the basis of such error rate in any manner other than the reduction of payments provided for under clause (i)(V).

(iii) **RULE OF CONSTRUCTION.**—Nothing in this paragraph shall be construed as relieving a State that elects to apply this paragraph from being subject to a penalty under section 1903(u), for payments made under the State Medicaid plan with respect to ineligible individuals and families that are determined to exceed the error rate permitted under that section (as determined without regard to the error rate determined under clause (i)(II)).

(iv) **ERROR RATE DEFINED.**—In this subparagraph, the term “error rate” means the rate of erroneous excess payments for medical assistance (as defined in section 1903(u)(1)(D)) for the period involved, except that such payments shall be limited to individuals for which eligibility determinations are made under this paragraph and except that in applying this paragraph under title XXI, there shall be substituted for references to provisions of this title corresponding provisions within title XXI.

(F) EXPRESS LANE AGENCY.—

(i) **IN GENERAL.**—In this paragraph, the term “Express Lane agency” means a public agency that—

(I) is determined by the State Medicaid agency or the State CHIP agency (as applicable) to be capable of making the determinations of one or more eligibility requirements described in subparagraph (A)(i);

(II) is identified in the State Medicaid plan or the State CHIP plan; and

(III) notifies the child's family—

(aa) of the information which shall be disclosed in accordance with this paragraph;

(bb) that the information disclosed will be used solely for purposes of determining eligibility for medical assistance under the State Medicaid plan or for child health assistance under the State CHIP plan; and

(cc) that the family may elect to not have the information disclosed for such purposes; and

(IV) enters into, or is subject to, an interagency agreement to limit the disclosure and use of the information disclosed.

(ii) **INCLUSION OF SPECIFIC PUBLIC AGENCIES AND INDIAN TRIBES AND TRIBAL ORGANIZATIONS.**—Such term includes the following:

(I) A public agency that determines eligibility for assistance under any of the following:

(aa) The temporary assistance for needy families program funded under part A of title IV.

(bb) A State program funded under part D of title IV.

(cc) The State Medicaid plan.

(dd) The State CHIP plan.

(ee) The Food and Nutrition Act of 2008 (7 U.S.C. 2011 et seq.).

(ff) The Head Start Act (42 U.S.C. 9801 et seq.).

(gg) The Richard B. Russell National School Lunch Act (42 U.S.C. 1751 et seq.).

(hh) The Child Nutrition Act of 1966 (42 U.S.C. 1771 et seq.).

(ii) The Child Care and Development Block Grant Act of 1990 (42 U.S.C. 9858 et seq.).

(jj) The Stewart B. McKinney Homeless Assistance Act (42 U.S.C. 11301 et seq.).

(kk) The United States Housing Act of 1937 (42 U.S.C. 1437 et seq.).

(ll) The Native American Housing Assistance and Self-Determination Act of 1996 (25 U.S.C. 4101 et seq.).

(II) A State-specified governmental agency that has fiscal liability or legal responsibility for the accuracy of the eligibility determination findings relied on by the State.

(III) A public agency that is subject to an inter-agency agreement limiting the disclosure and use of the information disclosed for purposes of determining eligibility under the State Medicaid plan or the State CHIP plan.

(IV) The Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization (as defined in section 1139(c)).

(iii) EXCLUSIONS.—Such term does not include an agency that determines eligibility for a program established under the Social Services Block Grant established under title XX or a private, for-profit organization.

(iv) RULES OF CONSTRUCTION.—Nothing in this paragraph shall be construed as—

(I) exempting a State Medicaid agency from complying with the requirements of section 1902(a)(4) relating to merit-based personnel standards for employees of the State Medicaid agency and safeguards against conflicts of interest); or

(II) authorizing a State Medicaid agency that elects to use Express Lane agencies under this subparagraph to use the Express Lane option to avoid complying with such requirements for purposes of making eligibility determinations under the State Medicaid plan.

(v) ADDITIONAL DEFINITIONS.—In this paragraph:

(I) STATE.—The term “State” means 1 of the 50 States or the District of Columbia.

(II) STATE CHIP AGENCY.—The term “State CHIP agency” means the State agency responsible for administering the State CHIP plan.

(III) STATE CHIP PLAN.—The term “State CHIP plan” means the State child health plan established under title XXI and includes any waiver of such plan.

(IV) STATE MEDICAID AGENCY.—The term “State Medicaid agency” means the State agency responsible for administering the State Medicaid plan.

(V) STATE MEDICAID PLAN.—The term “State Medicaid plan” means the State plan established under title XIX and includes any waiver of such plan.

(G) CHILD DEFINED.—For purposes of this paragraph, the term “child” means an individual under 19 years of age, or, at the option of a State, such higher age, not to exceed 21 years of age, as the State may elect.

(H) STATE OPTION TO RELY ON STATE INCOME TAX DATA OR RETURN.—At the option of the State, a finding from an Express Lane agency may include gross income or adjusted gross income shown by State income tax records or returns.

(I) APPLICATION.—This paragraph shall not apply with respect to eligibility determinations made after September 30, 2017.

(14) INCOME DETERMINED USING MODIFIED ADJUSTED GROSS INCOME.—

(A) IN GENERAL.—Notwithstanding subsection (r) or any other provision of this title, except as provided in subparagraph (D), for purposes of determining income eligibility for medical assistance under the State plan or under any waiver of such plan and for any other purpose applicable under the plan or waiver for which a determination of income is required, including with respect to the imposition of premiums and cost-sharing, a State shall use the modified adjusted gross income of an individual and, in the case of an individual in a family greater than 1, the household income of such family. A State shall establish income eligibility thresholds for populations to be eligible for medical assistance under the State plan or a waiver of the plan using modified adjusted gross income and household income that are not less than the effective income eligibility levels that applied under the State plan or waiver on the date of enactment of the Patient Protection and Affordable Care Act. For purposes of complying with the maintenance of effort requirements under subsection (gg) during the transition to modified adjusted gross income and household income, a State shall, working with the Secretary, establish an equivalent income test that ensures individuals eligible for medical assistance under the State plan or under a waiver of the plan on the date of enactment of the Patient Protection and Affordable Care Act, do not lose coverage under the State plan or under a waiver of the plan. The Secretary may waive such provisions of this title and title XXI as are necessary to ensure that States establish income and eligibility determination systems that protect beneficiaries.

(B) NO INCOME OR EXPENSE DISREGARDS.—Subject to subparagraph (I), no type of expense, block, or other income disregard shall be applied by a State to determine income eligibility for medical assistance under the State plan or under any waiver of such plan or for any other purpose

applicable under the plan or waiver for which a determination of income is required.

(C) NO ASSETS TEST.—A State shall not apply any assets or resources test for purposes of determining eligibility for medical assistance under the State plan or under a waiver of the plan.

(D) EXCEPTIONS.—

(i) INDIVIDUALS ELIGIBLE BECAUSE OF OTHER AID OR ASSISTANCE, ELDERLY INDIVIDUALS, MEDICALLY NEEDY INDIVIDUALS, AND INDIVIDUALS ELIGIBLE FOR MEDICARE COST-SHARING.—Subparagraphs (A), (B), and (C) shall not apply to the determination of eligibility under the State plan or under a waiver for medical assistance for the following:

(I) Individuals who are eligible for medical assistance under the State plan or under a waiver of the plan on a basis that does not require a determination of income by the State agency administering the State plan or waiver, including as a result of eligibility for, or receipt of, other Federal or State aid or assistance, individuals who are eligible on the basis of receiving (or being treated as if receiving) supplemental security income benefits under title XVI, and individuals who are eligible as a result of being or being deemed to be a child in foster care under the responsibility of the State.

(II) Individuals who have attained age 65.

(III) Individuals who qualify for medical assistance under the State plan or under any waiver of such plan on the basis of being blind or disabled (or being treated as being blind or disabled) without regard to whether the individual is eligible for supplemental security income benefits under title XVI on the basis of being blind or disabled and including an individual who is eligible for medical assistance on the basis of section 1902(e)(3).

(IV) Individuals described in subsection (a)(10)(C).

(V) Individuals described in any clause of subsection (a)(10)(E).

(ii) EXPRESS LANE AGENCY FINDINGS.—In the case of a State that elects the Express Lane option under paragraph (13), notwithstanding subparagraphs (A), (B), and (C), the State may rely on a finding made by an Express Lane agency in accordance with that paragraph relating to the income of an individual for purposes of determining the individual's eligibility for medical assistance under the State plan or under a waiver of the plan.

(iii) MEDICARE PRESCRIPTION DRUG SUBSIDIES DETERMINATIONS.—Subparagraphs (A), (B), and (C) shall not apply to any determinations of eligibility for premium and cost-sharing subsidies under and in accordance with section 1860D–14 made by the State pursuant to section 1935(a)(2).

(iv) LONG-TERM CARE.—Subparagraphs (A), (B), and (C) shall not apply to any determinations of eligibility for individuals for purposes of medical assistance for nursing facility services, a level of care in any institution equivalent to that of nursing facility services, home or community-based services furnished under a waiver or State plan amendment under section 1915 or a waiver under section 1115, and services described in section 1917(c)(1)(C)(ii).

(v) GRANDFATHER OF CURRENT ENROLLEES UNTIL DATE OF NEXT REGULAR REDETERMINATION.—An individual who, on January 1, 2014, is enrolled in the State plan or under a waiver of the plan and who would be determined ineligible for medical assistance solely because of the application of the modified adjusted gross income or household income standard described in subparagraph (A), shall remain eligible for medical assistance under the State plan or waiver (and subject to the same premiums and cost-sharing as applied to the individual on that date) through March 31, 2014, or the date on which the individual's next regularly scheduled redetermination of eligibility is to occur, whichever is later.

(E) TRANSITION PLANNING AND OVERSIGHT.—Each State shall submit to the Secretary for the Secretary's approval the income eligibility thresholds proposed to be established using modified adjusted gross income and household income, the methodologies and procedures to be used to determine income eligibility using modified adjusted gross income and household income and, if applicable, a State plan amendment establishing an optional eligibility category under subsection (a)(10)(A)(ii)(XX). To the extent practicable, the State shall use the same methodologies and procedures for purposes of making such determinations as the State used on the date of enactment of the Patient Protection and Affordable Care Act. The Secretary shall ensure that the income eligibility thresholds proposed to be established using modified adjusted gross income and household income, including under the eligibility category established under subsection (a)(10)(A)(ii)(XX), and the methodologies and procedures proposed to be used to determine income eligibility, will not result in children who would have been eligible for medical assistance under the State plan or under a waiver of the plan on the date of enactment of the Patient Protection and Affordable Care Act no longer being eligible for such assistance.

(F) LIMITATION ON SECRETARIAL AUTHORITY.—The Secretary shall not waive compliance with the requirements of this paragraph except to the extent necessary to permit a State to coordinate eligibility requirements for dual eligible individuals (as defined in section 1915(h)(2)(B)) under the State plan or under a waiver of the plan and under title XVIII and individuals who require the level of care provided in a hospital, a nursing facility, or an intermediate care facility for the mentally retarded.

(G) DEFINITIONS OF MODIFIED ADJUSTED GROSS INCOME AND HOUSEHOLD INCOME.—In this paragraph, the terms “modified adjusted gross income” and “household income” have the meanings given such terms in section 36B(d)(2) of the Internal Revenue Code of 1986.

(H) CONTINUED APPLICATION OF MEDICAID RULES REGARDING POINT-IN-TIME INCOME AND SOURCES OF INCOME.—The requirement under this paragraph for States to use modified adjusted gross income and household income to determine income eligibility for medical assistance under the State plan or under any waiver of such plan and for any other purpose applicable under the plan or waiver for which a determination of income is required shall not be construed as affecting or limiting the application of—

(i) the requirement under this title and under the State plan or a waiver of the plan to determine an individual’s income as of the point in time at which an application for medical assistance under the State plan or a waiver of the plan is processed; or

(ii) any rules established under this title or under the State plan or a waiver of the plan regarding sources of countable income.

(I) TREATMENT OF PORTION OF MODIFIED ADJUSTED GROSS INCOME.—For purposes of determining the income eligibility of an individual for medical assistance whose eligibility is determined based on the application of modified adjusted gross income under subparagraph (A), the State shall—

(i) determine the dollar equivalent of the difference between the upper income limit on eligibility for such an individual (expressed as a percentage of the poverty line) and such upper income limit increased by 5 percentage points; and

(ii) notwithstanding the requirement in subparagraph (A) with respect to use of modified adjusted gross income, utilize as the applicable income of such individual, in determining such income eligibility, an amount equal to the modified adjusted gross income applicable to such individual reduced by such dollar equivalent amount.

(14) EXCLUSION OF COMPENSATION FOR PARTICIPATION IN A CLINICAL TRIAL FOR TESTING OF TREATMENTS FOR A RARE DISEASE OR CONDITION.—The first \$2,000 received by an individual (who has attained 19 years of age) as compensation for participation in a clinical trial meeting the requirements of section 1612(b)(26) shall be disregarded for purposes of determining the income eligibility of such individual for medical assistance under the State plan or any waiver of such plan.

(f) Notwithstanding any other provision of this title, except as provided in subsection (e) and section 1619(b)(3) and section 1924, except with respect to qualified disabled and working individuals (described in section 1905(s)), and except with respect to qualified medicare beneficiaries, qualified severely impaired individuals, and individuals described in subsection (m)(1), no State not eligible to participate in the State plan program established under title XVI

shall be required to provide medical assistance to any aged, blind, or disabled individual (within the meaning of title XVI) for any month unless such State would be (or would have been) required to provide medical assistance to such individual for such month had its plan for medical assistance approved under this title and in effect on January 1, 1972, been in effect in such month, except that for this purpose any such individual shall be deemed eligible for medical assistance under such State plan if (in addition to meeting such other requirements as are or may be imposed under the State plan) the income of any such individual as determined in accordance with section 1903(f) (after deducting any supplemental security income payment and State supplementary payment made with respect to such individual, and incurred expenses for medical care as recognized under State law regardless of whether such expenses are reimbursed under another public program of the State or political subdivision thereof) is not in excess of the standard for medical assistance established under the State plan as in effect on January 1, 1972. In States which provide medical assistance to individuals pursuant to paragraph (10)(C) of subsection (a) of this section, an individual who is eligible for medical assistance by reason of the requirements of this section concerning the deduction of incurred medical expenses from income shall be considered an individual eligible for medical assistance under paragraph (10)(A) of that subsection if that individual is, or is eligible to be (1) an individual with respect to whom there is payable a State supplementary payment on the basis of which similarly situated individuals are eligible to receive medical assistance equal in amount, duration, and scope to that provided to individuals eligible under paragraph (10)(A), or (2) an eligible individual or eligible spouse, as defined in title XVI, with respect to whom supplemental security income benefits are payable; otherwise that individual shall be considered to be an individual eligible for medical assistance under paragraph (10)(C) of that subsection. In States which do not provide medical assistance to individuals pursuant to paragraph (10)(C) of that subsection, an individual who is eligible for medical assistance by reason of the requirements of this section concerning the deduction of incurred medical expenses from income shall be considered an individual eligible for medical assistance under paragraph (10)(A) of that subsection.

(g) In addition to any other sanction available to a State, a State may provide for a reduction of any payment amount otherwise due with respect to a person who furnishes services under the plan in an amount equal to up to three times the amount of any payment sought to be collected by that person in violation of subsection (a)(25)(C).

(h) Nothing in this title (including subsections (a)(13) and (a)(30) of this section) shall be construed as authorizing the Secretary to limit the amount of payment that may be made under a plan under this title for home and community care.

(i)(1) In addition to any other authority under State law, where a State determines that an intermediate care facility for the mentally retarded which is certified for participation under its plan no longer substantially meets the requirements for such a facility under this title and further determines that the facility's deficiencies—

(A) immediately jeopardize the health and safety of its patients, the State shall provide for the termination of the facility's certification for participation under the plan and may provide, or

(B) do not immediately jeopardize the health and safety of its patients, the State may, in lieu of providing for terminating the facility's certification for participation under the plan, establish alternative remedies if the State demonstrates to the Secretary's satisfaction that the alternative remedies are effective in deterring noncompliance and correcting deficiencies, and may provide

that no payment will be made under the State plan with respect to any individual admitted to such facility after a date specified by the State.

(2) The State shall not make such a decision with respect to a facility until the facility has had a reasonable opportunity, following the initial determination that it no longer substantially meets the requirements for such a facility under this title, to correct its deficiencies, and, following this period, has been given reasonable notice and opportunity for a hearing.

(3) The State's decision to deny payment may be made effective only after such notice to the public and to the facility as may be provided for by the State, and its effectiveness shall terminate (A) when the State finds that the facility is in substantial compliance (or is making good faith efforts to achieve substantial compliance) with the requirements for such a facility under this title, or (B) in the case described in paragraph (1)(B), with the end of the eleventh month following the month such decision is made effective, whichever occurs first. If a facility to which clause (B) of the previous sentence applies still fails to substantially meet the provisions of the respective section on the date specified in such clause, the State shall terminate such facility's certification for participation under the plan effective with the first day of the first month following the month specified in such clause.

(j) Notwithstanding any other requirement of this title, the Secretary may waive or modify any requirement of this title with respect to the medical assistance program in American Samoa and the Northern Mariana Islands, other than a waiver of the Federal medical assistance percentage, the limitation in section 1108(f), or the requirement that payment may be made for medical assistance only with respect to amounts expended by American Samoa or the Northern Mariana Islands for care and services described in a numbered paragraph of section 1905(a).

(k)(1) The medical assistance provided to an individual described in subclause (VIII) of subsection (a)(10)(A)(i) shall consist of benchmark coverage described in section 1937(b)(1) or benchmark equivalent coverage described in section 1937(b)(2). Such medical assistance shall be provided subject to the requirements of section 1937, without regard to whether a State otherwise has elected the option to provide medical assistance through coverage under that section, unless an individual described in subclause (VIII) of subsection (a)(10)(A)(i) is also an individual for whom, under subparagraph (B) of section 1937(a)(2), the State may not require enrollment in benchmark coverage described in subsection (b)(1) of section 1937

or benchmark equivalent coverage described in subsection (b)(2) of that section.

(2) Beginning with the first day of any fiscal year quarter that begins on or after April 1, 2010, and before January 1, 2014, a State may elect through a State plan amendment to provide medical assistance to individuals who would be described in subclause (VIII) of subsection (a)(10)(A)(i) if that subclause were effective before January 1, 2014. A State may elect to phase-in the extension of eligibility for medical assistance to such individuals based on income, so long as the State does not extend such eligibility to individuals described in such subclause with higher income before making individuals described in such subclause with lower income eligible for medical assistance.

(3) If an individual described in subclause (VIII) of subsection (a)(10)(A)(i) is the parent of a child who is under 19 years of age (or such higher age as the State may have elected) who is eligible for medical assistance under the State plan or under a waiver of such plan (under that subclause or under a State plan amendment under paragraph (2), the individual may not be enrolled under the State plan unless the individual's child is enrolled under the State plan or under a waiver of the plan or is enrolled in other health insurance coverage. For purposes of the preceding sentence, the term "parent" includes an individual treated as a caretaker relative for purposes of carrying out section 1931.

(1)(1) Individuals described in this paragraph are—

(A) women during pregnancy (and during the 60-day period beginning on the last day of the pregnancy),

(B) infants under one year of age,

(C) children who have attained one year of age but have not attained 6 years of age, and

(D) children born after September 30, 1983 (or, at the option of a State, after any earlier date), who have attained 6 years of age but have not attained 19 years of age,

who are not described in any of subclauses (I) through (III) of subsection (a)(10)(A)(i) and whose family income does not exceed the income level established by the State under paragraph (2) for a family size equal to the size of the family, including the woman, infant, or child.

(2)(A)(i) For purposes of paragraph (1) with respect to individuals described in subparagraph (A) or (B) of that paragraph, the State shall establish an income level which is a percentage (not less than the percentage provided under clause (ii) and not more than 185 percent) of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

(ii) The percentage provided under this clause, with respect to eligibility for medical assistance on or after—

(I) July 1, 1989, is 75 percent, or, if greater, the percentage provided under clause (iii), and

(II) April 1, 1990, 133 percent, or, if greater, the percentage provided under clause (iv).

(iii) In the case of a State which, as of the date of the enactment of this clause, has elected to provide, and provides, medical assistance to individuals described in this subsection or has enacted leg-

islation authorizing, or appropriating funds, to provide such assistance to such individuals before July 1, 1989, the percentage provided under clause (ii)(I) shall not be less than—

(I) the percentage specified by the State in an amendment to its State plan (whether approved or not) as of the date of the enactment of this clause, or

(II) if no such percentage is specified as of the date of the enactment of this clause, the percentage established under the State's authorizing legislation or provided for under the State's appropriations;

but in no case shall this clause require the percentage provided under clause (ii)(I) to exceed 100 percent.

(iv) In the case of a State which, as of the date of the enactment of this clause, has established under clause (i), or has enacted legislation authorizing, or appropriating funds, to provide for, a percentage (of the income official poverty line) that is greater than 133 percent, the percentage provided under clause (ii) for medical assistance on or after April 1, 1990, shall not be less than—

(I) the percentage specified by the State in an amendment to its State plan (whether approved or not) as of the date of the enactment of this clause, or

(II) if no such percentage is specified as of the date of the enactment of this clause, the percentage established under the State's authorizing legislation or provided for under the State's appropriations.

(B) For purposes of paragraph (1) with respect to individuals described in subparagraph (C) of such paragraph, the State shall establish an income level which is equal to 133 percent of the income official poverty line described in subparagraph (A) applicable to a family of the size involved.

(C) For purposes of paragraph (1) with respect to individuals described in subparagraph (D) of that paragraph, the State shall establish an income level which is equal to 100 percent (or, beginning January 1, 2014, 133 percent) of the income official poverty line described in subparagraph (A) applicable to a family of the size involved.

(3) Notwithstanding subsection (a)(17), for individuals who are eligible for medical assistance because of subsection (a)(10)(A)(i)(IV), (a)(10)(A)(i)(VI), (a)(10)(A)(i)(VII), or (a)(10)(A)(ii)(IX)—

(A) application of a resource standard shall be at the option of the State;

(B) any resource standard or methodology that is applied with respect to an individual described in subparagraph (A) of paragraph (1) may not be more restrictive than the resource standard or methodology that is applied under title XVI;

(C) any resource standard or methodology that is applied with respect to an individual described in subparagraph (B), (C), or (D) of paragraph (1) may not be more restrictive than the corresponding methodology that is applied under the State plan under part A of title IV;

(D) the income standard to be applied is the appropriate income standard established under paragraph (2); and

(E) family income shall be determined in accordance with the methodology employed under the State plan under part A or

E of title IV (except to the extent such methodology is inconsistent with clause (D) of subsection (a)(17)), and costs incurred for medical care or for any other type of remedial care shall not be taken into account.

Any different treatment provided under this paragraph for such individuals shall not, because of subsection (a)(17), require or permit such treatment for other individuals.

(4)(A) In the case of any State which is providing medical assistance to its residents under a waiver granted under section 1115, the Secretary shall require the State to provide medical assistance for pregnant women and infants under age 1 described in subsection (a)(10)(A)(i)(IV) and for children described in subsection (a)(10)(A)(i)(VI) or subsection (a)(10)(A)(i)(VII) in the same manner as the State would be required to provide such assistance for such individuals if the State had in effect a plan approved under this title.

(B) In the case of a State which is not one of the 50 States or the District of Columbia, the State need not meet the requirement of subsection (a)(10)(A)(i)(IV), (a)(10)(A)(i)(VI), or (a)(10)(A)(i)(VII) and, for purposes of paragraph (2)(A), the State may substitute for the percentage provided under clause (ii) of such paragraph any percentage.

(m)(1) Individuals described in this paragraph are individuals—

(A) who are 65 years of age or older or are disabled individuals (as determined under section 1614(a)(3)),

(B) whose income (as determined under section 1612 for purposes of the supplemental security income program, except as provided in paragraph (2)(C)) does not exceed an income level established by the State consistent with paragraph (2)(A), and

(C) whose resources (as determined under section 1613 for purposes of the supplemental security income program) do not exceed (except as provided in paragraph (2)(B)) the maximum amount of resources that an individual may have and obtain benefits under that program.

(2)(A) The income level established under paragraph (1)(B) may not exceed a percentage (not more than 100 percent) of the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

(B) In the case of a State that provides medical assistance to individuals not described in subsection (a)(10)(A) and at the State's option, the State may use under paragraph (1)(C) such resource level (which is higher than the level described in that paragraph) as may be applicable with respect to individuals described in paragraph (1)(A) who are not described in subsection (a)(10)(A).

(C) The provisions of section 1905(p)(2)(D) shall apply to determinations of income under this subsection in the same manner as they apply to determinations of income under section 1905(p).

(3) Notwithstanding subsection (a)(17), for individuals described in paragraph (1) who are covered under the State plan by virtue of subsection (a)(10)(A)(ii)(X)—

(A) the income standard to be applied is the income standard described in paragraph (1)(B), and

(B) except as provided in section 1612(b)(4)(B)(ii), costs incurred for medical care or for any other type of remedial care shall not be taken into account in determining income.

Any different treatment provided under this paragraph for such individuals shall not, because of subsection (a)(17), require or permit such treatment for other individuals.

(4) Notwithstanding subsection (a)(17), for qualified medicare beneficiaries described in section 1905(p)(1)—

(A) the income standard to be applied is the income standard described in section 1905(p)(1)(B), and

(B) except as provided in section 1612(b)(4)(B)(ii), costs incurred for medical care or for any other type of remedial care shall not be taken into account in determining income.

Any different treatment provided under this paragraph for such individuals shall not, because of subsection (a)(17), require or permit such treatment for other individuals.

(n)(1) In the case of medical assistance furnished under this title for medicare cost-sharing respecting the furnishing of a service or item to a qualified medicare beneficiary, the State plan may provide payment in an amount with respect to the service or item that results in the sum of such payment amount and any amount of payment made under title XVIII with respect to the service or item exceeding the amount that is otherwise payable under the State plan for the item or service for eligible individuals who are not qualified medicare beneficiaries.

(2) In carrying out paragraph (1), a State is not required to provide any payment for any expenses incurred relating to payment for deductibles, coinsurance, or copayments for medicare cost-sharing to the extent that payment under title XVIII for the service would exceed the payment amount that otherwise would be made under the State plan under this title for such service if provided to an eligible recipient other than a medicare beneficiary.

(3) In the case in which a State's payment for medicare cost-sharing for a qualified medicare beneficiary with respect to an item or service is reduced or eliminated through the application of paragraph (2)—

(A) for purposes of applying any limitation under title XVIII on the amount that the beneficiary may be billed or charged for the service, the amount of payment made under title XVIII plus the amount of payment (if any) under the State plan shall be considered to be payment in full for the service;

(B) the beneficiary shall not have any legal liability to make payment to a provider or to an organization described in section 1903(m)(1)(A) for the service; and

(C) any lawful sanction that may be imposed upon a provider or such an organization for excess charges under this title or title XVIII shall apply to the imposition of any charge imposed upon the individual in such case.

This paragraph shall not be construed as preventing payment of any medicare cost-sharing by a medicare supplemental policy or an employer retiree health plan on behalf of an individual.

(o) Notwithstanding any provision of subsection (a) to the contrary, a State plan under this title shall provide that any supplemental security income benefits paid by reason of subparagraph (E) or (G) of section 1611(e)(1) to an individual who—

(1) is eligible for medical assistance under the plan, and
 (2) is in a hospital, skilled nursing facility, or intermediate care facility at the time such benefits are paid,
 will be disregarded for purposes of determining the amount of any post-eligibility contribution by the individual to the cost of the care and services provided by the hospital, skilled nursing facility, or intermediate care facility.

(p)(1) In addition to any other authority, a State may exclude any individual or entity for purposes of participating under the State plan under this title for any reason for which the Secretary could exclude the individual or entity from participation in a program under title XVIII under section 1128, 1128A, or 1866(b)(2).

(2) In order for a State to receive payments for medical assistance under section 1903(a), with respect to payments the State makes to a medicaid managed care organization (as defined in section 1903(m)) or to an entity furnishing services under a waiver approved under section 1915(b)(1), the State must provide that it will exclude from participation, as such an organization or entity, any organization or entity that—

(A) could be excluded under section 1128(b)(8) (relating to owners and managing employees who have been convicted of certain crimes or received other sanctions),

(B) has, directly or indirectly, a substantial contractual relationship (as defined by the Secretary) with an individual or entity that is described in section 1128(b)(8)(B), or

(C) employs or contracts with any individual or entity that is excluded from participation under this title under section 1128 or 1128A for the provision of health care, utilization review, medical social work, or administrative services or employs or contracts with any entity for the provision (directly or indirectly) through such an excluded individual or entity of such services.

(3) As used in this subsection, the term “exclude” includes the refusal to enter into or renew a participation agreement or the termination of such an agreement.

(q)(1)(A) In order to meet the requirement of subsection (a)(50), the State plan must provide that, in the case of an institutionalized individual or couple described in subparagraph (B), in determining the amount of the individual’s or couple’s income to be applied monthly to payment for the cost of care in an institution, there shall be deducted from the monthly income (in addition to other allowances otherwise provided under the State plan) a monthly personal needs allowance—

(i) which is reasonable in amount for clothing and other personal needs of the individual (or couple) while in an institution, and

(ii) which is not less (and may be greater) than the minimum monthly personal needs allowance described in paragraph (2).

(B) In this subsection, the term “institutionalized individual or couple” means an individual or married couple—

(i) who is an inpatient (or who are inpatients) in a medical institution or nursing facility for which payments are made under this title throughout a month, and

(ii) who is or are determined to be eligible for medical assistance under the State plan.

(2) The minimum monthly personal needs allowance described in this paragraph is \$30 for an institutionalized individual and \$60 for an institutionalized couple (if both are aged, blind, or disabled, and their incomes are considered available to each other in determining eligibility).

(r)(1)(A) For purposes of sections 1902(a)(17) and 1924(d)(1)(D) and for purposes of a waiver under section 1915, with respect to the post-eligibility treatment of income of individuals who are institutionalized or receiving home or community-based services under such a waiver, the treatment described in subparagraph (B) shall apply, there shall be disregarded reparation payments made by the Federal Republic of Germany, and there shall be taken into account amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party, including—

(i) medicare and other health insurance premiums, deductibles, or coinsurance, and

(ii) necessary medical or remedial care recognized under State law but not covered under the State plan under this title, subject to reasonable limits the State may establish on the amount of these expenses.

(B)(i) In the case of a veteran who does not have a spouse or a child, if the veteran—

(I) receives, after the veteran has been determined to be eligible for medical assistance under the State plan under this title, a veteran's pension in excess of \$90 per month, and

(II) resides in a State veterans home with respect to which the Secretary of Veterans Affairs makes per diem payments for nursing home care pursuant to section 1741(a) of title 38, United States Code,

any such pension payment, including any payment made due to the need for aid and attendance, or for unreimbursed medical expenses, that is in excess of \$90 per month shall be counted as income only for the purpose of applying such excess payment to the State veterans home's cost of providing nursing home care to the veteran.

(ii) The provisions of clause (i) shall apply with respect to a surviving spouse of a veteran who does not have a child in the same manner as they apply to a veteran described in such clause.

(2)(A) The methodology to be employed in determining income and resource eligibility for individuals under subsection (a)(10)(A)(i)(III), (a)(10)(A)(i)(IV), (a)(10)(A)(i)(VI), (a)(10)(A)(i)(VII), (a)(10)(A)(ii), (a)(10)(C)(i)(III), or (f) or under section 1905(p) may be less restrictive, and shall be no more restrictive, than the methodology—

(i) in the case of groups consisting of aged, blind, or disabled individuals, under the supplemental security income program under title XVI, or

(ii) in the case of other groups, under the State plan most closely categorically related.

(B) For purposes of this subsection and subsection (a)(10), methodology is considered to be "no more restrictive" if, using the methodology, additional individuals may be eligible for medical assistance and no individuals who are otherwise eligible are made ineligible for such assistance.

(s) In order to meet the requirements of subsection (a)(55), the State plan must provide that payments to hospitals under the plan

for inpatient hospital services furnished to infants who have not attained the age of 1 year, and to children who have not attained the age of 6 years and who receive such services in a disproportionate share hospital described in section 1923(b)(1), shall—

(1) if made on a prospective basis (whether per diem, per case, or otherwise) provide for an outlier adjustment in payment amounts for medically necessary inpatient hospital services involving exceptionally high costs or exceptionally long lengths of stay,

(2) not be limited by the imposition of day limits with respect to the delivery of such services to such individuals, and

(3) not be limited by the imposition of dollar limits (other than such limits resulting from prospective payments as adjusted pursuant to paragraph (1)) with respect to the delivery of such services to any such individual who has not attained their first birthday (or in the case of such an individual who is an inpatient on his first birthday until such individual is discharged).

(t) Nothing in this title (including sections 1903(a) and 1905(a)) shall be construed as authorizing the Secretary to deny or limit payments to a State for expenditures, for medical assistance for items or services, attributable to taxes of general applicability imposed with respect to the provision of such items or services.

(u)(1) Individuals described in this paragraph are individuals—

(A) who are entitled to elect COBRA continuation coverage (as defined in paragraph (3)),

(B) whose income (as determined under section 1612 for purposes of the supplemental security income program) does not exceed 100 percent of the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved,

(C) whose resources (as determined under section 1613 for purposes of the supplemental security income program) do not exceed twice the maximum amount of resources that an individual may have and obtain benefits under that program, and

(D) with respect to whose enrollment for COBRA continuation coverage the State has determined that the savings in expenditures under this title resulting from such enrollment is likely to exceed the amount of payments for COBRA premiums made.

(2) For purposes of subsection (a)(10)(F) and this subsection, the term “COBRA premiums” means the applicable premium imposed with respect to COBRA continuation coverage.

(3) In this subsection, the term “COBRA continuation coverage” means coverage under a group health plan provided by an employer with 75 or more employees provided pursuant to title XXII of the Public Health Service Act, section 4980B of the Internal Revenue Code of 1986, or title VI of the Employee Retirement Income Security Act of 1974.

(4) Notwithstanding subsection (a)(17), for individuals described in paragraph (1) who are covered under the State plan by virtue of subsection (a)(10)(A)(ii)(XI)—

(A) the income standard to be applied is the income standard described in paragraph (1)(B), and

(B) except as provided in section 1612(b)(4)(B)(ii), costs incurred for medical care or for any other type of remedial care shall not be taken into account in determining income.

Any different treatment provided under this paragraph for such individuals shall not, because of subsection (a)(10)(B) or (a)(17), require or permit such treatment for other individuals.

(v) A State plan may provide for the making of determinations of disability or blindness for the purpose of determining eligibility for medical assistance under the State plan by the single State agency or its designee, and make medical assistance available to individuals whom it finds to be blind or disabled and who are determined otherwise eligible for such assistance during the period of time prior to which a final determination of disability or blindness is made by the Social Security Administration with respect to such an individual. In making such determinations, the State must apply the definitions of disability and blindness found in section 1614(a) of the Social Security Act.

(w)(1) For purposes of subsection (a)(57) and sections 1903(m)(1)(A) and 1919(c)(2)(E), the requirement of this subsection is that a provider or organization (as the case may be) maintain written policies and procedures with respect to all adult individuals receiving medical care by or through the provider or organization—

(A) to provide written information to each such individual concerning—

(i) an individual's rights under State law (whether statutory or as recognized by the courts of the State) to make decisions concerning such medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives (as defined in paragraph (3)), and

(ii) the provider's or organization's written policies respecting the implementation of such rights;

(B) to document in the individual's medical record whether or not the individual has executed an advance directive;

(C) not to condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;

(D) to ensure compliance with requirements of State law (whether statutory or as recognized by the courts of the State) respecting advance directives; and

(E) to provide (individually or with others) for education for staff and the community on issues concerning advance directives.

Subparagraph (C) shall not be construed as requiring the provision of care which conflicts with an advance directive.

(2) The written information described in paragraph (1)(A) shall be provided to an adult individual—

(A) in the case of a hospital, at the time of the individual's admission as an inpatient,

(B) in the case of a nursing facility, at the time of the individual's admission as a resident,

(C) in the case of a provider of home health care or personal care services, in advance of the individual coming under the care of the provider,

(D) in the case of a hospice program, at the time of initial receipt of hospice care by the individual from the program, and

(E) in the case of a medicaid managed care organization, at the time of enrollment of the individual with the organization.

(3) Nothing in this section shall be construed to prohibit the application of a State law which allows for an objection on the basis of conscience for any health care provider or any agent of such provider which as a matter of conscience cannot implement an advance directive.

(4) In this subsection, the term “advance directive” means a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State) and relating to the provision of such care when the individual is incapacitated.

(5) For construction relating to this subsection, see section 7 of the Assisted Suicide Funding Restriction Act of 1997 (relating to clarification respecting assisted suicide, euthanasia, and mercy killing).

(x) The Secretary shall establish a system, for implementation by not later than July 1, 1991, which provides for a unique identifier for each physician who furnishes services for which payment may be made under a State plan approved under this title.

(y)(1) In addition to any other authority under State law, where a State determines that a psychiatric hospital which is certified for participation under its plan no longer meets the requirements for a psychiatric hospital (referred to in section 1905(h)) and further finds that the hospital’s deficiencies—

(A) immediately jeopardize the health and safety of its patients, the State shall terminate the hospital’s participation under the State plan; or

(B) do not immediately jeopardize the health and safety of its patients, the State may terminate the hospital’s participation under the State plan, or provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the effective date of the finding, or both.

(2) Except as provided in paragraph (3), if a psychiatric hospital described in paragraph (1)(B) has not complied with the requirements for a psychiatric hospital under this title—

(A) within 3 months after the date the hospital is found to be out of compliance with such requirements, the State shall provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the end of such 3-month period, or

(B) within 6 months after the date the hospital is found to be out of compliance with such requirements, no Federal financial participation shall be provided under section 1903(a) with respect to further services provided in the hospital until the State finds that the hospital is in compliance with the requirements of this title.

(3) The Secretary may continue payments, over a period of not longer than 6 months from the date the hospital is found to be out of compliance with such requirements, if—

(A) the State finds that it is more appropriate to take alternative action to assure compliance of the hospital with the requirements than to terminate the certification of the hospital,

(B) the State has submitted a plan and timetable for corrective action to the Secretary for approval and the Secretary approves the plan of corrective action, and

(C) the State agrees to repay to the Federal Government payments received under this paragraph if the corrective action is not taken in accordance with the approved plan and timetable.

(z)(1) Individuals described in this paragraph are individuals not described in subsection (a)(10)(A)(i)—

(A) who are infected with tuberculosis;

(B) whose income (as determined under the State plan under this title with respect to disabled individuals) does not exceed the maximum amount of income a disabled individual described in subsection (a)(10)(A)(i) may have and obtain medical assistance under the plan; and

(C) whose resources (as determined under the State plan under this title with respect to disabled individuals) do not exceed the maximum amount of resources a disabled individual described in subsection (a)(10)(A)(i) may have and obtain medical assistance under the plan.

(2) For purposes of subsection (a)(10), the term “TB-related services” means each of the following services relating to treatment of infection with tuberculosis:

(A) Prescribed drugs.

(B) Physicians’ services and services described in section 1905(a)(2).

(C) Laboratory and X-ray services (including services to confirm the presence of infection).

(D) Clinic services and Federally-qualified health center services.

(E) Case management services (as defined in section 1915(g)(2)).

(F) Services (other than room and board) designed to encourage completion of regimens of prescribed drugs by outpatients, including services to observe directly the intake of prescribed drugs.

(aa) Individuals described in this subsection are individuals who—

(1) are not described in subsection (a)(10)(A)(i);

(2) have not attained age 65;

(3) have been screened for breast and cervical cancer under the Centers for Disease Control and Prevention breast and cervical cancer early detection program established under title XV of the Public Health Service Act (42 U.S.C. 300k et seq.) in accordance with the requirements of section 1504 of that Act (42 U.S.C. 300n) and need treatment for breast or cervical cancer; and

(4) are not otherwise covered under creditable coverage, as defined in section 2701(c) of the Public Health Service Act (42 U.S.C. 300gg(c)), but applied without regard to paragraph (1)(F) of such section.

(bb) PAYMENT FOR SERVICES PROVIDED BY FEDERALLY-QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS.—

(1) IN GENERAL.—Beginning with fiscal year 2001 with respect to services furnished on or after January 1, 2001, and each succeeding fiscal year, the State plan shall provide for payment for services described in section 1905(a)(2)(C) furnished by a Federally-qualified health center and services described in section 1905(a)(2)(B) furnished by a rural health clinic in accordance with the provisions of this subsection.

(2) FISCAL YEAR 2001.—Subject to paragraph (4), for services furnished on and after January 1, 2001, during fiscal year 2001, the State plan shall provide for payment for such services in an amount (calculated on a per visit basis) that is equal to 100 percent of the average of the costs of the center or clinic of furnishing such services during fiscal years 1999 and 2000 which are reasonable and related to the cost of furnishing such services, or based on such other tests of reasonableness as the Secretary prescribes in regulations under section 1833(a)(3), or, in the case of services to which such regulations do not apply, the same methodology used under section 1833(a)(3), adjusted to take into account any increase or decrease in the scope of such services furnished by the center or clinic during fiscal year 2001.

(3) FISCAL YEAR 2002 AND SUCCEEDING FISCAL YEARS.—Subject to paragraph (4), for services furnished during fiscal year 2002 or a succeeding fiscal year, the State plan shall provide for payment for such services in an amount (calculated on a per visit basis) that is equal to the amount calculated for such services under this subsection for the preceding fiscal year—

(A) increased by the percentage increase in the MEI (as defined in section 1842(i)(3)) applicable to primary care services (as defined in section 1842(i)(4)) for that fiscal year; and

(B) adjusted to take into account any increase or decrease in the scope of such services furnished by the center or clinic during that fiscal year.

(4) ESTABLISHMENT OF INITIAL YEAR PAYMENT AMOUNT FOR NEW CENTERS OR CLINICS.—In any case in which an entity first qualifies as a Federally-qualified health center or rural health clinic after fiscal year 2000, the State plan shall provide for payment for services described in section 1905(a)(2)(C) furnished by the center or services described in section 1905(a)(2)(B) furnished by the clinic in the first fiscal year in which the center or clinic so qualifies in an amount (calculated on a per visit basis) that is equal to 100 percent of the costs of furnishing such services during such fiscal year based on the rates established under this subsection for the fiscal year for other such centers or clinics located in the same or adjacent area with a similar case load or, in the absence of such a center or clinic, in accordance with the regulations and methodology referred to in paragraph (2) or based on such other tests of reasonableness as the Secretary may specify. For each fiscal year following the fiscal year in which the entity first qualifies as a Federally-qualified health center or rural health clinic, the

State plan shall provide for the payment amount to be calculated in accordance with paragraph (3).

(5) ADMINISTRATION IN THE CASE OF MANAGED CARE.—

(A) IN GENERAL.—In the case of services furnished by a Federally-qualified health center or rural health clinic pursuant to a contract between the center or clinic and a managed care entity (as defined in section 1932(a)(1)(B)), the State plan shall provide for payment to the center or clinic by the State of a supplemental payment equal to the amount (if any) by which the amount determined under paragraphs (2), (3), and (4) of this subsection exceeds the amount of the payments provided under the contract.

(B) PAYMENT SCHEDULE.—The supplemental payment required under subparagraph (A) shall be made pursuant to a payment schedule agreed to by the State and the Federally-qualified health center or rural health clinic, but in no case less frequently than every 4 months.

(6) ALTERNATIVE PAYMENT METHODOLOGIES.—Notwithstanding any other provision of this section, the State plan may provide for payment in any fiscal year to a Federally-qualified health center for services described in section 1905(a)(2)(C) or to a rural health clinic for services described in section 1905(a)(2)(B) in an amount which is determined under an alternative payment methodology that—

(A) is agreed to by the State and the center or clinic; and

(B) results in payment to the center or clinic of an amount which is at least equal to the amount otherwise required to be paid to the center or clinic under this section.

(cc)(1) Individuals described in this paragraph are individuals—

(A) who are children who have not attained 19 years of age and are born—

(i) on or after January 1, 2001 (or, at the option of a State, on or after an earlier date), in the case of the second, third, and fourth quarters of fiscal year 2007;

(ii) on or after October 1, 1995 (or, at the option of a State, on or after an earlier date), in the case of each quarter of fiscal year 2008; and

(iii) after October 1, 1989, in the case of each quarter of fiscal year 2009 and each quarter of any fiscal year thereafter;

(B) who would be considered disabled under section 1614(a)(3)(C) (as determined under title XVI for children but without regard to any income or asset eligibility requirements that apply under such title with respect to children); and

(C) whose family income does not exceed such income level as the State establishes and does not exceed—

(i) 300 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved; or

(ii) such higher percent of such poverty line as a State may establish, except that—

(I) any medical assistance provided to an individual whose family income exceeds 300 percent of such poverty line may only be provided with State funds; and

(II) no Federal financial participation shall be provided under section 1903(a) for any medical assistance provided to such an individual.

(2)(A) If an employer of a parent of an individual described in paragraph (1) offers family coverage under a group health plan (as defined in section 2791(a) of the Public Health Service Act), the State shall—

(i) notwithstanding section 1906, require such parent to apply for, enroll in, and pay premiums for such coverage as a condition of such parent's child being or remaining eligible for medical assistance under subsection (a)(10)(A)(ii)(XIX) if the parent is determined eligible for such coverage and the employer contributes at least 50 percent of the total cost of annual premiums for such coverage; and

(ii) if such coverage is obtained—

(I) subject to paragraph (2) of section 1916(h), reduce the premium imposed by the State under that section in an amount that reasonably reflects the premium contribution made by the parent for private coverage on behalf of a child with a disability; and

(II) treat such coverage as a third party liability under subsection (a)(25).

(B) In the case of a parent to which subparagraph (A) applies, a State, notwithstanding section 1906 but subject to paragraph (1)(C)(ii), may provide for payment of any portion of the annual premium for such family coverage that the parent is required to pay. Any payments made by the State under this subparagraph shall be considered, for purposes of section 1903(a), to be payments for medical assistance.

(dd) ELECTRONIC TRANSMISSION OF INFORMATION.—If the State agency determining eligibility for medical assistance under this title or child health assistance under title XXI verifies an element of eligibility based on information from an Express Lane Agency (as defined in subsection (e)(13)(F)), or from another public agency, then the applicant's signature under penalty of perjury shall not be required as to such element. Any signature requirement for an application for medical assistance may be satisfied through an electronic signature, as defined in section 1710(1) of the Government Paperwork Elimination Act (44 U.S.C. 3504 note). The requirements of subparagraphs (A) and (B) of section 1137(d)(2) may be met through evidence in digital or electronic form.

(ee)(1) For purposes of subsection (a)(46)(B)(ii), the requirements of this subsection with respect to an individual declaring to be a citizen or national of the United States for purposes of establishing eligibility under this title, are, in lieu of requiring the individual to present satisfactory documentary evidence of citizenship or nationality under section 1903(x) (if the individual is not described in paragraph (2) of that section), as follows:

(A) The State submits the name and social security number of the individual to the Commissioner of Social Security as part of the program established under paragraph (2).

(B) If the State receives notice from the Commissioner of Social Security that the name or social security number, or the declaration of citizenship or nationality, of the individual is in-

consistent with information in the records maintained by the Commissioner—

(i) the State makes a reasonable effort to identify and address the causes of such inconsistency, including through typographical or other clerical errors, by contacting the individual to confirm the accuracy of the name or social security number submitted or declaration of citizenship or nationality and by taking such additional actions as the Secretary, through regulation or other guidance, or the State may identify, and continues to provide the individual with medical assistance while making such effort; and

(ii) in the case such inconsistency is not resolved under clause (i), the State—

(I) notifies the individual of such fact;

(II) provides the individual with a period of 90 days from the date on which the notice required under subclause (I) is received by the individual to either present satisfactory documentary evidence of citizenship or nationality (as defined in section 1903(x)(3)) or resolve the inconsistency with the Commissioner of Social Security (and continues to provide the individual with medical assistance during such 90-day period); and

(III) disenrolls the individual from the State plan under this title within 30 days after the end of such 90-day period if no such documentary evidence is presented or if such inconsistency is not resolved.

(2)(A) Each State electing to satisfy the requirements of this subsection for purposes of section 1902(a)(46)(B) shall establish a program under which the State submits at least monthly to the Commissioner of Social Security for comparison of the name and social security number, of each individual newly enrolled in the State plan under this title that month who is not described in section 1903(x)(2) and who declares to be a United States citizen or national, with information in records maintained by the Commissioner.

(B) In establishing the State program under this paragraph, the State may enter into an agreement with the Commissioner of Social Security—

(i) to provide, through an on-line system or otherwise, for the electronic submission of, and response to, the information submitted under subparagraph (A) for an individual enrolled in the State plan under this title who declares to be citizen or national on at least a monthly basis; or

(ii) to provide for a determination of the consistency of the information submitted with the information maintained in the records of the Commissioner through such other method as agreed to by the State and the Commissioner and approved by the Secretary, provided that such method is no more burdensome for individuals to comply with than any burdens that may apply under a method described in clause (i).

(C) The program established under this paragraph shall provide that, in the case of any individual who is required to submit a social security number to the State under subparagraph (A) and who

is unable to provide the State with such number, shall be provided with at least the reasonable opportunity to present satisfactory documentary evidence of citizenship or nationality (as defined in section 1903(x)(3)) as is provided under clauses (i) and (ii) of section 1137(d)(4)(A) to an individual for the submittal to the State of evidence indicating a satisfactory immigration status.

(3)(A) The State agency implementing the plan approved under this title shall, at such times and in such form as the Secretary may specify, provide information on the percentage each month that the inconsistent submissions bears to the total submissions made for comparison for such month. For purposes of this subparagraph, a name, social security number, or declaration of citizenship or nationality of an individual shall be treated as inconsistent and included in the determination of such percentage only if—

(i) the information submitted by the individual is not consistent with information in records maintained by the Commissioner of Social Security;

(ii) the inconsistency is not resolved by the State;

(iii) the individual was provided with a reasonable period of time to resolve the inconsistency with the Commissioner of Social Security or provide satisfactory documentation of citizenship status and did not successfully resolve such inconsistency; and

(iv) payment has been made for an item or service furnished to the individual under this title.

(B) If, for any fiscal year, the average monthly percentage determined under subparagraph (A) is greater than 3 percent—

(i) the State shall develop and adopt a corrective plan to review its procedures for verifying the identities of individuals seeking to enroll in the State plan under this title and to identify and implement changes in such procedures to improve their accuracy; and

(ii) pay to the Secretary an amount equal to the amount which bears the same ratio to the total payments under the State plan for the fiscal year for providing medical assistance to individuals who provided inconsistent information as the number of individuals with inconsistent information in excess of 3 percent of such total submitted bears to the total number of individuals with inconsistent information.

(C) The Secretary may waive, in certain limited cases, all or part of the payment under subparagraph (B)(ii) if the State is unable to reach the allowable error rate despite a good faith effort by such State.

(D) Subparagraphs (A) and (B) shall not apply to a State for a fiscal year if there is an agreement described in paragraph (2)(B) in effect as of the close of the fiscal year that provides for the submission on a real-time basis of the information described in such paragraph.

(4) Nothing in this subsection shall affect the rights of any individual under this title to appeal any disenrollment from a State plan.

(ff) Notwithstanding any other requirement of this title or any other provision of Federal or State law, a State shall disregard the following property from resources for purposes of determining the

eligibility of an individual who is an Indian for medical assistance under this title:

(1) Property, including real property and improvements, that is held in trust, subject to Federal restrictions, or otherwise under the supervision of the Secretary of the Interior, located on a reservation, including any federally recognized Indian Tribe's reservation, pueblo, or colony, including former reservations in Oklahoma, Alaska Native regions established by the Alaska Native Claims Settlement Act, and Indian allotments on or near a reservation as designated and approved by the Bureau of Indian Affairs of the Department of the Interior.

(2) For any federally recognized Tribe not described in paragraph (1), property located within the most recent boundaries of a prior Federal reservation.

(3) Ownership interests in rents, leases, royalties, or usage rights related to natural resources (including extraction of natural resources or harvesting of timber, other plants and plant products, animals, fish, and shellfish) resulting from the exercise of federally protected rights.

(4) Ownership interests in or usage rights to items not covered by paragraphs (1) through (3) that have unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or a traditional lifestyle according to applicable tribal law or custom.

(gg) MAINTENANCE OF EFFORT.—

(1) GENERAL REQUIREMENT TO MAINTAIN ELIGIBILITY STANDARDS UNTIL STATE EXCHANGE IS FULLY OPERATIONAL.—Subject to the succeeding paragraphs of this subsection, during the period that begins on the date of enactment of the Patient Protection and Affordable Care Act and ends on the date on which the Secretary determines that an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act is fully operational, as a condition for receiving any Federal payments under section 1903(a) for calendar quarters occurring during such period, a State shall not have in effect eligibility standards, methodologies, or procedures under the State plan under this title or under any waiver of such plan that is in effect during that period, that are more restrictive than the eligibility standards, methodologies, or procedures, respectively, under the plan or waiver that are in effect on the date of enactment of the Patient Protection and Affordable Care Act.

(2) CONTINUATION OF ELIGIBILITY STANDARDS FOR CHILDREN UNTIL OCTOBER 1, 2019.—The requirement under paragraph (1) shall continue to apply to a State through September 30, 2019, with respect to the eligibility standards, methodologies, and procedures under the State plan under this title or under any waiver of such plan that are applicable to determining the eligibility for medical assistance of any child who is under 19 years of age (or such higher age as the State may have elected).

(3) NONAPPLICATION.—During the period that begins on January 1, 2011, and ends on December 31, 2013, the requirement under paragraph (1) shall not apply to a State with respect to nonpregnant, nondisabled adults who are eligible for medical

assistance under the State plan or under a waiver of the plan at the option of the State and whose income exceeds 133 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved if, on or after December 31, 2010, the State certifies to the Secretary that, with respect to the State fiscal year during which the certification is made, the State has a budget deficit, or with respect to the succeeding State fiscal year, the State is projected to have a budget deficit. Upon submission of such a certification to the Secretary, the requirement under paragraph (1) shall not apply to the State with respect to any remaining portion of the period described in the preceding sentence.

(4) DETERMINATION OF COMPLIANCE.—

(A) STATES SHALL APPLY MODIFIED ADJUSTED GROSS INCOME.—A State's determination of income in accordance with subsection (e)(14) shall not be considered to be eligibility standards, methodologies, or procedures that are more restrictive than the standards, methodologies, or procedures in effect under the State plan or under a waiver of the plan on the date of enactment of the Patient Protection and Affordable Care Act for purposes of determining compliance with the requirements of paragraph (1), (2), or (3).

(B) STATES MAY EXPAND ELIGIBILITY OR MOVE WAIVERED POPULATIONS INTO COVERAGE UNDER THE STATE PLAN.—With respect to any period applicable under paragraph (1), (2), or (3), a State that applies eligibility standards, methodologies, or procedures under the State plan under this title or under any waiver of the plan that are less restrictive than the eligibility standards, methodologies, or procedures, applied under the State plan or under a waiver of the plan on the date of enactment of the Patient Protection and Affordable Care Act, or that makes individuals who, on such date of enactment, are eligible for medical assistance under a waiver of the State plan, after such date of enactment eligible for medical assistance through a State plan amendment with an income eligibility level that is not less than the income eligibility level that applied under the waiver, or as a result of the application of subclause (VIII) of section 1902(a)(10)(A)(i), shall not be considered to have in effect eligibility standards, methodologies, or procedures that are more restrictive than the standards, methodologies, or procedures in effect under the State plan or under a waiver of the plan on the date of enactment of the Patient Protection and Affordable Care Act for purposes of determining compliance with the requirements of paragraph (1), (2), or (3).

(hh)(1) A State may elect to phase-in the extension of eligibility for medical assistance to individuals described in subclause (XX) of subsection (a)(10)(A)(ii) based on the categorical group (including nonpregnant childless adults) or income, so long as the State does not extend such eligibility to individuals described in such subclause with higher income before making individuals described in such subclause with lower income eligible for medical assistance.

(2) If an individual described in subclause (XX) of subsection (a)(10)(A)(ii) is the parent of a child who is under 19 years of age (or such higher age as the State may have elected) who is eligible for medical assistance under the State plan or under a waiver of such plan, the individual may not be enrolled under the State plan unless the individual's child is enrolled under the State plan or under a waiver of the plan or is enrolled in other health insurance coverage. For purposes of the preceding sentence, the term "parent" includes an individual treated as a caretaker relative for purposes of carrying out section 1931.

- (ii)(1) Individuals described in this subsection are individuals—
- (A) whose income does not exceed an income eligibility level established by the State that does not exceed the highest income eligibility level established under the State plan under this title (or under its State child health plan under title XXI) for pregnant women; and
 - (B) who are not pregnant.

(2) At the option of a State, individuals described in this subsection may include individuals who, had individuals applied on or before January 1, 2007, would have been made eligible pursuant to the standards and processes imposed by that State for benefits described in clause (XVI) of the matter following subparagraph (G) of section subsection (a)(10) pursuant to a waiver granted under section 1115.

(3) At the option of a State, for purposes of subsection (a)(17)(B), in determining eligibility for services under this subsection, the State may consider only the income of the applicant or recipient.

(jj) PRIMARY CARE SERVICES DEFINED.—For purposes of subsection (a)(13)(C), the term "primary care services" means—

(1) evaluation and management services that are procedure codes (for services covered under title XVIII) for services in the category designated Evaluation and Management in the Healthcare Common Procedure Coding System (established by the Secretary under section 1848(c)(5) as of December 31, 2009, and as subsequently modified); and

(2) services related to immunization administration for vaccines and toxoids for which CPT codes 90465, 90466, 90467, 90468, 90471, 90472, 90473, or 90474 (as subsequently modified) apply under such System.

(kk) PROVIDER AND SUPPLIER SCREENING, OVERSIGHT, AND REPORTING REQUIREMENTS.—For purposes of subsection (a)(77), the requirements of this subsection are the following:

(1) SCREENING.—The State complies with the process for screening providers and suppliers under this title, as established by the Secretary under section 1886(j)(2).

(2) PROVISIONAL PERIOD OF ENHANCED OVERSIGHT FOR NEW PROVIDERS AND SUPPLIERS.—The State complies with procedures to provide for a provisional period of enhanced oversight for new providers and suppliers under this title, as established by the Secretary under section 1886(j)(3).

(3) DISCLOSURE REQUIREMENTS.—The State requires providers and suppliers under the State plan or under a waiver of the plan to comply with the disclosure requirements established by the Secretary under section 1886(j)(4).

(4) TEMPORARY MORATORIUM ON ENROLLMENT OF NEW PROVIDERS OR SUPPLIERS.—

(A) TEMPORARY MORATORIUM IMPOSED BY THE SECRETARY.—

(i) IN GENERAL.—Subject to clause (ii), the State complies with any temporary moratorium on the enrollment of new providers or suppliers imposed by the Secretary under section 1886(j)(6).

(ii) EXCEPTION.—A State shall not be required to comply with a temporary moratorium described in clause (i) if the State determines that the imposition of such temporary moratorium would adversely impact beneficiaries' access to medical assistance.

(B) MORATORIUM ON ENROLLMENT OF PROVIDERS AND SUPPLIERS.—At the option of the State, the State imposes, for purposes of entering into participation agreements with providers or suppliers under the State plan or under a waiver of the plan, periods of enrollment moratoria, or numerical caps or other limits, for providers or suppliers identified by the Secretary as being at high-risk for fraud, waste, or abuse as necessary to combat fraud, waste, or abuse, but only if the State determines that the imposition of any such period, cap, or other limits would not adversely impact beneficiaries' access to medical assistance.

(5) COMPLIANCE PROGRAMS.—The State requires providers and suppliers under the State plan or under a waiver of the plan to establish, in accordance with the requirements of section 1866(j)(7), a compliance program that contains the core elements established under subparagraph (B) of that section 1866(j)(7) for providers or suppliers within a particular industry or category.

(6) REPORTING OF ADVERSE PROVIDER ACTIONS.—The State complies with the national system for reporting criminal and civil convictions, sanctions, negative licensure actions, and other adverse provider actions to the Secretary, through the Administrator of the Centers for Medicare & Medicaid Services, in accordance with regulations of the Secretary.

(7) ENROLLMENT AND NPI OF ORDERING OR REFERRING PROVIDERS.—The State requires—

(A) all ordering or referring physicians or other professionals to be enrolled under the State plan or under a waiver of the plan as a participating provider; and

(B) the national provider identifier of any ordering or referring physician or other professional to be specified on any claim for payment that is based on an order or referral of the physician or other professional.

(8) PROVIDER TERMINATIONS.—

(A) IN GENERAL.—Beginning on January 1, 2017, in the case of a notification under subsection (a)(41) with respect to a termination for a reason specified in section 455.101 of title 42, Code of Federal Regulations (as in effect on November 1, 2015) or for any other reason specified by the Secretary, of the participation of a provider of services or any other person under the State plan, the State, not later than 21 business days after the effective date of such termi-

nation, submits to the Secretary with respect to any such provider or person, as appropriate—

- (i) the name of such provider or person;
- (ii) the provider type of such provider or person;
- (iii) the specialty of such provider's or person's practice;
- (iv) the date of birth, Social Security number, national provider identifier, Federal taxpayer identification number, and the State license or certification number of such provider or person;
- (v) the reason for the termination;
- (vi) a copy of the notice of termination sent to the provider or person;
- (vii) the effective date of such termination specified in such notice; and
- (viii) any other information required by the Secretary.

(B) *EFFECTIVE DATE DEFINED.*—For purposes of this paragraph, the term “effective date” means, with respect to a termination described in subparagraph (A), the later of—

- (i) the date on which such termination is effective, as specified in the notice of such termination; or
- (ii) the date on which all appeal rights applicable to such termination have been exhausted or the timeline for any such appeal has expired.

[(8)] (9) *OTHER STATE OVERSIGHT.*—Nothing in this subsection shall be interpreted to preclude or limit the ability of a State to engage in provider and supplier screening or enhanced provider and supplier oversight activities beyond those required by the Secretary.

(ll) *TERMINATION NOTIFICATION DATABASE.*—In the case of a provider of services or any other person whose participation under this title, title XVIII, or title XXI is terminated (as described in subsection (kk)(8)), the Secretary shall, not later than 21 business days after the date on which the Secretary terminates such participation under title XVIII or is notified of such termination under subsection (a)(41) (as applicable), review such termination and, if the Secretary determines appropriate, include such termination in any database or similar system developed pursuant to section 6401(b)(2) of the Patient Protection and Affordable Care Act (42 U.S.C. 1395cc note; Public Law 111–148).

PAYMENT TO STATES

SEC. 1903. (a) From the sums appropriated therefor, the Secretary (except as otherwise provided in this section) shall pay to each State which has a plan approved under this title, for each quarter, beginning with the quarter commencing January 1, 1966—

(1) an amount equal to the Federal medical assistance percentage (as defined in section 1905(b), subject to subsections (g) and (j) of this section and subsection 1923(f)) of the total amount expended during such quarter as medical assistance under the State plan; plus

(2)(A) an amount equal to 75 per centum of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the

State plan) as are attributable to compensation or training of skilled professional medical personnel, and staff directly supporting such personnel, of the State agency or any other public agency; plus

(B) notwithstanding paragraph (1) or subparagraph (A), with respect to amounts expended for nursing aide training and competency evaluation programs, and competency evaluation programs, described in section 1919(e)(1) (including the costs for nurse aides to complete such competency evaluation programs), regardless of whether the programs are provided in or outside nursing facilities or of the skill of the personnel involved in such programs, an amount equal to 50 percent (or, for calendar quarters beginning on or after July 1, 1988, and before October 1, 1990, the lesser of 90 percent or the Federal medical assistance percentage plus 25 percentage points) of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to such programs; plus

(C) an amount equal to 75 percent of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to preadmission screening and resident review activities conducted by the State under section 1919(e)(7); plus

(D) for each calendar quarter during—

- (i) fiscal year 1991, an amount equal to 90 percent,
- (ii) fiscal year 1992, an amount equal to 85 percent,
- (iii) fiscal year 1993, an amount equal to 80 percent, and
- (iv) fiscal year 1994 and thereafter, an amount equal to 75 percent,

of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to State activities under section 1919(g); plus

(E) an amount equal to 75 percent of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to translation or interpretation services in connection with the enrollment of, retention of, and use of services under this title by, children of families for whom English is not the primary language; plus

(3) an amount equal to—

- (A)(i) 90 per centum of so much of the sums expended during such quarter as are attributable to the design, development, or installation of such mechanized claims processing and information retrieval systems as the Secretary determines are likely to provide more efficient, economical, and effective administration of the plan and to be compatible with the claims processing and information retrieval systems utilized in the administration of title XVIII, including the State's share of the cost of installing such a system to be used jointly in the administration of such State's plan and the plan of any other State approved under this title,

(ii) 90 per centum of so much of the sums expended during any such quarter in the fiscal year ending June 30, 1972, or the fiscal year ending June 30, 1973, as are attributable to the design, development, or installation of cost determination systems for State-owned general hospitals (except that the total amount paid to all States under this clause for either such fiscal year shall not exceed \$150,000), and

(iii) an amount equal to the Federal medical assistance percentage (as defined in section 1905(b)) of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to such developments or modifications of systems of the type described in clause (i) as are necessary for the efficient collection and reporting on child health measures; and

(B) 75 per centum of so much of the sums expended during such quarter as are attributable to the operation of systems (whether such systems are operated directly by the State or by another person under a contract with the State) of the type described in subparagraph (A)(i) (whether or not designed, developed, or installed with assistance under such subparagraph) which are approved by the Secretary and which include provision for prompt written notice to each individual who is furnished services covered by the plan, or to each individual in a sample group of individuals who are furnished such services, of the specific services (other than confidential services) so covered, the name of the person or persons furnishing the services, the date or dates on which the services were furnished, and the amount of the payment or payments made under the plan on account of the services; and

(C)(i) 75 per centum of the sums expended with respect to costs incurred during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to the performance of medical and utilization review by a utilization and quality control peer review organization or by an entity which meets the requirements of section 1152, as determined by the Secretary, under a contract entered into under section 1902(d); and

(ii) 75 percent of the sums expended with respect to costs incurred during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to the performance of independent external reviews conducted under section 1932(c)(2); and

(D) 75 percent of so much of the sums expended by the State plan during a quarter in 1991, 1992, or 1993, as the Secretary determines is attributable to the statewide adoption of a drug use review program which conforms to the requirements of section 1927(g);

(E) 50 percent of the sums expended with respect to costs incurred during such quarter as are attributable to providing—

(i) services to identify and educate individuals who are likely to be eligible for medical assistance under this title and who have Sickle Cell Disease or who are carriers of the sickle cell gene, including education regarding how to identify such individuals; or

(ii) education regarding the risks of stroke and other complications, as well as the prevention of stroke and other complications, in individuals who are likely to be eligible for medical assistance under this title and who have Sickle Cell Disease; and

(F)(i) 100 percent of so much of the sums expended during such quarter as are attributable to payments to Medicaid providers described in subsection (t)(1) to encourage the adoption and use of certified EHR technology; and

(ii) 90 percent of so much of the sums expended during such quarter as are attributable to payments for reasonable administrative expenses related to the administration of payments described in clause (i) if the State meets the condition described in subsection (t)(9); plus

(H)(i) 90 percent of the sums expended during the quarter as are attributable to the design, development, or installation of such mechanized verification and information retrieval systems as the Secretary determines are necessary to implement section 1902(ee) (including a system described in paragraph (2)(B) thereof), and

(ii) 75 percent of the sums expended during the quarter as are attributable to the operation of systems to which clause (i) applies, plus

(4) an amount equal to 100 percent of the sums expended during the quarter which are attributable to the costs of the implementation and operation of the immigration status verification system described in section 1137(d); plus

(5) an amount equal to 90 per centum of the sums expended during such quarter which are attributable to the offering, arranging, and furnishing (directly or on a contract basis) of family planning services and supplies;

(6) subject to subsection (b)(3), an amount equal to—

(A) 90 per centum of the sums expended during such a quarter within the twelve-quarter period beginning with the first quarter in which a payment is made to the State pursuant to this paragraph, and

(B) 75 per centum of the sums expended during each succeeding calendar quarter,

with respect to costs incurred during such quarter (as found necessary by the Secretary for the elimination of fraud in the provision and administration of medical assistance provided under the State plan) which are attributable to the establishment and operation of (including the training of personnel employed by) a State Medicaid fraud control unit (described in subsection (q)); plus

(7) subject to section 1919(g)(3)(B), an amount equal to 50 per centum of the remainder of the amounts expended during such quarter as found necessary by the Secretary for the proper and efficient administration of the State plan.

(b)(1) Notwithstanding the preceding provisions of this section, the amount determined under subsection (a)(1) for any State for any quarter beginning after December 31, 1969, shall not take into account any amounts expended as medical assistance with respect to individuals aged 65 or over and disabled individuals entitled to hospital insurance benefits under title XVIII which would not have been so expended if the individuals involved had been enrolled in the insurance program established by part B of title XVIII, other than amounts expended under provisions of the plan of such State required by section 1902(a)(34).

(2) For limitation on Federal participation for capital expenditures which are out of conformity with a comprehensive plan of a State or areawide planning agency, see section 1122.

(3) The amount of funds which the Secretary is otherwise obligated to pay a State during a quarter under subsection (a)(6) may not exceed the higher of—

(A) \$125,000, or

(B) one-quarter of 1 per centum of the sums expended by the Federal, State, and local governments during the previous quarter in carrying out the State's plan under this title.

(4) Amounts expended by a State for the use of an enrollment broker in marketing medicaid managed care organizations and other managed care entities to eligible individuals under this title shall be considered, for purposes of subsection (a)(7), to be necessary for the proper and efficient administration of the State plan but only if the following conditions are met with respect to the broker:

(A) The broker is independent of any such entity and of any health care providers (whether or not any such provider participates in the State plan under this title) that provide coverage of services in the same State in which the broker is conducting enrollment activities.

(B) No person who is an owner, employee, consultant, or has a contract with the broker either has any direct or indirect financial interest with such an entity or health care provider or has been excluded from participation in the program under this title or title XVIII or debarred by any Federal agency, or subject to a civil money penalty under this Act.

(5) Notwithstanding the preceding provisions of this section, the amount determined under subsection (a)(1) for any State shall be decreased in a quarter by the amount of any health care related taxes (described in section 1902(w)(3)(A)) that are imposed on a hospital described in subsection (w)(3)(F) in that quarter.

(c) Nothing in this title shall be construed as prohibiting or restricting, or authorizing the Secretary to prohibit or restrict, payment under subsection (a) for medical assistance for covered services furnished to a child with a disability because such services are included in the child's individualized education program established pursuant to part B of the Individuals with Disabilities Education Act or furnished to an infant or toddler with a disability because such services are included in the child's individualized family service plan adopted pursuant to part C of such Act.

(d)(1) Prior to the beginning of each quarter, the Secretary shall estimate the amount to which a State will be entitled under subsections (a) and (b) for such quarter, such estimates to be based on

(A) a report filed by the State containing its estimate of the total sum to be expended in such quarter in accordance with the provisions of such subsections, and stating the amount appropriated or made available by the State and its political subdivisions for such expenditures in such quarter, and if such amount is less than the State's proportionate share of the total sum of such estimated expenditures, the source or sources from which the difference is expected to be derived, and (B) such other investigation as the Secretary may find necessary.

(2)(A) The Secretary shall then pay to the State, in such installments as he may determine, the amount so estimated, reduced or increased to the extent of any overpayment or underpayment which the Secretary determines was made under this section to such State for any prior quarter and with respect to which adjustment has not already been made under this subsection.

(B) Expenditures for which payments were made to the State under subsection (a) shall be treated as an overpayment to the extent that the State or local agency administering such plan has been reimbursed for such expenditures by a third party pursuant to the provisions of its plan in compliance with section 1902(a)(25).

(C) For purposes of this subsection, when an overpayment is discovered, which was made by a State to a person or other entity, the State shall have a period of 1 year in which to recover or attempt to recover such overpayment before adjustment is made in the Federal payment to such State on account of such overpayment. Except as otherwise provided in subparagraph (D), the adjustment in the Federal payment shall be made at the end of the 1-year period, whether or not recovery was made.

(D)(i) In any case where the State is unable to recover a debt which represents an overpayment (or any portion thereof) made to a person or other entity on account of such debt having been discharged in bankruptcy or otherwise being uncollectable, no adjustment shall be made in the Federal payment to such State on account of such overpayment (or portion thereof).

(ii) In any case where the State is unable to recover a debt which represents an overpayment (or any portion thereof) made to a person or other entity due to fraud within 1 year of discovery because there is not a final determination of the amount of the overpayment under an administrative or judicial process (as applicable), including as a result of a judgment being under appeal, no adjustment shall be made in the Federal payment to such State on account of such overpayment (or portion thereof) before the date that is 30 days after the date on which a final judgment (including, if applicable, a final determination on an appeal) is made.

(3)(A) The pro rata share to which the United States is equitably entitled, as determined by the Secretary, of the net amount recovered during any quarter by the State or any political subdivision thereof with respect to medical assistance furnished under the State plan shall be considered an overpayment to be adjusted under this subsection.

(B)(i) Subparagraph (A) and paragraph (2)(B) shall not apply to any amount recovered or paid to a State as part of the comprehensive settlement of November 1998 between manufacturers of tobacco products, as defined in section 5702(d) of the Internal Revenue Code of 1986, and State Attorneys General, or as part of any

individual State settlement or judgment reached in litigation initiated or pursued by a State against one or more such manufacturers.

(ii) Except as provided in subsection (i)(19), a State may use amounts recovered or paid to the State as part of a comprehensive or individual settlement, or a judgment, described in clause (i) for any expenditures determined appropriate by the State.

(4) Upon the making of any estimate by the Secretary under this subsection, any appropriations available for payments under this section shall be deemed obligated.

(5) In any case in which the Secretary estimates that there has been an overpayment under this section to a State on the basis of a claim by such State that has been disallowed by the Secretary under section 1116(d), and such State disputes such disallowance, the amount of the Federal payment in controversy shall, at the option of the State, be retained by such State or recovered by the Secretary pending a final determination with respect to such payment amount. If such final determination is to the effect that any amount was properly disallowed, and the State chose to retain payment of the amount in controversy, the Secretary shall offset, from any subsequent payments made to such State under this title, an amount equal to the proper amount of the disallowance plus interest on such amount disallowed for the period beginning on the date such amount was disallowed and ending on the date of such final determination at a rate (determined by the Secretary) based on the average of the bond equivalent of the weekly 90-day treasury bill auction rates during such period.

(6)(A) Each State (as defined in subsection (w)(7)(D)) shall include, in the first report submitted under paragraph (1) after the end of each fiscal year, information related to—

(i) provider-related donations made to the State or units of local government during such fiscal year, and

(ii) health care related taxes collected by the State or such units during such fiscal year.

(B) Each State shall include, in the first report submitted under paragraph (1) after the end of each fiscal year, information related to the total amount of payment adjustments made, and the amount of payment adjustments made to individual providers (by provider), under section 1923(c) during such fiscal year.

(e) A State plan approved under this title may include, as a cost with respect to hospital services under the plan under this title, periodic expenditures made to reflect transitional allowances established with respect to a hospital closure or conversion under section 1884.

(f)(1)(A) Except as provided in paragraph (4), payment under the preceding provisions of this section shall not be made with respect to any amount expended as medical assistance in a calendar quarter, in any State, for any member of a family the annual income of which exceeds the applicable income limitation determined under this paragraph.

(B)(i) Except as provided in clause (ii) of this subparagraph, the applicable income limitation with respect to any family is the amount determined, in accordance with standards prescribed by the Secretary, to be equivalent to 133 $\frac{1}{3}$ percent of the highest amount which would ordinarily be paid to a family of the same size

without any income or resources, in the form of money payments, under the plan of the State approved under part A of title IV of this Act.

(ii) If the Secretary finds that the operation of a uniform maximum limits payments to families of more than one size, he may adjust the amount otherwise determined under clause (i) to take account of families of different sizes.

(C) The total amount of any applicable income limitation determined under subparagraph (B) shall, if it is not a multiple of \$100 or such other amount as the Secretary may prescribe, be rounded to the next higher multiple of \$100 or such other amount, as the case may be.

(2)(A) In computing a family's income for purposes of paragraph (1), there shall be excluded any costs (whether in the form of insurance premiums or otherwise and regardless of whether such costs are reimbursed under another public program of the State or political subdivision thereof) incurred by such family for medical care or for any other type of remedial care recognized under State law or, (B) notwithstanding section 1916 at State option, an amount paid by such family, at the family's option, to the State, provided that the amount, when combined with costs incurred in prior months, is sufficient when excluded from the family's income to reduce such family's income below the applicable income limitation described in paragraph (1). The amount of State expenditures for which medical assistance is available under subsection (a)(1) will be reduced by amounts paid to the State pursuant to this subparagraph.

(3) For purposes of paragraph (1)(B), in the case of a family consisting of only one individual, the "highest amount which would ordinarily be paid" to such family under the State's plan approved under part A of title IV of this Act shall be the amount determined by the State agency (on the basis of reasonable relationship to the amounts payable under such plan to families consisting of two or more persons) to be the amount of the aid which would ordinarily be payable under such plan to a family (without any income or resources) consisting of one person if such plan provided for aid to such a family.

(4) The limitations on payment imposed by the preceding provisions of this subsection shall not apply with respect to any amount expended by a State as medical assistance for any individual described in section 1902(a)(10)(A)(i)(III), 1902(a)(10)(A)(i)(IV), 1902(a)(10)(A)(i)(V), 1902(a)(10)(A)(i)(VI), 1902(a)(10)(A)(i)(VII), 1902(a)(10)(A)(i)(VIII), 1902(a)(10)(A)(i)(IX), 1902(a)(10)(A)(ii)(IX), 1902(a)(10)(A)(ii)(X), 1902(a)(10)(A)(ii)(XIII), 1902(a)(10)(A)(ii)(XIV), or 1902(a)(10)(A)(ii)(XV), 1902(a)(10)(A)(ii)(XVI), 1902(a)(10)(A)(ii)(XVII), 1902(a)(10)(A)(ii)(XVIII), 1902(a)(10)(A)(ii)(XIX), 1902(a)(10)(A)(ii)(XX), 1902(a)(10)(A)(ii)(XXI), 1902(a)(10)(A)(ii)(XXII), 1905(p)(1) or for any individual—

(A) who is receiving aid or assistance under any plan of the State approved under title I, X, XIV or XVI, or part A of title IV, or with respect to whom supplemental security income benefits are being paid under title XVI, or

(B) who is not receiving such aid or assistance, and with respect to whom such benefits are not being paid, but (i) is eligi-

ble to receive such aid or assistance, or to have such benefits paid with respect to him, or (ii) would be eligible to receive such aid or assistance, or to have such benefits paid with respect to him if he were not in a medical institution, or

(C) with respect to whom there is being paid, or who is eligible, or would be eligible if he were not in a medical institution, to have paid with respect to him, a State supplementary payment and is eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1902(a)(10)(A), or who is a PACE program eligible individual enrolled in a PACE program under section 1934, but only if the income of such individual (as determined under section 1612, but without regard to subsection (b) thereof) does not exceed 300 percent of the supplemental security income benefit rate established by section 1611(b)(1),

at the time of the provision of the medical assistance giving rise to such expenditure.

(g)(1) Subject to paragraph (3), with respect to amounts paid for the following services furnished under the State plan after June 30, 1973 (other than services furnished pursuant to a contract with a health maintenance organization as defined in section 1876 or which is a qualified health maintenance organization (as defined in section 1310(d) of the Public Health Service Act)), the Federal medical assistance percentage shall be decreased as follows: After an individual has received inpatient hospital services or services in an intermediate care facility for the mentally retarded for 60 days or inpatient mental hospital services for 90 days (whether or not such days are consecutive), during any fiscal year, the Federal medical assistance percentage with respect to amounts paid for any such care furnished thereafter to such individual shall be decreased by a per centum thereof (determined under paragraph (5)) unless the State agency responsible for the administration of the plan makes a showing satisfactory to the Secretary that, with respect to each calendar quarter for which the State submits a request for payment at the full Federal medical assistance percentage for amounts paid for inpatient hospital services or services in an intermediate care facility for the mentally retarded furnished beyond 60 days (or inpatient mental hospital services furnished beyond 90 days), such State has an effective program of medical review of the care of patients in mental hospitals and intermediate care facilities for the mentally retarded pursuant to paragraphs (26) and (31) of section 1902(a) whereby the professional management of each case is reviewed and evaluated at least annually by independent professional review teams. In determining the number of days on which an individual has received services described in this subsection, there shall not be counted any days with respect to which such individual is entitled to have payments made (in whole or in part) on his behalf under section 1812.

(2) The Secretary shall, as part of his validation procedures under this subsection, conduct timely sample onsite surveys of private and public institutions in which recipients of medical assistance may receive care and services under a State plan approved under this title, and his findings with respect to such surveys (as

well as the showings of the State agency required under this subsection) shall be made available for public inspection.

(3)(A) No reduction in the Federal medical assistance percentage of a State otherwise required to be imposed under this subsection shall take effect—

(i) if such reduction is due to the State's unsatisfactory or invalid showing made with respect to a calendar quarter beginning before January 1, 1977;

(ii) before January 1, 1978;

(iii) unless a notice of such reduction has been provided to the State at least 30 days before the date such reduction takes effect; or

(iv) due to the State's unsatisfactory or invalid showing made with respect to a calendar quarter beginning after September 30, 1977, unless notice of such reduction has been provided to the State no later than the first day of the fourth calendar quarter following the calendar quarter with respect to which such showing was made.

(B) The Secretary shall waive application of any reduction in the Federal medical assistance percentage of a State otherwise required to be imposed under paragraph (1) because a showing by the State, made under such paragraph with respect to a calendar quarter ending after January 1, 1977, and before January 1, 1978, is determined to be either unsatisfactory under such paragraph or invalid under paragraph (2), if the Secretary determines that the State's showing made under paragraph (1) with respect to any calendar quarter ending on or before December 31, 1978, is satisfactory under such paragraph and is valid under paragraph (2).

(4)(A) The Secretary may not find the showing of a State, with respect to a calendar quarter under paragraph (1), to be satisfactory if the showing is submitted to the Secretary later than the 30th day after the last day of the calendar quarter, unless the State demonstrates to the satisfaction of the Secretary good cause for not meeting such deadline.

(B) The Secretary shall find a showing of a State, with respect to a calendar quarter under paragraph (1), to be satisfactory under such paragraph with respect to the requirement that the State conduct annual onsite inspections in mental hospitals and intermediate care facilities for the mentally retarded under paragraphs (26) and (31) of section 1902(a), if the showing demonstrates that the State has conducted such an onsite inspection during the 12-month period ending on the last date of the calendar quarter—

(i) in each of not less than 98 per centum of the number of such hospitals and facilities requiring such inspection, and

(ii) in every such hospital or facility which has 200 or more beds,

and that, with respect to such hospitals and facilities not inspected within such period, the State has exercised good faith and due diligence in attempting to conduct such inspection, or if the State demonstrates to the satisfaction of the Secretary that it would have made such a showing but for failings of a technical nature only.

(5) In the case of a State's unsatisfactory or invalid showing made with respect to a type of facility or institutional services in a calendar quarter, the per centum amount of the reduction of the State's Federal medical assistance percentage for that type of serv-

ices under paragraph (1) is equal to $33\frac{1}{3}$ per centum multiplied by a fraction, the denominator of which is equal to the total number of patients receiving that type of services in that quarter under the State plan in facilities or institutions for which a showing was required to be made under this subsection, and the numerator of which is equal to the number of such patients receiving such type of services in that quarter in those facilities or institutions for which a satisfactory and valid showing was not made for that calendar quarter.

(6)(A) Recertifications required under section 1902(a)(44) shall be conducted at least every 60 days in the case of inpatient hospital services.

(B) Such recertifications in the case of services in an intermediate care facility for the mentally retarded shall be conducted at least—

- (i) 60 days after the date of the initial certification,
- (ii) 180 days after the date of the initial certification,
- (iii) 12 months after the date of the initial certification,
- (iv) 18 months after the date of the initial certification,
- (v) 24 months after the date of the initial certification, and
- (vi) every 12 months thereafter.

(C) For purposes of determining compliance with the schedule established by this paragraph, a recertification shall be considered to have been done on a timely basis if it was performed not later than 10 days after the date the recertification was otherwise required and the State establishes good cause why the physician or other person making such recertification did not meet such schedule.

(i) Payment under the preceding provisions of this section shall not be made—

(1) for organ transplant procedures unless the State plan provides for written standards respecting the coverage of such procedures and unless such standards provide that—

- (A) similarly situated individuals are treated alike; and
- (B) any restriction, on the facilities or practitioners which may provide such procedures, is consistent with the accessibility of high quality care to individuals eligible for the procedures under the State plan; or

(2) with respect to any amount expended for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) furnished—

(A) under the plan by any individual or entity during any period when the individual or entity is excluded from participation under title V, XVIII, or XX or under this title pursuant to section 1128, 1128A, 1156, or 1842(j)(2) **[,]**;

(B) at the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation under title V, XVIII, or XX or under this title pursuant to section 1128, 1128A, 1156, or 1842(j)(2) and when the person furnishing such item or service knew or had reason to know of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person); **[or]**

(C) by any individual or entity to whom the State has failed to suspend payments under the plan during any pe-

riod when there is pending an investigation of a credible allegation of fraud against the individual or entity, as determined by the State in accordance with regulations promulgated by the Secretary for purposes of section 1862(o) and this subparagraph, unless the State determines in accordance with such regulations there is good cause not to suspend such payments; or

(D) beginning not later than January 1, 2018, under the plan by any provider of services or person whose participation in the State plan is terminated (as described in section 1902(kk)(8)) after the date that is 60 days after the date on which such termination is included in the database or other system under section 1902(l); or

(3) with respect to any amount expended for inpatient hospital services furnished under the plan (other than amounts attributable to the special situation of a hospital which serves a disproportionate number of low income patients with special needs) to the extent that such amount exceeds the hospital's customary charges with respect to such services or (if such services are furnished under the plan by a public institution free of charge or at nominal charges to the public) exceeds an amount determined on the basis of those items (specified in regulations prescribed by the Secretary) included in the determination of such payment which the Secretary finds will provide fair compensation to such institution for such services; or

(4) with respect to any amount expended for care or services furnished under the plan by a hospital unless such hospital has in effect a utilization review plan which meets the requirements imposed by section 1861(k) for purposes of title XVIII; and if such hospital has in effect such a utilization review plan for purposes of title XVIII, such plan shall serve as the plan required by this subsection (with the same standards and procedures and the same review committee or group) as a condition of payment under this title; the Secretary is authorized to waive the requirements of this paragraph if the State agency demonstrates to his satisfaction that it has in operation utilization review procedures which are superior in their effectiveness to the procedures required under section 1861(k); or

(5) with respect to any amount expended for any drug product for which payment may not be made under part B of title XVIII because of section 1862(c); or

(6) with respect to any amount expended for inpatient hospital tests (other than in emergency situations) not specifically ordered by the attending physician or other responsible practitioner; or

(7) with respect to any amount expended for clinical diagnostic laboratory tests performed by a physician, independent laboratory, or hospital, to the extent such amount exceeds the amount that would be recognized under section 1833(h) for such tests performed for an individual enrolled under part B of title XVIII; or

(8) with respect to any amount expended for medical assistance (A) for nursing facility services to reimburse (or otherwise compensate) a nursing facility for payment of a civil money penalty imposed under section 1919(h) or (B) for home and

community care to reimburse (or otherwise compensate) a provider of such care for payment of a civil money penalty imposed under this title or title XI or for legal expenses in defense of an exclusion or civil money penalty under this title or title XI if there is no reasonable legal ground for the provider's case; or

(10)(A) with respect to covered outpatient drugs unless there is a rebate agreement in effect under section 1927 with respect to such drugs or unless section 1927(a)(3) applies,

(B) with respect to any amount expended for an innovator multiple source drug (as defined in section 1927(k)) dispensed on or after July 1, 1991, if, under applicable State law, a less expensive multiple source drug could have been dispensed, but only to the extent that such amount exceeds the upper payment limit for such multiple source drug;

(C) with respect to covered outpatient drugs described in section 1927(a)(7), unless information respecting utilization data and coding on such drugs that is required to be submitted under such section is submitted in accordance with such section, and

(D) with respect to any amount expended for reimbursement to a pharmacy under this title for the ingredient cost of a covered outpatient drug for which the pharmacy has already received payment under this title (other than with respect to a reasonable restocking fee for such drug); or

(11) with respect to any amount expended for physicians' services furnished on or after the first day of the first quarter beginning more than 60 days after the date of establishment of the physician identifier system under section 1902(x), unless the claim for the services includes the unique physician identifier provided under such system; or

(13) with respect to any amount expended to reimburse (or otherwise compensate) a nursing facility for payment of legal expenses associated with any action initiated by the facility that is dismissed on the basis that no reasonable legal ground existed for the institution of such action; or

(14) with respect to any amount expended on administrative costs to carry out the program under section 1928; or

(15) with respect to any amount expended for a single-antigen vaccine and its administration in any case in which the administration of a combined-antigen vaccine was medically appropriate (as determined by the Secretary); or

(16) with respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997; or

(17) with respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under a State plan under this title; or

(18) with respect to any amount expended for home health care services provided by an agency or organization unless the agency or organization provides the State agency on a continuing basis a surety bond in a form specified by the Secretary under paragraph (7) of section 1861(o) and in an amount that is not less than \$50,000 or such comparable sur-

ety bond as the Secretary may permit under the last sentence of such section; or

(19) with respect to any amount expended on administrative costs to initiate or pursue litigation described in subsection (d)(3)(B);

(20) with respect to amounts expended for medical assistance provided to an individual described in subclause (XV) or (XVI) of section 1902(a)(10)(A)(ii) for a fiscal year unless the State demonstrates to the satisfaction of the Secretary that the level of State funds expended for such fiscal year for programs to enable working individuals with disabilities to work (other than for such medical assistance) is not less than the level expended for such programs during the most recent State fiscal year ending before the date of the enactment of this paragraph;

(21) with respect to amounts expended for covered outpatient drugs described in section 1927(d)(2)(K) (relating to drugs when used for treatment of sexual or erectile dysfunction);

(22) with respect to amounts expended for medical assistance for an individual who declares under section 1137(d)(1)(A) to be a citizen or national of the United States for purposes of establishing eligibility for benefits under this title, unless the requirement of section 1902(a)(46)(B) is met;

(23) with respect to amounts expended for medical assistance for covered outpatient drugs (as defined in section 1927(k)(2)) for which the prescription was executed in written (and non-electronic) form unless the prescription was executed on a tamper-resistant pad;

(24) if a State is required to implement an asset verification program under section 1940 and fails to implement such program in accordance with such section, with respect to amounts expended by such State for medical assistance for individuals subject to asset verification under such section, unless—

(A) the State demonstrates to the Secretary's satisfaction that the State made a good faith effort to comply;

(B) not later than 60 days after the date of a finding that the State is in noncompliance, the State submits to the Secretary (and the Secretary approves) a corrective action plan to remedy such noncompliance; and

(C) not later than 12 months after the date of such submission (and approval), the State fulfills the terms of such corrective action plan;

(25) with respect to any amounts expended for medical assistance for individuals for whom the State does not report enrollee encounter data (as defined by the Secretary) to the Medicaid Statistical Information System (MSIS) in a timely manner (as determined by the Secretary); or

(26) with respect to any amounts expended for medical assistance for individuals described in subclause (VIII) of subsection (a)(10)(A)(i) other than medical assistance provided through benchmark coverage described in section 1937(b)(1) or benchmark equivalent coverage described in section 1937(b)(2).

Nothing in paragraph (1) shall be construed as permitting a State to provide services under its plan under this title that are not reasonable in amount, duration, and scope to achieve their purpose. Paragraphs (1), (2), (16), (17), and (18) shall apply with respect to

items or services furnished and amounts expended by or through a managed care entity (as defined in section 1932(a)(1)(B)) in the same manner as such paragraphs apply to items or services furnished and amounts expended directly by the State.

(j) Notwithstanding the preceding provisions of this section, the amount determined under subsection (a)(1) for any State for any quarter shall be adjusted in accordance with section 1914.

(k) The Secretary is authorized to provide at the request of any State (and without cost to such State) such technical and actuarial assistance as may be necessary to assist such State to contract with any medicaid managed care organization which meets the requirements of subsection (m) of this section for the purpose of providing medical care and services to individuals who are entitled to medical assistance under this title.

(m)(1)(A) The term “medicaid managed care organization” means a health maintenance organization, an eligible organization with a contract under section 1876 or a Medicare+Choice organization with a contract under part C of title XVIII, a provider sponsored organization, or any other public or private organization, which meets the requirement of section 1902(w) and—

(i) makes services it provides to individuals eligible for benefits under this title accessible to such individuals, within the area served by the organization, to the same extent as such services are made accessible to individuals (eligible for medical assistance under the State plan) not enrolled with the organization, and

(ii) has made adequate provision against the risk of insolvency, which provision is satisfactory to the State, meets the requirements of subparagraph (C)(i) (if applicable), and which assures that individuals eligible for benefits under this title are in no case held liable for debts of the organization in case of the organization’s insolvency.

An organization that is a qualified health maintenance organization (as defined in section 1310(d) of the Public Health Service Act) is deemed to meet the requirements of clauses (i) and (ii).

(B) The duties and functions of the Secretary, insofar as they involve making determinations as to whether an organization is a medicaid managed care organization within the meaning of subparagraph (A), shall be integrated with the administration of section 1312 (a) and (b) of the Public Health Service Act.

(C)(i) Subject to clause (ii), a provision meets the requirements of this subparagraph for an organization if the organization meets solvency standards established by the State for private health maintenance organizations or is licensed or certified by the State as a risk-bearing entity.

(ii) Clause (i) shall not apply to an organization if—

(I) the organization is not responsible for the provision (directly or through arrangements with providers of services) of inpatient hospital services and physicians’ services;

(II) the organization is a public entity;

(III) the solvency of the organization is guaranteed by the State; or

(IV) the organization is (or is controlled by) one or more Federally-qualified health centers and meets solvency standards established by the State for such an organization.

For purposes of subclause (IV), the term “control” means the possession, whether direct or indirect, of the power to direct or cause the direction of the management and policies of the organization through membership, board representation, or an ownership interest equal to or greater than 50.1 percent.

(2)(A) Except as provided in subparagraphs (B), (C), and (G), no payment shall be made under this title to a State with respect to expenditures incurred by it for payment (determined under a prepaid capitation basis or under any other risk basis) for services provided by any entity (including a health insuring organization) which is responsible for the provision (directly or through arrangements with providers of services) of inpatient hospital services and any other service described in paragraph (2), (3), (4), (5), or (7) of section 1905(a) or for the provision of any three or more of the services described in such paragraphs unless—

(i) the Secretary has determined that the entity is a medicaid managed care organization as defined in paragraph (1);

(iii) such services are provided for the benefit of individuals eligible for benefits under this title in accordance with a contract between the State and the entity under which prepaid payments to the entity are made on an actuarially sound basis and under which the Secretary must provide prior approval for contracts providing for expenditures in excess of \$1,000,000 for 1998 and, for a subsequent year, the amount established under this clause for the previous year increased by the percentage increase in the consumer price index for all urban consumers over the previous year;

(iv) such contract provides that the Secretary and the State (or any person or organization designated by either) shall have the right to audit and inspect any books and records of the entity (and of any subcontractor) that pertain (I) to the ability of the entity to bear the risk of potential financial losses, or (II) to services performed or determinations of amounts payable under the contract;

(v) such contract provides that in the entity’s enrollment, re-enrollment, or disenrollment of individuals who are eligible for benefits under this title and eligible to enroll, reenroll, or disenroll with the entity pursuant to the contract, the entity will not discriminate among such individuals on the basis of their health status or requirements for health care services;

(vi) such contract (I) permits individuals who have elected under the plan to enroll with the entity for provision of such benefits to terminate such enrollment in accordance with section 1932(a)(4), and (II) provides for notification in accordance with such section of each such individual, at the time of the individual’s enrollment, of such right to terminate such enrollment;

(vii) such contract provides that, in the case of medically necessary services which were provided (I) to an individual enrolled with the entity under the contract and entitled to benefits with respect to such services under the State’s plan and (II) other than through the organization because the services were immediately required due to an unforeseen illness, injury,

or condition, either the entity or the State provides for reimbursement with respect to those services,

(viii) such contract provides for disclosure of information in accordance with section 1124 and paragraph (4) of this subsection;

(ix) such contract provides, in the case of an entity that has entered into a contract for the provision of services with a Federally-qualified health center or a rural health clinic, that the entity shall provide payment that is not less than the level and amount of payment which the entity would make for the services if the services were furnished by a provider which is not a Federally-qualified health center or a rural health clinic;

(x) any physician incentive plan that it operates meets the requirements described in section 1876(i)(8);

(xi) such contract provides for maintenance of sufficient patient encounter data to identify the physician who delivers services to patients and for the provision of such data to the State at a frequency and level of detail to be specified by the Secretary;

(xii) such contract, and the entity complies with the applicable requirements of section 1932; and

(xiii) such contract provides that (I) covered outpatient drugs dispensed to individuals eligible for medical assistance who are enrolled with the entity shall be subject to the same rebate required by the agreement entered into under section 1927 as the State is subject to and that the State shall collect such rebates from manufacturers, (II) capitation rates paid to the entity shall be based on actual cost experience related to rebates and subject to the Federal regulations requiring actuarially sound rates, and (III) the entity shall report to the State, on such timely and periodic basis as specified by the Secretary in order to include in the information submitted by the State to a manufacturer and the Secretary under section 1927(b)(2)(A), information on the total number of units of each dosage form and strength and package size by National Drug Code of each covered outpatient drug dispensed to individuals eligible for medical assistance who are enrolled with the entity and for which the entity is responsible for coverage of such drug under this subsection (other than covered outpatient drugs that under subsection (j)(1) of section 1927 are not subject to the requirements of that section) and such other data as the Secretary determines necessary to carry out this subsection.

(B) Subparagraph (A) except with respect to clause (ix) of subparagraph (A), does not apply with respect to payments under this title to a State with respect to expenditures incurred by it for payment for services provided by an entity which—

(i)(I) received a grant of at least \$100,000 in the fiscal year ending June 30, 1976, under section 329(d)(1)(A) or 330(d)(1) of the Public Health Service Act, and for the period beginning July 1, 1976, and ending on the expiration of the period for which payments are to be made under this title has been the recipient of a grant under either such section; and

(II) provides to its enrollees, on a prepaid capitation risk basis or on any other risk basis, all of the services and benefits described in paragraphs (1), (2), (3), (4)(C), and (5) of section 1905(a) and, to the extent required by section 1902(a)(10)(D) to be provided under a State plan for medical assistance, the services and benefits described in paragraph (7) of section 1905(a); or

(ii) is a nonprofit primary health care entity located in a rural area (as defined by the Appalachian Regional Commission)—

(I) which received in the fiscal year ending June 30, 1976, at least \$100,000 (by grant, subgrant, or subcontract) under the Appalachian Regional Development Act of 1965, and

(II) for the period beginning July 1, 1976, and ending on the expiration of the period for which payments are to be made under this title either has been the recipient of a grant, subgrant, or subcontract under such Act or has provided services under a contract (initially entered into during a year in which the entity was the recipient of such a grant, subgrant, or subcontract) with a State agency under this title on a prepaid capitation risk basis or on any other risk basis; or

(iii) which has contracted with the single State agency for the provision of services (but not including inpatient hospital services) to persons eligible under this title on a prepaid risk basis prior to 1970.

(G) In the case of an entity which is receiving (and has received during the previous two years) a grant of at least \$100,000 under section 329(d)(1)(A) or 330(d)(1) of the Public Health Service Act or is receiving (and has received during the previous two years) at least \$100,000 (by grant, subgrant, or subcontract) under the Appalachian Regional Development Act of 1965, clause (i) of subparagraph (A) shall not apply.

(H) In the case of an individual who—

(i) in a month is eligible for benefits under this title and enrolled with a medicaid managed care organization with a contract under this paragraph or with a primary care case manager with a contract described in section 1905(t)(3),

(ii) in the next month (or in the next 2 months) is not eligible for such benefits, but

(iii) in the succeeding month is again eligible for such benefits,

the State plan, subject to subparagraph (A)(vi), may enroll the individual for that succeeding month with the organization described in clause (i) if the organization continues to have a contract under this paragraph with the State or with the manager described in such clause if the manager continues to have a contract described in section 1905(t)(3) with the State.

(3) *No payment shall be made under this title to a State with respect to expenditures incurred by the State for payment for services provided by a managed care entity (as defined under section 1932(a)(1)) under the State plan under this title (or under a waiver of the plan) unless the State—*

(A) beginning on the applicable date specified in subparagraph (A) of section 1932(d)(5), has a contract with such entity that complies with the requirement specified in such subparagraph; and

(B)(i) for the period specified in subparagraph (B) of such section, has a system in effect that meets the requirement specified in such subparagraph; and

(ii) after such period, complies with section 1932(d)(6).

(4)(A) Each medicaid managed care organization which is not a qualified health maintenance organization (as defined in section 1310(d) of the Public Health Service Act) must report to the State and, upon request, to the Secretary, the Inspector General of the Department of Health and Human Services, and the Comptroller General a description of transactions between the organization and a party in interest (as defined in section 1318(b) of such Act), including the following transactions:

(i) Any sale or exchange, or leasing of any property between the organization and such a party.

(ii) Any furnishing for consideration of goods, services (including management services), or facilities between the organization and such a party, but not including salaries paid to employees for services provided in the normal course of their employment.

(iii) Any lending of money or other extension of credit between the organization and such a party.

The State or Secretary may require that information reported respecting an organization which controls, or is controlled by, or is under common control with, another entity be in the form of a consolidated financial statement for the organization and such entity.

(B) Each organization shall make the information reported pursuant to subparagraph (A) available to its enrollees upon reasonable request.

(5)(A) If the Secretary determines that an entity with a contract under this subsection—

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

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

(iii) acts to discriminate among individuals in violation of the provision of paragraph (2)(A)(v), including expulsion or refusal to re-enroll an individual or engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment (except as permitted by this subsection) by eligible individuals with the organization whose medical condition or history indicates a need for substantial future medical services;

(iv) misrepresents or falsifies information that is furnished—

(I) to the Secretary or the State under this subsection,

or

(II) to an individual or to any other entity under this subsection, or

(v) fails to comply with the requirements of section 1876(i)(8), the Secretary may provide, in addition to any other remedies available under law, for any of the remedies described in subparagraph (B).

(B) The remedies described in this subparagraph are—

(i) civil money penalties of not more than \$25,000 for each determination under subparagraph (A), or, with respect to a determination under clause (iii) or (iv)(I) of such subparagraph, of not more than \$100,000 for each such determination, plus, with respect to a determination under subparagraph (A)(ii), double the excess amount charged in violation of such subparagraph (and the excess amount charged shall be deducted from the penalty and returned to the individual concerned), and plus, with respect to a determination under subparagraph (A)(iii), \$15,000 for each individual not enrolled as a result of a practice described in such subparagraph, or

(ii) denial of payment to the State for medical assistance furnished under the contract under this subsection for individuals enrolled after the date the Secretary notifies the organization of a determination under subparagraph (A) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur.

The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under clause (i) in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

(6)(A) For purposes of this subsection and section 1902(e)(2)(A), in the case of the State of New Jersey, the term “contract” shall be deemed to include an undertaking by the State agency, in the State plan under this title, to operate a program meeting all requirements of this subsection.

(B) The undertaking described in subparagraph (A) must provide—

(i) for the establishment of a separate entity responsible for the operation of a program meeting the requirements of this subsection, which entity may be a subdivision of the State agency administering the State plan under this title;

(ii) for separate accounting for the funds used to operate such program; and

(iii) for setting the capitation rates and any other payment rates for services provided in accordance with this subsection using a methodology satisfactory to the Secretary designed to ensure that total Federal matching payments under this title for such services will be lower than the matching payments that would be made for the same services, if provided under the State plan on a fee for service basis to an actuarially equivalent population.

(C) The undertaking described in subparagraph (A) shall be subject to approval (and annual re-approval) by the Secretary in the same manner as a contract under this subsection.

(D) The undertaking described in subparagraph (A) shall not be eligible for a waiver under section 1915(b).

(o) Notwithstanding the preceding provisions of this section, no payment shall be made to a State under the preceding provisions

of this section for expenditures for medical assistance provided for an individual under its State plan approved under this title to the extent that a private insurer (as defined by the Secretary by regulation and including a group health plan (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974), a service benefit plan, and a health maintenance organization) would have been obligated to provide such assistance but for a provision of its insurance contract which has the effect of limiting or excluding such obligation because the individual is eligible for or is provided medical assistance under the plan.

(p)(1) When a political subdivision of a State makes, for the State of which it is a political subdivision, or one State makes, for another State, the enforcement and collection of rights of support or payment assigned under section 1912, pursuant to a cooperative arrangement under such section (either within or outside of such State), there shall be paid to such political subdivision or such other State from amounts which would otherwise represent the Federal share of payments for medical assistance provided to the eligible individuals on whose behalf such enforcement and collection was made, an amount equal to 15 percent of any amount collected which is attributable to such rights of support or payment.

(2) Where more than one jurisdiction is involved in such enforcement or collection, the amount of the incentive payment determined under paragraph (1) shall be allocated among the jurisdictions in a manner to be prescribed by the Secretary.

(q) For the purposes of this section, the term "State medicaid fraud control unit" means a single identifiable entity of the State government which the Secretary certifies (and annually recertifies) as meeting the following requirements:

(1) The entity (A) is a unit of the office of the State Attorney General or of another department of State government which possesses statewide authority to prosecute individuals for criminal violations, (B) is in a State the constitution of which does not provide for the criminal prosecution of individuals by a statewide authority and has formal procedures, approved by the Secretary, that (i) assure its referral of suspected criminal violations relating to the program under this title to the appropriate authority or authorities in the State for prosecution and (ii) assure its assistance of, and coordination with, such authority or authorities in such prosecutions, or (C) has a formal working relationship with the office of the State Attorney General and has formal procedures (including procedures for its referral of suspected criminal violations to such office) which are approved by the Secretary and which provide effective coordination of activities between the entity and such office with respect to the detection, investigation, and prosecution of suspected criminal violations relating to the program under this title.

(2) The entity is separate and distinct from the single State agency that administers or supervises the administration of the State plan under this title.

(3) The entity's function is conducting a statewide program for the investigation and prosecution of violations of all applicable State laws regarding any and all aspects of fraud in connection with (A) any aspect of the provision of medical assist-

ance and the activities of providers of such assistance under the State plan under this title; and (B) upon the approval of the Inspector General of the relevant Federal agency, any aspect of the provision of health care services and activities of providers of such services under any Federal health care program (as defined in section 1128B(f)(1)), if the suspected fraud or violation of law in such case or investigation is primarily related to the State plan under this title.

(4)(A) The entity has—

(i) procedures for reviewing complaints of abuse or neglect of patients in health care facilities which receive payments under the State plan under this title;

(ii) at the option of the entity, procedures for reviewing complaints of abuse or neglect of patients residing in board and care facilities; and

(iii) procedures for acting upon such complaints under the criminal laws of the State or for referring such complaints to other State agencies for action.

(B) For purposes of this paragraph, the term “board and care facility” means a residential setting which receives payment (regardless of whether such payment is made under the State plan under this title) from or on behalf of two or more unrelated adults who reside in such facility, and for whom one or both of the following is provided:

(i) Nursing care services provided by, or under the supervision of, a registered nurse, licensed practical nurse, or licensed nursing assistant.

(ii) A substantial amount of personal care services that assist residents with the activities of daily living, including personal hygiene, dressing, bathing, eating, toileting, ambulation, transfer, positioning, self-medication, body care, travel to medical services, essential shopping, meal preparation, laundry, and housework.

(5) The entity provides for the collection, or referral for collection to a single State agency, of overpayments that are made under the State plan or under any Federal health care program (as so defined) to health care facilities and that are discovered by the entity in carrying out its activities. All funds collected in accordance with this paragraph shall be credited exclusively to, and available for expenditure under, the Federal health care program (including the State plan under this title) that was subject to the activity that was the basis for the collection.

(6) The entity employs such auditors, attorneys, investigators, and other necessary personnel and is organized in such a manner as is necessary to promote the effective and efficient conduct of the entity’s activities.

(7) The entity submits to the Secretary an application and annual reports containing such information as the Secretary determines, by regulation, to be necessary to determine whether the entity meets the other requirements of this subsection.

(r)(1) In order to receive payments under subsection (a) for use of automated data systems in administration of the State plan under this title, a State must, in addition to meeting the requirements of paragraph (3), have in operation mechanized claims proc-

essing and information retrieval systems that meet the requirements of this subsection and that the Secretary has found—

(A) are adequate to provide efficient, economical, and effective administration of such State plan;

(B) are compatible with the claims processing and information retrieval systems used in the administration of title XVIII, and for this purpose—

(i) have a uniform identification coding system for providers, other payees, and beneficiaries under this title or title XVIII;

(ii) provide liaison between States and carriers and intermediaries with agreements under title XVIII to facilitate timely exchange of appropriate data;

(iii) provide for exchange of data between the States and the Secretary with respect to persons sanctioned under this title or title XVIII; and

(iv) effective for claims filed on or after October 1, 2010, incorporate compatible methodologies of the National Correct Coding Initiative administered by the Secretary (or any successor initiative to promote correct coding and to control improper coding leading to inappropriate payment) and such other methodologies of that Initiative (or such other national correct coding methodologies) as the Secretary identifies in accordance with paragraph (4);

(C) are capable of providing accurate and timely data;

(D) are complying with the applicable provisions of part C of title XI;

(E) are designed to receive provider claims in standard formats to the extent specified by the Secretary; and

(F) effective for claims filed on or after January 1, 1999, provide for electronic transmission of claims data in the format specified by the Secretary and consistent with the Medicaid Statistical Information System (MSIS) (including detailed individual enrollee encounter data and other information that the Secretary may find necessary and including, for data submitted to the Secretary on or after January 1, 2010, data elements from the automated data system that the Secretary determines to be necessary for program integrity, program oversight, and administration, at such frequency as the Secretary shall determine).

(2) In order to meet the requirements of this paragraph, mechanized claims processing and information retrieval systems must meet the following requirements:

(A) The systems must be capable of developing provider, physician, and patient profiles which are sufficient to provide specific information as to the use of covered types of services and items, including prescribed drugs.

(B) The State must provide that information on probable fraud or abuse which is obtained from, or developed by, the systems, is made available to the State's medicaid fraud control unit (if any) certified under subsection (q) of this section.

(C) The systems must meet all performance standards and other requirements for initial approval developed by the Secretary.

(3) In order to meet the requirements of this paragraph, a State must have in operation an eligibility determination system which provides for data matching through the Public Assistance Reporting Information System (PARIS) facilitated by the Secretary (or any successor system), including matching with medical assistance programs operated by other States.

(4) For purposes of paragraph (1)(B)(iv), the Secretary shall do the following:

(A) Not later than September 1, 2010:

(i) Identify those methodologies of the National Correct Coding Initiative administered by the Secretary (or any successor initiative to promote correct coding and to control improper coding leading to inappropriate payment) which are compatible to claims filed under this title.

(ii) Identify those methodologies of such Initiative (or such other national correct coding methodologies) that should be incorporated into claims filed under this title with respect to items or services for which States provide medical assistance under this title and no national correct coding methodologies have been established under such Initiative with respect to title XVIII.

(iii) Notify States of—

(I) the methodologies identified under subparagraphs (A) and (B) (and of any other national correct coding methodologies identified under subparagraph (B)); and

(II) how States are to incorporate such methodologies into claims filed under this title.

(B) Not later than March 1, 2011, submit a report to Congress that includes the notice to States under clause (iii) of subparagraph (A) and an analysis supporting the identification of the methodologies made under clauses (i) and (ii) of subparagraph (A).

(s) Notwithstanding the preceding provisions of this section, no payment shall be made to a State under this section for expenditures for medical assistance under the State plan consisting of a designated health service (as defined in subsection (h)(6) of section 1877) furnished to an individual on the basis of a referral that would result in the denial of payment for the service under title XVIII if such title provided for coverage of such service to the same extent and under the same terms and conditions as under the State plan, and subsections (f) and (g)(5) of such section shall apply to a provider of such a designated health service for which payment may be made under this title in the same manner as such subsections apply to a provider of such a service for which payment may be made under such title.

(t)(1) For purposes of subsection (a)(3)(F), the payments described in this paragraph to encourage the adoption and use of certified EHR technology are payments made by the State in accordance with this subsection —

(A) to Medicaid providers described in paragraph (2)(A) not in excess of 85 percent of net average allowable costs (as defined in paragraph (3)(E)) for certified EHR technology (and support services including maintenance and training that is

for, or is necessary for the adoption and operation of, such technology) with respect to such providers; and

(B) to Medicaid providers described in paragraph (2)(B) not in excess of the maximum amount permitted under paragraph (5) for the provider involved.

(2) In this subsection and subsection (a)(3)(F), the term “Medicaid provider” means—

(A) an eligible professional (as defined in paragraph (3)(B))—

(i) who is not hospital-based and has at least 30 percent of the professional’s patient volume (as estimated in accordance with a methodology established by the Secretary) attributable to individuals who are receiving medical assistance under this title;

(ii) who is not described in clause (i), who is a pediatrician, who is not hospital-based, and who has at least 20 percent of the professional’s patient volume (as estimated in accordance with a methodology established by the Secretary) attributable to individuals who are receiving medical assistance under this title; and

(iii) who practices predominantly in a Federally qualified health center or rural health clinic and has at least 30 percent of the professional’s patient volume (as estimated in accordance with a methodology established by the Secretary) attributable to needy individuals (as defined in paragraph (3)(F)); and

(B)(i) a children’s hospital, or

(ii) an acute-care hospital that is not described in clause (i) and that has at least 10 percent of the hospital’s patient volume (as estimated in accordance with a methodology established by the Secretary) attributable to individuals who are receiving medical assistance under this title.

An eligible professional shall not qualify as a Medicaid provider under this subsection unless any right to payment under sections 1848(o) and 1853(l) with respect to the eligible professional has been waived in a manner specified by the Secretary. For purposes of calculating patient volume under subparagraph (A)(iii), insofar as it is related to uncompensated care, the Secretary may require the adjustment of such uncompensated care data so that it would be an appropriate proxy for charity care, including a downward adjustment to eliminate bad debt data from uncompensated care. In applying subparagraphs (A) and (B)(ii), the methodology established by the Secretary for patient volume shall include individuals enrolled in a Medicaid managed care plan (under section 1903(m) or section 1932).

(3) In this subsection and subsection (a)(3)(F):

(A) The term “certified EHR technology” means a qualified electronic health record (as defined in 3000(13) of the Public Health Service Act) that is certified pursuant to section 3001(c)(5) of such Act as meeting standards adopted under section 3004 of such Act that are applicable to the type of record involved (as determined by the Secretary, such as an ambulatory electronic health record for office-based physicians or an inpatient hospital electronic health record for hospitals).

(B) The term “eligible professional” means a—

(i) physician;

- (ii) dentist;
- (iii) certified nurse mid-wife;
- (iv) nurse practitioner; and
- (v) physician assistant insofar as the assistant is practicing in a rural health clinic that is led by a physician assistant or is practicing in a Federally qualified health center that is so led.

(C) The term “average allowable costs” means, with respect to certified EHR technology of Medicaid providers described in paragraph (2)(A) for—

- (i) the first year of payment with respect to such a provider, the average costs for the purchase and initial implementation or upgrade of such technology (and support services including training that is for, or is necessary for the adoption and initial operation of, such technology) for such providers, as determined by the Secretary based upon studies conducted under paragraph (4)(C); and
- (ii) a subsequent year of payment with respect to such a provider, the average costs not described in clause (i) relating to the operation, maintenance, and use of such technology for such providers, as determined by the Secretary based upon studies conducted under paragraph (4)(C).

(D) The term “hospital-based” means, with respect to an eligible professional, a professional (such as a pathologist, anesthesiologist, or emergency physician) who furnishes substantially all of the individual’s professional services in a hospital inpatient or emergency room setting and through the use of the facilities and equipment, including qualified electronic health records, of the hospital. The determination of whether an eligible professional is a hospital-based eligible professional shall be made on the basis of the site of service (as defined by the Secretary) and without regard to any employment or billing arrangement between the eligible professional and any other provider.

(E) The term “net average allowable costs” means, with respect to a Medicaid provider described in paragraph (2)(A), average allowable costs reduced by the average payment the Secretary estimates will be made to such Medicaid providers (determined on a percentage or other basis for such classes or types of providers as the Secretary may specify) from other sources (other than under this subsection, or by the Federal government or a State or local government) that is directly attributable to payment for certified EHR technology or support services described in subparagraph (C).

(F) The term “needy individual” means, with respect to a Medicaid provider, an individual—

- (i) who is receiving assistance under this title;
- (ii) who is receiving assistance under title XXI;
- (iii) who is furnished uncompensated care by the provider; or
- (iv) for whom charges are reduced by the provider on a sliding scale basis based on an individual’s ability to pay.

(4)(A) With respect to a Medicaid provider described in paragraph (2)(A), subject to subparagraph (B), in no case shall—

- (i) the net average allowable costs under this subsection for the first year of payment (which may not be later than 2016), which is intended to cover the costs described in paragraph (3)(C)(i), exceed \$25,000 (or such lesser amount as the Secretary determines based on studies conducted under subparagraph (C));
- (ii) the net average allowable costs under this subsection for a subsequent year of payment, which is intended to cover costs described in paragraph (3)(C)(ii), exceed \$10,000; and
- (iii) payments be made for costs described in clause (ii) after 2021 or over a period of longer than 5 years.

(B) In the case of Medicaid provider described in paragraph (2)(A)(ii), the dollar amounts specified in subparagraph (A) shall be $\frac{2}{3}$ of the dollar amounts otherwise specified.

(C) For the purposes of determining average allowable costs under this subsection, the Secretary shall study the average costs to Medicaid providers described in paragraph (2)(A) of purchase and initial implementation and upgrade of certified EHR technology described in paragraph (3)(C)(i) and the average costs to such providers of operations, maintenance, and use of such technology described in paragraph (3)(C)(ii). In determining such costs for such providers, the Secretary may utilize studies of such amounts submitted by States.

(5)(A) In no case shall the payments described in paragraph (1)(B) with respect to a Medicaid provider described in paragraph (2)(B) exceed—

- (i) in the aggregate the product of—
 - (I) the overall hospital EHR amount for the provider computed under subparagraph (B); and
 - (II) the Medicaid share for such provider computed under subparagraph (C);
- (ii) in any year 50 percent of the product described in clause (i); and
- (iii) in any 2-year period 90 percent of such product.

(B) For purposes of this paragraph, the overall hospital EHR amount, with respect to a Medicaid provider, is the sum of the applicable amounts specified in section 1886(n)(2)(A) for such provider for the first 4 payment years (as estimated by the Secretary) determined as if the Medicare share specified in clause (ii) of such section were 1. The Secretary shall establish, in consultation with the State, the overall hospital EHR amount for each such Medicaid provider eligible for payments under paragraph (1)(B). For purposes of this subparagraph in computing the amounts under section 1886(n)(2)(C) for payment years after the first payment year, the Secretary shall assume that in subsequent payment years discharges increase at the average annual rate of growth of the most recent 3 years for which discharge data are available per year.

(C) The Medicaid share computed under this subparagraph, for a Medicaid provider for a period specified by the Secretary, shall be calculated in the same manner as the Medicare share under section 1886(n)(2)(D) for such a hospital and period, except that there shall be substituted for the numerator under clause (i) of such section the amount that is equal to the number of inpatient-bed-days (as established by the Secretary) which are attributable to individ-

uals who are receiving medical assistance under this title and who are not described in section 1886(n)(2)(D)(i). In computing inpatient-bed-days under the previous sentence, the Secretary shall take into account inpatient-bed-days attributable to inpatient-bed-days that are paid for individuals enrolled in a Medicaid managed care plan (under section 1903(m) or section 1932).

(D) In no case may the payments described in paragraph (1)(B) with respect to a Medicaid provider described in paragraph (2)(B) be paid—

(i) for any year beginning after 2016 unless the provider has been provided payment under paragraph (1)(B) for the previous year; and

(ii) over a period of more than 6 years of payment.

(6) Payments described in paragraph (1) are not in accordance with this subsection unless the following requirements are met:

(A)(i) The State provides assurances satisfactory to the Secretary that amounts received under subsection (a)(3)(F) with respect to payments to a Medicaid provider are paid, subject to clause (ii), directly to such provider (or to an employer or facility to which such provider has assigned payments) without any deduction or rebate.

(ii) Amounts described in clause (i) may also be paid to an entity promoting the adoption of certified EHR technology, as designated by the State, if participation in such a payment arrangement is voluntary for the eligible professional involved and if such entity does not retain more than 5 percent of such payments for costs not related to certified EHR technology (and support services including maintenance and training) that is for, or is necessary for the operation of, such technology.

(B) A Medicaid provider described in paragraph (2)(A) is responsible for payment of the remaining 15 percent of the net average allowable cost and shall be determined to have met such responsibility to the extent that the payment to the Medicaid provider is not in excess of 85 percent of the net average allowable cost.

(C)(i) Subject to clause (ii), with respect to payments to a Medicaid provider—

(I) for the first year of payment to the Medicaid provider under this subsection, the Medicaid provider demonstrates that it is engaged in efforts to adopt, implement, or upgrade certified EHR technology; and

(II) for a year of payment, other than the first year of payment to the Medicaid provider under this subsection, the Medicaid provider demonstrates meaningful use of certified EHR technology through a means that is approved by the State and acceptable to the Secretary, and that may be based upon the methodologies applied under section 1848(o) or 1886(n).

(ii) In the case of a Medicaid provider who has completed adopting, implementing, or upgrading such technology prior to the first year of payment to the Medicaid provider under this subsection, clause (i)(I) shall not apply and clause (i)(II) shall apply to each year of payment to the Medicaid provider under this subsection, including the first year of payment.

(D) To the extent specified by the Secretary, the certified EHR technology is compatible with State or Federal administrative management systems.

For purposes of subparagraph (B), a Medicaid provider described in paragraph (2)(A) may accept payments for the costs described in such subparagraph from a State or local government. For purposes of subparagraph (C), in establishing the means described in such subparagraph, which may include clinical quality reporting to the State, the State shall ensure that populations with unique needs, such as children, are appropriately addressed.

(7) With respect to Medicaid providers described in paragraph (2)(A), the Secretary shall ensure coordination of payment with respect to such providers under sections 1848(o) and 1853(l) and under this subsection to assure no duplication of funding. Such coordination shall include, to the extent practicable, a data matching process between State Medicaid agencies and the Centers for Medicare & Medicaid Services using national provider identifiers. For such purposes, the Secretary may require the submission of such data relating to payments to such Medicaid providers as the Secretary may specify.

(8) In carrying out paragraph (6)(C), the State and Secretary shall seek, to the maximum extent practicable, to avoid duplicative requirements from Federal and State governments to demonstrate meaningful use of certified EHR technology under this title and title XVIII. In doing so, the Secretary may deem satisfaction of requirements for such meaningful use for a payment year under title XVIII to be sufficient to qualify as meaningful use under this subsection. The Secretary may also specify the reporting periods under this subsection in order to carry out this paragraph.

(9) In order to be provided Federal financial participation under subsection (a)(3)(F)(ii), a State must demonstrate to the satisfaction of the Secretary, that the State—

(A) is using the funds provided for the purposes of administering payments under this subsection, including tracking of meaningful use by Medicaid providers;

(B) is conducting adequate oversight of the program under this subsection, including routine tracking of meaningful use attestations and reporting mechanisms; and

(C) is pursuing initiatives to encourage the adoption of certified EHR technology to promote health care quality and the exchange of health care information under this title, subject to applicable laws and regulations governing such exchange.

(10) The Secretary shall periodically submit reports to the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate on status, progress, and oversight of payments described in paragraph (1), including steps taken to carry out paragraph (7). Such reports shall also describe the extent of adoption of certified EHR technology among Medicaid providers resulting from the provisions of this subsection and any improvements in health outcomes, clinical quality, or efficiency resulting from such adoption.

(u)(1)(A) Notwithstanding subsection (a)(1), if the ratio of a State's erroneous excess payments for medical assistance (as defined in subparagraph (D)) to its total expenditures for medical assistance under the State plan approved under this title exceeds

0.03, for the period consisting of the third and fourth quarters of fiscal year 1983, or for any full fiscal year thereafter, then the Secretary shall make no payment for such period or fiscal year with respect to so much of such erroneous excess payments as exceeds such allowable error rate of 0.03.

(B) The Secretary may waive, in certain limited cases, all or part of the reduction required under subparagraph (A) with respect to any State if such State is unable to reach the allowable error rate for a period or fiscal year despite a good faith effort by such State.

(C) In estimating the amount to be paid to a State under subsection (d), the Secretary shall take into consideration the limitation on Federal financial participation imposed by subparagraph (A) and shall reduce the estimate he makes under subsection (d)(1), for purposes of payment to the State under subsection (d)(3), in light of any expected erroneous excess payments for medical assistance (estimated in accordance with such criteria, including sampling procedures, as he may prescribe and subject to subsequent adjustment, if necessary, under subsection (d)(2)).

(D)(i) For purposes of this subsection, the term "erroneous excess payments for medical assistance" means the total of—

(I) payments under the State plan with respect to ineligible individuals and families, and

(II) overpayments on behalf of eligible individuals and families by reason of error in determining the amount of expenditures for medical care required of an individual or family as a condition of eligibility.

(ii) In determining the amount of erroneous excess payments for medical assistance to an ineligible individual or family under clause (i)(I), if such ineligibility is the result of an error in determining the amount of the resources of such individual or family, the amount of the erroneous excess payment shall be the smaller of (I) the amount of the payment with respect to such individual or family, or (II) the difference between the actual amount of such resources and the allowable resource level established under the State plan.

(iii) In determining the amount of erroneous excess payments for medical assistance to an individual or family under clause (i)(II), the amount of the erroneous excess payment shall be the smaller of (I) the amount of the payment on behalf of the individual or family, or (II) the difference between the actual amount incurred for medical care by the individual or family and the amount which should have been incurred in order to establish eligibility for medical assistance.

(iv) In determining the amount of erroneous excess payments, there shall not be included any error resulting from a failure of an individual to cooperate or give correct information with respect to third-party liability as required under section 1912(a)(1)(C) or 402(a)(26)(C) or with respect to payments made in violation of section 1906.

(v) In determining the amount of erroneous excess payments, there shall not be included any erroneous payments made for ambulatory prenatal care provided during a presumptive eligibility period (as defined in section 1920(b)(1)), for items and services described in subsection (a) of section 1920A provided to a child during a presumptive eligibility period under such section, for medical as-

sistance provided to an individual described in subsection (a) of section 1920B during a presumptive eligibility period under such section, or for medical assistance provided to an individual during a presumptive eligibility period resulting from a determination of presumptive eligibility made by a hospital that elects under section 1902(a)(47)(B) to be a qualified entity for such purpose.

(E) For purposes of subparagraph (D), there shall be excluded, in determining both erroneous excess payments for medical assistance and total expenditures for medical assistance—

(i) payments with respect to any individual whose eligibility therefor was determined exclusively by the Secretary under an agreement pursuant to section 1634 and such other classes of individuals as the Secretary may by regulation prescribe whose eligibility was determined in part under such an agreement; and

(ii) payments made as the result of a technical error.

(2) The State agency administering the plan approved under this title shall, at such times and in such form as the Secretary may specify, provide information on the rates of erroneous excess payments made (or expected, with respect to future periods specified by the Secretary) in connection with its administration of such plan, together with any other data he requests that are reasonably necessary for him to carry out the provisions of this subsection.

(3)(A) If a State fails to cooperate with the Secretary in providing information necessary to carry out this subsection, the Secretary, directly or through contractual or such other arrangements as he may find appropriate, shall establish the error rates for that State on the basis of the best data reasonably available to him and in accordance with such techniques for sampling and estimating as he finds appropriate.

(B) In any case in which it is necessary for the Secretary to exercise his authority under subparagraph (A) to determine a State's error rates for a fiscal year, the amount that would otherwise be payable to such State under this title for quarters in such year shall be reduced by the costs incurred by the Secretary in making (directly or otherwise) such determination.

(4) This subsection shall not apply with respect to Puerto Rico, Guam, the Virgin Islands, the Northern Mariana Islands, or American Samoa.

(v)(1) Notwithstanding the preceding provisions of this section, except as provided in paragraphs (2) and (4), no payment may be made to a State under this section for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law.

(2) Payment shall be made under this section for care and services that are furnished to an alien described in paragraph (1) only if—

(A) such care and services are necessary for the treatment of an emergency medical condition of the alien,

(B) such alien otherwise meets the eligibility requirements for medical assistance under the State plan approved under this title (other than the requirement of the receipt of aid or assistance under title IV, supplemental security income benefits under title XVI, or a State supplementary payment), and

(C) such care and services are not related to an organ transplant procedure.

(3) For purposes of this subsection, the term “emergency medical condition” means a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—

- (A) placing the patient’s health in serious jeopardy,
- (B) serious impairment to bodily functions, or
- (C) serious dysfunction of any bodily organ or part.

(4)(A) A State may elect (in a plan amendment under this title) to provide medical assistance under this title, notwithstanding sections 401(a), 402(b), 403, and 421 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, to children and pregnant women who are lawfully residing in the United States (including battered individuals described in section 431(c) of such Act) and who are otherwise eligible for such assistance, within either or both of the following eligibility categories:

(i) PREGNANT WOMEN.—Women during pregnancy (and during the 60-day period beginning on the last day of the pregnancy).

(ii) CHILDREN.—Individuals under 21 years of age, including optional targeted low-income children described in section 1905(u)(2)(B).

(B) In the case of a State that has elected to provide medical assistance to a category of aliens under subparagraph (A), no debt shall accrue under an affidavit of support against any sponsor of such an alien on the basis of provision of assistance to such category and the cost of such assistance shall not be considered as an unreimbursed cost.

(C) As part of the State’s ongoing eligibility redetermination requirements and procedures for an individual provided medical assistance as a result of an election by the State under subparagraph (A), a State shall verify that the individual continues to lawfully reside in the United States using the documentation presented to the State by the individual on initial enrollment. If the State cannot successfully verify that the individual is lawfully residing in the United States in this manner, it shall require that the individual provide the State with further documentation or other evidence to verify that the individual is lawfully residing in the United States.

(w)(1)(A) Notwithstanding the previous provisions of this section, for purposes of determining the amount to be paid to a State (as defined in paragraph (7)(D)) under subsection (a)(1) for quarters in any fiscal year, the total amount expended during such fiscal year as medical assistance under the State plan (as determined without regard to this subsection) shall be reduced by the sum of any revenues received by the State (or by a unit of local government in the State) during the fiscal year—

(i) from provider-related donations (as defined in paragraph (2)(A)), other than—

- (I) bona fide provider-related donations (as defined in paragraph (2)(B)), and
- (II) donations described in paragraph (2)(C);

(ii) from health care related taxes (as defined in paragraph (3)(A)), other than broad-based health care related taxes (as defined in paragraph (3)(B));

(iii) from a broad-based health care related tax, if there is in effect a hold harmless provision (described in paragraph (4)) with respect to the tax; or

(iv) only with respect to State fiscal years (or portions thereof) occurring on or after January 1, 1992, and before October 1, 1995, from broad-based health care related taxes to the extent the amount of such taxes collected exceeds the limit established under paragraph (5).

(B) Notwithstanding the previous provisions of this section, for purposes of determining the amount to be paid to a State under subsection (a)(7) for all quarters in a Federal fiscal year (beginning with fiscal year 1993), the total amount expended during the fiscal year for administrative expenditures under the State plan (as determined without regard to this subsection) shall be reduced by the sum of any revenues received by the State (or by a unit of local government in the State) during such quarters from donations described in paragraph (2)(C), to the extent the amount of such donations exceeds 10 percent of the amounts expended under the State plan under this title during the fiscal year for purposes described in paragraphs (2), (3), (4), (6), and (7) of subsection (a).

(C)(i) Except as otherwise provided in clause (ii), subparagraph (A)(i) shall apply to donations received on or after January 1, 1992.

(ii) Subject to the limits described in clause (iii) and subparagraph (E), subparagraph (A)(i) shall not apply to donations received before the effective date specified in subparagraph (F) if such donations are received under programs in effect or as described in State plan amendments or related documents submitted to the Secretary by September 30, 1991, and applicable to State fiscal year 1992, as demonstrated by State plan amendments, written agreements, State budget documentation, or other documentary evidence in existence on that date.

(iii) In applying clause (ii) in the case of donations received in State fiscal year 1993, the maximum amount of such donations to which such clause may be applied may not exceed the total amount of such donations received in the corresponding period in State fiscal year 1992 (or not later than 5 days after the last day of the corresponding period).

(D)(i) Except as otherwise provided in clause (ii), subparagraphs (A)(ii) and (A)(iii) shall apply to taxes received on or after January 1, 1992.

(ii) Subparagraphs (A)(ii) and (A)(iii) shall not apply to impermissible taxes (as defined in clause (iii)) received before the effective date specified in subparagraph (F) to the extent the taxes (including the tax rate or base) were in effect, or the legislation or regulations imposing such taxes were enacted or adopted, as of November 22, 1991.

(iii) In this subparagraph and subparagraph (E), the term "impermissible tax" means a health care related tax for which a reduction may be made under clause (ii) or (iii) of subparagraph (A).

(E)(i) In no case may the total amount of donations and taxes permitted under the exception provided in subparagraphs (C)(ii) and (D)(ii) for the portion of State fiscal year 1992 occurring during

calendar year 1992 exceed the limit under paragraph (5) minus the total amount of broad-based health care related taxes received in the portion of that fiscal year.

(ii) In no case may the total amount of donations and taxes permitted under the exception provided in subparagraphs (C)(ii) and (D)(ii) for State fiscal year 1993 exceed the limit under paragraph (5) minus the total amount of broad-based health care related taxes received in that fiscal year.

(F) In this paragraph in the case of a State—

(i) except as provided in clause (iii), with a State fiscal year beginning on or before July 1, the effective date is October 1, 1992,

(ii) except as provided in clause (iii), with a State fiscal year that begins after July 1, the effective date is January 1, 1993, or

(iii) with a State legislature which is not scheduled to have a regular legislative session in 1992, with a State legislature which is not scheduled to have a regular legislative session in 1993, or with a provider-specific tax enacted on November 4, 1991, the effective date is July 1, 1993.

(2)(A) In this subsection (except as provided in paragraph (6)), the term “provider-related donation” means any donation or other voluntary payment (whether in cash or in kind) made (directly or indirectly) to a State or unit of local government by—

(i) a health care provider (as defined in paragraph (7)(B)),

(ii) an entity related to a health care provider (as defined in paragraph (7)(C)), or

(iii) an entity providing goods or services under the State plan for which payment is made to the State under paragraph (2), (3), (4), (6), or (7) of subsection (a).

(B) For purposes of paragraph (1)(A)(i)(I), the term “bona fide provider-related donation” means a provider-related donation that has no direct or indirect relationship (as determined by the Secretary) to payments made under this title to that provider, to providers furnishing the same class of items and services as that provider, or to any related entity, as established by the State to the satisfaction of the Secretary. The Secretary may by regulation specify types of provider-related donations described in the previous sentence that will be considered to be bona fide provider-related donations.

(C) For purposes of paragraph (1)(A)(i)(II), donations described in this subparagraph are funds expended by a hospital, clinic, or similar entity for the direct cost (including costs of training and of preparing and distributing outreach materials) of State or local agency personnel who are stationed at the hospital, clinic, or entity to determine the eligibility of individuals for medical assistance under this title and to provide outreach services to eligible or potentially eligible individuals.

(3)(A) In this subsection (except as provided in paragraph (6)), the term “health care related tax” means a tax (as defined in paragraph (7)(F)) that—

(i) is related to health care items or services, or to the provision of, the authority to provide, or payment for, such items or services, or

(ii) is not limited to such items or services but provides for treatment of individuals or entities that are providing or paying for such items or services that is different from the treatment provided to other individuals or entities.

In applying clause (i), a tax is considered to relate to health care items or services if at least 85 percent of the burden of such tax falls on health care providers.

(B) In this subsection, the term “broad-based health care related tax” means a health care related tax which is imposed with respect to a class of health care items or services (as described in paragraph (7)(A)) or with respect to providers of such items or services and which, except as provided in subparagraphs (D), (E), and (F)—

(i) is imposed at least with respect to all items or services in the class furnished by all non-Federal, nonpublic providers in the State (or, in the case of a tax imposed by a unit of local government, the area over which the unit has jurisdiction) or is imposed with respect to all non-Federal, nonpublic providers in the class; and

(ii) is imposed uniformly (in accordance with subparagraph (C)).

(C)(i) Subject to clause (ii), for purposes of subparagraph (B)(ii), a tax is considered to be imposed uniformly if—

(I) in the case of a tax consisting of a licensing fee or similar tax on a class of health care items or services (or providers of such items or services), the amount of the tax imposed is the same for every provider providing items or services within the class;

(II) in the case of a tax consisting of a licensing fee or similar tax imposed on a class of health care items or services (or providers of such services) on the basis of the number of beds (licensed or otherwise) of the provider, the amount of the tax is the same for each bed of each provider of such items or services in the class;

(III) in the case of a tax based on revenues or receipts with respect to a class of items or services (or providers of items or services) the tax is imposed at a uniform rate for all items and services (or providers of such items or services) in the class on all the gross revenues or receipts, or net operating revenues, relating to the provision of all such items or services (or all such providers) in the State (or, in the case of a tax imposed by a unit of local government within the State, in the area over which the unit has jurisdiction); or

(IV) in the case of any other tax, the State establishes to the satisfaction of the Secretary that the tax is imposed uniformly.

(ii) Subject to subparagraphs (D) and (E), a tax imposed with respect to a class of health care items and services is not considered to be imposed uniformly if the tax provides for any credits, exclusions, or deductions which have as their purpose or effect the return to providers of all or a portion of the tax paid in a manner that is inconsistent with subclauses (I) and (II) of subparagraph (E)(ii) or provides for a hold harmless provision described in paragraph (4).

(D) A tax imposed with respect to a class of health care items and services is considered to be imposed uniformly—

(i) notwithstanding that the tax is not imposed with respect to items or services (or the providers thereof) for which payment is made under a State plan under this title or title XVIII, or

(ii) in the case of a tax described in subparagraph (C)(i)(III), notwithstanding that the tax provides for exclusion (in whole or in part) of revenues or receipts from a State plan under this title or title XVIII.

(E)(i) A State may submit an application to the Secretary requesting that the Secretary treat a tax as a broad-based health care related tax, notwithstanding that the tax does not apply to all health care items or services in class (or all providers of such items and services), provides for a credit, deduction, or exclusion, is not applied uniformly, or otherwise does not meet the requirements of subparagraph (B) or (C). Permissible waivers may include exemptions for rural or sole-community providers.

(ii) The Secretary shall approve such an application if the State establishes to the satisfaction of the Secretary that—

(I) the net impact of the tax and associated expenditures under this title as proposed by the State is generally redistributive in nature, and

(II) the amount of the tax is not directly correlated to payments under this title for items or services with respect to which the tax is imposed.

The Secretary shall by regulation specify types of credits, exclusions, and deductions that will be considered to meet the requirements of this subparagraph.

(F) In no case shall a tax not qualify as a broad-based health care related tax under this paragraph because it does not apply to a hospital that is described in section 501(c)(3) of the Internal Revenue Code of 1986 and exempt from taxation under section 501(a) of such Code and that does not accept payment under the State plan under this title or under title XVIII.

(4) For purposes of paragraph (1)(A)(iii), there is in effect a hold harmless provision with respect to a broad-based health care related tax imposed with respect to a class of items or services if the Secretary determines that any of the following applies:

(A) The State or other unit of government imposing the tax provides (directly or indirectly) for a payment (other than under this title) to taxpayers and the amount of such payment is positively correlated either to the amount of such tax or to the difference between the amount of the tax and the amount of payment under the State plan.

(B) All or any portion of the payment made under this title to the taxpayer varies based only upon the amount of the total tax paid.

(C)(i) The State or other unit of government imposing the tax provides (directly or indirectly) for any payment, offset, or waiver that guarantees to hold taxpayers harmless for any portion of the costs of the tax.

(ii) For purposes of clause (i), a determination of the existence of an indirect guarantee shall be made under paragraph (3)(i) of section 433.68(f) of title 42, Code of Federal Regulations, as in effect on November 1, 2006, except that for portions of fiscal years beginning on or after January 1, 2008, and be-

fore October 1, 2011, “5.5 percent” shall be substituted for “6 percent” each place it appears.

The provisions of this paragraph shall not prevent use of the tax to reimburse health care providers in a class for expenditures under this title nor preclude States from relying on such reimbursement to justify or explain the tax in the legislative process.

(5)(A) For purposes of this subsection, the limit under this subparagraph with respect to a State is an amount equal to 25 percent (or, if greater, the State base percentage, as defined in subparagraph (B)) of the non-Federal share of the total amount expended under the State plan during a State fiscal year (or portion thereof), as it would be determined pursuant to paragraph (1)(A) without regard to paragraph (1)(A)(iv).

(B)(i) In subparagraph (A), the term “State base percentage” means, with respect to a State, an amount (expressed as a percentage) equal to—

(I) the total of the amount of health care related taxes (whether or not broad-based) and the amount of provider-related donations (whether or not bona fide) projected to be collected (in accordance with clause (ii)) during State fiscal year 1992, divided by

(II) the non-Federal share of the total amount estimated to be expended under the State plan during such State fiscal year.

(ii) For purposes of clause (i)(I), in the case of a tax that is not in effect throughout State fiscal year 1992 or the rate (or base) of which is increased during such fiscal year, the Secretary shall project the amount to be collected during such fiscal year as if the tax (or increase) were in effect during the entire State fiscal year.

(C)(i) The total amount of health care related taxes under subparagraph (B)(i)(I) shall be determined by the Secretary based on only those taxes (including the tax rate or base) which were in effect, or for which legislation or regulations imposing such taxes were enacted or adopted, as of November 22, 1991.

(ii) The amount of provider-related donations under subparagraph (B)(i)(I) shall be determined by the Secretary based on programs in effect on September 30, 1991, and applicable to State fiscal year 1992, as demonstrated by State plan amendments, written agreements, State budget documentation, or other documentary evidence in existence on that date.

(iii) The amount of expenditures described in subparagraph (B)(i)(II) shall be determined by the Secretary based on the best data available as of the date of the enactment of this subsection.

(6)(A) Notwithstanding the provisions of this subsection, the Secretary may not restrict States’ use of funds where such funds are derived from State or local taxes (or funds appropriated to State university teaching hospitals) transferred from or certified by units of government within a State as the non-Federal share of expenditures under this title, regardless of whether the unit of government is also a health care provider, except as provided in section 1902(a)(2), unless the transferred funds are derived by the unit of government from donations or taxes that would not otherwise be recognized as the non-Federal share under this section.

(B) For purposes of this subsection, funds the use of which the Secretary may not restrict under subparagraph (A) shall not be

considered to be a provider-related donation or a health care related tax.

(7) For purposes of this subsection:

(A) Each of the following shall be considered a separate class of health care items and services:

- (i) Inpatient hospital services.
- (ii) Outpatient hospital services.
- (iii) Nursing facility services (other than services of intermediate care facilities for the mentally retarded).
- (iv) Services of intermediate care facilities for the mentally retarded.
- (v) Physicians' services.
- (vi) Home health care services.
- (vii) Outpatient prescription drugs.
- (viii) Services of managed care organizations (including health maintenance organizations, preferred provider organizations, and such other similar organizations as the Secretary may specify by regulation).

(ix) Such other classification of health care items and services consistent with this subparagraph as the Secretary may establish by regulation.

(B) The term "health care provider" means an individual or person that receives payments for the provision of health care items or services.

(C) An entity is considered to be "related" to a health care provider if the entity—

- (i) is an organization, association, corporation or partnership formed by or on behalf of health care providers;
- (ii) is a person with an ownership or control interest (as defined in section 1124(a)(3)) in the provider;
- (iii) is the employee, spouse, parent, child, or sibling of the provider (or of a person described in clause (ii)); or
- (iv) has a similar, close relationship (as defined in regulations) to the provider.

(D) The term "State" means only the 50 States and the District of Columbia but does not include any State whose entire program under this title is operated under a waiver granted under section 1115.

(E) The "State fiscal year" means, with respect to a specified year, a State fiscal year ending in that specified year.

(F) The term "tax" includes any licensing fee, assessment, or other mandatory payment, but does not include payment of a criminal or civil fine or penalty (other than a fine or penalty imposed in lieu of or instead of a fee, assessment, or other mandatory payment).

(G) The term "unit of local government" means, with respect to a State, a city, county, special purpose district, or other governmental unit in the State.

(x)(1) For purposes of section 1902(a)(46)(B)(i), the requirement of this subsection is, with respect to an individual declaring to be a citizen or national of the United States, that, subject to paragraph (2), there is presented satisfactory documentary evidence of citizenship or nationality (as defined in paragraph (3)) of the individual.

(2) The requirement of paragraph (1) shall not apply to an individual declaring to be a citizen or national of the United States who is eligible for medical assistance under this title—

(A) and is entitled to or enrolled for benefits under any part of title XVIII;

(B) and is receiving—

(i) disability insurance benefits under section 223 or monthly insurance benefits under section 202 based on such individual's disability (as defined in section 223(d)); or

(ii) supplemental security income benefits under title XVI;

(C) and with respect to whom—

(i) child welfare services are made available under part B of title IV on the basis of being a child in foster care; or

(ii) adoption or foster care assistance is made available under part E of title IV;

(D) pursuant to the application of section 1902(e)(4) (and, in the case of an individual who is eligible for medical assistance on such basis, the individual shall be deemed to have provided satisfactory documentary evidence of citizenship or nationality and shall not be required to provide further documentary evidence on any date that occurs during or after the period in which the individual is eligible for medical assistance on such basis); or

(E) on such basis as the Secretary may specify under which satisfactory documentary evidence of citizenship or nationality has been previously presented.

(3)(A) For purposes of this subsection, the term "satisfactory documentary evidence of citizenship or nationality" means—

(i) any document described in subparagraph (B); or

(ii) a document described in subparagraph (C) and a document described in subparagraph (D).

(B) The following are documents described in this subparagraph:

(i) A United States passport.

(ii) Form N-550 or N-570 (Certificate of Naturalization).

(iii) Form N-560 or N-561 (Certificate of United States Citizenship).

(iv) A valid State-issued driver's license or other identity document described in section 274A(b)(1)(D) of the Immigration and Nationality Act, but only if the State issuing the license or such document requires proof of United States citizenship before issuance of such license or document or obtains a social security number from the applicant and verifies before certification that such number is valid and assigned to the applicant who is a citizen.

(v)(I) Except as provided in subclause (II), a document issued by a federally recognized Indian tribe evidencing membership or enrollment in, or affiliation with, such tribe (such as a tribal enrollment card or certificate of degree of Indian blood).

(II) With respect to those federally recognized Indian tribes located within States having an international border whose membership includes individuals who are not citizens of the United States, the Secretary shall, after consulting with such

tribes, issue regulations authorizing the presentation of such other forms of documentation (including tribal documentation, if appropriate) that the Secretary determines to be satisfactory documentary evidence of citizenship or nationality for purposes of satisfying the requirement of this subsection.

(vi) Such other document as the Secretary may specify, by regulation, that provides proof of United States citizenship or nationality and that provides a reliable means of documentation of personal identity.

(C) The following are documents described in this subparagraph:

(i) A certificate of birth in the United States.

(ii) Form FS-545 or Form DS-1350 (Certification of Birth Abroad).

(iii) Form I-197 (United States Citizen Identification Card).

(iv) Form FS-240 (Report of Birth Abroad of a Citizen of the United States).

(v) Such other document (not described in subparagraph (B)(iv)) as the Secretary may specify that provides proof of United States citizenship or nationality.

(D) The following are documents described in this subparagraph:

(i) Any identity document described in section 274A(b)(1)(D) of the Immigration and Nationality Act.

(ii) Any other documentation of personal identity of such other type as the Secretary finds, by regulation, provides a reliable means of identification.

(E) A reference in this paragraph to a form includes a reference to any successor form.

(4) In the case of an individual declaring to be a citizen or national of the United States with respect to whom a State requires the presentation of satisfactory documentary evidence of citizenship or nationality under section 1902(a)(46)(B)(i), the individual shall be provided at least the reasonable opportunity to present satisfactory documentary evidence of citizenship or nationality under this subsection as is provided under clauses (i) and (ii) of section 1137(d)(4)(A) to an individual for the submittal to the State of evidence indicating a satisfactory immigration status.

(5) Nothing in subparagraph (A) or (B) of section 1902(a)(46), the preceding paragraphs of this subsection, or the Deficit Reduction Act of 2005, including section 6036 of such Act, shall be construed as changing the requirement of section 1902(e)(4) that a child born in the United States to an alien mother for whom medical assistance for the delivery of such child is available as treatment of an emergency medical condition pursuant to subsection (v) shall be deemed eligible for medical assistance during the first year of such child's life.

(y) PAYMENTS FOR ESTABLISHMENT OF ALTERNATE NON-EMERGENCY SERVICES PROVIDERS.—

(1) PAYMENTS.—In addition to the payments otherwise provided under subsection (a), subject to paragraph (2), the Secretary shall provide for payments to States under such subsection for the establishment of alternate non-emergency service providers (as defined in section 1916A(e)(5)(B)), or networks of such providers.

(2) LIMITATION.—The total amount of payments under this subsection shall not exceed \$50,000,000 during the 4-year pe-

riod beginning with 2006. This subsection constitutes budget authority in advance of appropriations Acts and represents the obligation of the Secretary to provide for the payment of amounts provided under this subsection.

(3) PREFERENCE.—In providing for payments to States under this subsection, the Secretary shall provide preference to States that establish, or provide for, alternate non-emergency services providers or networks of such providers that—

(A) serve rural or underserved areas where beneficiaries under this title may not have regular access to providers of primary care services; or

(B) are in partnership with local community hospitals.

(4) FORM AND MANNER OF PAYMENT.—Payment to a State under this subsection shall be made only upon the filing of such application in such form and in such manner as the Secretary shall specify. Payment to a State under this subsection shall be made in the same manner as other payments under section 1903(a).

(z) MEDICAID TRANSFORMATION PAYMENTS.—

(1) IN GENERAL.—In addition to the payments provided under subsection (a), subject to paragraph (4), the Secretary shall provide for payments to States for the adoption of innovative methods to improve the effectiveness and efficiency in providing medical assistance under this title.

(2) PERMISSIBLE USES OF FUNDS.—The following are examples of innovative methods for which funds provided under this subsection may be used:

(A) Methods for reducing patient error rates through the implementation and use of electronic health records, electronic clinical decision support tools, or e-prescribing programs.

(B) Methods for improving rates of collection from estates of amounts owed under this title.

(C) Methods for reducing waste, fraud, and abuse under the program under this title, such as reducing improper payment rates as measured by annual payment error rate measurement (PERM) project rates.

(D) Implementation of a medication risk management program as part of a drug use review program under section 1927(g).

(E) Methods in reducing, in clinically appropriate ways, expenditures under this title for covered outpatient drugs, particularly in the categories of greatest drug utilization, by increasing the utilization of generic drugs through the use of education programs and other incentives to promote greater use of generic drugs.

(F) Methods for improving access to primary and specialty physician care for the uninsured using integrated university-based hospital and clinic systems.

(3) APPLICATION; TERMS AND CONDITIONS.—

(A) IN GENERAL.—No payments shall be made to a State under this subsection unless the State applies to the Secretary for such payments in a form, manner, and time specified by the Secretary.

(B) TERMS AND CONDITIONS.—Such payments are made under such terms and conditions consistent with this subsection as the Secretary prescribes.

(C) ANNUAL REPORT.—Payment to a State under this subsection is conditioned on the State submitting to the Secretary an annual report on the programs supported by such payment. Such report shall include information on—

- (i) the specific uses of such payment;
- (ii) an assessment of quality improvements and clinical outcomes under such programs; and
- (iii) estimates of cost savings resulting from such programs.

(4) FUNDING.—

(A) LIMITATION ON FUNDS.—The total amount of payments under this subsection shall be equal to, and shall not exceed—

- (i) \$75,000,000 for fiscal year 2007; and
- (ii) \$75,000,000 for fiscal year 2008.

This subsection constitutes budget authority in advance of appropriations Acts and represents the obligation of the Secretary to provide for the payment of amounts provided under this subsection.

(B) ALLOCATION OF FUNDS.—The Secretary shall specify a method for allocating the funds made available under this subsection among States. Such method shall provide preference for States that design programs that target health providers that treat significant numbers of Medicaid beneficiaries. Such method shall provide that not less than 25 percent of such funds shall be allocated among States the population of which (as determined according to data collected by the United States Census Bureau) as of July 1, 2004, was more than 105 percent of the population of the respective State (as so determined) as of April 1, 2000.

(C) FORM AND MANNER OF PAYMENT.—Payment to a State under this subsection shall be made in the same manner as other payments under section 1903(a). There is no requirement for State matching funds to receive payments under this subsection.

(5) MEDICATION RISK MANAGEMENT PROGRAM.—

(A) IN GENERAL.—For purposes of this subsection, the term “medication risk management program” means a program for targeted beneficiaries that ensures that covered outpatient drugs are appropriately used to optimize therapeutic outcomes through improved medication use and to reduce the risk of adverse events.

(B) ELEMENTS.—Such program may include the following elements:

- (i) The use of established principles and standards for drug utilization review and best practices to analyze prescription drug claims of targeted beneficiaries and identify outlier physicians.
- (ii) On an ongoing basis provide outlier physicians—
 - (I) a comprehensive pharmacy claims history for each targeted beneficiary under their care;

(II) information regarding the frequency and cost of relapses and hospitalizations of targeted beneficiaries under the physician's care; and

(III) applicable best practice guidelines and empirical references.

(iii) Monitor outlier physician's prescribing, such as failure to refill, dosage strengths, and provide incentives and information to encourage the adoption of best clinical practices.

(C) TARGETED BENEFICIARIES.—For purposes of this paragraph, the term “targeted beneficiaries” means Medicaid eligible beneficiaries who are identified as having high prescription drug costs and medical costs, such as individuals with behavioral disorders or multiple chronic diseases who are taking multiple medications.

* * * * *

PROVISIONS RELATING TO MANAGED CARE

SEC. 1932. (a) STATE OPTION TO USE MANAGED CARE.—

(1) USE OF MEDICAID MANAGED CARE ORGANIZATIONS AND PRIMARY CARE CASE MANAGERS.—

(A) IN GENERAL.—Subject to the succeeding provisions of this section, and notwithstanding paragraph (1), (10)(B), or (23)(A) of section 1902(a), a State—

(i) may require an individual who is eligible for medical assistance under the State plan under this title to enroll with a managed care entity as a condition of receiving such assistance (and, with respect to assistance furnished by or under arrangements with such entity, to receive such assistance through the entity), if—

(I) the entity and the contract with the State meet the applicable requirements of this section and section 1903(m) or section 1905(t), and

(II) the requirements described in the succeeding paragraphs of this subsection are met; and

(ii) may restrict the number of provider agreements with managed care entities under the State plan if such restriction does not substantially impair access to services.

(B) DEFINITION OF MANAGED CARE ENTITY.—In this section, the term “managed care entity” means—

(i) a medicaid managed care organization, as defined in section 1903(m)(1)(A), that provides or arranges for services for enrollees under a contract pursuant to section 1903(m); and

(ii) a primary care case manager, as defined in section 1905(t)(2).

(2) SPECIAL RULES.—

(A) EXEMPTION OF CERTAIN CHILDREN WITH SPECIAL NEEDS.—A State may not require under paragraph (1) the enrollment in a managed care entity of an individual under 19 years of age who—

- (i) is eligible for supplemental security income under title XVI;
- (ii) is described in section 501(a)(1)(D);
- (iii) is described in section 1902(e)(3);
- (iv) is receiving foster care or adoption assistance under part E of title IV; or
- (v) is in foster care or otherwise in an out-of-home placement.

(B) EXEMPTION OF MEDICARE BENEFICIARIES.—A State may not require under paragraph (1) the enrollment in a managed care entity of an individual who is a qualified medicare beneficiary (as defined in section 1905(p)(1)) or an individual otherwise eligible for benefits under title XVIII.

(C) INDIAN ENROLLMENT.—A State may not require under paragraph (1) the enrollment in a managed care entity of an individual who is an Indian (as defined in section 4(c) of the Indian Health Care Improvement Act of 1976 (25 U.S.C. 1603(c)) unless the entity is one of the following (and only if such entity is participating under the plan):

- (i) The Indian Health Service.
- (ii) An Indian health program operated by an Indian tribe or tribal organization pursuant to a contract, grant, cooperative agreement, or compact with the Indian Health Service pursuant to the Indian Self-Determination Act (25 U.S.C. 450 et seq.).
- (iii) An urban Indian health program operated by an urban Indian organization pursuant to a grant or contract with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.).

(3) CHOICE OF COVERAGE.—

(A) IN GENERAL.—A State must permit an individual to choose a managed care entity from not less than two such entities that meet the applicable requirements of this section, and of section 1903(m) or section 1905(t).

(B) STATE OPTION.—At the option of the State, a State shall be considered to meet the requirements of subparagraph (A) in the case of an individual residing in a rural area, if the State requires the individual to enroll with a managed care entity if such entity—

- (i) permits the individual to receive such assistance through not less than two physicians or case managers (to the extent that at least two physicians or case managers are available to provide such assistance in the area), and
- (ii) permits the individual to obtain such assistance from any other provider in appropriate circumstances (as established by the State under regulations of the Secretary).

(C) TREATMENT OF CERTAIN COUNTY-OPERATED HEALTH INSURING ORGANIZATIONS.—A State shall be considered to meet the requirement of subparagraph (A) if—

- (i) the managed care entity in which the individual is enrolled is a health-insuring organization which—

(I) first became operational prior to January 1, 1986, or

(II) is described in section 9517(c)(3) of the Omnibus Budget Reconciliation Act of 1985 (as added by section 4734(2) of the Omnibus Budget Reconciliation Act of 1990), and

(ii) the individual is given a choice between at least two providers within such entity.

(4) PROCESS FOR ENROLLMENT AND TERMINATION AND CHANGE OF ENROLLMENT.—As conditions under paragraph (1)(A)—

(A) IN GENERAL.—The State, enrollment broker (if any), and managed care entity shall permit an individual eligible for medical assistance under the State plan under this title who is enrolled with the entity under this title to terminate (or change) such enrollment—

(i) for cause at any time (consistent with section 1903(m)(2)(A)(vi)), and

(ii) without cause—

(I) during the 90-day period beginning on the date the individual receives notice of such enrollment, and

(II) at least every 12 months thereafter.

(B) NOTICE OF TERMINATION RIGHTS.—The State shall provide for notice to each such individual of the opportunity to terminate (or change) enrollment under such conditions. Such notice shall be provided at least 60 days before each annual enrollment opportunity described in subparagraph (A)(ii)(II).

(C) ENROLLMENT PRIORITIES.—In carrying out paragraph (1)(A), the State shall establish a method for establishing enrollment priorities in the case of a managed care entity that does not have sufficient capacity to enroll all such individuals seeking enrollment under which individuals already enrolled with the entity are given priority in continuing enrollment with the entity.

(D) DEFAULT ENROLLMENT PROCESS.—In carrying out paragraph (1)(A), the State shall establish a default enrollment process—

(i) under which any such individual who does not enroll with a managed care entity during the enrollment period specified by the State shall be enrolled by the State with such an entity which has not been found to be out of substantial compliance with the applicable requirements of this section and of section 1903(m) or section 1905(t); and

(ii) that takes into consideration—

(I) maintaining existing provider-individual relationships or relationships with providers that have traditionally served beneficiaries under this title; and

(II) if maintaining such provider relationships is not possible, the equitable distribution of such individuals among qualified managed care entities

available to enroll such individuals, consistent with the enrollment capacities of the entities.

(5) PROVISION OF INFORMATION.—

(A) INFORMATION IN EASILY UNDERSTOOD FORM.—Each State, enrollment broker, or managed care entity shall provide all enrollment notices and informational and instructional materials relating to such an entity under this title in a manner and form which may be easily understood by enrollees and potential enrollees of the entity who are eligible for medical assistance under the State plan under this title.

(B) INFORMATION TO ENROLLEES AND POTENTIAL ENROLLEES.—Each managed care entity that is a medicaid managed care organization shall, upon request, make available to enrollees and potential enrollees in the organization's service area information concerning the following:

(i) PROVIDERS.—The identity, locations, qualifications, and availability of health care providers that participate with the organization.

(ii) ENROLLEE RIGHTS AND RESPONSIBILITIES.—The rights and responsibilities of enrollees.

(iii) GRIEVANCE AND APPEAL PROCEDURES.—The procedures available to an enrollee and a health care provider to challenge or appeal the failure of the organization to cover a service.

(iv) INFORMATION ON COVERED ITEMS AND SERVICES.—All items and services that are available to enrollees under the contract between the State and the organization that are covered either directly or through a method of referral and prior authorization. Each managed care entity that is a primary care case manager shall, upon request, make available to enrollees and potential enrollees in the organization's service area the information described in clause (iii).

(C) COMPARATIVE INFORMATION.—A State that requires individuals to enroll with managed care entities under paragraph (1)(A) shall annually (and upon request) provide, directly or through the managed care entity, to such individuals a list identifying the managed care entities that are (or will be) available and information (presented in a comparative, chart-like form) relating to the following for each such entity offered:

(i) BENEFITS AND COST-SHARING.—The benefits covered and cost-sharing imposed by the entity.

(ii) SERVICE AREA.—The service area of the entity.

(iii) QUALITY AND PERFORMANCE.—To the extent available, quality and performance indicators for the benefits under the entity.

(D) INFORMATION ON BENEFITS NOT COVERED UNDER MANAGED CARE ARRANGEMENT.—A State, directly or through managed care entities, shall, on or before an individual enrolls with such an entity under this title, inform the enrollee in a written and prominent manner of any benefits to which the enrollee may be entitled to under this title but which are not made available to the enrollee

through the entity. Such information shall include information on where and how such enrollees may access benefits not made available to the enrollee through the entity.

(b) BENEFICIARY PROTECTIONS.—

(1) SPECIFICATION OF BENEFITS.—Each contract with a managed care entity under section 1903(m) or under section 1905(t)(3) shall specify the benefits the provision (or arrangement) for which the entity is responsible.

(2) ASSURING COVERAGE TO EMERGENCY SERVICES.—

(A) IN GENERAL.—Each contract with a medicaid managed care organization under section 1903(m) and each contract with a primary care case manager under section 1905(t)(3) shall require the organization or manager—

(i) to provide coverage for emergency services (as defined in subparagraph (B)) without regard to prior authorization or the emergency care provider's contractual relationship with the organization or manager, and

(ii) to comply with guidelines established under section 1852(d)(2) (respecting coordination of post-stabilization care) in the same manner as such guidelines apply to Medicare+Choice plans offered under part C of title XVIII.

The requirement under clause (ii) shall first apply 30 days after the date of promulgation of the guidelines referred to in such clause.

(B) EMERGENCY SERVICES DEFINED.—In subparagraph (A)(i), the term “emergency services” means, with respect to an individual enrolled with an organization, covered inpatient and outpatient services that—

(i) are furnished by a provider that is qualified to furnish such services under this title, and

(ii) are needed to evaluate or stabilize an emergency medical condition (as defined in subparagraph (C)).

(C) EMERGENCY MEDICAL CONDITION DEFINED.—In subparagraph (B)(ii), the term “emergency medical condition” means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in—

(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

(ii) serious impairment to bodily functions, or

(iii) serious dysfunction of any bodily organ or part.

(D) EMERGENCY SERVICES FURNISHED BY NON-CONTRACT PROVIDERS.—Any provider of emergency services that does not have in effect a contract with a Medicaid managed care entity that establishes payment amounts for services furnished to a beneficiary enrolled in the entity's Medicaid managed care plan must accept as payment in full no more than the amounts (less any payments for indirect costs of medical education and direct costs of graduate medical education) that it could collect if the beneficiary received

medical assistance under this title other than through enrollment in such an entity. In a State where rates paid to hospitals under the State plan are negotiated by contract and not publicly released, the payment amount applicable under this subparagraph shall be the average contract rate that would apply under the State plan for general acute care hospitals or the average contract rate that would apply under such plan for tertiary hospitals.

(3) PROTECTION OF ENROLLEE-PROVIDER COMMUNICATIONS.—

(A) IN GENERAL.—Subject to subparagraphs (B) and (C), under a contract under section 1903(m) a medicaid managed care organization (in relation to an individual enrolled under the contract) shall not prohibit or otherwise restrict a covered health care professional (as defined in subparagraph (D)) from advising such an individual who is a patient of the professional about the health status of the individual or medical care or treatment for the individual's condition or disease, regardless of whether benefits for such care or treatment are provided under the contract, if the professional is acting within the lawful scope of practice.

(B) CONSTRUCTION.—Subparagraph (A) shall not be construed as requiring a medicaid managed care organization to provide, reimburse for, or provide coverage of, a counseling or referral service if the organization—

(i) objects to the provision of such service on moral or religious grounds; and

(ii) in the manner and through the written instrumentalities such organization deems appropriate, makes available information on its policies regarding such service to prospective enrollees before or during enrollment and to enrollees within 90 days after the date that the organization adopts a change in policy regarding such a counseling or referral service.

Nothing in this subparagraph shall be construed to affect disclosure requirements under State law or under the Employee Retirement Income Security Act of 1974.

(C) HEALTH CARE PROFESSIONAL DEFINED.—For purposes of this paragraph, the term “health care professional” means a physician (as defined in section 1861(r)) or other health care professional if coverage for the professional's services is provided under the contract referred to in subparagraph (A) for the services of the professional. Such term includes a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist and therapy assistant, speech-language pathologist, audiologist, registered or licensed practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse-midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician.

(4) GRIEVANCE PROCEDURES.—Each medicaid managed care organization shall establish an internal grievance procedure under which an enrollee who is eligible for medical assistance

under the State plan under this title, or a provider on behalf of such an enrollee, may challenge the denial of coverage of or payment for such assistance.

(5) DEMONSTRATION OF ADEQUATE CAPACITY AND SERVICES.—Each medicaid managed care organization shall provide the State and the Secretary with adequate assurances (in a time and manner determined by the Secretary) that the organization, with respect to a service area, has the capacity to serve the expected enrollment in such service area, including assurances that the organization—

(A) offers an appropriate range of services and access to preventive and primary care services for the population expected to be enrolled in such service area, and

(B) maintains a sufficient number, mix, and geographic distribution of providers of services.

(6) PROTECTING ENROLLEES AGAINST LIABILITY FOR PAYMENT.—Each medicaid managed care organization shall provide that an individual eligible for medical assistance under the State plan under this title who is enrolled with the organization may not be held liable—

(A) for the debts of the organization, in the event of the organization's insolvency,

(B) for services provided to the individual—

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

(ii) in the event of a health care provider with a contractual, referral, or other arrangement with the organization failing to receive payment from the State or the organization for such services, or

(C) for payments to a provider that furnishes covered services under a contractual, referral, or other arrangement with the organization in excess of the amount that would be owed by the individual if the organization had directly provided the services.

(7) ANTIDISCRIMINATION.—A medicaid managed care organization shall not discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification. This paragraph shall not be construed to prohibit an organization from including providers only to the extent necessary to meet the needs of the organization's enrollees or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the organization.

(8) COMPLIANCE WITH CERTAIN MATERNITY AND MENTAL HEALTH REQUIREMENTS.—Each medicaid managed care organization shall comply with the requirements of subpart 2 of part A of title XXVII of the Public Health Service Act insofar as such requirements apply and are effective with respect to a health insurance issuer that offers group health insurance coverage.

(c) QUALITY ASSURANCE STANDARDS.—

(1) QUALITY ASSESSMENT AND IMPROVEMENT STRATEGY.—

(A) IN GENERAL.—If a State provides for contracts with medicaid managed care organizations under section 1903(m), the State shall develop and implement a quality assessment and improvement strategy consistent with this paragraph. Such strategy shall include the following:

(i) ACCESS STANDARDS.—Standards for access to care so that covered services are available within reasonable timeframes and in a manner that ensures continuity of care and adequate primary care and specialized services capacity.

(ii) OTHER MEASURES.—Examination of other aspects of care and service directly related to the improvement of quality of care (including grievance procedures and marketing and information standards).

(iii) MONITORING PROCEDURES.—Procedures for monitoring and evaluating the quality and appropriateness of care and services to enrollees that reflect the full spectrum of populations enrolled under the contract and that includes requirements for provision of quality assurance data to the State using the data and information set that the Secretary has specified for use under part C of title XVIII or such alternative data as the Secretary approves, in consultation with the State.

(iv) PERIODIC REVIEW.—Regular, periodic examinations of the scope and content of the strategy.

(B) STANDARDS.—The strategy developed under subparagraph (A) shall be consistent with standards that the Secretary first establishes within 1 year after the date of the enactment of this section. Such standards shall not preempt any State standards that are more stringent than such standards. Guidelines relating to quality assurance that are applied under section 1915(b)(1) shall apply under this subsection until the effective date of standards for quality assurance established under this subparagraph.

(C) MONITORING.—The Secretary shall monitor the development and implementation of strategies under subparagraph (A).

(D) CONSULTATION.—The Secretary shall conduct activities under subparagraphs (B) and (C) in consultation with the States.

(2) EXTERNAL INDEPENDENT REVIEW OF MANAGED CARE ACTIVITIES.—

(A) REVIEW OF CONTRACTS.—

(i) IN GENERAL.—Each contract under section 1903(m) with a medicaid managed care organization shall provide for an annual (as appropriate) external independent review conducted by a qualified independent entity of the quality outcomes and timeliness of, and access to, the items and services for which the organization is responsible under the contract. The requirement for such a review shall not apply until after the date that the Secretary establishes the identification method described in clause (ii).

(ii) QUALIFICATIONS OF REVIEWER.—The Secretary, in consultation with the States, shall establish a meth-

od for the identification of entities that are qualified to conduct reviews under clause (i).

(iii) USE OF PROTOCOLS.—The Secretary, in coordination with the National Governors' Association, shall contract with an independent quality review organization (such as the National Committee for Quality Assurance) to develop the protocols to be used in external independent reviews conducted under this paragraph on and after January 1, 1999.

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

(B) NONDUPLICATION OF ACCREDITATION.—A State may provide that, in the case of a medicaid managed care organization that is accredited by a private independent entity (such as those described in section 1852(e)(4)) or that has an external review conducted under section 1852(e)(3), the external review activities conducted under subparagraph (A) with respect to the organization shall not be duplicative of review activities conducted as part of the accreditation process or the external review conducted under such section.

(C) DEEMED COMPLIANCE FOR MEDICARE MANAGED CARE ORGANIZATIONS.—At the option of a State, the requirements of subparagraph (A) shall not apply with respect to a medicaid managed care organization if the organization is an eligible organization with a contract in effect under section 1876 or a Medicare+Choice organization with a contract in effect under part C of title XVIII and the organization has had a contract in effect under section 1903(m) at least during the previous 2-year period.

(d) PROTECTIONS AGAINST FRAUD AND ABUSE.—

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

(A) IN GENERAL.—A managed care entity may not knowingly—

(i) have a person described in subparagraph (C) as a director, officer, partner, or person with beneficial ownership of more than 5 percent of the entity's equity, or

(ii) have an employment, consulting, or other agreement with a person described in such subparagraph for the provision of items and services that are significant and material to the entity's obligations under its contract with the State.

(B) EFFECT OF NONCOMPLIANCE.—If a State finds that a managed care entity is not in compliance with clause (i) or (ii) of subparagraph (A), the State—

(i) shall notify the Secretary of such noncompliance;

(ii) may continue an existing agreement with the entity unless the Secretary (in consultation with the In-

spector General of the Department of Health and Human Services) directs otherwise; and

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

(C) PERSONS DESCRIBED.—A person is described in this subparagraph if such person—

(i) is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued pursuant to Executive Order No. 12549 or under guidelines implementing such order; or

(ii) is an affiliate (as defined in such Regulation) of a person described in clause (i).

(2) RESTRICTIONS ON MARKETING.—

(A) DISTRIBUTION OF MATERIALS.—

(i) IN GENERAL.—A managed care entity, with respect to activities under this title, may not distribute directly or through any agent or independent contractor marketing materials within any State—

(I) without the prior approval of the State, and

(II) that contain false or materially misleading information.

The requirement of subclause (I) shall not apply with respect to a State until such date as the Secretary specifies in consultation with such State.

(ii) CONSULTATION IN REVIEW OF MARKET MATERIALS.—In the process of reviewing and approving such materials, the State shall provide for consultation with a medical care advisory committee.

(B) SERVICE MARKET.—A managed care entity shall distribute marketing materials to the entire service area of such entity covered under the contract under section 1903(m) or section 1905(t)(3).

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

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

(E) PROHIBITION OF "COLD-CALL" MARKETING.—Each managed care entity shall not, directly or indirectly, conduct door-to-door, telephonic, or other "cold-call" marketing of enrollment under this title.

(3) STATE CONFLICT-OF-INTEREST SAFEGUARDS IN MEDICAID RISK CONTRACTING.—A medicaid managed care organization may not enter into a contract with any State under section 1903(m) unless the State has in effect conflict-of-interest safeguards with respect to officers and employees of the State with responsibilities relating to contracts with such organizations or to the default enrollment process described in subsection (a)(4)(C)(ii) that are at least as effective as the Federal safeguards provided under section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423), against conflicts of interest that apply with respect to Federal procurement officials with comparable responsibilities with respect to such contracts.

(4) USE OF UNIQUE PHYSICIAN IDENTIFIER FOR PARTICIPATING PHYSICIANS.—Each medicaid managed care organization shall require each physician providing services to enrollees eligible for medical assistance under the State plan under this title to have a unique identifier in accordance with the system established under section 1173(b).

(5) STATE REPORTING REQUIREMENTS FOR MANAGED CARE ENTITIES.—

(A) IN GENERAL.—*With respect to any contract with a managed care entity under section 1903(m) or 1905(t)(3) (as applicable), beginning on the later of the first day of the first plan year for such managed care entity that begins after the date of the enactment of this paragraph or January 1, 2017, the State shall require that such contract include a provision that providers of services or persons terminated (as described in section 1902(kk)(8)) from participation under this title, title XVIII, or title XXI be terminated from participating under this title as a provider in any network of such entity that serves individuals eligible to receive medical assistance under this title.*

(B) NOTIFICATION OF TERMINATION.—*For the period beginning on January 1, 2017, and ending on the date on which the enrollment of providers under paragraph (6) is complete for a State, the State shall provide for a system for notifying managed care entities (as defined in subsection (a)(1)) of the termination (as described in section 1902(kk)(8)) of providers of services or persons from participation under this title, title XVIII, or title XXI.*

(6) ENROLLMENT OF PARTICIPATING PROVIDERS.—

(A) IN GENERAL.—*Beginning not later than January 1, 2018, a State shall require that, in order to participate as a provider in the network of a managed care entity that provides services to, or orders, prescribes, refers, or certifies eligibility for services for, individuals who are eligible for medical assistance under the State plan under this title and who are enrolled with the entity, the provider is enrolled with the State agency administering the State plan under this title. Such enrollment shall include providing to the State agency the provider's identifying information, including the name, specialty, date of birth, Social Security number, national provider identifier, Federal taxpayer identification number, and the State license or certification number of the provider.*

(B) RULE OF CONSTRUCTION.—Nothing in subparagraph (A) shall be construed as requiring a provider described in such subparagraph to provide services to individuals who are not enrolled with a managed care entity under this title.

(e) SANCTIONS FOR NONCOMPLIANCE.—

(1) USE OF INTERMEDIATE SANCTIONS BY THE STATE TO ENFORCE REQUIREMENTS.—

(A) IN GENERAL.—A State may not enter into or renew a contract under section 1903(m) unless the State has established intermediate sanctions, which may include any of the types described in paragraph (2), other than the termination of a contract with a medicaid managed care organization, which the State may impose against a medicaid managed care organization with such a contract, if the organization—

(i) fails substantially to provide medically necessary items and services that are required (under law or under such organization's contract with the State) to be provided to an enrollee covered under the contract;

(ii) imposes premiums or charges on enrollees in excess of the premiums or charges permitted under this title;

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

(iv) misrepresents or falsifies information that is furnished—

(I) to the Secretary or the State under this title;

or

(II) to an enrollee, potential enrollee, or a health care provider under such title; or

(v) fails to comply with the applicable requirements of section 1903(m)(2)(A)(x).

The State may also impose such intermediate sanction against a managed care entity if the State determines that the entity distributed directly or through any agent or independent contractor marketing materials in violation of subsection (d)(2)(A)(i)(II).

(B) RULE OF CONSTRUCTION.—Clause (i) of subparagraph (A) shall not apply to the provision of abortion services, except that a State may impose a sanction on any medicaid managed care organization that has a contract to provide abortion services if the organization does not provide such services as provided for under the contract.

(2) INTERMEDIATE SANCTIONS.—The sanctions described in this paragraph are as follows:

(A) Civil money penalties as follows:

(i) Except as provided in clause (ii), (iii), or (iv), not more than \$25,000 for each determination under paragraph (1)(A).

(ii) With respect to a determination under clause (iii) or (iv)(I) of paragraph (1)(A), not more than \$100,000 for each such determination.

(iii) With respect to a determination under paragraph (1)(A)(ii), double the excess amount charged in violation of such subsection (and the excess amount charged shall be deducted from the penalty and returned to the individual concerned).

(iv) Subject to clause (ii), with respect to a determination under paragraph (1)(A)(iii), \$15,000 for each individual not enrolled as a result of a practice described in such subsection.

(B) The appointment of temporary management—

(i) to oversee the operation of the medicaid managed care organization upon a finding by the State that there is continued egregious behavior by the organization or there is a substantial risk to the health of enrollees; or

(ii) to assure the health of the organization's enrollees, if there is a need for temporary management while—

(I) there is an orderly termination or reorganization of the organization; or

(II) improvements are made to remedy the violations found under paragraph (1), except that temporary management under this subparagraph may not be terminated until the State has determined that the medicaid managed care organization has the capability to ensure that the violations shall not recur.

(C) Permitting individuals enrolled with the managed care entity to terminate enrollment without cause, and notifying such individuals of such right to terminate enrollment.

(D) Suspension or default of all enrollment of individuals under this title after the date the Secretary or the State notifies the entity of a determination of a violation of any requirement of section 1903(m) or this section.

(E) Suspension of payment to the entity under this title for individuals enrolled after the date the Secretary or State notifies the entity of such a determination and until the Secretary or State is satisfied that the basis for such determination has been corrected and is not likely to recur.

(3) TREATMENT OF CHRONIC SUBSTANDARD ENTITIES.—In the case of a medicaid managed care organization which has repeatedly failed to meet the requirements of section 1903(m) and this section, the State shall (regardless of what other sanctions are provided) impose the sanctions described in subparagraphs (B) and (C) of paragraph (2).

(4) AUTHORITY TO TERMINATE CONTRACT.—

(A) IN GENERAL.—In the case of a managed care entity which has failed to meet the requirements of this part or

a contract under section 1903(m) or 1905(t)(3), the State shall have the authority to terminate such contract with the entity and to enroll such entity's enrollees with other managed care entities (or to permit such enrollees to receive medical assistance under the State plan under this title other than through a managed care entity).

(B) AVAILABILITY OF HEARING PRIOR TO TERMINATION OF CONTRACT.—A State may not terminate a contract with a managed care entity under subparagraph (A) unless the entity is provided with a hearing prior to the termination.

(C) NOTICE AND RIGHT TO DISENROLL IN CASES OF TERMINATION HEARING.—A State may—

- (i) notify individuals enrolled with a managed care entity which is the subject of a hearing to terminate the entity's contract with the State of the hearing, and
- (ii) in the case of such an entity, permit such enrollees to disenroll immediately with the entity without cause.

(5) OTHER PROTECTIONS FOR MANAGED CARE ENTITIES AGAINST SANCTIONS IMPOSED BY STATE.—Before imposing any sanction against a managed care entity other than termination of the entity's contract, the State shall provide the entity with notice and such other due process protections as the State may provide, except that a State may not provide a managed care entity with a pre-termination hearing before imposing the sanction described in paragraph (2)(B).

(f) TIMELINESS OF PAYMENT; ADEQUACY OF PAYMENT FOR PRIMARY CARE SERVICES.—A contract under section 1903(m) with a medicaid managed care organization shall provide that the organization shall make payment to health care providers for items and services which are subject to the contract and that are furnished to individuals eligible for medical assistance under the State plan under this title who are enrolled with the organization on a timely basis consistent with the claims payment procedures described in section 1902(a)(37)(A), unless the health care provider and the organization agree to an alternate payment schedule and, in the case of primary care services described in section 1902(a)(13)(C), consistent with the minimum payment rates specified in such section (regardless of the manner in which such payments are made, including in the form of capitation or partial capitation).

(g) IDENTIFICATION OF PATIENTS FOR PURPOSES OF MAKING DSH PAYMENTS.—Each contract with a managed care entity under section 1903(m) or under section 1905(t)(3) shall require the entity either—

- (1) to report to the State information necessary to determine the hospital services provided under the contract (and the identity of hospitals providing such services) for purposes of applying sections 1886(d)(5)(F) and 1923; or
- (2) to include a sponsorship code in the identification card issued to individuals covered under this title in order that a hospital may identify a patient as being entitled to benefits under this title.

(h) SPECIAL RULES WITH RESPECT TO INDIAN ENROLLEES, INDIAN HEALTH CARE PROVIDERS, AND INDIAN MANAGED CARE ENTITIES.—

(1) ENROLLEE OPTION TO SELECT AN INDIAN HEALTH CARE PROVIDER AS PRIMARY CARE PROVIDER.—In the case of a non-Indian Medicaid managed care entity that—

(A) has an Indian enrolled with the entity; and

(B) has an Indian health care provider that is participating as a primary care provider within the network of the entity,

insofar as the Indian is otherwise eligible to receive services from such Indian health care provider and the Indian health care provider has the capacity to provide primary care services to such Indian, the contract with the entity under section 1903(m) or under section 1905(t)(3) shall require, as a condition of receiving payment under such contract, that the Indian shall be allowed to choose such Indian health care provider as the Indian's primary care provider under the entity.

(2) ASSURANCE OF PAYMENT TO INDIAN HEALTH CARE PROVIDERS FOR PROVISION OF COVERED SERVICES.—Each contract with a managed care entity under section 1903(m) or under section 1905(t)(3) shall require any such entity, as a condition of receiving payment under such contract, to satisfy the following requirements:

(A) DEMONSTRATION OF ACCESS TO INDIAN HEALTH CARE PROVIDERS AND APPLICATION OF ALTERNATIVE PAYMENT ARRANGEMENTS.—Subject to subparagraph (C), to—

(i) demonstrate that the number of Indian health care providers that are participating providers with respect to such entity are sufficient to ensure timely access to covered Medicaid managed care services for those Indian enrollees who are eligible to receive services from such providers; and

(ii) agree to pay Indian health care providers, whether such providers are participating or non-participating providers with respect to the entity, for covered Medicaid managed care services provided to those Indian enrollees who are eligible to receive services from such providers at a rate equal to the rate negotiated between such entity and the provider involved or, if such a rate has not been negotiated, at a rate that is not less than the level and amount of payment which the entity would make for the services if the services were furnished by a participating provider which is not an Indian health care provider.

The Secretary shall establish procedures for applying the requirements of clause (i) in States where there are no or few Indian health providers.

(B) PROMPT PAYMENT.—To agree to make prompt payment (consistent with rule for prompt payment of providers under section 1932(f)) to Indian health care providers that are participating providers with respect to such entity or, in the case of an entity to which subparagraph (A)(ii) or (C) applies, that the entity is required to pay in accordance with that subparagraph.

(C) APPLICATION OF SPECIAL PAYMENT REQUIREMENTS FOR FEDERALLY-QUALIFIED HEALTH CENTERS AND FOR SERV-

ICES PROVIDED BY CERTAIN INDIAN HEALTH CARE PROVIDERS.—

(i) FEDERALLY-QUALIFIED HEALTH CENTERS.—

(I) MANAGED CARE ENTITY PAYMENT REQUIREMENT.—To agree to pay any Indian health care provider that is a federally-qualified health center under this title but not a participating provider with respect to the entity, for the provision of covered Medicaid managed care services by such provider to an Indian enrollee of the entity at a rate equal to the amount of payment that the entity would pay a federally-qualified health center that is a participating provider with respect to the entity but is not an Indian health care provider for such services.

(II) CONTINUED APPLICATION OF STATE REQUIREMENT TO MAKE SUPPLEMENTAL PAYMENT.—Nothing in subclause (I) or subparagraph (A) or (B) shall be construed as waiving the application of section 1902(bb)(5) regarding the State plan requirement to make any supplemental payment due under such section to a federally-qualified health center for services furnished by such center to an enrollee of a managed care entity (regardless of whether the federally-qualified health center is or is not a participating provider with the entity).

(ii) PAYMENT RATE FOR SERVICES PROVIDED BY CERTAIN INDIAN HEALTH CARE PROVIDERS.—If the amount paid by a managed care entity to an Indian health care provider that is not a federally-qualified health center for services provided by the provider to an Indian enrollee with the managed care entity is less than the rate that applies to the provision of such services by the provider under the State plan, the plan shall provide for payment to the Indian health care provider, whether the provider is a participating or nonparticipating provider with respect to the entity, of the difference between such applicable rate and the amount paid by the managed care entity to the provider for such services.

(D) CONSTRUCTION.—Nothing in this paragraph shall be construed as waiving the application of section 1902(a)(30)(A) (relating to application of standards to assure that payments are consistent with efficiency, economy, and quality of care).

(3) SPECIAL RULE FOR ENROLLMENT FOR INDIAN MANAGED CARE ENTITIES.—Regarding the application of a Medicaid managed care program to Indian Medicaid managed care entities, an Indian Medicaid managed care entity may restrict enrollment under such program to Indians in the same manner as Indian Health Programs may restrict the delivery of services to Indians.

(4) DEFINITIONS.—For purposes of this subsection:

(A) INDIAN HEALTH CARE PROVIDER.—The term “Indian health care provider” means an Indian Health Program or an Urban Indian Organization.

(B) INDIAN MEDICAID MANAGED CARE ENTITY.—The term “Indian Medicaid managed care entity” means a managed care entity that is controlled (within the meaning of the last sentence of section 1903(m)(1)(C)) by the Indian Health Service, a Tribe, Tribal Organization, or Urban Indian Organization, or a consortium, which may be composed of 1 or more Tribes, Tribal Organizations, or Urban Indian Organizations, and which also may include the Service.

(C) NON-INDIAN MEDICAID MANAGED CARE ENTITY.—The term “non-Indian Medicaid managed care entity” means a managed care entity that is not an Indian Medicaid managed care entity.

(D) COVERED MEDICAID MANAGED CARE SERVICES.—The term “covered Medicaid managed care services” means, with respect to an individual enrolled with a managed care entity, items and services for which benefits are available with respect to the individual under the contract between the entity and the State involved.

(E) MEDICAID MANAGED CARE PROGRAM.—The term “Medicaid managed care program” means a program under sections 1903(m), 1905(t), and 1932 and includes a managed care program operating under a waiver under section 1915(b) or 1115 or otherwise.

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TITLE XXI—STATE CHILDREN’S HEALTH INSURANCE PROGRAM

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SEC. 2107. STRATEGIC OBJECTIVES AND PERFORMANCE GOALS; PLAN ADMINISTRATION.

(a) STRATEGIC OBJECTIVES AND PERFORMANCE GOALS.—

(1) DESCRIPTION.—A State child health plan shall include a description of—

- (A) the strategic objectives,
- (B) the performance goals, and
- (C) the performance measures,

the State has established for providing child health assistance to targeted low-income children under the plan and otherwise for maximizing health benefits coverage for other low-income children and children generally in the State.

(2) STRATEGIC OBJECTIVES.—Such plan shall identify specific strategic objectives relating to increasing the extent of creditable health coverage among targeted low-income children and other low-income children.

(3) PERFORMANCE GOALS.—Such plan shall specify one or more performance goals for each such strategic objective so identified.

(4) PERFORMANCE MEASURES.—Such plan shall describe how performance under the plan will be—

- (A) measured through objective, independently verifiable means, and
- (B) compared against performance goals, in order to determine the State's performance under this title.
- (b) RECORDS, REPORTS, AUDITS, AND EVALUATION.—
- (1) DATA COLLECTION, RECORDS, AND REPORTS.—A State child health plan shall include an assurance that the State will collect the data, maintain the records, and furnish the reports to the Secretary, at the times and in the standardized format the Secretary may require in order to enable the Secretary to monitor State program administration and compliance and to evaluate and compare the effectiveness of State plans under this title.
- (2) STATE ASSESSMENT AND STUDY.—A State child health plan shall include a description of the State's plan for the annual assessments and reports under section 2108(a) and the evaluation required by section 2108(b).
- (3) AUDITS.—A State child health plan shall include an assurance that the State will afford the Secretary access to any records or information relating to the plan for the purposes of review or audit.
- (c) PROGRAM DEVELOPMENT PROCESS.—A State child health plan shall include a description of the process used to involve the public in the design and implementation of the plan and the method for ensuring ongoing public involvement.
- (d) PROGRAM BUDGET.—A State child health plan shall include a description of the budget for the plan. The description shall be updated periodically as necessary and shall include details on the planned use of funds and the sources of the non-Federal share of plan expenditures, including any requirements for cost-sharing by beneficiaries.
- (e) APPLICATION OF CERTAIN GENERAL PROVISIONS.—The following sections of this Act shall apply to States under this title in the same manner as they apply to a State under title XIX:
- (1) TITLE XIX PROVISIONS.—
- (A) Section 1902(a)(4)(C) (relating to conflict of interest standards).
- (B) *Section 1902(a)(39) (relating to termination of participation of certain providers).*
- (C) *Section 1902(a)(78) (relating to enrollment of providers participating in State plans providing medical assistance on a fee-for-service basis).*
- [(B)]** *(D) Section 1902(a)(72) (relating to limiting FQHC contracting for provision of dental services).*
- [(C)]** *(E) Section 1902(a)(73) (relating to requiring certain States to seek advice from designees of Indian Health Programs and Urban Indian Organizations).*
- [(D)]** *(F) Subsections (a)(77) and (kk) of section 1902 (relating to provider and supplier screening, oversight, and reporting requirements).*
- [(E)]** *(G) Section 1902(e)(13) (relating to the State option to rely on findings from an Express Lane agency to help evaluate a child's eligibility for medical assistance).*

【(F)】 *(H)* Section 1902(e)(14) (relating to income determined using modified adjusted gross income and household income).

【(G)】 *(I)* Section 1902(bb) (relating to payment for services provided by Federally-qualified health centers and rural health clinics).

【(H)】 *(J)* Section 1902(ff) (relating to disregard of certain property for purposes of making eligibility determinations).

【(I)】 *(K)* Paragraphs (2), (16), and (17) of section 1903(i) (relating to limitations on payment).

(L) Section 1903(m)(3) (relating to limitation on payment with respect to managed care).

【(J)】 *(M)* Paragraph (4) of section 1903(v) (relating to optional coverage of categories of lawfully residing immigrant children or pregnant women), but only if the State has elected to apply such paragraph with respect to such category of children or pregnant women under title XIX.

【(K)】 *(N)* Section 1903(w) (relating to limitations on provider taxes and donations).

【(L)】 *(O)* Section 1920A (relating to presumptive eligibility for children).

【(M)】 *(P)* Subsections 【(a)(2)(C) and (h)】 *(a)(2)(C)* (relating to Indian enrollment), *(d)(5)* (relating to reporting requirements for managed care entities), *(d)(6)* (relating to enrollment of providers participating with a managed care entity), and *(h)* (relating to special rules with respect to Indian enrollees, Indian health care providers, and Indian managed care entities) of section 1932.

【(N)】 *(Q)* Section 1942 (relating to authorization to receive data directly relevant to eligibility determinations).

【(O)】 *(R)* Section 1943(b) (relating to coordination with State Exchanges and the State Medicaid agency).

(2) TITLE XI PROVISIONS.—

(A) Section 1115 (relating to waiver authority).

(B) Section 1116 (relating to administrative and judicial review), but only insofar as consistent with this title.

(C) Section 1124 (relating to disclosure of ownership and related information).

(D) Section 1126 (relating to disclosure of information about certain convicted individuals).

(E) Section 1128A (relating to civil monetary penalties).

(F) Section 1128B(d) (relating to criminal penalties for certain additional charges).

(G) Section 1132 (relating to periods within which claims must be filed).

(f) LIMITATION OF WAIVER AUTHORITY.—Notwithstanding subsection (e)(2)(A) and section 1115(a)(1):

(1) The Secretary may not approve a waiver, experimental, pilot, or demonstration project that would allow funds made available under this title to be used to provide child health assistance or other health benefits coverage to a nonpregnant childless adult or a parent (as defined in section 2111(c)(2)(A)), who is not pregnant, of a targeted low-income child.

(2) The Secretary may not approve, extend, renew, or amend a waiver, experimental, pilot, or demonstration project with respect to a State after the date of enactment of the Children's Health Insurance Program Reauthorization Act of 2009 that would waive or modify the requirements of section 2111.

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ADDITIONAL VIEWS

H.R. 3716 would build on Section 6501 of the Affordable Care Act, which amended Social Security Act Section 1902 (a)(39) which required that a state Medicaid program must terminate the participation of a specific provider from its Medicaid program if that specific provider's participation was terminated from Medicare or from another state Medicaid program, for reasons later defined by the Secretary in 42 CFR 455.101. Specifically, this legislation would require reporting of such terminations by all state Medicaid programs to a centralized database, and would further require enrollment of providers in state Medicaid programs for both managed care and fee-for-service. Ensuring that all states have access to such comprehensive information is critical to effectuating Section 6501 of the Affordable Care Act.

I have some outstanding technical concerns to the draft language as marked up by this Committee. First, the effective dates in the legislation must reflect the time that states and the federal government will need to update policy appropriately. As currently drafted, I do not believe the effective dates of this legislation are adequate to do so; as an example, it will not be possible for states to adequately report, and the federal government to adequately update a comprehensive database with this information, in a year's time. I strongly believe that an additional time is needed to fully implement the policy changes in this legislation.

Furthermore, the intent of this legislation is to allow for the data needed to better implement Section 6501 (referenced above) and as such, the terminology "for cause" referenced throughout the marked-up bill should more clearly reference 42 CFR 455.101, as this is a "term of art" that can have many different meanings depending on statutory reference within or outside the Medicare and Medicaid programs, or common language usage. The bill's intent is to reference the definition as it is defined in 42 CFR 455.101.

Finally, the legislation as it was marked up by the Committee continues to have minor technical errors related to references of managed care contracts. These references, along with those that I have outlined above, must be addressed in order to fully capture the intent of the legislation upon implementation.

FRANK PALLONE, JR.

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