

HELPING ENSURE ACCESS FOR LITTLE ONES, TODDLERS,
AND HOPEFUL YOUTH BY KEEPING INSURANCE DELIV-
ERY STABLE ACT OF 2017

OCTOBER 19, 2017.—Ordered to be printed

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

R E P O R T

together with

MINORITY VIEWS

[To accompany H.R. 3921]

[Including cost estimate of the Congressional Budget Office]

The Committee on Energy and Commerce, to whom was referred
the bill (H.R. 3921) to extend funding for the Children’s Health In-
surance Program, and for other purposes, having considered the
same, report favorably thereon with an amendment and rec-
ommend that the bill as amended do pass.

CONTENTS

Purpose and Summary	Page 12
Background and Need for Legislation	12
Committee Action	13
Committee Votes	14
Oversight Findings and Recommendations	20
New Budget Authority, Entitlement Authority, and Tax Expenditures	20
Congressional Budget Office Estimate	20
Federal Mandates Statement	39
Statement of General Performance Goals and Objectives	39
Duplication of Federal Programs	39
Committee Cost Estimate	39
Earmark, Limited Tax Benefits, and Limited Tariff Benefits	39
Disclosure of Directed Rule Makings	39
Advisory Committee Statement	39
Applicability to Legislative Branch	39
Section-by-Section Analysis of the Legislation	40
Changes in Existing Law Made by the Bill, as Reported	42

Minority Views	257
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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 “Helping Ensure Access for Little Ones, Toddlers, and Hopeful Youth by Keeping Insurance Delivery Stable Act of 2017” or the “HEALTHY KIDS Act”.

SEC. 2. TABLE OF CONTENTS.

The table of contents for this Act is as follows:

Sec. 1. Short title.

Sec. 2. Table of contents.

TITLE I—CHIP EXTENSION AND OTHER MEDICAID AND CHIP PROVISIONS

Sec. 101. Five-year funding extension of the Children’s Health Insurance Program.

Sec. 102. Extension of certain programs and demonstration projects.

Sec. 103. Extension of outreach and enrollment program.

Sec. 104. Extension and reduction of additional Federal financial participation for CHIP.

Sec. 105. Modifying reduction in Medicaid DSH allotments.

Sec. 106. Puerto Rico and the Virgin Islands Medicaid payments.

TITLE II—OFFSETS

Sec. 201. Medicaid third party liability provisions.

Sec. 202. Treatment of lottery winnings and other lump-sum income for purposes of income eligibility under Medicaid.

Sec. 203. Adjustments to Medicare part B and part D premium subsidies for higher income individuals.

TITLE I—CHIP EXTENSION AND OTHER MEDICAID AND CHIP PROVISIONS

SEC. 101. FIVE-YEAR FUNDING EXTENSION OF THE CHILDREN’S HEALTH INSURANCE PROGRAM.

(a) APPROPRIATION; TOTAL ALLOTMENT.—Section 2104(a) of the Social Security Act (42 U.S.C. 1397dd(a)) is amended—

(1) in paragraph (19), by striking “and”;

(2) in paragraph (20), by striking the period at the end and inserting a semicolon; and

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

“(21) for fiscal year 2018, \$21,500,000,000;

“(22) for fiscal year 2019, \$22,600,000,000;

“(23) for fiscal year 2020, \$23,700,000,000;

“(24) for fiscal year 2021, \$24,800,000,000; and

“(25) for fiscal year 2022, for purposes of making 2 semi-annual allotments—

“(A) \$2,850,000,000 for the period beginning on October 1, 2021, and ending on March 31, 2022; and

“(B) \$2,850,000,000 for the period beginning on April 1, 2022, and ending on September 30, 2022.”.

(b) ALLOTMENTS.—

(1) IN GENERAL.—Section 2104(m) of the Social Security Act (42 U.S.C. 1397dd(m)) is amended—

(A) in paragraph (2)—

(i) in the heading, by striking “THROUGH 2016” and inserting “THROUGH 2022”; and

(ii) in subparagraph (B)—

(I) in the matter preceding clause (i), by striking “(19)” and inserting “(24)”;

(II) in clause (ii), in the matter preceding subclause (I), by inserting “(other than fiscal year 2022)” after “even-numbered fiscal year”; and

(III) in clause (ii)(I), by inserting “(or, in the case of fiscal year 2018, under paragraph (4))” after “clause (i)”;

(B) in paragraph (5)—

(i) by striking “or (4)” and inserting “(4), or (10)”;

(ii) by striking “or 2017” and inserting “, 2017, or 2022”;

(C) in paragraph (7)—

(i) in subparagraph (A), by striking “2017” and inserting “2022”;

(ii) in subparagraph (B), in the matter preceding clause (i), by inserting “(or, in the case of fiscal year 2018, by not later than the date that is 60 days after the date of the enactment of the HEALTHY KIDS Act

of 2017” after “before the August 31 preceding the beginning of the fiscal year”; and

(iii) in the matter following subparagraph (B), by striking “or fiscal year 2016” and inserting “fiscal year 2016, fiscal year 2018, fiscal year 2020, or fiscal year 2022”;

(D) in paragraph (9)—

(i) in the heading, by striking “FISCAL YEARS 2015 AND 2017” and inserting “CERTAIN FISCAL YEARS”;

(ii) by striking “or (4)” and inserting “, (4), or (10)”; and

(iii) by striking “or fiscal year 2017” and inserting “, 2017, or 2022”; and

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

“(10) FOR FISCAL YEAR 2022.—

“(A) FIRST HALF.—Subject to paragraphs (5) and (7), from the amount made available under subparagraph (A) of paragraph (25) of subsection (a) for the semi-annual period described in such subparagraph, increased by the amount of the appropriation for such period under section 101(b)(3) of the HEALTHY KIDS Act, the Secretary shall compute a State allotment for each State (including the District of Columbia and each commonwealth and territory) for such semi-annual period in an amount equal to the first half ratio (described in subparagraph (D)) of the amount described in subparagraph (C).

“(B) SECOND HALF.—Subject to paragraphs (5) and (7), from the amount made available under subparagraph (B) of paragraph (25) of subsection (a) for the semi-annual period described in such subparagraph, the Secretary shall compute a State allotment for each State (including the District of Columbia and each commonwealth and territory) for such semi-annual period in an amount equal to the amount made available under such subparagraph, multiplied by the ratio of—

“(i) the amount of the allotment to such State under subparagraph

(A); to

“(ii) the total of the amount of all of the allotments made available under such subparagraph.

“(C) FULL YEAR AMOUNT BASED ON GROWTH FACTOR UPDATED AMOUNT.—The amount described in this subparagraph for a State is equal to the sum of—

“(i) the amount of the State allotment for fiscal year 2021 determined under paragraph (2)(B)(i); and

“(ii) the amount of any payments made to the State under subsection

(n) for fiscal year 2021, multiplied by the allotment increase factor under paragraph (6) for fiscal year 2022.

“(D) FIRST HALF RATIO.—The first half ratio described in this subparagraph is the ratio of—

“(i) the sum of—

“(I) the amount made available under subsection (a)(25)(A); and

“(II) the amount of the appropriation for such period under section 101(b)(3) of the HEALTHY KIDS Act; to

“(ii) the sum of—

“(I) the amount described in clause (i); and

“(II) the amount made available under subsection (a)(25)(B).”.

(2) TECHNICAL AMENDMENT.—Section 2104(m)(2)(A) of such Act (42 U.S.C. 1397dd(m)(2)(A)) is amended by striking “the allotment increase factor under paragraph (5)” each place it appears and inserting “the allotment increase factor under paragraph (6)”.

(3) ONE-TIME APPROPRIATION FOR FISCAL YEAR 2022.—There is appropriated to the Secretary of Health and Human Services, out of any money in the Treasury not otherwise appropriated, \$20,200,000,000 to accompany the allotment made for the period beginning on October 1, 2021, and ending on March 31, 2022, under paragraph (25)(A) of section 2104(a) of the Social Security Act (42 U.S.C. 1397dd(a)) (as added by subsection (a)(3)), to remain available until expended. Such amount shall be used to provide allotments to States under paragraph (10) of section 2104(m) of such Act (as added by subsection (b)(1)(E)) for the first 6 months of fiscal year 2022 in the same manner as allotments are provided under subsection (a)(25)(A) of such section 2104 and subject to the same terms and conditions as apply to the allotments provided from such subsection (a)(25)(A).

(c) EXTENSION OF THE CHILD ENROLLMENT CONTINGENCY FUND.—Section 2104(n) of the Social Security Act (42 U.S.C. 1397dd(n)) is amended—

- (1) in paragraph (2)—
 - (A) in subparagraph (A)(ii)—
 - (i) by striking “2010, 2011, 2012, 2013, 2014, and 2016” and inserting “2010 through 2014, 2016, and 2018 through 2021”; and
 - (ii) by striking “fiscal year 2015 and fiscal year 2017” and inserting “fiscal years 2015, 2017, and 2022”; and
 - (B) in subparagraph (B)—
 - (i) by striking “2010, 2011, 2012, 2013, 2014, and 2016” and inserting “2010 through 2014, 2016, and 2018 through 2021”; and
 - (ii) by striking “fiscal year 2015 and fiscal year 2017” and inserting “fiscal years 2015, 2017, and 2022”; and
- (2) in paragraph (3)(A), in the matter preceding clause (i), by striking “or a semi-annual allotment period for fiscal year 2015 or 2017” and inserting “or in any of fiscal years 2018 through 2021 (or a semi-annual allotment period for fiscal year 2015, 2017, or 2022)”.
- (d) EXTENSION OF QUALIFYING STATES OPTION.—Section 2105(g)(4) of the Social Security Act (42 U.S.C. 1397ee(g)(4)) is amended—
 - (1) in the heading, by striking “THROUGH 2017” and inserting “THROUGH 2022”; and
 - (2) in subparagraph (A), by striking “2017” and inserting “2022”.
- (e) EXTENSION OF EXPRESS LANE ELIGIBILITY OPTION.—Section 1902(e)(13)(I) of the Social Security Act (42 U.S.C. 1396a(e)(13)(I)) is amended by striking “2017” and inserting “2022”.
- (f) ASSURANCE OF AFFORDABILITY STANDARD FOR CHILDREN AND FAMILIES.—
 - (1) IN GENERAL.—Section 2105(d)(3) of the Social Security Act (42 U.S.C. 1397ee(d)(3)) is amended—
 - (A) in the paragraph heading, by striking “UNTIL OCTOBER 1, 2019” and inserting “THROUGH SEPTEMBER 30, 2022”; and
 - (B) in subparagraph (A), in the matter preceding clause (i)—
 - (i) by striking “2019” and inserting “2022”; and
 - (ii) by striking “The preceding sentence shall not be construed as preventing a State during such period” and inserting “During the period that begins on October 1, 2019, and ends on September 30, 2022, the preceding sentence shall only apply with respect to children in families whose income does not exceed 300 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved. The preceding sentences shall not be construed as preventing a State during any such periods”.
 - (2) CONFORMING AMENDMENTS.—Section 1902(gg)(2) of the Social Security Act (42 U.S.C. 1396a(gg)(2)) is amended—
 - (A) in the paragraph heading, by striking “UNTIL OCTOBER 1, 2019” and inserting “THROUGH SEPTEMBER 30, 2022”; and
 - (B) by striking “September 30, 2019,” and inserting “September 30, 2022 (but during the period that begins on October 1, 2019, and ends on September 30, 2022, only with respect to children in families whose income does not exceed 300 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved)”.
- (g) CHIP LOOK-ALIKE PLANS.—
 - (1) BLENDING RISK POOLS.—Section 2107 of the Social Security Act (42 U.S.C. 1397gg) is amended by adding at the end the following:

“(g) USE OF BLENDED RISK POOLS.—

“(1) IN GENERAL.—Nothing in this title (or any other provision of Federal law) shall be construed as preventing a State from considering children enrolled in a qualified CHIP look-alike program and children enrolled in a State child health plan under this title (or a waiver of such plan) as members of a single risk pool.

“(2) QUALIFIED CHIP LOOK-ALIKE PROGRAM.—In this subsection, the term ‘qualified CHIP look-alike program’ means a State program—

“(A) under which children who are under the age of 19 and are not eligible to receive medical assistance under title XIX or child health assistance under this title may purchase coverage through the State that provides benefits that are at least identical to the benefits provided under the State child health plan under this title (or a waiver of such plan); and

“(B) that is funded exclusively through non-Federal funds, including funds received by the State in the form of premiums for the purchase of such coverage.”.
 - (2) COVERAGE RULE.—
 - (A) IN GENERAL.—Section 5000A(f)(1) of the Internal Revenue Code of 1986 is amended in subparagraph (A)(iii), by inserting “or under a qualified

CHIP look-alike program (as defined in section 2107(g) of the Social Security Act)” before the comma at the end.

(B) EFFECTIVE DATE.—The amendment made by subparagraph (A) shall apply with respect to taxable years beginning after December 31, 2017.

SEC. 102. EXTENSION OF CERTAIN PROGRAMS AND DEMONSTRATION PROJECTS.

(a) CHILDHOOD OBESITY DEMONSTRATION PROJECT.—Section 1139A(e)(8) of the Social Security Act (42 U.S.C. 1320b–9a(e)(8)) is amended—

(1) by striking “and \$10,000,000” and inserting “, \$10,000,000”; and

(2) by inserting after “2017” the following: “, and \$25,000,000 for the period of fiscal years 2018 through 2022”.

(b) PEDIATRIC QUALITY MEASURES PROGRAM.—Section 1139A(i) of the Social Security Act (42 U.S.C. 1320b–9a(i)) is amended—

(1) by striking “Out of any” and inserting the following:

“(1) IN GENERAL.—Out of any”;

(2) by striking “there is appropriated for each” and inserting “there is appropriated—

“(A) for each”;

(3) by striking “, and there is appropriated for the period” and inserting “; “(B) for the period”;

(4) by striking “. Funds appropriated under this subsection shall remain available until expended.” and inserting “; and”; and

(5) by adding at the end the following:

“(C) for the period of fiscal years 2018 through 2022, \$75,000,000 for the purpose of carrying out this section (other than subsections (e), (f), and (g)).

“(2) AVAILABILITY.—Funds appropriated under this subsection shall remain available until expended.”.

SEC. 103. EXTENSION OF OUTREACH AND ENROLLMENT PROGRAM.

(a) IN GENERAL.—Section 2113 of the Social Security Act (42 U.S.C. 1397mm) is amended—

(1) in subsection (a)(1), by striking “2017” and inserting “2022”; and

(2) in subsection (g)—

(A) by striking “and \$40,000,000” and inserting “, \$40,000,000”; and

(B) by inserting after “2017” the following: “, and \$100,000,000 for the period of fiscal years 2018 through 2022”.

(b) MAKING PARENT MENTORS ELIGIBLE TO RECEIVE GRANTS.—Section 2113(f) of the Social Security Act (42 U.S.C. 1397mm(f)) is amended—

(1) in paragraph (1), by adding at the end the following new subparagraph: “(H) Parent mentors.”; and

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

“(5) PARENT MENTOR.—The term ‘parent mentor’ means an individual who—

“(A) is a parent or guardian of at least one child who is an eligible child under this title or title XIX; and

“(B) is trained to assist families with children who have no health insurance coverage with respect to improving the social determinants of the health of such children, including by providing—

“(i) education about health insurance coverage, including, with respect to obtaining such coverage, eligibility criteria and application and renewal processes;

“(ii) assistance with completing and submitting applications for health insurance coverage;

“(iii) a liaison between families and representatives of State plans under title XIX or State child health plans under this title;

“(iv) guidance on identifying medical and dental homes and community pharmacies for children; and

“(v) assistance and referrals to successfully address social determinants of children’s health, including poverty, food insufficiency, and housing.”.

SEC. 104. EXTENSION AND REDUCTION OF ADDITIONAL FEDERAL FINANCIAL PARTICIPATION FOR CHIP.

Section 2105(b) of the Social Security Act (42 U.S.C. 1397ee(b)) is amended in the second sentence by inserting “and during the period that begins on October 1, 2019, and ends on September 30, 2020, the enhanced FMAP determined for a State for a fiscal year (or for any portion of a fiscal year occurring during such period) shall be increased by 11.5 percentage points” after “23 percentage points,”.

SEC. 105. MODIFYING REDUCTION IN MEDICAID DSH ALLOTMENTS.

Section 1923(f)(7)(A)(ii) of the Social Security Act (42 U.S.C. 1396r–4(f)(7)(A)(ii)) is amended—

- (1) by striking subclause (I) and redesignating subclauses (II) through (VIII) as subclauses (I) through (VII), respectively;
- (2) in subclause (VI), as redesignated by paragraph (1), by striking at the end “and”;
- (3) in subclause (VII), as redesignated by paragraph (1), by striking at the end the period and inserting a semicolon; and
- (4) by adding at the end the following new subclauses:
 - “(VIII) \$8,000,000,000 for fiscal year 2026; and
 - “(IX) \$8,000,000,000 for fiscal year 2027.”.

SEC. 106. PUERTO RICO AND THE VIRGIN ISLANDS MEDICAID PAYMENTS.

(a) INCREASED CAP.—Section 1108(g) of the Social Security Act (42 U.S.C. 1308(g)) is amended—

- (1) in paragraph (2)—
 - (A) in subparagraph (A), by inserting “(or, with respect to fiscal years 2018 and 2019, increased by such percentage increase plus one percentage point)” after “beginning of the fiscal year”; and
 - (B) in subparagraph (B), by inserting “(or, with respect to fiscal years 2018 and 2019, increased by such percentage increase plus one percentage point)” after “percentage increase referred to in subparagraph (A)”;
- (2) in paragraph (5)—
 - (A) in subparagraph (A), by striking “subparagraph (B)” and inserting “subparagraphs (B), (C), (D), (E), and (F)”;
 - (B) by adding at the end the following new subparagraphs:
 - “(C) The amount of the increase otherwise provided under subparagraph (A) for Puerto Rico shall be further increased by \$880,000,000.
 - “(D)(i) For the period beginning October 1, 2017, and ending December 31, 2019, the amount of the increase otherwise provided under subparagraph (A) for Puerto Rico shall be further increased by \$120,000,000 if the Financial Oversight and Management Board for Puerto Rico established under section 101 of the Puerto Rico Oversight, Management, and Economic Stability Act (48 U.S.C. 2121) certifies by a majority vote that Puerto Rico has taken reasonable and appropriate steps during such period to—
 - “(I) reduce fraud, waste, and abuse under the program under title XIX;
 - “(II) implement strategies to reduce unnecessary, inefficient, or excessive spending under title XIX;
 - “(III) improve the use and availability of Medicaid data for program operation and oversight; and
 - “(IV) improve the quality of care and patient experience for individuals enrolled under the program under title XIX.
 - “(ii) As a condition of any additional increase pursuant to clause (i), not later than October 1, 2018, Puerto Rico shall submit to the Financial Oversight and Management Board for Puerto Rico a report regarding steps taken to achieve each of the goals described in subclauses (I) through (IV) of clause (i).
 - “(E) Payments under section 1903(a)(8) for a quarter of a fiscal year shall not be taken into account in applying subsection (f) (as increased in accordance with this paragraph and paragraphs (1), (2), (3), and (4)) to Puerto Rico or the Virgin Islands for such fiscal year.
 - “(F)(i) For the period beginning October 1, 2017, and ending December 31, 2019, the amount of the increase otherwise provided under subparagraph (A) for the Virgin Islands shall be further increased by an amount equal to the per capita equivalent of the total amount of the increase provided for Puerto Rico under subparagraphs (C) and (D) for such period.
 - “(ii) For purposes of clause (i), the term ‘per capita equivalent’ means the ratio of—
 - “(I) the population of the Virgin Islands, as determined by the most recent census estimate released by the Bureau of the Census before September 4, 2017; to
 - “(II) the population of Puerto Rico, as so determined.”.

(b) FEDERAL MATCH FOR MEDICAL PERSONNEL AND FRAUD REDUCTION.—Section 1903(a) of the Social Security Act (42 U.S.C. 1396b(a)) is amended—

- (1) in paragraph (2)(A), by inserting “subject to paragraph (8),” before “an amount”;
- (2) in paragraph (6)—
 - (A) in subparagraph (B), by inserting “subject to paragraph (8),” before “75 per centum”; and
 - (B) by striking at the end “plus”;

(3) in paragraph (7), by striking at the end the period and inserting “; plus”
; and

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

“(8) for quarters during the period beginning January 1, 2018, and ending December 31, 2019, paragraphs (2)(A) and (6) shall apply with respect to Puerto Rico and the Virgin Islands as if—

“(A) the reference to ‘75 per centum’ in paragraph (2)(A) were a reference to ‘90 per centum’; and

“(B) the reference to ‘75 per centum’ in paragraph (6)(B) were a reference to ‘90 per centum’.”.

TITLE II—OFFSETS

SEC. 201. MEDICAID THIRD PARTY LIABILITY PROVISIONS.

(a) MEDICAID THIRD PARTY LIABILITY.—

(1) DELAY OF BIPARTISAN BUDGET ACT OF 2013 THIRD PARTY LIABILITY PROVISIONS.—

(A) IN GENERAL.—Section 202(c) of the Bipartisan Budget Act of 2013 (Public Law 113–67; 127 Stat. 1177; 42 U.S.C. 1396a note), as amended by section 211 of the Protecting Access to Medicare Act of 2014 (Public Law 113–93; 128 Stat. 1047; 42 U.S.C. 1396a note) and section 220 of the Medicare Access and CHIP Reauthorization Act of 2015 (Public Law 114–10), is amended by striking “2017” and inserting “2019”.

(B) EFFECTIVE DATE; TREATMENT.—The amendment made by subparagraph (A) shall take effect on September 30, 2017, and shall apply with respect to claims generated or filed after such date.

(2) CLARIFICATION OF DEFINITIONS APPLICABLE TO THIRD PARTY LIABILITY.—

(A) IN GENERAL.—Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended by adding at the end the following new subsection:

“(nn) RESPONSIBLE THIRD PARTY AND HEALTH INSURER DEFINITIONS.—For purposes of subsection (a)(25) and section 1903(d)(2)(B):

“(1) RESPONSIBLE THIRD PARTY.—The term ‘responsible third party’ means a health insurer, an accountable care organization, or any other party that is, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service. Such term does not include a party if payment by such party has been made or can reasonably be expected to be made under a workmen’s compensation law or plan of the United States or a State, or under an automobile or liability insurance policy or plan (including a self-insured plan), or under no fault insurance.

“(2) HEALTH INSURER.—The term ‘health insurer’ means a group health plan, as defined in section 607(1) of the Employee Retirement Income Security Act of 1974, a self-insured plan, a fully-insured plan, a service benefit plan, a medicare managed care plan under section 1903(m) or 1932, a pharmacy benefit manager, and any other health plan determined appropriate by the Secretary.”.

(B) CONFORMING AMENDMENTS.—Section 1902(a)(25) of the Social Security Act (42 U.S.C. 1396a(a)(25)) is amended—

(i) in subparagraph (A), in the matter preceding clause (i), by striking “third parties” and all that follows through “item or service)” and inserting “responsible third parties”;

(ii) in subparagraph (G), by striking “health insurer” and all that follows through “item or service)” and inserting “responsible third party”;

(iii) in subparagraph (I), in the matter preceding clause (i), by striking “health insurers” and all that follows through “item or service” and inserting “responsible third parties”; and

(iv) by inserting “responsible” before “third” each place it appears in subparagraphs (A)(i), (A)(ii), (C), (D), and (H).

(3) REMOVAL OF SPECIAL TREATMENT OF CERTAIN TYPES OF CARE AND PAYMENTS UNDER MEDICAID THIRD PARTY LIABILITY RULES.—Section 1902(a)(25) of the Social Security Act (42 U.S.C. 1396a(a)(25)), as amended by section 202(c) of the Bipartisan Budget Act of 2013 (after application of paragraph (1)), is amended by striking subparagraphs (E) and (F).

(4) CLARIFICATION OF ROLE OF HEALTH INSURERS WITH RESPECT TO THIRD PARTY LIABILITY.—

(A) IN GENERAL.—Section 1902(a)(25) of the Social Security Act (42 U.S.C. 1396a(a)(25)), as amended by paragraph (3), is further amended by inserting after subparagraph (D) the following new subparagraphs:

“(E) that, in the case of a State that provides medical assistance under this title through a contract with a health insurer, such contract shall specify whether the State is—

“(i) delegating to such insurer all or some of its right of recovery from a responsible third party for an item or service for which payment has been made under the State plan (or under a waiver of the plan); and

“(ii) transferring to such insurer all or some of the assignment to the State of any right of an individual or other entity to payment from a responsible third party for an item or service for which payment has been made under the State plan (or under a waiver of the plan);

“(F) that, in the case of a State that elects an option described in clause (i) or (ii) of subparagraph (E) with respect to a health insurer, the State shall provide assurances to the Secretary that the State laws referred to in subparagraph (I) confer to the health insurer the authority of the State with respect to the requirements specified in clauses (i) through (iv) of such subparagraph;”.

(B) TREATMENT OF COLLECTED AMOUNTS.—Section 1903(d)(2)(B) of the Social Security Act (42 U.S.C. 1396b(d)(2)(B)) is amended by adding at the end the following: “For purposes of this subparagraph, reimbursements made by a responsible third party to health insurers pursuant to section 1902(a)(25)(E) shall be treated in the same manner as reimbursements made to a State under the previous sentence.”.

(5) INCREASING STATE FLEXIBILITY WITH RESPECT TO THIRD PARTY LIABILITY.—Section 1902(a)(25)(I) of the Social Security Act (42 U.S.C. 1396a(a)(25)(I)) is amended—

(A) in clause (i), by striking “medical assistance under the State plan” and inserting “medical assistance under a State plan (or under a waiver of the plan)”; and

(B) by striking clause (ii) and inserting the following new clause:

“(ii) accept—

“(I) any State’s right of recovery and the assignment to any 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 respective State’s plan (or under a waiver of the plan); and

“(II) as a valid authorization of the responsible third party for the furnishing of an item or service to an individual eligible to receive medical assistance under this title, an authorization made on behalf of such individual under the State plan (or under a waiver of such plan) for the furnishing of such item or service to such individual;”.

(C) in clause (iii)—

(i) by striking “respond to” and inserting “not later than 60 days after receiving”; and

(ii) by striking “; and” at the end and inserting “, respond to such inquiry; and”; and

(D) in clause (iv), by inserting “a failure to obtain a prior authorization,” after “claim form.”.

(6) STATE INCENTIVE TO PURSUE THIRD PARTY LIABILITY FOR NEWLY ELIGIBLES.—Section 1903(d)(2)(B) of the Social Security Act (42 U.S.C. 1396b(d)(2)(B)), as amended by paragraph (4)(B), is further amended by adding at the end the following: “In the case of expenditures for medical assistance provided during 2017 and subsequent years for individuals described in subclause (VIII) of section 1902(a)(10)(A)(i), in determining the amount, if any, of overpayment under this subparagraph with respect to such medical assistance, the Secretary shall apply the Federal medical assistance percentage for the State under section 1905(b), notwithstanding the application of section 1905(y).”.

(b) COMPLIANCE WITH THIRD PARTY INSURANCE REPORTING.—Section 1903 of the Social Security Act (42 U.S.C. 1396b) is amended by inserting after subsection (m) the following new subsection:

“(n)(1) For any year beginning after 2020 (or a sooner year as provided in paragraph (2)), if a State fails to comply with the requirements of section 1902(a)(25) with respect to each calendar quarter in such year, the Secretary may reduce the Federal medical assistance percentage by 0.1 percentage point for calendar quarters in each subsequent year in which the State fails to so comply (and cumulatively for a failure to so comply for a period of consecutive years).

“(2) The Secretary may apply paragraph (1)—

“(A) for any year beginning after 2018, if a State fails to comply with the requirements of section 1902(a)(25) with respect to payment for items and serv-

ices furnished to individuals described in subclause (VIII) of section 1902(a)(10)(A)(i) or non-expansion individuals; and

“(B) for any year beginning after 2019, if a State fails to comply with the requirements of section 1902(a)(25) with respect to payment for items and services furnished to individuals described in subdivision (i), (iii), or (iv) of section 1905(a).

“(3) For purposes of this subsection, the term ‘non-expansion individual’ means, with respect to a State for a month, an individual who is—

“(A) eligible for medical assistance for items or services under this title and enrolled under the State plan (or a waiver of such plan) under this title for the month;

“(B) not under 19 years of age;

“(C) not 65 years of age or older; and

“(D) not eligible for medical assistance under this title on the basis of being blind or disabled.”.

(c) APPLICATION TO 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) through (R) as subparagraphs (C) through (S), respectively; and

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

“(B) Section 1902(a)(25) (relating to third party liability).”.

(2) MANDATORY REPORTING.—Section 1902(a)(25)(I)(i) of the Social Security Act (42 U.S.C. 1396a(a)(25)(I)(i)), as amended by subsection (a)(5), is further amended—

(A) by striking “(and, at State option, child” and inserting “and child”; and

(B) by striking “title XXI” and inserting “title XXI”.

(d) TRAINING ON THIRD PARTY LIABILITY.—Section 1936 of the Social Security Act (42 U.S.C. 1396u–6) is amended—

(1) in subsection (b)(4), by striking “and quality of care” and inserting “, quality of care, and the liability of responsible third parties (as defined in section 1902(nn))”; and

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

“(f) THIRD PARTY LIABILITY TRAINING.—With respect to education or training activities carried out pursuant to subsection (b)(4) with respect to the liability of responsible third parties (as defined in section 1902(nn) for payment for items and services furnished under State plans (or under waivers of such plans)) under this title, the Secretary shall—

“(1) publish (and update on an annual basis) on the public Internet website of the Centers for Medicare & Medicaid Services a dedicated Internet page containing best practices to be used in assessing such liability;

“(2) monitor efforts to assess such liability and analyze the challenges posed by that assessment;

“(3) distribute to State agencies administering the State plan under this title information related to such efforts and challenges; and

“(4) provide guidance to such State agencies with respect to State oversight of efforts under a medicare managed care plan under section 1903(m) or 1932 to assess such liability.”.

(e) DEVELOPMENT OF MODEL UNIFORM FIELDS FOR STATES TO REPORT THIRD PARTY INFORMATION.—Not later than January 1, 2019, the Secretary of Health and Human Services shall, in consultation with the States, develop and make available to the States a model uniform reporting field that States may use for purposes of reporting to the Secretary through the Transformed Medicaid Statistical Information System (T-MSIS) (or a successor system), or within CMS Form 64 (or any successor form), information identifying responsible third parties (as defined in subsection (nn) of section 1902 of the Social Security Act (42 U.S.C. 1396a), as added by subsection (a)(2)(A)) and other relevant information for ascertaining the legal responsibility of such third parties to pay for care and services available under the State plan (or under a waiver of the plan) under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

(f) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), this section and the amendments made by this section (other than as specified in the preceding provisions of this section) shall take effect on October 1, 2019, and shall apply to medical assistance or child health assistance provided on or after such date.

(2) EXCEPTION IF STATE LEGISLATION REQUIRED.—In the case of a State plan for medical assistance under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), or a State child health plan for child health assistance under title XXI

of such Act (42 U.S.C. 1397aa et seq.), that the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirement imposed by the amendments made under this section, such plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet this additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

SEC. 202. TREATMENT OF LOTTERY WINNINGS AND OTHER LUMP-SUM INCOME FOR PURPOSES OF INCOME ELIGIBILITY UNDER MEDICAID.

(a) IN GENERAL.—Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended—

(1) in subsection (a)(17), by striking “(e)(14), (e)(14)” and inserting “(e)(14), (e)(15)”; and

(2) in subsection (e)—

(A) in paragraph (14) (relating to modified adjusted gross income), by adding at the end the following new subparagraph:

“(J) TREATMENT OF CERTAIN LOTTERY WINNINGS AND INCOME RECEIVED AS A LUMP SUM.—

“(i) IN GENERAL.—In the case of an individual who is the recipient of qualified lottery winnings (pursuant to lotteries occurring on or after January 1, 2018) or qualified lump sum income (received on or after such date) and whose eligibility for medical assistance is determined based on the application of modified adjusted gross income under subparagraph (A), a State shall, in determining such eligibility, include such winnings or income (as applicable) as income received—

“(I) in the month in which such winnings or income (as applicable) is received if the amount of such winnings or income is less than \$80,000;

“(II) over a period of 2 months if the amount of such winnings or income (as applicable) is greater than or equal to \$80,000 but less than \$90,000;

“(III) over a period of 3 months if the amount of such winnings or income (as applicable) is greater than or equal to \$90,000 but less than \$100,000; and

“(IV) over a period of 3 months plus 1 additional month for each increment of \$10,000 of such winnings or income (as applicable) received, not to exceed a period of 120 months (for winnings or income of \$1,260,000 or more), if the amount of such winnings or income is greater than or equal to \$100,000.

“(ii) COUNTING IN EQUAL INSTALLMENTS.—For purposes of subclauses (II), (III), and (IV) of clause (i), winnings or income to which such subclause applies shall be counted in equal monthly installments over the period of months specified under such subclause.

“(iii) HARDSHIP EXEMPTION.—An individual whose income, by application of clause (i), exceeds the applicable eligibility threshold established by the State, shall continue to be eligible for medical assistance to the extent that the State determines, under procedures established by the State (in accordance with standards specified by the Secretary), that the denial of eligibility of the individual would cause an undue medical or financial hardship as determined on the basis of criteria established by the Secretary.

“(iv) NOTIFICATIONS AND ASSISTANCE REQUIRED IN CASE OF LOSS OF ELIGIBILITY.—A State shall, with respect to an individual who loses eligibility for medical assistance under the State plan (or a waiver of such plan) by reason of clause (i)—

“(I) before the date on which the individual loses such eligibility, inform the individual—

“(aa) of the individual’s opportunity to enroll in a qualified health plan offered through an Exchange established under title I of the Patient Protection and Affordable Care Act during the special enrollment period specified in section 9801(f)(3) of the Internal Revenue Code of 1986 (relating to loss of Medicaid or CHIP coverage); and

“(bb) of the date on which the individual would no longer be considered ineligible by reason of clause (i) to receive medical

assistance under the State plan or under any waiver of such plan and be eligible to reapply to receive such medical assistance; and

“(II) provide technical assistance to the individual seeking to enroll in such a qualified health plan.

“(v) QUALIFIED LOTTERY WINNINGS DEFINED.—In this subparagraph, the term ‘qualified lottery winnings’ means winnings from a sweepstakes, lottery, or pool described in paragraph (3) of section 4402 of the Internal Revenue Code of 1986 or a lottery operated by a multistate or multijurisdictional lottery association, including amounts awarded as a lump sum payment.

“(vi) QUALIFIED LUMP SUM INCOME DEFINED.—In this subparagraph, the term ‘qualified lump sum income’ means income that is received as a lump sum from one of the following sources:

“(I) Monetary winnings from gambling (as defined by the Secretary and including gambling activities described in section 1955(b)(4) of title 18, United States Code).

“(II) Damages received, whether by suit or agreement and whether as lump sums or as periodic payments (other than monthly payments), on account of causes of action other than causes of action arising from personal physical injuries or physical sickness.

“(III) Income received as liquid assets from the estate (as defined in section 1917(b)(4)) of a deceased individual.”; and

(B) by striking “(14) EXCLUSION” and inserting “(15) EXCLUSION”.

(b) RULES OF CONSTRUCTION.—

(1) INTERCEPTION OF LOTTERY WINNINGS ALLOWED.—Nothing in the amendment made by subsection (a)(2)(A) shall be construed as preventing a State from intercepting the State lottery winnings awarded to an individual in the State to recover amounts paid by the State under the State Medicaid plan under title XIX of the Social Security Act for medical assistance furnished to the individual.

(2) APPLICABILITY LIMITED TO ELIGIBILITY OF RECIPIENT OF LOTTERY WINNINGS OR LUMP SUM INCOME.—Nothing in the amendment made by subsection (a)(2)(A) shall be construed, with respect to a determination of household income for purposes of a determination of eligibility for medical assistance under the State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) (or a waiver of such plan) made by applying modified adjusted gross income under subparagraph (A) of section 1902(e)(14) of such Act (42 U.S.C. 1396a(e)(14)), as limiting the eligibility for such medical assistance of any individual that is a member of the household other than the individual who received qualified lottery winnings or qualified lump-sum income (as defined in subparagraph (J) of such section 1902(e)(14), as added by subsection (a)(2)(A) of this section).

SEC. 203. ADJUSTMENTS TO MEDICARE PART B AND PART D PREMIUM SUBSIDIES FOR HIGHER INCOME INDIVIDUALS.

(a) IN GENERAL.—Section 1839(i)(3)(C)(i)(II) of the Social Security Act (42 U.S.C. 1395r(i)(3)(C)(i)(II)) is amended, in the table, by striking the last row and inserting the following new rows:

“More than \$160,000 but less than \$500,000	80 percent
At least \$500,000	100 percent.”.

(b) JOINT RETURNS.—Section 1839(i)(3)(C)(ii) of the Social Security Act (42 U.S.C. 1395r(i)(3)(C)(ii)) is amended by inserting before the period the following: “except, with respect to the dollar amounts applied in the last row of the table under subclause (II) of such clause (and the second dollar amount specified in the second to last row of such table), clause (i) shall be applied by substituting dollar amounts which are 175 percent of such dollar amounts for the calendar year”.

(c) INFLATION ADJUSTMENT.—Section 1839(i) of the Social Security Act (42 U.S.C. 1395r(i)) is amended—

(1) in paragraph (5)—

(A) in subparagraph (A), by striking “In the case” and inserting “Subject to subparagraph (C), in the case”;

(B) in subparagraph (B), by striking “subparagraph (A)” and inserting “subparagraph (A) or (C)”;

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

“(C) TREATMENT OF ADJUSTMENTS FOR CERTAIN HIGHER INCOME INDIVIDUALS.—

“(i) IN GENERAL.—Subparagraph (A) shall not apply with respect to each dollar amount in paragraph (3) of \$500,000.

“(ii) ADJUSTMENT BEGINNING 2027.—In the case of any calendar year beginning after 2026, each dollar amount in paragraph (3) of \$500,000 shall be increased by an amount equal to—
 “(I) such dollar amount, multiplied by
 “(II) the percentage (if any) by which the average of the Consumer Price Index for all urban consumers (United States city average) for the 12-month period ending with August of the preceding calendar year exceeds such average for the 12-month period ending with August 2025.”; and
 (2) in paragraph (6)(B), by inserting “(other than \$500,000)” after “the dollar amounts”.

PURPOSE AND SUMMARY

H.R. 3921 was introduced on October 3, 2017, by Representative Michael C. Burgess (R-TX). The bill extends federal funding for the Children’s Health Insurance Program (CHIP) for fiscal year (FY) 2018 through FY 2022, eliminates the FY 2018 reductions in Medicaid Disproportionate Share Hospital (DSH) allotments, and provides funding for Puerto Rico’s Medicaid program for FY 2018 through the end of calendar year 2019.

BACKGROUND AND NEED FOR LEGISLATION

The Children’s Health Insurance Program is a means-tested federal-state program that provides health coverage to targeted low-to-moderate income children and pregnant women who have annual income above Medicaid eligibility levels. CHIP is jointly financed by the federal government and states, and the states are responsible for administering CHIP.

In FY 2015, 8.4 million children received CHIP-funded coverage. Spending for FY 2015 totaled \$13.7 billion (\$9.7 billion in federal funds and \$4.0 billion in state funds). About 40 percent of participants (3.4 million) were children under the age of 19 in separate CHIP programs, 56 percent (4.7 million) were children in Medicaid-expansion CHIP programs, and just under 4 percent (0.3 million) were unborn children in separate CHIP programs. States may also provide CHIP-funded coverage to pregnant women. In FY 2015, states electing this option covered 4,200 pregnant women.

CHIP spending is reimbursed by the federal government at a matching rate higher than Medicaid’s. CHIP’s enhanced federal medical assistance percentage (E-FMAP) varies by state, historically ranging from 65 percent to 81 percent, compared to 50 percent to 73 percent for children in Medicaid. Federal CHIP allotments are provided to states annually, with amounts based on each state’s recent CHIP spending increased by a growth factor. States have two years to spend each allotment, with unspent funds available for redistribution to other states. In addition to redistribution funds, federal CHIP contingency funds are available to qualifying states that exhaust their CHIP allotments.

Section 2101 of the Affordable Care Act increased the CHIP E-FMAP by 23 percent from October 1, 2016 through September 30, 2019. Therefore, under current law, the CHIP matching rate ranges from 88 percent to 100 percent through FY 2019. In FY 2017, 12 states have E-FMAPs at 100 percent. However, the Patient Protection and Affordable Care Act (ACA) did not include additional or extended funding for CHIP, so Congress had to extend funding in MACRA. The ACA also required states to maintain in-

come eligibility levels for CHIP through September 30, 2019, as a condition for receiving payments under Medicaid (notwithstanding the lack of corresponding federal appropriations for FY 2018 and FY 2019). This provision is referred to as the “Maintenance of Effort” (MOE) requirement.

Under the CHIP program, the federal government sets basic requirements for CHIP, but states have the flexibility to design their version of CHIP within the federal government’s basic framework. As a result, there is significant variation across CHIP programs. Currently, state upper-income eligibility limits for children range from a low of 175 percent of the federal poverty level (FPL) to a high of 405 percent of FPL. However, roughly 90 percent of CHIP enrollees are at or below 250 percent FPL. States may also extend CHIP coverage to pregnant women when certain conditions are met. While individuals who meet Medicaid program criteria (including the criteria for Medicaid-expansion state CHIP programs) are entitled to Medicaid coverage, there is no individual entitlement to coverage in separate state CHIP programs.

On September 30, 2017, the FY 2017 funding for the Children’s Health Insurance Program expired. After the expiration of FY 2017 funds, and until the provision of FY 2018 funds, states may use redistributed funds and unspent FY 2017 allotments to continue to provide health coverage. States could eventually exhaust all federal CHIP funding, although this has not occurred since the enactment of the current allotment structure in the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA). However, without the FY 2018 federal funding, states could start to exhaust these funds as early as November. Before the exhaustion of program funds in each state, states are required to notify CHIP enrollees that their coverage will be terminated, and states would eventually have to terminate their CHIP programs. The majority of children currently enrolled in CHIP would be eligible for health coverage in Medicaid, the Exchanges, or employer-sponsored coverage. However, not all children would be insured and children and families could face higher cost-sharing, less access to quality pediatric providers, and other challenges in other coverage sources. Previous analysis from U.S. Government Accountability Office (GAO) and the Medicaid and CHIP Payment and Access Commission (MACPAC) has demonstrated that CHIP offers higher quality, more affordable coverage for children relative to Exchange coverage. Additionally, since CHIP is funded by federal and state governments, it is generally more cost-effective for the federal government to provide health coverage to children through CHIP than through Exchange coverage.

COMMITTEE ACTION

On Wednesday, June 23, 2017, the Subcommittee on Health held a hearing entitled “Examining the Extension of Safety Net Health Programs.” The purpose of this hearing was to examine the extension of funding for two federal safety net health programs, the Community Health Center Fund and the State Children’s Health Insurance Program. Witnesses included:

- Michael Holmes, CEO, Cook Area Health Services;

- Jami Snyder, Associate Commissioner for Medicaid/SCHIP Services, Health and Human Services Commission, State of Texas; and
- Cindy Mann, Partner, Manatt Health.

On October 4, 2017, the full Committee on Energy and Commerce met in open markup session and ordered H.R. 3921, as amended, favorably reported to the House by a vote of 28 yeas and 23 nays.

COMMITTEE VOTES

Clause 3(b) of rule XIII requires the Committee to list the record votes on the motion to report legislation and amendments thereto. The following reflects the record votes taken during the Committee consideration:

**COMMITTEE ON ENERGY AND COMMERCE -- 115TH CONGRESS
ROLL CALL VOTE # 48**

BILL: H.R. 3921, HEALTHY KIDS Act of 2017

AMENDMENT: An amendment offered by Mr. Pallone, No. 5, to extend and reauthorize the appropriation for the Children's Health Insurance Program; to ensure access to mental health services for children; to delay Medicaid DSH reductions for each of fiscal years 2018 through 2025; to provide an increase of \$6,500,000,000 of Medicaid funding to Puerto Rico and U.S. Virgin Islands and increasing the Federal medical assistance percentage to 100 percent; to delay the Third Party Liability provision of the Bipartisan Budget Act of 2013 by five years; to delay certain Medicare plan payment dates and to transfer 50 percent of the money remaining from this delay to the Medicare Improvement Fund and 50 percent of the money to the Medicaid Improvement Fund.

DISPOSITION: NOT AGREED TO, by a roll call vote of 22 yeas and 28 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Walden		X		Mr. Pallone	X		
Mr. Barton		X		Mr. Rush	X		
Mr. Upton		X		Ms. Eshoo	X		
Mr. Shimkus		X		Mr. Engel	X		
Mr. Murphy				Mr. Green	X		
Mr. Burgess		X		Ms. DeGette	X		
Mrs. Blackburn		X		Mr. Doyle			
Mr. Scalise				Ms. Schakowsky	X		
Mr. Latta		X		Mr. Butterfield			
Mrs. McMorris Rodgers		X		Ms. Matsui	X		
Mr. Harper		X		Ms. Castor	X		
Mr. Lance		X		Mr. Sarbanes	X		
Mr. Guthrie		X		Mr. McNerney	X		
Mr. Olson		X		Mr. Welch	X		
Mr. McKinley		X		Mr. Lujan	X		
Mr. Kinzinger		X		Mr. Tonko	X		
Mr. Griffith		X		Ms. Clarke	X		
Mr. Bilirakis		X		Mr. Loeb sack	X		
Mr. Johnson		X		Mr. Schrader	X		
Mr. Long				Mr. Kennedy	X		
Mr. Bucshon		X		Mr. Cardenas	X		
Mr. Flores		X		Mr. Ruiz	X		
Mrs. Brooks		X		Mr. Peters	X		
Mr. Mullin		X		Ms. Dingell	X		
Mr. Hudson		X					
Mr. Collins		X					
Mr. Cramer		X					
Mr. Walberg		X					
Mrs. Walters		X					
Mr. Costello		X					
Mr. Carter		X					

10/04/2017

**COMMITTEE ON ENERGY AND COMMERCE -- 115TH CONGRESS
ROLL CALL VOTE # 49**

BILL: H.R. 3921, HEALTHY KIDS Act of 2017

AMENDMENT: An amendment offered by Mr. Lujan, No. 6, to strike section 106, Puerto Rico Medicaid payments, and to provide that, for the period of fiscal years 2018 and 2019, the amount of the increase otherwise provided under section 1108(g)(5)(A) for Puerto Rico and the Virgin Islands shall be further increased by \$6,500,000,000, and to provide that for the period of fiscal years 2018 and 2019, the Federal medical assistance percentage for Puerto Rico and the Virgin Islands shall be 100 per centum.

DISPOSITION: NOT AGREED TO, by a roll call vote of 22 yeas and 28 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Walden		X		Mr. Pallone	X		
Mr. Barton		X		Mr. Rush	X		
Mr. Upton		X		Ms. Eshoo	X		
Mr. Shimkus		X		Mr. Engel	X		
Mr. Murphy				Mr. Green	X		
Mr. Burgess		X		Ms. DeGette	X		
Mrs. Blackburn		X		Mr. Doyle			
Mr. Scalise				Ms. Schakowsky			
Mr. Latta		X		Mr. Butterfield	X		
Mrs. McMorris Rodgers		X		Ms. Matsui	X		
Mr. Harper		X		Ms. Castor	X		
Mr. Lance		X		Mr. Sarbanes	X		
Mr. Guthrie		X		Mr. McNerney	X		
Mr. Olson		X		Mr. Welch	X		
Mr. McKinley		X		Mr. Lujan	X		
Mr. Kinzinger		X		Mr. Tonko	X		
Mr. Griffith		X		Ms. Clarke	X		
Mr. Bilirakis		X		Mr. Loeb sack	X		
Mr. Johnson		X		Mr. Schrader	X		
Mr. Long				Mr. Kennedy	X		
Mr. Bucshon		X		Mr. Cardenas	X		
Mr. Flores		X		Mr. Ruiz	X		
Mrs. Brooks		X		Mr. Peters	X		
Mr. Mullin		X		Ms. Dingell	X		
Mr. Hudson		X					
Mr. Collins		X					
Mr. Cramer		X					
Mr. Walberg		X					
Mrs. Walters		X					
Mr. Costello		X					
Mr. Carter		X					

10/04/2017

COMMITTEE ON ENERGY AND COMMERCE -- 115TH CONGRESS
ROLL CALL VOTE # 50

BILL: H.R. 3921, HEALTHY KIDS Act of 2017

AMENDMENT: An amendment offered by Mr. Engel, No. 7, to strike section 105, Modifying reduction in Medicaid DSH allotments, and to delay for two years Medicaid DSH Reductions for each of fiscal years 2018 through 2025.

DISPOSITION: NOT AGREED TO, by a roll call vote of 23 yeas and 28 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Walden		X		Mr. Pallone	X		
Mr. Barton		X		Mr. Rush	X		
Mr. Upton		X		Ms. Eshoo	X		
Mr. Shimkus		X		Mr. Engel	X		
Mr. Murphy				Mr. Green	X		
Mr. Burgess		X		Ms. DeGette	X		
Mrs. Blackburn		X		Mr. Doyle			
Mr. Scalise				Ms. Schakowsky	X		
Mr. Latta		X		Mr. Butterfield	X		
Mrs. McMorris Rodgers		X		Ms. Matsui	X		
Mr. Harper		X		Ms. Castor	X		
Mr. Lance		X		Mr. Sarbanes	X		
Mr. Guthrie		X		Mr. McNerney	X		
Mr. Olson		X		Mr. Welch	X		
Mr. McKinley		X		Mr. Lujan	X		
Mr. Kinzinger		X		Mr. Tonko	X		
Mr. Griffith		X		Ms. Clarke	X		
Mr. Bilirakis		X		Mr. Loebsack	X		
Mr. Johnson		X		Mr. Schrader	X		
Mr. Long				Mr. Kennedy	X		
Mr. Bucshon		X		Mr. Cardenas	X		
Mr. Flores		X		Mr. Ruiz	X		
Mrs. Brooks		X		Mr. Peters	X		
Mr. Mullin		X		Ms. Dingell	X		
Mr. Hudson		X					
Mr. Collins		X					
Mr. Cramer		X					
Mr. Walberg		X					
Mrs. Walters		X					
Mr. Costello		X					
Mr. Carter		X					

10/04/2017

COMMITTEE ON ENERGY AND COMMERCE -- 115TH CONGRESS
ROLL CALL VOTE # 51

BILL: H.R. 3921, HEALTHY KIDS Act of 2017

AMENDMENT: An amendment offered by Mr. Welch, No. 10, to strike section 203, Adjustments to Medicare part B and part D premium subsidies for higher income individuals, and to amend section 1860D-11 of the Social Security Act to strike subsection (i) (relating to noninterference) and to provide that the Secretary of Health and Human Services shall negotiate with pharmaceutical manufacturers the prices (including discounts, rebates, and other price concessions) that may be charged to PDP sponsors and MA organizations for covered part D drugs for part D eligible individuals who are enrolled under a prescription drug plan or under an MA-PD plan.

DISPOSITION: NOT AGREED TO, by a roll call vote of 21 yeas and 28 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Walden		X		Mr. Pallone	X		
Mr. Barton		X		Mr. Rush	X		
Mr. Upton		X		Ms. Eshoo	X		
Mr. Shimkus		X		Mr. Engel	X		
Mr. Murphy				Mr. Green	X		
Mr. Burgess		X		Ms. DeGette	X		
Mrs. Blackburn		X		Mr. Doyle			
Mr. Scalise				Ms. Schakowsky	X		
Mr. Latta		X		Mr. Butterfield	X		
Mrs. McMorris Rodgers		X		Ms. Matsui	X		
Mr. Harper		X		Ms. Castor	X		
Mr. Lance		X		Mr. Sarbanes	X		
Mr. Guthrie		X		Mr. McNerney	X		
Mr. Olson		X		Mr. Welch	X		
Mr. McKinley		X		Mr. Lujan	X		
Mr. Kinzinger		X		Mr. Tonko	X		
Mr. Griffith		X		Ms. Clarke			
Mr. Bilirakis		X		Mr. Loeb sack	X		
Mr. Johnson		X		Mr. Schrader			
Mr. Long				Mr. Kennedy	X		
Mr. Bucshon		X		Mr. Cardenas	X		
Mr. Flores		X		Mr. Ruiz	X		
Mrs. Brooks		X		Mr. Peters	X		
Mr. Mullin		X		Ms. Dingell	X		
Mr. Hudson		X					
Mr. Collins		X					
Mr. Cramer		X					
Mr. Walberg		X					
Mrs. Walters		X					
Mr. Costello		X					
Mr. Carter		X					

10/04/2017

**COMMITTEE ON ENERGY AND COMMERCE -- 115TH CONGRESS
ROLL CALL VOTE # 52**

BILL: H.R. 3921, HEALTHY KIDS Act of 2017

AMENDMENT: A motion by Mr. Walden to order H.R. 3921 favorably reported to the House, as amended.
(Final Passage)

DISPOSITION: **AGREED TO**, by a roll call vote of 28 yeas and 23 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Walden	X			Mr. Pallone		X	
Mr. Barton	X			Mr. Rush		X	
Mr. Upton	X			Ms. Eshoo		X	
Mr. Shimkus	X			Mr. Engel		X	
Mr. Murphy				Mr. Green		X	
Mr. Burgess	X			Ms. DeGette		X	
Mrs. Blackburn	X			Mr. Doyle			
Mr. Scalise				Ms. Schakowsky		X	
Mr. Latta	X			Mr. Butterfield		X	
Mrs. McMorris Rodgers	X			Ms. Matsui		X	
Mr. Harper	X			Ms. Castor		X	
Mr. Lance	X			Mr. Sarbanes		X	
Mr. Guthrie	X			Mr. McNerney		X	
Mr. Olson	X			Mr. Welch		X	
Mr. McKinley	X			Mr. Lujan		X	
Mr. Kinzinger	X			Mr. Tonko		X	
Mr. Griffith	X			Ms. Clarke		X	
Mr. Bilirakis	X			Mr. Loeb sack		X	
Mr. Johnson	X			Mr. Schrader		X	
Mr. Long				Mr. Kennedy		X	
Mr. Bucshon	X			Mr. Cardenas		X	
Mr. Flores	X			Mr. Ruiz		X	
Mrs. Brooks	X			Mr. Peters		X	
Mr. Mullin	X			Ms. Dingell		X	
Mr. Hudson	X						
Mr. Collins	X						
Mr. Cramer	X						
Mr. Walberg	X						
Mrs. Walters	X						
Mr. Costello	X						
Mr. Carter	X						

10/04/2017

OVERSIGHT FINDINGS AND RECOMMENDATIONS

Pursuant to clause 2(b)(1) of rule X and clause 3(c)(1) of rule XIII, the Committee held a hearing and made findings that are reflected in this report.

NEW BUDGET AUTHORITY, ENTITLEMENT AUTHORITY, AND TAX EXPENDITURES

Pursuant to clause 3(c)(2) of rule XIII, the Committee finds that H.R. 3921 would result in no new or increased budget authority, entitlement authority, or tax expenditures or revenues.

CONGRESSIONAL BUDGET OFFICE ESTIMATE

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

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, October 19, 2017.

Hon. GREG WALDEN,
*Chairman, Committee on Energy and Commerce,
House of Representatives, Washington, DC.*

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for H.R. 3921, the HEALTHY KIDS Act of 2017.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Robert Stewart.

Sincerely,

KEITH HALL,
Director.

Enclosure.

H.R. 3921—HEALTHY KIDS Act of 2017

Summary: H.R. 3921 would extend federal funding for the Children's Health Insurance Program (CHIP) for five years, increase Medicaid funding for Puerto Rico and the Virgin Islands, and change policies that require other sources of health coverage to pay claims before Medicaid. The bill also would modify payments to hospitals that treat a disproportionate share of uninsured and Medicaid patients and require states to count lottery winnings as income for purposes of determining Medicaid eligibility. Finally, H.R. 3921 would make adjustments to Medicare premium subsidies for higher-income individuals.

On net, CBO estimates that implementing the legislation would reduce the deficit by \$1.1 billion over the 2018–2027 period. Because enacting H.R. 3921 would affect direct spending and revenues, pay-as-you-go procedures apply.

CBO estimates that enacting H.R. 3921 would not increase net direct spending or on-budget deficits in one or more of the four consecutive 10-year periods beginning in 2028.

H.R. 3921 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 effect of H.R. 3921 is shown in the following table. The costs of this legislation fall within budget function 550 (health).

By fiscal year, in millions of dollars—										
	2018	2019	2020	2021	2022	2023	2024	2025	2026	2018— 2022
INCREASES OR DECREASES (–) IN DIRECT SPENDING										
Sec. 101–104—CHIP:										
Estimated Budget Authority	14,704	11,210	12,828	13,498	14,304	–5,859	–4,756	0	0	66,545
Estimated Outlays	1,438	4,489	3,601	1,615	1,740	1,372	632	4	2	12,883
Sec. 105—Modifying Reduction in Medicaid DSH Allotments:										
Estimated Budget Authority	1,356	0	0	0	0	0	0	0	–761	1,356
Estimated Outlays	1,356	0	0	0	0	0	0	0	–761	1,356
Sec. 106—Puerto Rico and the Virgin Islands Medicaid Payments:										
Estimated Budget Authority	1,032	8	0	0	0	0	0	0	0	1,040
Estimated Outlays	796	241	4	0	0	0	0	0	0	1,040
Sec. 201—Medicaid Third Party Liability:										
Estimated Budget Authority	70	110	–160	–330	–520	–535	–555	–580	–605	–830
Estimated Outlays	70	110	–160	–330	–520	–535	–555	–580	–605	–830
Sec. 202—Treatment of Lottery Winnings:										
Estimated Budget Authority	–13	–27	–43	–61	–66	–70	–75	–80	–86	–210
Estimated Outlays	–13	–27	–43	–61	–66	–70	–75	–80	–86	–210
Sec. 203—Medicare Premium Subsidies										
Estimated Budget Authority	–270	–380	–410	–470	–550	–600	–650	–740	–830	–2,080
Estimated Outlays	–270	–380	–410	–470	–550	–600	–650	–740	–830	–2,080
Total Changes:										
Estimated Budget Authority	18,176	16,610	17,387	18,239	19,064	–1,205	–1,280	–1,400	–2,282	89,476
Estimated Outlays	3,377	4,432	2,992	754	604	167	–647	–1,396	–2,281	12,159
INCREASES OR DECREASES (–) IN REVENUES										
Sec. 101—CHIP:										
Estimated Revenues	160	736	998	1,169	1,311	1,262	1,036	–1	0	4,374
On-Budget	105	486	660	772	866	836	687	–1	0	2,889
Off-Budget ^a	55	250	338	397	445	426	349	0	0	1,485
NET INCREASE OR DECREASE (–) IN THE DEFICIT FROM INCREASES OR DECREASES (–) IN DIRECT SPENDING AND REVENUES										
Impact on Deficit	3,217	3,696	1,994	–415	–707	–1,095	–1,683	–1,395	–2,281	7,785
On-Budget	3,272	3,946	2,332	–18	–262	–669	–1,334	–1,395	–2,281	9,270

Off-Budget	— 55	— 250	— 338	— 397	— 445	— 426	— 349	0	0	0	— 1,485	— 2,260
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Notes: Components may not add to totals because of rounding: CHIP = Children's Health Insurance Program; DSH = payments to hospitals that treat a disproportionate share of uninsured and Medicaid patients.
 *All off-budget effects would come from changes in Social Security revenues.

Basis of estimate: For this estimate, CBO assumes that H.R. 3921 will be enacted near the start of calendar year 2018.

Children's Health Insurance Program

H.R. 3921 would extend funding for CHIP through 2022, change the federal matching rate in 2020, and extend certain eligibility requirements. CBO and JCT estimate that enacting this legislation would increase federal spending by \$14.9 billion and revenues by \$6.7 billion, for a net cost of \$8.2 billion over the 2018–2027 period, relative to CBO's baseline.

Extension of Funding. The bill would provide a total of \$118.5 billion for CHIP allotments to states over five years. The net cost of the extension described above (\$8.2 billion) is substantially less than the amount of funding provided for three reasons. First, pursuant to the rules that govern CBO's baseline, certain expiring programs, including CHIP, are assumed to continue in the baseline beyond their scheduled expiration dates. In accordance with those rules and the structure of CHIP financing in 2017, CBO assumes the continuation of \$5.7 billion of CHIP funding in each year over the 2018–2027 period. CBO's estimate of CHIP spending under this bill is net of that spending already assumed in the baseline.

Second, the increase in spending for CHIP would be partially offset by reductions in the net costs of federal subsidies provided for other forms of health insurance, including Medicaid, insurance purchased through the health insurance marketplaces established under the ACA, and employment-based health insurance. Those reductions would occur because most of the people who would receive coverage through CHIP as a result of enacting H.R. 3921 would otherwise receive federally-subsidized coverage under current law. Specifically, CBO estimates that of the approximately six million children who would be covered by CHIP under H.R. 3921:

- About 40 percent would be covered by Medicaid under current law. Thus, enacting H.R. 3921 would reduce federal Medicaid spending by \$15.1 billion during the 2018–2027 period relative to CBO's baseline.
- About 25 percent would receive subsidies for private health insurance purchased through the marketplaces under current law. Children in families with income between 138 percent and 400 percent of the poverty guidelines who are not eligible for Medicaid would generally qualify for subsidies to purchase health insurance through the marketplaces if they do not have access to employment-based coverage through a parent. If H.R. 3921 is enacted, CBO estimates those subsidies would be \$20 billion lower over the 2018–2027 period because those children would enroll in CHIP instead of purchasing coverage through the marketplaces. The estimated decrease in subsidies for coverage purchased through marketplaces comprises a \$19.2 billion reduction in outlays and a \$0.7 billion increase in revenues.
- About 25 percent would participate in employment-based health insurance under current law, because some parents with offers of family coverage through an employer will choose to enroll their children in such plans. Under H.R. 3921, CBO and JCT estimate that revenues would be \$3.8 billion higher over the 2018–2027 period because parents who would no

longer enroll their children in health insurance through their employer would receive less of their income in nontaxable health benefits and more in taxable wages.

- Fewer than 10 percent would be uninsured under current law and some would be subject to the penalty associated with the individual mandate. Enacting H.R. 3921 would reduce federal revenues associated with collecting that penalty by less than \$50 million over the 2018–2027 period.

Finally, the net cost of the extension is less than the \$118.5 billion that would be provided by H.R. 3921 because CBO does not expect that all of the appropriated funds would be spent.

Enhanced Federal Matching Rate. Under current law, a 23 percentage point increase in the CHIP federal matching rate that went into effect in 2016 will expire after 2019. The average matching rate would return to historical levels of about 70 percent beginning in 2020. Under H.R. 3921, states would receive an 11.5 percentage point increase in the matching rate in 2020 and the matching rate would return to historical levels beginning in 2021. CBO estimates that approximately \$2 billion of the net cost of H.R. 3921 is due to this provision.

Maintenance of Eligibility Levels Requirement. Under current law, states are required to maintain CHIP eligibility levels, methodologies, and procedures as they were on March 23, 2010 through September 30, 2019. CBO expects that, under current law, some states would lower CHIP eligibility levels and/or impose more restrictive eligibility procedures (such as waiting periods) beginning in 2020, which would reduce the number of children eligible for CHIP.

H.R. 3921 would mostly extend this requirement through 2022. Instead of the requirement applying to all children, beginning in 2020 it would be limited to children in families with income below 300 percent of the poverty guidelines. It would also apply to children in families with income above 300 percent of the poverty guidelines who do not have access to an offer of employer-sponsored insurance through a family member. (Because the vast majority of children in CHIP are in families with incomes below 300 percent of the poverty guidelines, CBO estimates that continuing this requirement, as modified by H.R. 3921, would affect at least 98 percent of children who would be enrolled in CHIP if the current requirement were fully extended through 2022.)

CBO expects that more children would enroll in CHIP under H.R. 3921 because of the extension of the eligibility requirements that are scheduled to expire in 2019. Overall, the cost to the federal government of covering these children in CHIP would be less than the average cost of covering them in the marketplaces and employment-based insurance. As a result, CBO estimates that this provision would reduce the estimated net cost of extending CHIP funding through 2022 by about \$700 million.

Demonstration Programs. The bill would provide \$200 million of funding for the Childhood Obesity Demonstration Project, the Pediatric Quality Measures Program, and outreach activities to children that aim to increase enrollment in Medicaid and CHIP. Based on historical spending patterns for similar activities, CBO estimates that those provisions would increase outlays by approximately \$200 million over the 2018–2027 period.

Modifying reduction in Medicaid DSH allotments

Under current law, allotments are made to states for payments to hospitals that treat a disproportionate share of uninsured and Medicaid patients (DSH allotments). In 2017 states received \$12 billion in allotments. DSH allotments are increased each year by the percent change in the consumer price index and then will be adjusted by scheduled cuts between 2018 and 2025. Those cuts begin at \$2 billion in 2018 and grow by \$1 billion per year until they reach \$8 billion in 2024 and 2025. H.R. 3921 would eliminate the \$2 billion reduction for 2018 and add \$8 billion in allotment cuts to 2026 and 2027. On net, CBO estimates that this provision would reduce direct spending by \$193 million over the 2018–2027 period. The level of savings is smaller than the net change to the DSH allotments because some states do not spend all of their DSH allotments and because CBO expects that by 2026 states will have adjusted to the reduced DSH allotments of prior years and will not spend substantially more for DSH in 2026 and 2027 than what is projected to be spent in 2025. As a result, CBO estimates that the additional \$8 billion in allotment cuts added to 2026 and 2027 would only lead to a modest reduction in DSH spending in those years.

Puerto Rico and the Virgin Islands Medicaid payments

Over the 2018 and 2019 period, H.R. 3921 would increase the total amount of block grant funding available to Puerto Rico under the Medicaid program, by more than \$1 billion, and increase the funds available to the U.S. Virgin Islands by approximately \$30 million. In total, CBO estimates the provision would increase direct spending by \$1,040 million over the 2018–2027 period relative to CBO's baseline.

Medicaid third party liability

The bill would make several changes to policies in Medicaid that require other sources of health coverage, or third parties, to pay claims under their policies before Medicaid will pay for the care of an enrollee. On net, those changes are expected to reduce direct spending by \$3.7 billion over the 2018–2027 period.

Under current law, if a state is aware that a Medicaid enrollee has potential third-party coverage, the state must reject a provider's claim until it has been submitted to the third party. If a state identifies a third party after a claim is paid, the state must seek reimbursement from the third party. For certain services, states are required to pay first or to pay Medicaid claims even if a third party is likely liable and then seek to recoup that payment from the third party. Currently, states must pay those claims within 30 days. However, beginning in 2018, states will have 90 days to make such payments. Any amounts recouped by the states from third parties must be shared with the federal government at the same rate as the federal government reimburses states for Medicaid services. Based on administrative data from the Department of Health and Human Services, CBO estimates that less than 10 percent of adults and children have other private or public sources of coverage. In fiscal year 2016, states collected and returned to the federal government over \$870 million in reimbursements from third parties for such claims.

Two provisions of the bill would amend current standards for paying claims that fall under the exception to states paying first. Beginning in fiscal year 2018 the bill would delay, for two years, policies that allow states to wait up to 90 days before paying claims that fall under the exception. In fiscal year 2020 the bill also would eliminate the requirement for states to pay first for services for prenatal care, preventive pediatric, and for individuals on whose behalf child support enforcement is being carried out. On net, CBO expects that these provisions would increase the amount paid for services by third parties and reduce the amount paid by Medicaid. In total, CBO estimates these provisions would reduce direct spending by \$6.6 billion over the 2018–2027 period.

H.R. 3921 also would amend the definition of other sources of health coverage to exclude worker's compensation and property and auto insurers. In fiscal year 2016, collections from these insurers accounted for approximately 30 percent of total reimbursements from third parties. CBO estimates that excluding these insurers from liability would increase direct spending by \$2.8 billion over the 2018–2027 period.

Finally, the bill would allow states to keep a larger percentage of payments recouped from third parties who provide coverage to individuals who were made eligible for Medicaid under the Affordable Care Act (ACA). This provision would provide an incentive for states to increase their efforts to recoup payments. However, CBO expects that few individuals made eligible under the ACA have coverage from a liable third party and, as a result, recoveries would not increase recoveries enough to offset the cost of allowing states to keep a greater share of the recoveries. On net, CBO estimates that the provision would increase direct spending by \$60 million over the 2018–2027 period.

Treatment of lottery winnings

Under current law, most non-disabled adults who apply for Medicaid and have substantial funds in a bank account could still qualify for Medicaid because the eligibility rules do not permit assets tests (an asset test counts the resources, such as savings accounts, that applicants may have available to them beyond their earnings and other income). Similarly, while most current enrollees who gain substantial lump sum income must report that income to their state Medicaid agencies, which would cause most to lose their coverage, those individuals could reapply again the next month once the lump sum income would be treated as an asset.

H.R. 3921 would require states to treat monetary winnings from lotteries and other lump sum forms of income such as from gambling, legal judgements, and inheritances as income for purposes of determining Medicaid eligibility. For amounts less than \$80,000, these types of income would be countable as income for Medicaid eligibility purposes in the month received. For each \$10,000 increment of income above \$80,000, the amounts would be divided into equal monthly installments for up to 120 months (\$90,000 in income would be divided over two months, \$100,000 in income over three months, and so on). As a result, the bill would reduce Medicaid spending by preventing some individuals from receiving Medicaid benefits for the applicable period of time.

Based on lottery data from the state of Michigan, additional information collected from lottery industry groups, and the relatively low probability of low-income individuals receiving large sums from lotteries, gambling, legal judgements, and inheritances, CBO estimates that the number of people who would lose Medicaid because of H.R. 3921 would be modest, ranging from 16,000 to 18,000 in most years of the budget window. Assuming the typical per capita cost for Medicaid adults (which ranges from an estimated \$4,600 in 2018 to \$6,800 in 2027), CBO estimates that this provision would reduce direct spending by \$612 million over the 2018–2027 period.

Medicare premium subsidies

Under current law, an income-related monthly adjustment amount (IRMAA) is applied to basic premiums for Medicare enrollees in parts B (which covers physicians' and other outpatient services) and D (which covers outpatient prescription drugs) with relatively high income. The income thresholds for the higher premiums are divided among four brackets, which are frozen through 2019. The lowest bracket is set at \$85,000 for single beneficiaries or \$170,000 for married couples filing joint tax returns. The thresholds will increase by about 2 percent in 2020 and will be indexed after that for general price inflation. H.R. 3921 would modify the income thresholds for the highest premium bracket (80 percent) and create an additional bracket (100 percent) beginning in calendar year 2018. The new bracket would be set at \$500,000 for single beneficiaries and \$875,000, or 1.75 times the single beneficiary's amount, for married couples filing jointly. Beneficiaries earning more than those amounts would be required to pay a combined basic premium and IRMAA that will cover 100 percent of the expected costs for an average enrollee. In addition, this section would also change the rate of increase by about 5 percent for the 100 percent premium bracket beginning in 2027. CBO estimates that this section would save \$5.8 billion over the 2018–2027 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 and revenues that are subject to those pay-as-you-go procedures are shown in the following table. Only on-budget changes to outlays or revenues are subject to pay-as-you-go procedures.

CBO ESTIMATE OF PAY-AS-YOU-GO EFFECTS FOR H.R. 3921, AS ORDERED REPORTED BY THE HOUSE COMMITTEE ON ENERGY AND COMMERCE ON OCTOBER 4, 2017

	By fiscal year, in millions of dollars—										
	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2018– 2027
NET INCREASE OR DECREASE (-) IN THE ON-BUDGET DEFICIT											
Statutory Pay-As-You-Go Impact	3,272	3,946	2,332	- 18	- 262	- 669	- 1,334	- 1,395	- 2,281	- 2,394	1,197
Memorandum:											
Changes in Outlays	3,377	4,432	2,992	754	604	167	- 647	- 1,396	- 2,281	- 2,394	5,608
Changes in Revenues	105	486	660	772	866	836	687	- 1	0	0	4,411

Increase in long-term direct spending and deficits: CBO estimates that enacting the legislation would not increase net direct spending or on-budget deficits in any of the four consecutive 10-year periods beginning in 2028.

Intergovernmental and private-sector impact: H.R. 3921 contains no intergovernmental or private-sector mandates as defined in UMRA.

Estimate prepared by: Federal Costs: Kate Fritzsche, Emily King, Jamease Kowalczyk, Lisa Ramirez-Branum, Robert Stewart, Rebecca Yip, and the staff of the Joint Committee on Taxation; Intergovernmental and private-sector impact: Amy Petz.

Estimate approved by: Holly Harvey, Deputy Assistant Director for Budget Analysis. (i.e., eliminating the FY 2017 reductions and extending the reductions to FY 2025) and increasing the aggregate reduction amounts from \$35.1 billion to \$43.0 billion.

Section 105 would further amend the reductions by eliminating the FY 2018 cuts and offsetting the federal cost of this policy by extending the reductions to FY 2026 and FY 2027.

Section 106. Puerto Rico Medicaid payments

Section 106 would make available from October 1, 2017, through December 31, 2019, \$880 million for Puerto Rico's Medicaid program. It would also make an additional \$120 million available for that period if the Financial Oversight and Management Board for Puerto Rico certifies by a majority vote that the Puerto Rico Medicaid program has taken reasonable and appropriate steps to:

- Reduce Medicaid fraud, waste, and abuse;
- Implement strategies to reduce unnecessary, inefficient, or excessive Medicaid spending; and
- Improve the use and availability of Medicaid data for program operation and oversight; and improve the quality of care and patient experience for Medicaid enrollees.

Section 106 would also provide a temporary increase in the growth rate of the annual funding ceiling and provide a 90 percent federal matching rate for both state expenditures related to the operation of a state Medicaid fraud control unit and for costs attributable to compensation or training of skilled professional medical personnel, and staff directly supporting such personnel. Finally, this provision also requires additional reporting to the Financial Oversight and Management Board for Puerto Rico.

TITLE II—OFFSETS

Section 201. Medicaid third party liability

Section 201 takes several steps to modernize and improve Medicaid third party liability.

Under current law, if a beneficiary has another source of payment for health services or items covered by Medicaid, that source should pay up to the extent of its liability before Medicaid does. These other sources of payment are referred to as third parties. Third party liability (TPL) refers to the legal obligation of third parties (e.g., certain individuals, entities, insurers, or programs) to pay part or all of the expenditures for medical assistance furnished under a Medicaid state plan to a Medicaid beneficiary. When private third parties—such as health insurers—pay for health care

services instead of Medicaid, savings accrue not only to states, but also to the federal government.

Today, millions of Medicaid beneficiaries have additional health insurance through third-party sources. For example, some adults may be covered by employer-sponsored private health insurance even though they also qualify for Medicaid. Children similarly may be eligible for Medicaid while also being covered as a dependent on a parent's private health plan. Individuals age 65 and older may receive private coverage from a former employer or purchase such coverage to supplement their Medicare coverage. According to work by GAO and HHS Office of Inspector General (OIG), it is common for Medicaid beneficiaries to have one or more additional sources of coverage for health care services. A January 2015 GAO report estimated that in 2012, 7.6 million Medicaid enrollees (13.4 percent) had private health insurance. A January 2013 HHS OIG report found that "from 2008 to 2010, an estimated 15 percent (approximately 6.8 million) of Medicaid beneficiaries had employer-sponsored health insurance annually"—and the number is likely even higher when other sources of coverage are considered. GAO also noted that the number of Medicaid enrollees with private health insurance has increased with the expansion of Medicaid under the ACA. Using a projection from 2012 Census data, GAO estimated that "about 868,000 of the projected seven million new enrollees in 2014 would be expected to have private insurance."

Currently, most Medicaid claims are paid using a cost-avoidance approach. Cost-avoidance occurs when states do not pay providers for services until other coverage has paid to the extent of its liability, rather than paying up front and recovering costs later. After a state has verified other coverage, it must generally seek to ensure that health care providers' claims are directed to the responsible party. When states recognize claims as belonging to beneficiaries who have other insurance, they will deny payment and return the claims to providers, who are then required to bill and collect payment from any liable third parties. If states have electronic claims processing systems, they can automatically deny payment when claims enter their systems. Federal regulations generally require states to use cost-avoidance when probable TPL is established.

There is an exception to the types of Medicaid claims that can be paid using cost-avoidance strategies. The Social Security Act requires that states pay and chase claims instead of using cost-avoidance when the service is prenatal care, the service is preventive pediatric care, or coverage is through a parent whose obligation to pay support is enforced by the states' child enforcement agency. Without the ability to use cost-avoidance strategies, states must use a "pay-and-chase" method. This refers to when states pay providers for submitted claims and then attempt to recover payments from liable third parties.

This barrier to states' wider use of cost-avoidance strategies has the effect of increasing federal and state Medicaid spending. Based on available data, if states were allowed to use cost-avoidance strategies more broadly, they could save billions of dollars. HHS OIG found that:

[C]ost-avoidance is the most cost-effective way to ensure that Medicaid is the payer of last resort. When states

avoid costs, they do not pay money upfront or spend resources on recovery. Once states deny payment and notify providers of a liable third party, providers should bill future claims to the third party first, rather than the states.

According to GAO, “states have substantially improved their TPL identification and recovery efforts [sic] in recent years, generating significant savings for the federal government as well as for themselves.” GAO explained:

Substantial increases in TPL cost savings in recent years highlight that improvements to TPL efforts, such as heightened attention to coverage identification, can substantially improve TPL cost avoidance and recoveries. The scale of the cost savings to Medicaid at both federal and state levels through the identification of coverage through, and payment of services by, private health insurance—reportedly nearly \$14 billion in 2011—underscores the potentially significant return on investment that may be gained from continued TPL improvement efforts and attention to resolving remaining gaps in state access to available coverage data.

States’ reported cost-avoidance savings accounted for most third party liability growth and total savings between 2001 and 2011. States’ reported savings from cost-avoidance grew 117 percent, from \$33 billion to \$70 billion, between 2001 and 2011. Cumulatively, states reported that they avoided paying \$512 billion from 2001 to 2011—an amount roughly equivalent to what the entire Medicaid program cost federal and state taxpayers last year.

What follows is a review of the specific provisions of this section.

- Section 201(a)(1) delays a provision from the Bipartisan Budget Act of 2013 related to Medicaid Amendments Relating to Beneficiary Liability Settlements from October 1, 2017 to October 1, 2019. Congress has previously delayed this provision on a bipartisan basis. The provision would take effect on September 30, 2017, and apply with respect to claims generated or filed after that date.

- Section 201(a)(2) clarifies the definitions applicable to third party liability. Under current law, states must fulfill numerous obligations with respect to *third parties*, including:

- (1) collecting information sufficient to enable the state to pursue claims against *third parties* at the time of Medicaid eligibility determinations and redeterminations;

- (2) submitting to the Secretary of the Department of Health and Human Services a plan for pursuing *third parties*, which is to be monitored as part of the Secretary’s review of the state’s mechanized claims processing system;

- (3) seeking reimbursement from *third parties* where liability is found to exist after the state Medicaid agency has paid for a service;

- (4) limiting beneficiaries’ financial liability for services for which *third parties* are liable;

- (5) prohibiting Medicaid providers from denying services to beneficiaries because of a *third party’s* potential liability; and,

- (6) ensuring, through state law, that to the extent to which Medicaid has already paid for an item or service for which a *third party*

is liable, the beneficiary's right to payment from the *third party* is considered to be assigned by the beneficiary to the state.

Current law also imposes obligations on states to ensure that *TPL* rules are followed in states' arrangements with *health insurers* and regulation of *health insurers*. The statute does not define *health insurer*, but instead includes two substantially identical lists of types of *health insurers*.

Section 201(a)(2) would substitute the terms *third party* and *health insurer* with one term, *responsible third party* and define the term, *responsible third party*.

Section 201(a)(2)(B) would, with respect to each of the state's duties concerning *third parties* and *health insurers*, replace the applicable term with *responsible third party*.

- Section 201(a)(3) would remove the special treatment of certain types of care and payments under Medicaid third party liability rules. Currently, under Medicaid law regulations, states are generally required to use *cost-avoidance* for third party liability. If a state has established the probable liability of a *third party* for a service at the time a provider files a claim for payment, the state must reject the claim and return it to the provider. The state may pay the claim only after the state receives confirmation from a provider or a third party resource indicating the extent of third party liability. However, there are two exceptions to this rule: (1) the state may not withhold Medicaid payment pending determination of third party liability, but instead must pay the full amount of the provider's claim and then seek reimbursement from any liable *third party*, if the claim is for prenatal care or for preventive pediatric care, including services under Medicaid's early and periodic screening, diagnosis, and testing (EPSDT) benefit; and (2) with respect to Medicaid services provided to any child on whose behalf child support enforcement is being carried out, the state is required to make full payment for the service, without regard to the rule set forth above, if the third party liability is derived from the parent whose obligation to pay child support is being enforced, and if a *third party* has not paid a provider's claim within 30 days after the services are furnished.

Section 201(a)(3) would repeal the requirement that state Medicaid programs must use a "pay and chase" approach when seeking payment from third parties for such Medicaid claims. The policy rationale for this prohibition on states using cost-avoidance for these claims can be understood in the concern articulated in the conference report for the Consolidated Omnibus Budget Reconciliation Act of 1985. At the time, the concern was that "the administrative burdens associated with third party liability collection efforts not discourage participation in the Medicare program by physicians and other provider of preventative pediatric and prenatal care, since the beneficiaries in need of such services already have difficulty finding quality providers in many communities." This restriction may have been appropriate in the mid-1980s. At that time, much of Medicaid program's claims billing and administrative processes were paper-based and transactions occurred routinely through mailing hard copies of documents through the U.S. postal service. Most pregnant women and children were also enrolled in fee-for-service Medicaid programs where claims were processed directly by the state program.

Today, more than 30 years later, the Medicaid program looks dramatically different. Women and children enrolled in Medicaid programs today generally have good access to quality providers. Pregnant women and children constitute a large percentage of beneficiaries enrolled in the program and the bulk of these populations are served through Medicaid managed care organizations. Because managed care organizations receive a capitated payment for an enrollee, in addition to current federal requirements regarding provider networks and patient access, such organizations also generally have an incentive to ensure patients receive timely preventative and primary care that keeps patients healthy. Research published by GAO in 2015 found that “Medicaid enrollees report having access to care that is generally comparable to that of privately insured individuals.” Other research bears out similar conclusions. GAO’s research did not identify administrative burdens related to Medicaid billing requirements were among the top concerns states identified when they were asked to identify factors that affected providers’ participation in Medicaid. Additionally, although GAO noted that some patient populations (such as certain non-pregnant adults) in some states have faced challenges accessing some types of providers (such as mental health providers and dentists). Research from GAO and other entities identifies a range of policy tools and payment levers states can use to help increase provider participation in Medicaid. Moreover, states have successfully used cost-avoidance approaches in Medicaid third party liability with claims for other populations without harming access to care.

Medical billing systems also look dramatically different than they did more than 30 years ago. Since the 1980s, there have been tremendous advances across the health care system in medical billing, as electronic billing systems, digital transactions, online verification systems, and other technologies have significantly transformed standard Medicaid reimbursement and third party liability practices. Technological advances have resulted in tangible efficiencies for state Medicaid programs. A 2013 HHS OIG report examining Medicaid third party liability claims found that “electronic systems improved the efficiency with which [states] were able to identify beneficiaries with third-party insurance. This improved efficiency resulted from: (1) conducting online verification of coverage and (2) having electronic data-matching agreements with third parties.” Electronic systems helped states identify third parties more efficiently, which helped states save money. For example, verifying coverage online through a third-party web site is quicker than phoning or faxing a third party. The OIG report also noted that states found using third party liability clearinghouse—vendors with electronic agreements with many insurance companies—was beneficial to improve efficiency and reduce unnecessary spending. As the OIG report explained, “states pay clearinghouses to match coverage information for beneficiaries against a clearinghouse’s collection of data.”

Data-matching agreements also increase efficiency because they allow states to check for third-party insurance for many beneficiaries at one time. As the OIG report elaborated, “in these cases, states share their Medicaid enrollment with third parties, which then compare states’ lists to their covered individuals and produce

a report of all matches for states.” Using electronic systems increased states’ efficiency in avoiding costs and recovering payments. Electronic claims occur when providers submit claims electronically for services provided to Medicaid beneficiaries to states for payment. Electronic billing occurs when states send their invoices for reimbursement to third parties via electronic means. Both technologies help save money because automated processes replace manual processes. For example, as the OIG report highlights, when electronic claims from providers are transmitted directly to states’ claim management processing systems, claim reviews, third party liability checks, and cost-avoidance activities happen automatically, rather than manually. By improving the third party payments owed to providers so they are paid accurately and quickly, these reforms may actually help improve providers’ experience in the Medicaid program.

The Committee has consulted with a number of nonpartisan Medicaid policy experts and program analysts in developing and advancing this reform to Medicaid third party liability rules. Based on a careful review of existing Medicaid research from a range of entities (including GAO, HHS OIG, and MACPAC), as well as conversations with nonpartisan experts, current or former Medicaid directors, and others, the Committee believes this is a responsible step that will remove a statutory barrier. This targeted modernization of the program recognizes how the Medicaid program and medical billing has dramatically changed over the past 30 years and will result in improved efficiencies for state Medicaid programs without negatively impact access to care.

- Section 201(a)(4) clarifies the roles of health insurers with respect to third party liability.

Section 201(a)(4)(A) would clarify both the role of Medicaid managed care entities (and other *health insurers*) in furnishing Medicaid benefits under contract with the state, as well as the role of *health insurers* as *responsible third parties*.

Where states provide Medicaid services through a contract with a *health insurer*, the contract would be required specify (1) whether the state is delegating to the *health insurer* all or some of its right of recovery from *responsible third parties* for items or services for which Medicaid payment has been made; and (2) whether the state is transferring to the *health insurer* all or some of the assignment to the state of beneficiaries’ right to payment by *third parties*.

wherein addition, if a state elects either of the two options set forth in subparagraph (E), the state must provide assurances to the Secretary that the state laws referred to in SSA 1902(a)(25)(I) would confer on the *health insurer* the same authority that the state would otherwise have with respect to the four requirements relating to the state’s dealings with *health insurers* on third party liability matters outlined in subparagraph (I). For example, *health insurers* that are *responsible third parties* would be required to provide information regarding their coverage of Medicaid beneficiaries to the *health insurer* that has contracted with the state to furnish Medicaid services and has contractually agreed to carry out third party liability responsibilities.

Section 201(a)(4)(B) would require that reimbursements made by *responsible third parties* to a *health insurer* under contract with the state would be treated as overpayments, just as such reimburse-

ments would be treated if paid by the *responsible third party* directly to the state.

- Section 201(a)(5) would clarify the scope of the third party liability obligations that states must impose on health insurers.

Section 201(a)(5)(A) and (B) would ensure that services furnished under waivers of the Medicaid state plan are subjected to the same third party liability requirements as Medicaid state plan services, and clarify that *health insurers*, as a condition of doing business in a state, must accept *any* state's right of recovery of third party liability (not merely the right of the state Medicaid agency in the state in which the service is rendered).

Section 201(a)(5)(B) would further require *health insurers* as *responsible third parties* to accept, as a valid authorization for the furnishing of an item or service to a Medicaid-eligible individual, an authorization made on the individual's behalf pursuant to Medicaid rules.

Section 201(a)(5)(C) would require *health insurers* to provide the required response to a state's inquiries regarding claims submitted to the *health insurer* within 60 days.

Section 201(a)(5)(D) would require states to require *health insurers*, in addition to agreeing not to deny a claim submitted by the state solely on the basis of the date of submission of the claim, or the type or format of the claim form, also to not deny a claim submitted by the state merely on the ground of failure to obtain prior authorization.

- Section 201(a)(6) would provide that, with respect to expenditures for Medicaid services provided to a member of the *newly eligible* group in 2017 and subsequent years, the Secretary, in determining the amount of the federal overpayment to the state relating to a third party liability recovery (i.e., the federal share of the state's overpayment to the provider), would apply the state's standard FMAP rate, rather than the *newly eligible* FMAP rate. This creates a useful financial incentive for states seeking third party liability reimbursements for this patient population.

- Section 201(b) addresses a state's failure to comply with the third party liability requirements. In general, the Centers for Medicare and Medicaid Services (CMS) has the authority to disallow federal participation in states' Medicaid expenditures in specific instances where CMS determines that the expenditure does not comply with the state plan or federal Medicaid requirements.

This section would provide that, beginning in 2021, if a state fails to comply with the third party liability requirements with respect to each calendar quarter of a year, the Secretary may reduce the FMAP by 0.1 percentage point (one-tenth of one percent) for calendar quarters of each subsequent year in which the state also fails to comply. The reduction would be cumulative for the period of consecutive years that a state fails to comply. For various populations, the Secretary could choose to implement the FMAP reduction earlier, including applying the penalty provision beginning in 2019 if a state fails to comply with third party liability requirements with respect to medical assistance furnished to members of the *newly eligible* population, or to *non-expansion individuals*. *Non-expansion individuals* would be defined as Medicaid beneficiaries who are (1) not under 19 years of age; (2) not 65 years of age or older; and (3) not eligible for Medicaid on the basis of being blind

or disabled. The Secretary could choose to apply the penalty provision beginning in 2020 if a state fails to comply with third party liability requirements with respect to medical assistance furnished to (1) certain individuals who are under age 21 (or at the state's option, under the age of 20, 19, or 18), (2) certain individuals 65 years of age or older, or (3) certain blind individuals.

- Section 201(c) would provide that states must require *health insurers* to provide to the state, upon request, information concerning Medicaid beneficiaries or Medicaid-eligible individuals to determine during what period the individual was covered by the *health insurer*. The same requirements must also be imposed on *health insurers* with respect to CHIP beneficiaries or eligible individuals.

- Section 201(d) would require that the education and training included in the Medicaid Integrity Program include training on the liability of *responsible third parties*. It would require that, as part of this education and training, the Secretary: (1) publish information on its website concerning third party liability best practices; (2) monitor states' efforts to assess third party liability and analyze the challenges posed by such assessment; (3) distribute to state Medicaid agencies information relating to these efforts and challenges; and (4) provide guidance to state Medicaid agencies concerning state oversight of third party liability efforts by Medicaid managed care plans.

- Section 201(e) would require the Secretary, in consultation with the states, to develop and make available to states a model uniform reporting field that states may use for the purposes of reporting to CMS through the Transformed Medicaid Statistical Information System (T-MSIS) or within Form CMS-64, information identifying *responsible third parties* and other information relevant to the state's third party liability obligations.

Under current law, CMS makes quarterly Medicaid grants to the states and the amount of the grant is determined on the basis of information submitted by the state to CMS in quarterly estimate and quarterly expenditure reports. States are required to submit Form CMS-64, the Quarterly Medicaid Statement of Expenditures, within 30 days after the end of each quarter. The Form CMS-64 contains a schedule relating to aggregate *TPL* collections and cost avoidance.

- Section 201(f) sets an effective date for the Medicaid third party liability reforms. Except as otherwise specified, section 201 would take effect on October 1, 2019, and apply to Medicaid and state CHIP services provided after that date. If, under a state Medicaid plan or state CHIP plan, state legislation would be needed in order for the state to meet a specific statutory requirement under section 201, then the requirement would be deemed to take effect on the first day of the first calendar quarter beginning after the close of the first regular session of the state legislature beginning after enactment.

Section 202. Treatment of lottery winnings and other lump-sum income for purposes of income eligibility under Medicaid

Section 202 would specify how a state must treat qualified lottery winnings and lump sum income for purposes of determining an individual's income-based eligibility for a state Medicaid pro-

gram. Specifically, a state shall include such winnings or income as income received: (1) in the month in which it was received, if the amount is less than \$80,000; (2) over a period of two months, if the amount is at least \$80,000, but less than \$90,000; (3) over a period of three months, if the amount is at least \$90,000, but less than \$100,000; and (4) over an additional one-month period for each increment of \$10,000 received, not to exceed 120 months.

An individual whose income exceeds the applicable eligibility threshold due to qualified lump-sum income shall continue to be eligible for medical assistance to the extent that the state determines that denial of eligibility would cause undue medical or financial hardship. With respect to an individual who loses eligibility due to qualified lump-sum income, a state must provide specified notice and assistance related to the individual's potential enrollment in a qualified health plan under the Patient Protection and Affordable Care Act.

Section 203. Adjustments to Medicare Part B and Part D premium subsidies for higher-income individuals

The portion of the Medicare Part B and Part D premium that a beneficiary pays is based on the beneficiary's income. Section 203 would increase the percentage that Medicare beneficiaries with modified adjusted gross income (MAGI) above \$500,000 (\$875,000 for a couple filing jointly) from 80 percent to 100 percent.

Currently, beneficiaries that have incomes of \$160,001 and above (\$320,001 and above for a couple), subsequent to changes made in MACRA, pay 80 percent of their premium costs for Medicare Parts B and D. Individuals making between \$160,001 and \$500,000 per year (couples filing jointly below \$875,000) would remain in the 80 percent bracket, but individuals making above \$500,000 would be in a new 100 percent bracket. Additionally, the language would index these higher amounts for inflation after 2027.

Congress has previously increased Medicare premiums on higher income seniors in various pieces of legislation, including the Medicare Modernization Act, the Patient Protection and Affordable Care Act, and the Medicare Access and CHIP Reauthorization Act. Further income relating of Medicare premiums has been supported by members of Congress from both parties in legislative proposals.

In addition, President Obama's FY 2013, FY 2014, FY 2015, FY 2016, and FY 2017 Budget proposals envisioned that Medicare beneficiaries would pay up to 90 percent of their premium costs if they were in the top income bracket under his proposal. President Obama also supported increasing income relating for individuals making below \$214,000 a year, whereas this policy only increases income relating for individuals above \$500,000 a year.

It is estimated that in 2015, fewer than 500,000 Medicare beneficiaries had incomes over \$214,000. This legislative provision would more than double that income threshold. As a result, CBO estimates that the policy would impact *less than one percent of Medicare beneficiaries*—the very wealthiest seniors who are at the top of the income distribution for Medicare beneficiaries. In addition, the income level of \$500,000 is 4,145 percent of FPL for an individual, and an income level of \$875,000 is 5,387 percent FPL for a family of two. Based on consultation with non-partisan experts, if this policy is enacted, seniors with annual income of

\$500,000 or more would pay about \$100 more per month for Medicare.

The Committee believes this is a reasonable approach to provide low income children access to affordable, high-quality health coverage.

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.

STATEMENT OF GENERAL PERFORMANCE GOALS AND OBJECTIVES

Pursuant to clause 3(c)(4) of rule XIII, the general performance goal or objective of this legislation is to reauthorize the Children's Health Insurance Program for five years, provide funding for Puerto Rico's Medicaid program, and delay the DSH cuts by one year.

DUPLICATION OF FEDERAL PROGRAMS

Pursuant to clause 3(c)(5) of rule XIII, no provision of H.R. 3921 is known to be duplicative of another federal program, including any program that was included in a report to Congress pursuant to section 21 of Public Law 111-139 or the most recent Catalog of Federal Domestic Assistance.

COMMITTEE COST ESTIMATE

Pursuant to clause 3(d)(1) of rule XIII, 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.

earmark, limited tax benefits, and limited tariff benefits

Pursuant to clause 9(e), 9(f), and 9(g) of rule XXI, the Committee finds that H.R. 3921 contains no earmarks, limited tax benefits, or limited tariff benefits.

DISCLOSURE OF DIRECTED RULE MAKINGS

Pursuant to section 3(i) of H. Res. 5, the Committee finds that H.R. 3921 contains no directed rule makings.

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

Section 1 provides that the Act may be cited as the “Helping Ensure Access for Little Ones, Toddlers, and Hopeful Youth by Keeping Insurance Delivery Stable Act of 2017” or the “HEALTHY KIDS Act.”

Section 2: Table of contents

Section 2 provides the table of contents for the Act.

TITLE I—CHIP EXTENSION AND OTHER MEDICAID AND CHIP PROVISIONS

Section 101. Five-year funding extension of the Children’s Health Insurance Program

Section 101 would extend federal CHIP funding for five years. The funding amounts are:

- \$21.5 billion for FY 2018;
- \$22.6 billion for FY 2019;
- \$23.7 billion for FY 2020;
- \$24.8 billion for FY 2021, and;
- \$25.9 billion for FY 2022.

The funding for FY 2022 would be structured as it was FY 2017, with semiannual appropriations of \$2.85 billion, plus a one-time appropriation in the amount of \$20.2 billion, which would be provided for in the first six months of the fiscal year and would remain available until expended.

Section 101 would extend the funding mechanism for the Child Enrollment Contingency Fund, payments from the fund, the qualifying state option, and authority for Express Lane eligibility determinations through FY 2022.

Section 101 would also extend the CHIP MOE requirements for children in families with annual income of less than 300 percent of the federal poverty level for three years from October 1, 2019, through September 30, 2022.

Section 101 also creates an option that would allow a state to run a CHIP Look-Alike plan, also known as CHIP buy-in plans. Generally, a buy-in program requires families to pay what the state pays for the coverage and, in some instances, the program’s administrative costs. Buy-in programs have the potential to offer families a lower premium level than what is available in the private market or exchanges because of administrative efficiencies and the size and composition of the risk pool.

According to a Georgetown Center for Children and Families 2009 report, in 2008, there were eight states who operated a CHIP buy-in program for ten years or more (Connecticut, Florida, Maine, Minnesota, New Hampshire, New York, North Carolina, and Wisconsin). In 2016, the Secretary of the Department of Health and Human Service (HHS) determined that there was not a single health plan offered through the federal marketplace for any state, that provided benefits at least comparable to those offered through the CHIP program. A CHIP buy-in program that has health benefits at least identical to the CHIP benefits provides proven, child-centric coverage suited to the special needs of children.

CHIP buy-in programs were never formally established in statute under Title XXI of the Social Security Act (SSA) (although buy-in program benefits may mirror the CHIP benefits). Therefore, they are not exempt from the Minimum Essential Coverage (MEC) requirements of the ACA like CHIP is. Additionally, some states have blended the buy-in population with the traditional CHIP population for purposes of establishing family premiums, which increases the size of the risk pool and tends to reduce those premiums for the buy-in population.

Recognizing past state successes in operating CHIP buy-in programs that offer high-quality, affordable coverage for children, this provision recognizes CHIP buy-in programs as meeting the minimum essential coverage test under current law, and allows states to blend the risk pools between the CHIP program and the CHIP buy-in program. This change does not increase federal spending or deficits.

Section 102. Extension of certain programs and demonstration projects

Section 102 would extend funding for the Childhood Obesity Demonstration Project for FY 2018 through FY 2022 and would appropriate \$25 billion for the program.

Section 102 would also appropriate funding in the amount of \$75 million for the period of FY 2018 through FY 2022 to be used to carry out the pediatric quality measures.

Section 103. Extension of outreach and enrollment program

Section 103 would appropriate \$100 million for CHIP outreach and enrollment grants for the period of FY 2018 through FY 2022.

Section 104. Extension and reduction of additional federal financial participation for CHIP

Section 104 continues the 23 percent increased E-FMAP rate under in current law (section 2105(b) of the SAA) for two years from FY 2018 to FY 2019. The rate would then decrease compared to the previous year to 11.5 percent in FY 2020, with no increased E-FMAP in FY 2021 and FY 2022.

Section 105. Modifying reduction in Medicaid DSH allotments

The Medicaid statute requires states to make DSH payments to hospitals treating large numbers of low-income patients. The federal government provides each state an annual DSH allotment, which is the maximum amount of federal matching funds that each state can claim for Medicaid DSH payments. The ACA included a provision directing the Secretary of HHS to make aggregate reductions in Medicaid DSH allotments in specified annual amounts for FY 2014 through FY 2020. Since the ACA, a number of laws have amended the ACA Medicaid DSH reductions by eliminating the reductions for FY 2014 through FY 2016, changing the reduction amounts, and extending the reductions through FY 2024. Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) followed suit by eliminating the FY 2017 reductions and extending the reductions to FY 2025.

Section 412 of MACRA amended the Medicaid DSH reductions by pushing the Medicaid DSH reductions out one year

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 italics, and existing law in which no change is proposed is shown in roman):

SOCIAL SECURITY ACT

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**TITLE XI—GENERAL PROVISIONS, PEER REVIEW, AND
ADMINISTRATIVE SIMPLIFICATION****PART A—GENERAL PROVISIONS**

* * * * *

SEC. 1108. ADDITIONAL GRANTS TO PUERTO RICO, THE VIRGIN ISLANDS, GUAM, AND AMERICAN SAMOA; LIMITATION ON TOTAL PAYMENTS.**(a) LIMITATION ON TOTAL PAYMENTS TO EACH TERRITORY.—**

(1) IN GENERAL.—Notwithstanding any other provision of this Act (except for paragraph (2) of this subsection), the total amount certified by the Secretary of Health and Human Services under titles I, X, XIV, and XVI, under parts A and E of title IV, and under subsection (b) of this section, for payment to any territory for a fiscal year shall not exceed the ceiling amount for the territory for the fiscal year.

(2) CERTAIN PAYMENTS DISREGARDED.—Paragraph (1) of this subsection shall be applied without regard to any payment made under section 403(a)(2), 403(a)(4), 403(a)(5), 406, or 413(f).

(b) ENTITLEMENT TO MATCHING GRANT.—

(1) IN GENERAL.—Each territory shall be entitled to receive from the Secretary for each fiscal year a grant in an amount equal to 75 percent of the amount (if any) by which—

(A) the total expenditures of the territory during the fiscal year under the territory programs funded under parts A and E of title IV, including any amount paid to the State under part A of title IV that is transferred in accordance with section 404(d) and expended under the program to which transferred; exceeds

(B) the sum of—

(i) the amount of the family assistance grant payable to the territory without regard to section 409; and

(ii) the total amount expended by the territory during fiscal year 1995 pursuant to parts A and F of title IV (as so in effect), other than for child care.

(2) APPROPRIATION.—Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated for each of fiscal years 2017 and 2018, such sums as are necessary for grants under this paragraph.

(c) DEFINITIONS.—As used in this section:

(1) TERRITORY.—The term “territory” means Puerto Rico, the Virgin Islands, Guam, and American Samoa.

(2) CEILING AMOUNT.—The term “ceiling amount” means, with respect to a territory and a fiscal year, the mandatory ceiling amount with respect to the territory, reduced for the fiscal year in accordance with subsection (e), and reduced by the amount of any penalty imposed on the territory under any provision of law specified in subsection (a) during the fiscal year.

(3) FAMILY ASSISTANCE GRANT.—The term “family assistance grant” has the meaning given such term by section 403(a)(1)(B).

(4) MANDATORY CEILING AMOUNT.—The term “mandatory ceiling amount” means—

(A) \$107,255,000 with respect to Puerto Rico;

(B) \$4,686,000 with respect to Guam;

(C) \$3,554,000 with respect to the Virgin Islands; and

(D) \$1,000,000 with respect to American Samoa.

(5) TOTAL AMOUNT EXPENDED BY THE TERRITORY.—The term “total amount expended by the territory”—

(A) does not include expenditures during the fiscal year from amounts made available by the Federal Government; and

(B) when used with respect to fiscal year 1995, also does not include—

(i) expenditures during fiscal year 1995 under subsection (g) or (i) of section 402 (as in effect on September 30, 1995); or

(ii) any expenditures during fiscal year 1995 for which the territory (but for section 1108, as in effect on September 30, 1995) would have received reimbursement from the Federal Government.

(d) AUTHORITY TO TRANSFER FUNDS TO CERTAIN PROGRAMS.—A territory to which an amount is paid under subsection (b) of this section may use the amount in accordance with section 404(d).

(f) Subject to subsection (g) and section 1935(e)(1)(B), the total amount certified by the Secretary under title XIX with respect to a fiscal year for payment to—

(1) Puerto Rico shall not exceed (A) \$116,500,000 for fiscal year 1994 and (B) for each succeeding fiscal year the amount provided in this paragraph for the preceding fiscal year increased by the percentage increase in the medical care component of the consumer price index for all urban consumers (as published by the Bureau of Labor Statistics) for the twelve-month period ending in March preceding the beginning of the fiscal year, rounded to the nearest \$100,000;

(2) the Virgin Islands shall not exceed (A) \$3,837,500 for fiscal year 1994, and (B) for each succeeding fiscal year the amount provided in this paragraph for the preceding fiscal year increased by the percentage increase referred to in paragraph (1)(B), rounded to the nearest \$10,000;

(3) Guam shall not exceed (A) \$3,685,000 for fiscal year 1994, and (B) for each succeeding fiscal year the amount provided in this paragraph for the preceding fiscal year increased by the percentage increase referred to in paragraph (1)(B), rounded to the nearest \$10,000;

(4) Northern Mariana Islands shall not exceed (A) \$1,110,000 for fiscal year 1994, and (B) for each succeeding fiscal year the amount provided in this paragraph for the preceding fiscal year increased by the percentage increase referred to in paragraph (1)(B), rounded to the nearest \$10,000; and

(5) American Samoa shall not exceed (A) \$2,140,000 for fiscal year 1994, and (B) for each succeeding fiscal year the amount provided in this paragraph for the preceding fiscal year increased by the percentage increase referred to in paragraph (1)(B), rounded to the nearest \$10,000.

(g) MEDICAID PAYMENTS TO TERRITORIES FOR FISCAL YEAR 1998 AND THEREAFTER.—

(1) FISCAL YEAR 1998.—With respect to fiscal year 1998, the amounts otherwise determined for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa under subsection (f) for such fiscal year shall be increased by the following amounts:

(A) For Puerto Rico, \$30,000,000.

(B) For the Virgin Islands, \$750,000.

(C) For Guam, \$750,000.

(D) For the Northern Mariana Islands, \$500,000.

(E) For American Samoa, \$500,000.

(2) FISCAL YEAR 1999 AND THEREAFTER.—Notwithstanding subsection (f) and subject to and section 1323(a)(2) of the Patient Protection and Affordable Care Act paragraphs (3) and (5), with respect to fiscal year 1999 and any fiscal year thereafter, the total amount certified by the Secretary under title XIX for payment to—

(A) Puerto Rico shall not exceed the sum of the amount provided in this subsection for the preceding fiscal year increased by the percentage increase in the medical care component of the Consumer Price Index for all urban consumers (as published by the Bureau of Labor Statistics) for the 12-month period ending in March preceding the beginning of the fiscal year (*or, with respect to fiscal years 2018 and 2019, increased by such percentage increase plus one percentage point*), rounded to the nearest \$100,000;

(B) the Virgin Islands shall not exceed the sum of the amount provided in this subsection for the preceding fiscal year increased by the percentage increase referred to in subparagraph (A) (*or, with respect to fiscal years 2018 and 2019, increased by such percentage increase plus one percentage point*), rounded to the nearest \$10,000;

(C) Guam shall not exceed the sum of the amount provided in this subsection for the preceding fiscal year increased by the percentage increase referred to in subparagraph (A), rounded to the nearest \$10,000;

(D) the Northern Mariana Islands shall not exceed the sum of the amount provided in this subsection for the preceding fiscal year increased by the percentage increase referred to in subparagraph (A), rounded to the nearest \$10,000; and

(E) American Samoa shall not exceed the sum of the amount provided in this subsection for the preceding fiscal

year increased by the percentage increase referred to in subparagraph (A), rounded to the nearest \$10,000.

(3) FISCAL YEARS 2006 AND 2007 FOR CERTAIN INSULAR AREAS.—The amounts otherwise determined under this subsection for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa for fiscal year 2006 and fiscal year 2007 shall be increased by the following amounts:

(A) For Puerto Rico, \$12,000,000 for fiscal year 2006 and \$12,000,000 for fiscal year 2007.

(B) For the Virgin Islands, \$2,500,000 for fiscal year 2006 and \$5,000,000 for fiscal year 2007.

(C) For Guam, \$2,500,000 for fiscal year 2006 and \$5,000,000 for fiscal year 2007.

(D) For the Northern Mariana Islands, \$1,000,000 for fiscal year 2006 and \$2,000,000 for fiscal year 2007.

(E) For American Samoa, \$2,000,000 for fiscal year 2006 and \$4,000,000 for fiscal year 2007.

Such amounts shall not be taken into account in applying paragraph (2) for fiscal year 2007 but shall be taken into account in applying such paragraph for fiscal year 2008 and subsequent fiscal years.

(4) EXCLUSION OF CERTAIN EXPENDITURES FROM PAYMENT LIMITS.—With respect to fiscal years beginning with fiscal year 2009, if Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, or American Samoa qualify for a payment under subparagraph (A)(i), (B), or (F) of section 1903(a)(3) and with respect to fiscal years beginning with fiscal year 2017, if Puerto Rico qualifies for a payment under section 1903(a)(6) for a calendar quarter (beginning on or after July 1, 2017) of such fiscal year for a calendar quarter of such fiscal year, the payment shall not be taken into account in applying subsection (f) (as increased in accordance with paragraphs (1), (2), (3), and (4) of this subsection) to such commonwealth or territory for such fiscal year.

(5) ADDITIONAL INCREASE.—(A) Subject to [subparagraph (B)] *subparagraphs (B), (C), (D), (E), and (F)*, the Secretary shall increase the amounts otherwise determined under this subsection for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa (after the application of subsection (f) and the preceding paragraphs of this subsection) for the period beginning July 1, 2011, and ending on September 30, 2019, by such amounts that the total additional payments under title XIX to such territories equals \$6,300,000,000 for such period. The Secretary shall increase such amounts in proportion to the amounts applicable to such territories under this subsection and subsection (f) on the date of enactment of this paragraph.

(B) The amount of the increase otherwise provided under subparagraph (A) for Puerto Rico shall be further increased by \$295,900,000.

(C) *The amount of the increase otherwise provided under subparagraph (A) for Puerto Rico shall be further increased by \$880,000,000.*

(D)(i) For the period beginning October 1, 2017, and ending December 31, 2019, the amount of the increase otherwise provided under subparagraph (A) for Puerto Rico shall be further increased by \$120,000,000 if the Financial Oversight and Management Board for Puerto Rico established under section 101 of the Puerto Rico Oversight, Management, and Economic Stability Act (48 U.S.C. 2121) certifies by a majority vote that Puerto Rico has taken reasonable and appropriate steps during such period to—

(I) reduce fraud, waste, and abuse under the program under title XIX;

(II) implement strategies to reduce unnecessary, inefficient, or excessive spending under title XIX;

(III) improve the use and availability of Medicaid data for program operation and oversight; and

(IV) improve the quality of care and patient experience for individuals enrolled under the program under title XIX.

(ii) As a condition of any additional increase pursuant to clause (i), not later than October 1, 2018, Puerto Rico shall submit to the Financial Oversight and Management Board for Puerto Rico a report regarding steps taken to achieve each of the goals described in subclauses (I) through (IV) of clause (i).

(E) Payments under section 1903(a)(8) for a quarter of a fiscal year shall not be taken into account in applying subsection (f) (as increased in accordance with this paragraph and paragraphs (1), (2), (3), and (4)) to Puerto Rico or the Virgin Islands for such fiscal year.

(F)(i) For the period beginning October 1, 2017, and ending December 31, 2019, the amount of the increase otherwise provided under subparagraph (A) for the Virgin Islands shall be further increased by an amount equal to the per capita equivalent of the total amount of the increase provided for Puerto Rico under subparagraphs (C) and (D) for such period.

(ii) For purposes of clause (i), the term “per capita equivalent” means the ratio of—

(I) the population of the Virgin Islands, as determined by the most recent census estimate released by the Bureau of the Census before September 4, 2017; to

(II) the population of Puerto Rico, as so determined.

* * * * *

SEC. 1139A. CHILD HEALTH QUALITY MEASURES.

(a) DEVELOPMENT OF AN INITIAL CORE SET OF HEALTH CARE QUALITY MEASURES FOR CHILDREN ENROLLED IN MEDICAID OR CHIP.—

(1) IN GENERAL.—Not later than January 1, 2010, the Secretary shall identify and publish for general comment an initial, recommended core set of child health quality measures for use by State programs administered under titles XIX and XXI, health insurance issuers and managed care entities that enter into contracts with such programs, and providers of items and services under such programs.

(2) IDENTIFICATION OF INITIAL CORE MEASURES.—In consultation with the individuals and entities described in subsection (b)(3), the Secretary shall identify existing quality of care measures for children that are in use under public and privately sponsored health care coverage arrangements, or that are part of reporting systems that measure both the presence and duration of health insurance coverage over time.

(3) RECOMMENDATIONS AND DISSEMINATION.—Based on such existing and identified measures, the Secretary shall publish an initial core set of child health quality measures that includes (but is not limited to) the following:

(A) The duration of children's health insurance coverage over a 12-month time period.

(B) The availability and effectiveness of a full range of—

(i) preventive services, treatments, and services for acute conditions, including services to promote healthy birth, prevent and treat premature birth, and detect the presence or risk of physical or mental conditions that could adversely affect growth and development; and

(ii) treatments to correct or ameliorate the effects of physical and mental conditions, including chronic conditions and, with respect to dental care, conditions requiring the restoration of teeth, relief of pain and infection, and maintenance of dental health, in infants, young children, school-age children, and adolescents.

(C) The availability of care in a range of ambulatory and inpatient health care settings in which such care is furnished.

(D) The types of measures that, taken together, can be used to estimate the overall national quality of health care for children, including children with special needs, and to perform comparative analyses of pediatric health care quality and racial, ethnic, and socioeconomic disparities in child health and health care for children.

(4) ENCOURAGE VOLUNTARY AND STANDARDIZED REPORTING.—Not later than 2 years after the date of enactment of the Children's Health Insurance Program Reauthorization Act of 2009, the Secretary, in consultation with States, shall develop a standardized format for reporting information and procedures and approaches that encourage States to use the initial core measurement set to voluntarily report information regarding the quality of pediatric health care under titles XIX and XXI.

(5) ADOPTION OF BEST PRACTICES IN IMPLEMENTING QUALITY PROGRAMS.—The Secretary shall disseminate information to States regarding best practices among States with respect to measuring and reporting on the quality of health care for children, and shall facilitate the adoption of such best practices. In developing best practices approaches, the Secretary shall give particular attention to State measurement techniques that ensure the timeliness and accuracy of provider reporting, encourage provider reporting compliance, encourage successful quality improvement strategies, and improve efficiency in data collection using health information technology.

(6) **REPORTS TO CONGRESS.**—Not later than January 1, 2011, and every 3 years thereafter, the Secretary shall report to Congress on—

(A) the status of the Secretary's efforts to improve—

(i) quality related to the duration and stability of health insurance coverage for children under titles XIX and XXI;

(ii) the quality of children's health care under such titles, including preventive health services, dental care, health care for acute conditions, chronic health care, and health services to ameliorate the effects of physical and mental conditions and to aid in growth and development of infants, young children, school-age children, and adolescents with special health care needs; and

(iii) the quality of children's health care under such titles across the domains of quality, including clinical quality, health care safety, family experience with health care, health care in the most integrated setting, and elimination of racial, ethnic, and socioeconomic disparities in health and health care;

(B) the status of voluntary reporting by States under titles XIX and XXI, utilizing the initial core quality measurement set; and

(C) any recommendations for legislative changes needed to improve the quality of care provided to children under titles XIX and XXI, including recommendations for quality reporting by States.

(7) **TECHNICAL ASSISTANCE.**—The Secretary shall provide technical assistance to States to assist them in adopting and utilizing core child health quality measures in administering the State plans under titles XIX and XXI.

(8) **DEFINITION OF CORE SET.**—In this section, the term “core set” means a group of valid, reliable, and evidence-based quality measures that, taken together—

(A) provide information regarding the quality of health coverage and health care for children;

(B) address the needs of children throughout the developmental age span; and

(C) allow purchasers, families, and health care providers to understand the quality of care in relation to the preventive needs of children, treatments aimed at managing and resolving acute conditions, and diagnostic and treatment services whose purpose is to correct or ameliorate physical, mental, or developmental conditions that could, if untreated or poorly treated, become chronic.

(b) **ADVANCING AND IMPROVING PEDIATRIC QUALITY MEASURES.**—

(1) **ESTABLISHMENT OF PEDIATRIC QUALITY MEASURES PROGRAM.**—Not later than January 1, 2011, the Secretary shall establish a pediatric quality measures program to—

(A) improve and strengthen the initial core child health care quality measures established by the Secretary under subsection (a);

(B) expand on existing pediatric quality measures used by public and private health care purchasers and advance

the development of such new and emerging quality measures; and

(C) increase the portfolio of evidence-based, consensus pediatric quality measures available to public and private purchasers of children's health care services, providers, and consumers.

(2) EVIDENCE-BASED MEASURES.—The measures developed under the pediatric quality measures program shall, at a minimum, be—

(A) evidence-based and, where appropriate, risk adjusted;

(B) designed to identify and eliminate racial and ethnic disparities in child health and the provision of health care;

(C) designed to ensure that the data required for such measures is collected and reported in a standard format that permits comparison of quality and data at a State, plan, and provider level;

(D) periodically updated; and

(E) responsive to the child health needs, services, and domains of health care quality described in clauses (i), (ii), and (iii) of subsection (a)(6)(A).

(3) PROCESS FOR PEDIATRIC QUALITY MEASURES PROGRAM.—In identifying gaps in existing pediatric quality measures and establishing priorities for development and advancement of such measures, the Secretary shall consult with—

(A) States;

(B) pediatricians, children's hospitals, and other primary and specialized pediatric health care professionals (including members of the allied health professions) who specialize in the care and treatment of children, particularly children with special physical, mental, and developmental health care needs;

(C) dental professionals, including pediatric dental professionals;

(D) health care providers that furnish primary health care to children and families who live in urban and rural medically underserved communities or who are members of distinct population sub-groups at heightened risk for poor health outcomes;

(E) national organizations representing children, including children with disabilities and children with chronic conditions;

(F) national organizations representing consumers and purchasers of children's health care;

(G) national organizations and individuals with expertise in pediatric health quality measurement; and

(H) voluntary consensus standards setting organizations and other organizations involved in the advancement of evidence-based measures of health care.

(4) DEVELOPING, VALIDATING, AND TESTING A PORTFOLIO OF PEDIATRIC QUALITY MEASURES.—As part of the program to advance pediatric quality measures, the Secretary shall—

(A) award grants and contracts for the development, testing, and validation of new, emerging, and innovative evidence-based measures for children's health care services

across the domains of quality described in clauses (i), (ii), and (iii) of subsection (a)(6)(A); and

(B) award grants and contracts for—

(i) the development of consensus on evidence-based measures for children’s health care services;

(ii) the dissemination of such measures to public and private purchasers of health care for children; and

(iii) the updating of such measures as necessary.

(5) REVISING, STRENGTHENING, AND IMPROVING INITIAL CORE MEASURES.—Beginning no later than January 1, 2013, and annually thereafter, the Secretary shall publish recommended changes to the core measures described in subsection (a) that shall reflect the testing, validation, and consensus process for the development of pediatric quality measures described in subsection paragraphs (1) through (4).

(6) DEFINITION OF PEDIATRIC QUALITY MEASURE.—In this subsection, the term “pediatric quality measure” means a measurement of clinical care that is capable of being examined through the collection and analysis of relevant information, that is developed in order to assess 1 or more aspects of pediatric health care quality in various institutional and ambulatory health care settings, including the structure of the clinical care system, the process of care, the outcome of care, or patient experiences in care.

(7) CONSTRUCTION.—Nothing in this section shall be construed as supporting the restriction of coverage, under title XIX or XXI or otherwise, to only those services that are evidence-based.

(c) ANNUAL STATE REPORTS REGARDING STATE-SPECIFIC QUALITY OF CARE MEASURES APPLIED UNDER MEDICAID OR CHIP.—

(1) ANNUAL STATE REPORTS.—Each State with a State plan approved under title XIX or a State child health plan approved under title XXI shall annually report to the Secretary on the—

(A) State-specific child health quality measures applied by the States under such plans, including measures described in subparagraphs (A) and (B) of subsection (a)(6); and

(B) State-specific information on the quality of health care furnished to children under such plans, including information collected through external quality reviews of managed care organizations under section 1932 of the Social Security Act (42 U.S.C. 1396u–4) and benchmark plans under sections 1937 and 2103 of such Act (42 U.S.C. 1396u–7, 1397cc).

(2) PUBLICATION.—Not later than September 30, 2010, and annually thereafter, the Secretary shall collect, analyze, and make publicly available the information reported by States under paragraph (1).

(d) DEMONSTRATION PROJECTS FOR IMPROVING THE QUALITY OF CHILDREN’S HEALTH CARE AND THE USE OF HEALTH INFORMATION TECHNOLOGY.—

(1) IN GENERAL.—During the period of fiscal years 2009 through 2013, the Secretary shall award not more than 10 grants to States and child health providers to conduct demonstration projects to evaluate promising ideas for improving

the quality of children's health care provided under title XIX or XXI, including projects to—

- (A) experiment with, and evaluate the use of, new measures of the quality of children's health care under such titles (including testing the validity and suitability for reporting of such measures);
- (B) promote the use of health information technology in care delivery for children under such titles;
- (C) evaluate provider-based models which improve the delivery of children's health care services under such titles, including care management for children with chronic conditions and the use of evidence-based approaches to improve the effectiveness, safety, and efficiency of health care services for children; or
- (D) demonstrate the impact of the model electronic health record format for children developed and disseminated under subsection (f) on improving pediatric health, including the effects of chronic childhood health conditions, and pediatric health care quality as well as reducing health care costs.

(2) REQUIREMENTS.—In awarding grants under this subsection, the Secretary shall ensure that—

- (A) only 1 demonstration project funded under a grant awarded under this subsection shall be conducted in a State; and
- (B) demonstration projects funded under grants awarded under this subsection shall be conducted evenly between States with large urban areas and States with large rural areas.

(3) AUTHORITY FOR MULTISTATE PROJECTS.—A demonstration project conducted with a grant awarded under this subsection may be conducted on a multistate basis, as needed.

(4) FUNDING.—\$20,000,000 of the amount appropriated under subsection (i) for a fiscal year shall be used to carry out this subsection.

(e) CHILDHOOD OBESITY DEMONSTRATION PROJECT.—

(1) AUTHORITY TO CONDUCT DEMONSTRATION.—The Secretary, in consultation with the Administrator of the Centers for Medicare & Medicaid Services, shall conduct a demonstration project to develop a comprehensive and systematic model for reducing childhood obesity by awarding grants to eligible entities to carry out such project. Such model shall—

- (A) identify, through self-assessment, behavioral risk factors for obesity among children;
- (B) identify, through self-assessment, needed clinical preventive and screening benefits among those children identified as target individuals on the basis of such risk factors;
- (C) provide ongoing support to such target individuals and their families to reduce risk factors and promote the appropriate use of preventive and screening benefits; and
- (D) be designed to improve health outcomes, satisfaction, quality of life, and appropriate use of items and services for which medical assistance is available under title XIX or

child health assistance is available under title XXI among such target individuals.

(2) ELIGIBILITY ENTITIES.—For purposes of this subsection, an eligible entity is any of the following:

- (A) A city, county, or Indian tribe.
- (B) A local or tribal educational agency.
- (C) An accredited university, college, or community college.
- (D) A Federally-qualified health center.
- (E) A local health department.
- (F) A health care provider.
- (G) A community-based organization.
- (H) Any other entity determined appropriate by the Secretary, including a consortia or partnership of entities described in any of subparagraphs (A) through (G).

(3) USE OF FUNDS.—An eligible entity awarded a grant under this subsection shall use the funds made available under the grant to—

(A) carry out community-based activities related to reducing childhood obesity, including by—

(i) forming partnerships with entities, including schools and other facilities providing recreational services, to establish programs for after school and weekend community activities that are designed to reduce childhood obesity;

(ii) forming partnerships with daycare facilities to establish programs that promote healthy eating behaviors and physical activity; and

(iii) developing and evaluating community educational activities targeting good nutrition and promoting healthy eating behaviors;

(B) carry out age-appropriate school-based activities that are designed to reduce childhood obesity, including by—

(i) developing and testing educational curricula and intervention programs designed to promote healthy eating behaviors and habits in youth, which may include—

(I) after hours physical activity programs; and

(II) science-based interventions with multiple components to prevent eating disorders including nutritional content, understanding and responding to hunger and satiety, positive body image development, positive self-esteem development, and learning life skills (such as stress management, communication skills, problemsolving and decisionmaking skills), as well as consideration of cultural and developmental issues, and the role of family, school, and community;

(ii) providing education and training to educational professionals regarding how to promote a healthy lifestyle and a healthy school environment for children;

(iii) planning and implementing a healthy lifestyle curriculum or program with an emphasis on healthy eating behaviors and physical activity; and

(iv) planning and implementing healthy lifestyle classes or programs for parents or guardians, with an emphasis on healthy eating behaviors and physical activity for children;

(C) carry out educational, counseling, promotional, and training activities through the local health care delivery systems including by—

(i) promoting healthy eating behaviors and physical activity services to treat or prevent eating disorders, being overweight, and obesity;

(ii) providing patient education and counseling to increase physical activity and promote healthy eating behaviors;

(iii) training health professionals on how to identify and treat obese and overweight individuals which may include nutrition and physical activity counseling; and

(iv) providing community education by a health professional on good nutrition and physical activity to develop a better understanding of the relationship between diet, physical activity, and eating disorders, obesity, or being overweight; and

(D) provide, through qualified health professionals, training and supervision for community health workers to—

(i) educate families regarding the relationship between nutrition, eating habits, physical activity, and obesity;

(ii) educate families about effective strategies to improve nutrition, establish healthy eating patterns, and establish appropriate levels of physical activity; and

(iii) educate and guide parents regarding the ability to model and communicate positive health behaviors.

(4) PRIORITY.—In awarding grants under paragraph (1), the Secretary shall give priority to awarding grants to eligible entities—

(A) that demonstrate that they have previously applied successfully for funds to carry out activities that seek to promote individual and community health and to prevent the incidence of chronic disease and that can cite published and peer-reviewed research demonstrating that the activities that the entities propose to carry out with funds made available under the grant are effective;

(B) that will carry out programs or activities that seek to accomplish a goal or goals set by the State in the Healthy People 2010 plan of the State;

(C) that provide non-Federal contributions, either in cash or in-kind, to the costs of funding activities under the grants;

(D) that develop comprehensive plans that include a strategy for extending program activities developed under grants in the years following the fiscal years for which they receive grants under this subsection;

(E) located in communities that are medically underserved, as determined by the Secretary;

(F) located in areas in which the average poverty rate is at least 150 percent or higher of the average poverty rate in the State involved, as determined by the Secretary; and

(G) that submit plans that exhibit multisectoral, cooperative conduct that includes the involvement of a broad range of stakeholders, including—

- (i) community-based organizations;
- (ii) local governments;
- (iii) local educational agencies;
- (iv) the private sector;
- (v) State or local departments of health;
- (vi) accredited colleges, universities, and community colleges;
- (vii) health care providers;
- (viii) State and local departments of transportation and city planning; and
- (ix) other entities determined appropriate by the Secretary.

(5) PROGRAM DESIGN.—

(A) INITIAL DESIGN.—Not later than 1 year after the date of enactment of the Children’s Health Insurance Program Reauthorization Act of 2009, the Secretary shall design the demonstration project. The demonstration should draw upon promising, innovative models and incentives to reduce behavioral risk factors. The Administrator of the Centers for Medicare & Medicaid Services shall consult with the Director of the Centers for Disease Control and Prevention, the Director of the Office of Minority Health, the heads of other agencies in the Department of Health and Human Services, and such professional organizations, as the Secretary determines to be appropriate, on the design, conduct, and evaluation of the demonstration.

(B) NUMBER AND PROJECT AREAS.—Not later than 2 years after the date of enactment of the Children’s Health Insurance Program Reauthorization Act of 2009, the Secretary shall award 1 grant that is specifically designed to determine whether programs similar to programs to be conducted by other grantees under this subsection should be implemented with respect to the general population of children who are eligible for child health assistance under State child health plans under title XXI in order to reduce the incidence of childhood obesity among such population.

(6) REPORT TO CONGRESS.—Not later than 3 years after the date the Secretary implements the demonstration project under this subsection, the Secretary shall submit to Congress a report that describes the project, evaluates the effectiveness and cost effectiveness of the project, evaluates the beneficiary satisfaction under the project, and includes any such other information as the Secretary determines to be appropriate.

(7) DEFINITIONS.—In this subsection:

(A) FEDERALLY-QUALIFIED HEALTH CENTER.—The term “Federally-qualified health center” has the meaning given that term in section 1905(l)(2)(B).

(B) INDIAN TRIBE.—The term “Indian tribe” has the meaning given that term in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

(C) SELF-ASSESSMENT.—The term “self-assessment” means a form that—

- (i) includes questions regarding—
 - (I) behavioral risk factors;
 - (II) needed preventive and screening services; and
 - (III) target individuals’ preferences for receiving follow-up information;
- (ii) is assessed using such computer generated assessment programs; and
- (iii) allows for the provision of such ongoing support to the individual as the Secretary determines appropriate.

(D) ONGOING SUPPORT.—The term “ongoing support” means—

- (i) to provide any target individual with information, feedback, health coaching, and recommendations regarding—
 - (I) the results of a self-assessment given to the individual;
 - (II) behavior modification based on the self-assessment; and
 - (III) any need for clinical preventive and screening services or treatment including medical nutrition therapy;
- (ii) to provide any target individual with referrals to community resources and programs available to assist the target individual in reducing health risks; and
- (iii) to provide the information described in clause (i) to a health care provider, if designated by the target individual to receive such information.

(8) APPROPRIATION.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to carry out this subsection, \$25,000,000 for the period of fiscal years 2010 through 2014, ~~and \$10,000,000~~, *\$10,000,000* for the period of fiscal years 2016 and 2017, *and \$25,000,000 for the period of fiscal years 2018 through 2022.*

(f) DEVELOPMENT OF MODEL ELECTRONIC HEALTH RECORD FORMAT FOR CHILDREN ENROLLED IN MEDICAID OR CHIP.—

(1) IN GENERAL.—Not later than January 1, 2010, the Secretary shall establish a program to encourage the development and dissemination of a model electronic health record format for children enrolled in the State plan under title XIX or the State child health plan under title XXI that is—

- (A) subject to State laws, accessible to parents, caregivers, and other consumers for the sole purpose of demonstrating compliance with school or leisure activity requirements, such as appropriate immunizations or physicals;
- (B) designed to allow interoperable exchanges that conform with Federal and State privacy and security requirements;

(C) structured in a manner that permits parents and caregivers to view and understand the extent to which the care their children receive is clinically appropriate and of high quality; and

(D) capable of being incorporated into, and otherwise compatible with, other standards developed for electronic health records.

(2) FUNDING.—\$5,000,000 of the amount appropriated under subsection (i) for a fiscal year shall be used to carry out this subsection.

(g) STUDY OF PEDIATRIC HEALTH AND HEALTH CARE QUALITY MEASURES.—

(1) IN GENERAL.—Not later than July 1, 2010, the Institute of Medicine shall study and report to Congress on the extent and quality of efforts to measure child health status and the quality of health care for children across the age span and in relation to preventive care, treatments for acute conditions, and treatments aimed at ameliorating or correcting physical, mental, and developmental conditions in children. In conducting such study and preparing such report, the Institute of Medicine shall—

(A) consider all of the major national population-based reporting systems sponsored by the Federal Government that are currently in place, including reporting requirements under Federal grant programs and national population surveys and estimates conducted directly by the Federal Government;

(B) identify the information regarding child health and health care quality that each system is designed to capture and generate, the study and reporting periods covered by each system, and the extent to which the information so generated is made widely available through publication;

(C) identify gaps in knowledge related to children's health status, health disparities among subgroups of children, the effects of social conditions on children's health status and use and effectiveness of health care, and the relationship between child health status and family income, family stability and preservation, and children's school readiness and educational achievement and attainment; and

(D) make recommendations regarding improving and strengthening the timeliness, quality, and public transparency and accessibility of information about child health and health care quality.

(2) FUNDING.—Up to \$1,000,000 of the amount appropriated under subsection (i) for a fiscal year shall be used to carry out this subsection.

(h) RULE OF CONSTRUCTION.—Notwithstanding any other provision in this section, no evidence based quality measure developed, published, or used as a basis of measurement or reporting under this section may be used to establish an irrebuttable presumption regarding either the medical necessity of care or the maximum permissible coverage for any individual child who is eligible for and receiving medical assistance under title XIX or child health assistance under title XXI.

(i) APPROPRIATION.—**[Out of any]**

(1) *IN GENERAL.*—*Out of any* funds in the Treasury not otherwise appropriated, **[there is appropriated for each]** *there is appropriated—*

(A) *for each* of fiscal years 2009 through 2013, \$45,000,000 for the purpose of carrying out this section (other than subsection (e))**[, and there is appropriated for the period]**;

(B) *for the period* of fiscal years 2016 and 2017, \$20,000,000 for the purpose of carrying out this section (other than subsections (e), (f), and (g))**[. Funds appropriated under this subsection shall remain available until expended.]**; and

(C) *for the period* of fiscal years 2018 through 2022, \$75,000,000 for the purpose of carrying out this section (other than subsections (e), (f), and (g)).

(2) AVAILABILITY.—*Funds appropriated under this subsection shall remain available until expended.*

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TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND DISABLED

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PART B—SUPPLEMENTARY MEDICAL INSURANCE BENEFITS FOR THE AGED AND DISABLED

* * * * *

AMOUNTS OF PREMIUMS

SEC. 1839. (a)(1) The Secretary shall, during September of 1983 and of each year thereafter, determine the monthly actuarial rate for enrollees age 65 and over which shall be applicable for the succeeding calendar year. Subject to paragraphs (5) and (6), such actuarial rate shall be the amount the Secretary estimates to be necessary so that the aggregate amount for such calendar year with respect to those enrollees age 65 and older will equal one-half of the total of the benefits and administrative costs which he estimates will be payable from the Federal Supplementary Medical Insurance Trust Fund for services performed and related administrative costs incurred in such calendar year with respect to such enrollees. In calculating the monthly actuarial rate, the Secretary shall include an appropriate amount for a contingency margin. In applying this paragraph there shall not be taken into account additional payments under section 1848(o) and section 1853(l)(3) and the Government contribution under section 1844(a)(3).

(2) The monthly premium of each individual enrolled under this part for each month after December 1983 shall be the amount determined under paragraph (3), adjusted as required in accordance with subsections (b), (c), (f), and (i), and to reflect any credit provided under section 1854(b)(1)(C)(ii)(III).

(3) The Secretary, during September of each year, shall determine and promulgate a monthly premium rate for the succeeding calendar year that (except as provided in subsection (g)) is equal

to 50 percent of the monthly actuarial rate for enrollees age 65 and over, determined according to paragraph (1), for that succeeding calendar year. Whenever the Secretary promulgates the dollar amount which shall be applicable as the monthly premium rate for any period, he shall, at the time such promulgation is announced, issue a public statement setting forth the actuarial assumptions and bases employed by him in arriving at the amount of an adequate actuarial rate for enrollees age 65 and older as provided in paragraph (1).

(4) The Secretary shall also, during September of 1983 and of each year thereafter, determine the monthly actuarial rate for disabled enrollees under age 65 which shall be applicable for the succeeding calendar year. Such actuarial rate shall be the amount the Secretary estimates to be necessary so that the aggregate amount for such calendar year with respect to disabled enrollees under age 65 will equal one-half of the total of the benefits and administrative costs which he estimates will be payable from the Federal Supplementary Medical Insurance Trust Fund for services performed and related administrative costs incurred in such calendar year with respect to such enrollees. In calculating the monthly actuarial rate under this paragraph, the Secretary shall include an appropriate amount for a contingency margin.

(5)(A) In applying this part (including subsection (i) and section 1833(b)), the monthly actuarial rate for enrollees age 65 and over for 2016 shall be determined as if subsection (f) did not apply.

(B) Subsection (f) shall continue to be applied to paragraph (6)(A) (during a repayment month, as described in paragraph (6)(B)) and without regard to the application of subparagraph (A).

(6)(A) With respect to a repayment month (as described in subparagraph (B)), the monthly premium otherwise established under paragraph (3) shall be increased by, subject to subparagraph (D), \$3.

(B) For purposes of this paragraph, a repayment month is a month during a year, beginning with 2016, for which a balance due amount is computed under subparagraph (C) as greater than zero.

(C) For purposes of this paragraph, the balance due amount computed under this subparagraph, with respect to a month, is the amount estimated by the Chief Actuary of the Centers for Medicare & Medicaid Services to be equal to—

- (i) the amount transferred under section 1844(d)(1); plus
- (ii) the amount that is equal to the aggregate reduction, for all individuals enrolled under this part, in the income related monthly adjustment amount as a result of the application of paragraph (5); minus
- (iii) the amounts payable under this part as a result of the application of this paragraph for preceding months.

(D) If the balance due amount computed under subparagraph (C), without regard to this subparagraph, for December of a year would be less than zero, the Chief Actuary of the Centers for Medicare & Medicaid Services shall estimate, and the Secretary shall apply, a reduction to the dollar amount increase applied under subparagraph (A) for each month during such year in a manner such that the balance due amount for January of the subsequent year is equal to zero.

(b) In the case of an individual whose coverage period began pursuant to an enrollment after his initial enrollment period (determined pursuant to subsection (c) or (d) of section 1837) and not pursuant to a special enrollment period under subsection (i)(4) or (l) of section 1837, the monthly premium determined under subsection (a) (without regard to any adjustment under subsection (i)) shall be increased by 10 percent of the monthly premium so determined for each full 12 months (in the same continuous period of eligibility) in which he could have been but was not enrolled. For purposes of the preceding sentence, there shall be taken into account (1) the months which elapsed between the close of his initial enrollment period and the close of the enrollment period in which he enrolled, plus (in the case of an individual who reenrolls) (2) the months which elapsed between the date of termination of a previous coverage period and the close of the enrollment period in which he reenrolled, but there shall not be taken into account months for which the individual can demonstrate that the individual was enrolled in a group health plan described in section 1862(b)(1)(A)(v) by reason of the individual's (or the individual's spouse's) current employment or months during which the individual has not attained the age of 65 and for which the individual can demonstrate that the individual was enrolled in a large group health plan as an active individual (as those terms are defined in section 1862(b)(1)(B)(iii)) or months for which the individual can demonstrate that the individual was an individual described in section 1837(k)(3). Any increase in an individual's monthly premium under the first sentence of this subsection with respect to a particular continuous period of eligibility shall not be applicable with respect to any other continuous period of eligibility which such individual may have. No increase in the premium shall be effected for a month in the case of an individual who enrolls under this part during 2001, 2002, 2003, or 2004 and who demonstrates to the Secretary before December 31, 2004, that the individual is a covered beneficiary (as defined in section 1072(5) of title 10, United States Code). The Secretary of Health and Human Services shall consult with the Secretary of Defense in identifying individuals described in the previous sentence.

(c) If any monthly premium determined under the foregoing provisions of this section is not a multiple of 10 cents, such premium shall be rounded to the nearest multiple of 10 cents.

(d) For purposes of subsection (b) (and section 1837(g)(1)), an individual's "continuous period of eligibility" is the period beginning with the first day on which he is eligible to enroll under section 1836 and ending with his death; except that any period during all of which an individual satisfied paragraph (1) of section 1836 and which terminated in or before the month preceding the month in which he attained age 65 shall be a separate "continuous period of eligibility" with respect to such individual (and each such period which terminates shall be deemed not to have existed for purposes of subsequently applying this section).

(e)(1) Upon the request of a State (or any appropriate State or local governmental entity specified by the Secretary), the Secretary may enter into an agreement with the State (or such entity) under which the State (or such entity) agrees to pay on a quarterly or other periodic basis to the Secretary (to be deposited in the Treas-

ury to the credit of the Federal Supplementary Medical Insurance Trust Fund) an amount equal to the amount of the part B late enrollment premium increases with respect to the premiums for eligible individuals (as defined in paragraph (3)(A)).

(2) No part B late enrollment premium increase shall apply to an eligible individual for premiums for months for which the amount of such an increase is payable under an agreement under paragraph (1).

(3) In this subsection:

(A) The term “eligible individual” means an individual who is enrolled under this part B and who is within a class of individuals specified in the agreement under paragraph (1).

(B) The term “part B late enrollment premium increase” means any increase in a premium as a result of the application of subsection (b).

(f) For any calendar year after 1988, if an individual is entitled to monthly benefits under section 202 or 223 or to a monthly annuity under section 3(a), 4(a), or 4(f) of the Railroad Retirement Act of 1974 for November and December of the preceding year, if the monthly premium of the individual under this section for December and for January is deducted from those benefits under section 1840(a)(1) or section 1840(b)(1), and if the amount of the individual’s premium is not adjusted for such January under subsection (i), the monthly premium otherwise determined under this section for an individual for that year shall not be increased, pursuant to this subsection, to the extent that such increase would reduce the amount of benefits payable to that individual for that December below the amount of benefits payable to that individual for that November (after the deduction of the premium under this section). For purposes of this subsection, retroactive adjustments or payments and deductions on account of work shall not be taken into account in determining the monthly benefits to which an individual is entitled under section 202 or 223 or under the Railroad Retirement Act of 1974.

(g) In estimating the benefits and administrative costs which will be payable from the Federal Supplementary Medical Insurance Trust Fund for a year for purposes of determining the monthly premium rate under subsection (a)(3), the Secretary shall exclude an estimate of any benefits and administrative costs attributable to—

(1) the application of section 1861(v)(1)(L)(viii) or to the establishment under section 1861(v)(1)(L)(i)(V) of a per visit limit at 106 percent of the median (instead of 105 percent of the median), but only to the extent payment for home health services under this title is not being made under section 1895 (relating to prospective payment for home health services); and

(2) the medicare prescription drug discount card and transitional assistance program under section 1860D–31.

(h) POTENTIAL APPLICATION OF COMPARATIVE COST ADJUSTMENT IN CCA AREAS.—

(1) IN GENERAL.—Certain individuals who are residing in a CCA area under section 1860C–1 who are not enrolled in an MA plan under part C may be subject to a premium adjustment under subsection (f) of such section for months in which the CCA program under such section is in effect in such area.

(2) NO EFFECT ON LATE ENROLLMENT PENALTY OR INCOME-RELATED ADJUSTMENT IN SUBSIDIES.—Nothing in this subsection or section 1860C–1(f) shall be construed as affecting the amount of any premium adjustment under subsection (b) or (i). Subsection (f) shall be applied without regard to any premium adjustment referred to in paragraph (1).

(3) IMPLEMENTATION.—In order to carry out a premium adjustment under this subsection and section 1860C–1(f) (insofar as it is effected through the manner of collection of premiums under section 1840(a)), the Secretary shall transmit to the Commissioner of Social Security—

(A) at the beginning of each year, the name, social security account number, and the amount of the premium adjustment (if any) for each individual enrolled under this part for each month during the year; and

(B) periodically throughout the year, information to update the information previously transmitted under this paragraph for the year.

(i) REDUCTION IN PREMIUM SUBSIDY BASED ON INCOME.—

(1) IN GENERAL.—In the case of an individual whose modified adjusted gross income exceeds the threshold amount under paragraph (2), the monthly amount of the premium subsidy applicable to the premium under this section for a month after December 2006 shall be reduced (and the monthly premium shall be increased) by the monthly adjustment amount specified in paragraph (3).

(2) THRESHOLD AMOUNT.—For purposes of this subsection, subject to paragraph (6), the threshold amount is—

(A) except as provided in subparagraph (B), \$80,000 (or, beginning with 2018, \$85,000), and

(B) in the case of a joint return, twice the amount applicable under subparagraph (A) for the calendar year.

(3) MONTHLY ADJUSTMENT AMOUNT.—

(A) IN GENERAL.—Subject to subparagraph (B), the monthly adjustment amount specified in this paragraph for an individual for a month in a year is equal to the product of the following:

(i) SLIDING SCALE PERCENTAGE.—Subject to paragraph (6), the applicable percentage specified in the applicable table in subparagraph (C) for the individual minus 25 percentage points.

(ii) UNSUBSIDIZED PART B PREMIUM AMOUNT.—

(I) 200 percent of the monthly actuarial rate for enrollees age 65 and over (as determined under subsection (a)(1) for the year); plus

(II) 4 times the amount of the increase in the monthly premium under subsection (a)(6) for a month in the year.

(B) 3-YEAR PHASE IN.—The monthly adjustment amount specified in this paragraph for an individual for a month in a year before 2009 is equal to the following percentage of the monthly adjustment amount specified in subparagraph (A):

(i) For 2007, 33 percent.

(ii) For 2008, 67 percent.

(C) APPLICABLE PERCENTAGE.—

(i) IN GENERAL.—

(I) Subject to paragraphs (5) and (6), for years before 2018:

If the modified adjusted gross income is:	The applicable percentage is:
More than \$80,000 but not more than \$100,000	35 percent
More than \$100,000 but not more than \$150,000	50 percent
More than \$150,000 but not more than \$200,000	65 percent
More than \$200,000	80 percent.

(II) Subject to paragraph (5), for years beginning with 2018:

If the modified adjusted gross income is:	The applicable percentage is:
More than \$85,000 but not more than \$107,000	35 percent
More than \$107,000 but not more than \$133,500	50 percent
More than \$133,500 but not more than \$160,000	65 percent
[More than \$160,000]	80 percent.]
<i>More than \$160,000 but less than \$500,000</i>	<i>80 percent</i>
<i>At least \$500,000</i>	<i>100 percent.</i>

(ii) JOINT RETURNS.—In the case of a joint return, clause (i) shall be applied by substituting dollar amounts which are twice the dollar amounts otherwise applicable under clause (i) for the calendar year *except, with respect to the dollar amounts applied in the last row of the table under subclause (II) of such clause (and the second dollar amount specified in the second to last row of such table), clause (i) shall be applied by substituting dollar amounts which are 175 percent of such dollar amounts for the calendar year.*

(iii) MARRIED INDIVIDUALS FILING SEPARATE RETURNS.—In the case of an individual who—

(I) is married as of the close of the taxable year (within the meaning of section 7703 of the Internal Revenue Code of 1986) but does not file a joint return for such year, and

(II) does not live apart from such individual's spouse at all times during the taxable year, clause (i) shall be applied by reducing each of the dollar amounts otherwise applicable under such clause for the calendar year by the threshold amount for such year applicable to an unmarried individual.

(4) MODIFIED ADJUSTED GROSS INCOME.—

(A) IN GENERAL.—For purposes of this subsection, the term “modified adjusted gross income” means adjusted

gross income (as defined in section 62 of the Internal Revenue Code of 1986)—

- (i) determined without regard to sections 135, 911, 931, and 933 of such Code; and
- (ii) increased by the amount of interest received or accrued during the taxable year which is exempt from tax under such Code.

In the case of an individual filing a joint return, any reference in this subsection to the modified adjusted gross income of such individual shall be to such return's modified adjusted gross income.

(B) TAXABLE YEAR TO BE USED IN DETERMINING MODIFIED ADJUSTED GROSS INCOME.—

(i) IN GENERAL.—In applying this subsection for an individual's premiums in a month in a year, subject to clause (ii) and subparagraph (C), the individual's modified adjusted gross income shall be such income determined for the individual's last taxable year beginning in the second calendar year preceding the year involved.

(ii) TEMPORARY USE OF OTHER DATA.—If, as of October 15 before a calendar year, the Secretary of the Treasury does not have adequate data for an individual in appropriate electronic form for the taxable year referred to in clause (i), the individual's modified adjusted gross income shall be determined using the data in such form from the previous taxable year. Except as provided in regulations prescribed by the Commissioner of Social Security in consultation with the Secretary, the preceding sentence shall cease to apply when adequate data in appropriate electronic form are available for the individual for the taxable year referred to in clause (i), and proper adjustments shall be made to the extent that the premium adjustments determined under the preceding sentence were inconsistent with those determined using such taxable year.

(iii) NON-FILERS.—In the case of individuals with respect to whom the Secretary of the Treasury does not have adequate data in appropriate electronic form for either taxable year referred to in clause (i) or clause (ii), the Commissioner of Social Security, in consultation with the Secretary, shall prescribe regulations which provide for the treatment of the premium adjustment with respect to such individual under this subsection, including regulations which provide for—

(I) the application of the highest applicable percentage under paragraph (3)(C) to such individual if the Commissioner has information which indicates that such individual's modified adjusted gross income might exceed the threshold amount for the taxable year referred to in clause (i), and

(II) proper adjustments in the case of the application of an applicable percentage under subclause (I) to such individual which is inconsistent

with such individual's modified adjusted gross income for such taxable year.

(C) USE OF MORE RECENT TAXABLE YEAR.—

(i) IN GENERAL.—The Commissioner of Social Security in consultation with the Secretary of the Treasury shall establish a procedures under which an individual's modified adjusted gross income shall, at the request of such individual, be determined under this subsection—

(I) for a more recent taxable year than the taxable year otherwise used under subparagraph (B), or

(II) by such methodology as the Commissioner, in consultation with such Secretary, determines to be appropriate, which may include a methodology for aggregating or disaggregating information from tax returns in the case of marriage or divorce.

(ii) STANDARD FOR GRANTING REQUESTS.—A request under clause (i)(I) to use a more recent taxable year may be granted only if—

(I) the individual furnishes to such Commissioner with respect to such year such documentation, such as a copy of a filed Federal income tax return or an equivalent document, as the Commissioner specifies for purposes of determining the premium adjustment (if any) under this subsection; and

(II) the individual's modified adjusted gross income for such year is significantly less than such income for the taxable year determined under subparagraph (B) by reason of the death of such individual's spouse, the marriage or divorce of such individual, or other major life changing events specified in regulations prescribed by the Commissioner in consultation with the Secretary.

(5) INFLATION ADJUSTMENT.—

(A) IN GENERAL.—**[In the case]** *Subject to subparagraph (C), in the case* of any calendar year beginning after 2007 (other than 2018 and 2019), each dollar amount in paragraph (2) or (3) shall be increased by an amount equal to—

(i) such dollar amount, multiplied by

(ii) the percentage (if any) by which the average of the Consumer Price Index for all urban consumers (United States city average) for the 12-month period ending with August of the preceding calendar year exceeds such average for the 12-month period ending with August 2006 (or, in the case of a calendar year beginning with 2020, August 2018).

(B) ROUNDING.—If any dollar amount after being increased under **[subparagraph (A)]** *subparagraph (A) or (C)* is not a multiple of \$1,000, such dollar amount shall be rounded to the nearest multiple of \$1,000.

(C) *TREATMENT OF ADJUSTMENTS FOR CERTAIN HIGHER INCOME INDIVIDUALS.*—

(i) *IN GENERAL.*—Subparagraph (A) shall not apply with respect to each dollar amount in paragraph (3) of \$500,000.

(ii) *ADJUSTMENT BEGINNING 2027.*—In the case of any calendar year beginning after 2026, each dollar amount in paragraph (3) of \$500,000 shall be increased by an amount equal to—

(I) such dollar amount, multiplied by

(II) the percentage (if any) by which the average of the Consumer Price Index for all urban consumers (United States city average) for the 12-month period ending with August of the preceding calendar year exceeds such average for the 12-month period ending with August 2025.

(6) *TEMPORARY ADJUSTMENT TO INCOME THRESHOLDS.*—Notwithstanding any other provision of this subsection, during the period beginning on January 1, 2011, and ending on December 31, 2017—

(A) the threshold amount otherwise applicable under paragraph (2) shall be equal to such amount for 2010; and

(B) the dollar amounts (*other than \$500,000*) otherwise applicable under paragraph (3)(C)(i) shall be equal to such dollar amounts for 2010.

(7) *JOINT RETURN DEFINED.*—For purposes of this subsection, the term “joint return” has the meaning given to such term by section 7701(a)(38) of the Internal Revenue Code of 1986.

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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 per-

sonnel 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 applica-

ble 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 (l)(1) and whose family income does not exceed the minimum income level the State is required to establish under subsection (l)(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 (l)(1) and whose family income does not exceed the income level the State is required to establish under subsection (l)(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), sup-

plemental 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 (l)(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 assist-

ance 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), (e)(14)] (e)(14), (e)(15), (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 income 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)] *responsible third parties* 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 *responsible* 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 *responsible* 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;

(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 *responsible* 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 *responsible* 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 *responsible* 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 *responsible* 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, except that the State may, if the State determines doing so is cost-effective and will not adversely affect access to care, only make such payment if a third party so liable has not made payment within 90 days after the date the provider of such services has initially submitted a claim to such 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 90 days after the date the provider of such services has initially submitted a claim to such third party for payment for such services, except that the State may make such payment within 30 days after such date if the State determines doing so is cost-effective and necessary to ensure access to care;

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

(E) that, in the case of a State that provides medical assistance under this title through a contract with a health insurer, such contract shall specify whether the State is—

(i) *delegating to such insurer all or some of its right of recovery from a responsible third party for an item or service for which payment has been made under the State plan (or under a waiver of the plan); and*

(ii) *transferring to such insurer all or some of the assignment to the State of any right of an individual or other entity to payment from a responsible third party for an item or service for which payment has been made under the State plan (or under a waiver of the plan);*

(F) *that, in the case of a State that elects an option described in clause (i) or (ii) of subparagraph (E) with respect to a health insurer, the State shall provide assurances to the Secretary that the State laws referred to in subparagraph (I) confer to the health insurer the authority of the State with respect to the requirements specified in clauses (i) through (iv) of such subparagraph;*

(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)] responsible third party, 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 responsible 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 any payments by such responsible third party; 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 agreement, legally responsible for payment of a claim for a health care item or service] responsible third parties, 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] *medical assistance under a State plan (or under a waiver of the plan)* under this title [(and, at State option, child] *and child health assistance under [title XXI] 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;]

(ii) *accept—*

(I) *any State's right of recovery and the assignment to any 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 respective State's plan (or under a waiver of the plan); and*

(II) *as a valid authorization of the responsible third party for the furnishing of an item or service to an individual eligible to receive medical assistance under this title, an authorization made on behalf of such individual under the State plan (or under a waiver of such plan) for the furnishing of such item or service to such individual;*

(iii) [respond to] *not later than 60 days after receiving 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], respond to such inquiry; 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, *a failure to obtain a prior authorization*, 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 per-

son 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, any other State plan under this title (or waiver of the plan), or any State child health plan under title XXI (or waiver of the plan) and such termination is included by the Secretary in any database or similar system de-

veloped pursuant to section 6401(b)(2) of the Patient Protection and Affordable Care Act, 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, 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 pre-

sumptive 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 without 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 directives 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 de-

financed 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 individuals, 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 that pursuant to its State plan or waiver of the plan for medical assistance pays for medical assistance on a fee-for-service basis, the State shall require each provider furnishing items and services to, or ordering, prescribing, referring, or certifying eligibility for, services for 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 (if applicable), Federal taxpayer identification number, and the State license or certification number of the provider (if applicable);

(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;

(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;

(82) provide that the State agency responsible for administering the State plan under this title provides assurances to the Secretary that the State agency is in compliance with subparagraphs (A), (B), and (C) of section 1128K(b)(2); and

(83) provide that, not later than January 1, 2017, in the case of a State plan (or waiver of the plan) that provides medical assistance on a fee-for-service basis or through a primary care case-management system described in section 1915(b)(1) (other than a primary care case management entity (as defined by the Secretary)), the State shall publish (and update on at least an annual basis) on the public website of the State agency administering the State plan, a directory of the physicians described in subsection (mm) and, at State option, other providers described in such subsection that—

(A) includes—

(i) with respect to each such physician or provider—

(I) the name of the physician or provider;

(II) the specialty of the physician or provider;

(III) the address at which the physician or provider provides services; and

(IV) the telephone number of the physician or provider; and

(ii) with respect to any such physician or provider participating in such a primary care case-management system, information regarding—

(I) whether the physician or provider is accepting as new patients individuals who receive medical assistance under this title; and

(II) the physician's or provider's cultural and linguistic capabilities, including the languages spoken by the physician or provider or by the skilled medical interpreter providing interpretation services at the physician's or provider's office; and

(B) may include, at State option, with respect to each such physician or provider—

(i) the Internet website of such physician or provider; or

(ii) whether the physician or provider is accepting as new patients individuals who receive medical assistance under this title.

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 re-

quirements 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] 2022.

(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 of 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.

(J) TREATMENT OF CERTAIN LOTTERY WINNINGS AND INCOME RECEIVED AS A LUMP SUM.—

(i) *IN GENERAL.*—In the case of an individual who is the recipient of qualified lottery winnings (pursuant to lotteries occurring on or after January 1, 2018) or qualified lump sum income (received on or after such date) and whose eligibility for medical assistance is determined based on the application of modified adjusted gross income under subparagraph (A), a State shall, in determining such eligibility, include such winnings or income (as applicable) as income received—

(I) in the month in which such winnings or income (as applicable) is received if the amount of such winnings or income is less than \$80,000;

(II) over a period of 2 months if the amount of such winnings or income (as applicable) is greater than or equal to \$80,000 but less than \$90,000;

(III) over a period of 3 months if the amount of such winnings or income (as applicable) is greater than or equal to \$90,000 but less than \$100,000; and

(IV) over a period of 3 months plus 1 additional month for each increment of \$10,000 of such winnings or income (as applicable) received, not to exceed a period of 120 months (for winnings or income of \$1,260,000 or more), if the amount of such winnings or income is greater than or equal to \$100,000.

(ii) **COUNTING IN EQUAL INSTALLMENTS.**—For purposes of subclauses (II), (III), and (IV) of clause (i), winnings or income to which such subclause applies shall be counted in equal monthly installments over the period of months specified under such subclause.

(iii) **HARDSHIP EXEMPTION.**—An individual whose income, by application of clause (i), exceeds the applicable eligibility threshold established by the State, shall continue to be eligible for medical assistance to the extent that the State determines, under procedures established by the State (in accordance with standards specified by the Secretary), that the denial of eligibility of the individual would cause an undue medical or financial hardship as determined on the basis of criteria established by the Secretary.

(iv) **NOTIFICATIONS AND ASSISTANCE REQUIRED IN CASE OF LOSS OF ELIGIBILITY.**—A State shall, with respect to an individual who loses eligibility for medical assistance under the State plan (or a waiver of such plan) by reason of clause (i)—

(I) before the date on which the individual loses such eligibility, inform the individual—

(aa) of the individual's opportunity to enroll in a qualified health plan offered through an Exchange established under title I of the Patient Protection and Affordable Care Act during the special enrollment period specified in section 9801(f)(3) of the Internal Revenue Code of 1986 (relating to loss of Medicaid or CHIP coverage); and

(bb) of the date on which the individual would no longer be considered ineligible by reason of clause (i) to receive medical assistance under the State plan or under any waiver of such plan and be eligible to reapply to receive such medical assistance; and

(II) provide technical assistance to the individual seeking to enroll in such a qualified health plan.

(v) **QUALIFIED LOTTERY WINNINGS DEFINED.**—In this subparagraph, the term “qualified lottery winnings”

means winnings from a sweepstakes, lottery, or pool described in paragraph (3) of section 4402 of the Internal Revenue Code of 1986 or a lottery operated by a multistate or multijurisdictional lottery association, including amounts awarded as a lump sum payment.

(vi) QUALIFIED LUMP SUM INCOME DEFINED.—In this subparagraph, the term “qualified lump sum income” means income that is received as a lump sum from one of the following sources:

(I) Monetary winnings from gambling (as defined by the Secretary and including gambling activities described in section 1955(b)(4) of title 18, United States Code).

(II) Damages received, whether by suit or agreement and whether as lump sums or as periodic payments (other than monthly payments), on account of causes of action other than causes of action arising from personal physical injuries or physical sickness.

(III) Income received as liquid assets from the estate (as defined in section 1917(b)(4)) of a deceased individual.

[(14)] (15) 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 in-

dividuals 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 a 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 cor-

rect 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 legislation 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 pro-

vide 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 inconsistent 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 citizen-

ship 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] *THROUGH SEPTEMBER 30, 2022.*—The requirement under paragraph (1) shall continue to apply to a State through [September 30, 2019,] *September 30, 2022 (but during the period that begins on October 1, 2019, and ends on September 30, 2022, only with respect to children in families whose income does not exceed 300 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved)* 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 1866(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 1866(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 1866(j)(5).

(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 1866(j)(7).

(ii) EXCEPTIONS.—

(I) COMPLIANCE WITH MORATORIUM.—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.

(II) FFP AVAILABLE.—Notwithstanding section 1903(i)(2)(E), payment may be made to a State

under this title with respect to amounts expended for items and services described in such section if the Secretary, in consultation with the State agency administering the State plan under this title (or a waiver of the plan), determines that denying payment to the State pursuant to such section would adversely impact beneficiaries' access to medical assistance.

(iii) LIMITATION ON CHARGES TO BENEFICIARIES.—With respect to any amount expended for items or services furnished during calendar quarters beginning on or after October 1, 2017, the State prohibits, during the period of a temporary moratorium described in clause (i), a provider meeting the requirements specified in subparagraph (C)(iii) of section 1866(j)(7) from charging an individual or other person eligible to receive medical assistance under the State plan under this title (or a waiver of the plan) for an item or service described in section 1903(i)(2)(E) furnished to such an individual.

(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 July 1, 2018, 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 (or under a waiver of the plan), the State, not later than 30 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 (if applicable), Federal taxpayer identification number, and the State license or certification number of such provider or person (if applicable);
- (v) the reason for the termination;
- (vi) a copy of the notice of termination sent to the provider or person;
- (vii) the date on which such termination is effective, as specified in the 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.

(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.

(II) TERMINATION NOTIFICATION DATABASE.—In the case of a provider of services or any other person whose participation under this title or title XXI is terminated (as described in subsection (kk)(8)), the Secretary shall, not later than 30 days after the date on which the Secretary 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).

(mm) DIRECTORY PHYSICIAN OR PROVIDER DESCRIBED.—A physician or provider described in this subsection is—

- (1) in the case of a physician or provider of a provider type for which the State agency, as a condition on receiving payment for items and services furnished by the physician or pro-

vider to individuals eligible to receive medical assistance under the State plan, requires the enrollment of the physician or provider with the State agency, a physician or a provider that—

(A) is enrolled with the agency as of the date on which the directory is published or updated (as applicable) under subsection (a)(83); and

(B) received payment under the State plan in the 12-month period preceding such date; and

(2) in the case of a physician or provider of a provider type for which the State agency does not require such enrollment, a physician or provider that received payment under the State plan (or a waiver of the plan) in the 12-month period preceding the date on which the directory is published or updated (as applicable) under subsection (a)(83).

(nn) *RESPONSIBLE THIRD PARTY AND HEALTH INSURER DEFINITIONS.*—For purposes of subsection (a)(25) and section 1903(d)(2)(B):

(1) *RESPONSIBLE THIRD PARTY.*—The term “responsible third party” means a health insurer, an accountable care organization, or any other party that is, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service. Such term does not include a party if payment by such party has been made or can reasonably be expected to be made under a workmen’s compensation law or plan of the United States or a State, or under an automobile or liability insurance policy or plan (including a self-insured plan), or under no fault insurance.

(2) *HEALTH INSURER.*—The term “health insurer” means a group health plan, as defined in section 607(1) of the Employee Retirement Income Security Act of 1974, a self-insured plan, a fully-insured plan, a service benefit plan, a medicaid managed care plan under section 1903(m) or 1932, a pharmacy benefit manager, and any other health plan determined appropriate by the Secretary.

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) *subject to paragraph (8)*, 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) *subject to paragraph (8)*, 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**[.]; plus**

(8) *for quarters during the period beginning January 1, 2018, and ending December 31, 2019, paragraphs (2)(A) and (6) shall apply with respect to Puerto Rico and the Virgin Islands as if—*

(A) the reference to “75 per centum” in paragraph (2)(A) were a reference to “90 per centum”; and

(B) the reference to “75 per centum” in paragraph (6)(B) were a reference to “90 per centum”.

(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). *For purposes of this subparagraph, reimbursements made by a responsible third party to health insurers pursuant to section 1902(a)(25)(E) shall be treated in the same manner as reimbursements made to a State under the previous sentence. In the case of expenditures for medical assistance provided during 2017 and subsequent years for individuals described in subclause (VIII) of section 1902(a)(10)(A)(i), in determining the amount, if any, of overpayment under this subparagraph with respect to such medical assistance, the Secretary shall apply the Federal medical assistance percentage for the State under section 1905(b), notwithstanding the application of section 1905(y).*

(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 ac-

count 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 eligible 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 services 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);

(C) by any individual or entity to whom the State has failed to suspend payments under the plan during any period 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;

(D) beginning on July 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

(E) with respect to any amount expended for such an item or service furnished during calendar quarters beginning on or after October 1, 2017, subject to section 1902(kk)(4)(A)(ii)(II), within a geographic area that is subject to a moratorium imposed under section 1866(j)(7) by a provider or supplier that meets the requirements specified in subparagraph (C)(iii) of such section, during the period of such moratorium; 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 condi-

tion 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 surety 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)(C) (relating to drugs when used for cosmetic purposes or hair growth), except where medically necessary, and 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);

(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); or

(27) with respect to any amounts expended by the State on the basis of a fee schedule for items described in section 1861(n) and furnished on or after January 1, 2018, as determined in the aggregate with respect to each class of such items as defined by the Secretary, in excess of the aggregate amount, if any, that would be paid for such items within such class on a fee-for-service basis under the program under part B of title XVIII, including, as applicable, under a competitive acquisition program under section 1847 in an area of the State.

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.

(l)(1) Subject to paragraphs (3) and (4), with respect to any amount expended for personal care services or home health care services requiring an in-home visit by a provider that are provided under a State plan under this title (or under a waiver of the plan) and furnished in a calendar quarter beginning on or after January 1, 2019 (or, in the case of home health care services, on or after

January 1, 2023), unless a State requires the use of an electronic visit verification system for such services furnished in such quarter under the plan or such waiver, the Federal medical assistance percentage shall be reduced—

- (A) in the case of personal care services—
 - (i) for calendar quarters in 2019 and 2020, by .25 percentage points;
 - (ii) for calendar quarters in 2021, by .5 percentage points;
 - (iii) for calendar quarters in 2022, by .75 percentage points; and
 - (iv) for calendar quarters in 2023 and each year thereafter, by 1 percentage point; and
- (B) in the case of home health care services—
 - (i) for calendar quarters in 2023 and 2024, by .25 percentage points;
 - (ii) for calendar quarters in 2025, by .5 percentage points;
 - (iii) for calendar quarters in 2026, by .75 percentage points; and
 - (iv) for calendar quarters in 2027 and each year thereafter, by 1 percentage point.

(2) Subject to paragraphs (3) and (4), in implementing the requirement for the use of an electronic visit verification system under paragraph (1), a State shall—

- (A) consult with agencies and entities that provide personal care services, home health care services, or both under the State plan (or under a waiver of the plan) to ensure that such system—
 - (i) is minimally burdensome;
 - (ii) takes into account existing best practices and electronic visit verification systems in use in the State; and
 - (iii) is conducted in accordance with the requirements of HIPAA privacy and security law (as defined in section 3009 of the Public Health Service Act);
- (B) take into account a stakeholder process that includes input from beneficiaries, family caregivers, individuals who furnish personal care services or home health care services, and other stakeholders, as determined by the State in accordance with guidance from the Secretary; and
- (C) ensure that individuals who furnish personal care services, home health care services, or both under the State plan (or under a waiver of the plan) are provided the opportunity for training on the use of such system.

(3) Paragraphs (1) and (2) shall not apply in the case of a State that, as of the date of the enactment of this subsection, requires the use of any system for the electronic verification of visits conducted as part of both personal care services and home health care services, so long as the State continues to require the use of such system with respect to the electronic verification of such visits.

(4)(A) In the case of a State described in subparagraph (B), the reduction under paragraph (1) shall not apply—

- (i) in the case of personal care services, for calendar quarters in 2019; and

(ii) in the case of home health care services, for calendar quarters in 2023.

(B) For purposes of subparagraph (A), a State described in this subparagraph is a State that demonstrates to the Secretary that the State—

(i) has made a good faith effort to comply with the requirements of paragraphs (1) and (2) (including by taking steps to adopt the technology used for an electronic visit verification system); and

(ii) in implementing such a system, has encountered unavoidable system delays.

(5) In this subsection:

(A) The term “electronic visit verification system” means, with respect to personal care services or home health care services, a system under which visits conducted as part of such services are electronically verified with respect to—

- (i) the type of service performed;
- (ii) the individual receiving the service;
- (iii) the date of the service;
- (iv) the location of service delivery;
- (v) the individual providing the service; and
- (vi) the time the service begins and ends.

(B) The term “home health care services” means services described in section 1905(a)(7) provided under a State plan under this title (or under a waiver of the plan).

(C) The term “personal care services” means personal care services provided under a State plan under this title (or under a waiver of the plan), including services provided under section 1905(a)(24), 1915(c), 1915(i), 1915(j), or 1915(k) or under a wavier under section 1115.

(6)(A) In the case in which a State requires personal care service and home health care service providers to utilize an electronic visit verification system operated by the State or a contractor on behalf of the State, the Secretary shall pay to the State, for each quarter, an amount equal to 90 per centum of so much of the sums expended during such quarter as are attributable to the design, development, or installation of such system, and 75 per centum of so much of the sums for the operation and maintenance of such system.

(B) Subparagraph (A) shall not apply in the case in which a State requires personal care service and home health care service providers to utilize an electronic visit verification system that is not operated by the State or a contractor on behalf of the State.

(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 July 1, 2018, has a contract with such entity that complies with the requirement specified in section 1932(d)(5); and

(B) beginning on January 1, 2018, complies with the requirement specified in section 1932(d)(6)(A).

(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).

(n)(1) For any year beginning after 2020 (or a sooner year as provided in paragraph (2)), if a State fails to comply with the requirements of section 1902(a)(25) with respect to each calendar quarter in such year, the Secretary may reduce the Federal medical assistance percentage by 0.1 percentage point for calendar quarters in each subsequent year in which the State fails to so comply (and cumulatively for a failure to so comply for a period of consecutive years).

(2) The Secretary may apply paragraph (1)—

(A) for any year beginning after 2018, if a State fails to comply with the requirements of section 1902(a)(25) with respect to payment for items and services furnished to individuals described in subclause (VIII) of section 1902(a)(10)(A)(i) or non-expansion individuals; and

(B) for any year beginning after 2019, if a State fails to comply with the requirements of section 1902(a)(25) with respect to payment for items and services furnished to individuals described in subdivision (i), (iii), or (iv) of section 1905(a).

(3) For purposes of this subsection, the term “non-expansion individual” means, with respect to a State for a month, an individual who is—

(A) eligible for medical assistance for items or services under this title and enrolled under the State plan (or a waiver of such plan) under this title for the month;

(B) not under 19 years of age;

(C) not 65 years of age or older; and

(D) not eligible for medical assistance under this title on the basis of being blind or disabled.

(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 assistance 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.

* * * * *

ADJUSTMENT IN PAYMENT FOR INPATIENT HOSPITAL SERVICES FURNISHED BY DISPROPORTIONATE SHARE HOSPITALS

SEC. 1923. (a) IMPLEMENTATION OF REQUIREMENT.—

(1) A State plan under this title shall not be considered to meet the requirement of section 1902(a)(13)(A)(iv) (insofar as it requires payments to hospitals to take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs), as of July 1, 1988, unless the State has submitted to the Secretary, by not later than such date, an amendment to such plan that—

(A) specifically defines the hospitals so described (and includes in such definition any disproportionate share hospital described in subsection (b)(1) which meets the requirements of subsection (d)), and

(B) provides, effective for inpatient hospital services provided not later than July 1, 1988, for an appropriate increase in the rate or amount of payment for such services provided by such hospitals, consistent with subsection (c).

(2)(A) In order to be considered to have met such requirement of section 1902(a)(13)(A) as of July 1, 1989, the State must submit to the Secretary by not later than April 1, 1989, the State plan amendment described in paragraph (1), consistent with subsection (c), effective for inpatient hospital services provided on or after July 1, 1989.

(B) In order to be considered to have met such requirement of section 1902(a)(13)(A) as of July 1, 1990, the State must submit to the Secretary by not later than April 1, 1990, the State plan amendment described in paragraph (1), consistent with subsections (c) and (f), effective for inpatient hospital services provided on or after July 1, 1990.

(C) If a State plan under this title provides for payments for inpatient hospital services on a prospective basis (whether per diem, per case, or otherwise), in order for the plan to be considered to have met such requirement of section 1902(a)(13)(A) as of July 1, 1989, the State must submit to the Secretary by not later than April 1, 1989, a State plan amendment that provides, in the case of hospitals defined by the State as dis-

proportionate share hospitals under paragraph (1)(A), for an outlier adjustment in payment amounts for medically necessary inpatient hospital services provided on or after July 1, 1989, involving exceptionally high costs or exceptionally long lengths of stay for individuals under one year of age.

(D) A State plan under this title shall not be considered to meet the requirements of section 1902(a)(13)(A)(iv) (insofar as it requires payments to hospitals to take into account the situation of hospitals that serve a disproportionate number of low-income patients with special needs), as of October 1, 1998, unless the State has submitted to the Secretary by such date a description of the methodology used by the State to identify and to make payments to disproportionate share hospitals, including children's hospitals, on the basis of the proportion of low-income and medicaid patients (including such patients who receive benefits through a managed care entity) served by such hospitals. The State shall provide an annual report to the Secretary describing the disproportionate share payments to each such disproportionate share hospital.

(3) The Secretary shall, not later than 90 days after the date a State submits an amendment under this subsection, review each such amendment for compliance with such requirement and by such date shall approve or disapprove each such amendment. If the Secretary disapproves such an amendment, the State shall immediately submit a revised amendment which meets such requirement.

(4) The requirement of this subsection may not be waived under section 1915(b)(4).

(b) HOSPITALS DEEMED DISPROPORTIONATE SHARE.—

(1) For purposes of subsection (a)(1), a hospital which meets the requirements of subsection (d) is deemed to be a disproportionate share hospital if—

(A) the hospital's medicaid inpatient utilization rate (as defined in paragraph (2)) is at least one standard deviation above the mean medicaid inpatient utilization rate for hospitals receiving medicaid payments in the State; or

(B) the hospital's low-income utilization rate (as defined in paragraph (3)) exceeds 25 percent.

(2) For purposes of paragraph (1)(A), the term "medicaid inpatient utilization rate" means, for a hospital, a fraction (expressed as a percentage), the numerator of which is the hospital's number of inpatient days attributable to patients who (for such days) were eligible for medical assistance under a State plan approved under this title in a period (regardless of whether such patients receive medical assistance on a fee-for-service basis or through a managed care entity), and the denominator of which is the total number of the hospital's inpatient days in that period. In this paragraph, the term "inpatient day" includes each day in which an individual (including a newborn) is an inpatient in the hospital, whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere.

(3) For purposes of paragraph (1)(B), the term "low-income utilization rate" means, for a hospital, the sum of—

(A) the fraction (expressed as a percentage)—

(i) the numerator of which is the sum (for a period) of (I) the total revenues paid the hospital for patient services under a State plan under this title (regardless of whether the services were furnished on a fee-for-service basis or through a managed care entity) and (II) the amount of the cash subsidies for patient services received directly from State and local governments, and

(ii) the denominator of which is the total amount of revenues of the hospital for patient services (including the amount of such cash subsidies) in the period; and

(B) a fraction (expressed as a percentage)—

(i) the numerator of which is the total amount of the hospital's charges for inpatient hospital services which are attributable to charity care in a period, less the portion of any cash subsidies described in clause (i)(II) of subparagraph (A) in the period reasonably attributable to inpatient hospital services, and

(ii) the denominator of which is the total amount of the hospital's charges for inpatient hospital services in the hospital in the period.

The numerator under subparagraph (B)(i) shall not include contractual allowances and discounts (other than for indigent patients not eligible for medical assistance under a State plan approved under this title).

(4) The Secretary may not restrict a State's authority to designate hospitals as disproportionate share hospitals under this section. The previous sentence shall not be construed to affect the authority of the Secretary to reduce payments pursuant to section 1903(w)(1)(A)(iii) if the Secretary determines that, as a result of such designations, there is in effect a hold harmless provision described in section 1903(w)(4).

(c) PAYMENT ADJUSTMENT.—Subject to subsections (f) and (g), in order to be consistent with this subsection, a payment adjustment for a disproportionate share hospital must either—

(1) be in an amount equal to at least the product of (A) the amount paid under the State plan to the hospital for operating costs for inpatient hospital services (of the kind described in section 1886(a)(4)), and (B) the hospital's disproportionate share adjustment percentage (established under section 1886(d)(5)(F)(iv));

(2) provide for a minimum specified additional payment amount (or increased percentage payment) and (without regard to whether the hospital is described in subparagraph (A) or (B) of subsection (b)(1)) for an increase in such a payment amount (or percentage payment) in proportion to the percentage by which the hospital's medicaid utilization rate (as defined in subsection (b)(2)) exceeds one standard deviation above the mean medicaid inpatient utilization rate for hospitals receiving medicaid payments in the State or the hospital's low-income utilization rate (as defined in paragraph (b)(3)); or

(3) provide for a minimum specified additional payment amount (or increased percentage payment) that varies according to type of hospital under a methodology that—

(A) applies equally to all hospitals of each type; and
 (B) results in an adjustment for each type of hospital that is reasonably related to the costs, volume, or proportion of services provided to patients eligible for medical assistance under a State plan approved under this title or to low-income patients, except that, for purposes of paragraphs (1)(B) and (2)(A) of subsection (a), the payment adjustment for a disproportionate share hospital is consistent with this subsection if the appropriate increase in the rate or amount of payment is equal to at least one-third of the increase otherwise applicable under this subsection (in the case of such paragraph (1)(B)) and at least two-thirds of such increase (in the case of such paragraph (2)(A)). In the case of a hospital described in subsection (d)(2)(A)(i) (relating to children's hospitals), in computing the hospital's disproportionate share adjustment percentage for purposes of paragraph (1)(B) of this subsection, the disproportionate patient percentage (defined in section 1886(d)(5)(F)(vi)) shall be computed by substituting for the fraction described in subclause (I) of such section the fraction described in subclause (II) of that section. If a State elects in a State plan amendment under subsection (a) to provide the payment adjustment described in paragraph (2), the State must include in the amendment a detailed description of the specific methodology to be used in determining the specified additional payment amount (or increased percentage payment) to be made to each hospital qualifying for such a payment adjustment and must publish at least annually the name of each hospital qualifying for such a payment adjustment and the amount of such payment adjustment made for each such hospital.

(d) REQUIREMENTS TO QUALIFY AS DISPROPORTIONATE SHARE HOSPITAL.—

(1) Except as provided in paragraph (2), no hospital may be defined or deemed as a disproportionate share hospital under a State plan under this title or under subsection (b) of this section unless the hospital has at least 2 obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to individuals who are entitled to medical assistance for such services under such State plan.

(2)(A) Paragraph (1) shall not apply to a hospital—

- (i) the inpatients of which are predominantly individuals under 18 years of age; or
- (ii) which does not offer nonemergency obstetric services to the general population as of the date of the enactment of this Act.

(B) In the case of a hospital located in a rural area (as defined for purposes of section 1886), in paragraph (1) the term “obstetrician” includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

(3) No hospital may be defined or deemed as a disproportionate share hospital under a State plan under this title or under subsection (b) or (e) of this section unless the hospital has a medicaid inpatient utilization rate (as defined in subsection (b)(2)) of not less than 1 percent.

(e) SPECIAL RULE.—(1) A State plan shall be considered to meet the requirement of section 1902(a)(13)(A)(iv) (insofar as it requires payments to hospitals to take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs) without regard to the requirement of subsection (a) if (A)(i) the plan provided for payment adjustments based on a pooling arrangement involving a majority of the hospitals participating under the plan for disproportionate share hospitals as of January 1, 1984, or (ii) the plan as of January 1, 1987, provided for payment adjustments based on a statewide pooling arrangement involving all acute care hospitals and the arrangement provides for reimbursement of the total amount of uncompensated care provided by each participating hospital, (B) the aggregate amount of the payment adjustments under the plan for such hospitals is not less than the aggregate amount of such adjustments otherwise required to be made under such subsection, and (C) the plan meets the requirement of subsection (d)(3) and such payment adjustments are made consistent with the last sentence of subsection (c).

(2) In the case of a State that used a health insuring organization before January 1, 1986, to administer a portion of its plan on a state-wide basis, beginning on July 1, 1988—

(A) the requirements of subsections (b) and (c) (other than the last sentence of subsection (c)) shall not apply if the aggregate amount of the payment adjustments under the plan for disproportionate share hospitals (as defined under the State plan) is not less than the aggregate amount of payment adjustments otherwise required to be made if such subsections applied,

(B) subsection (d)(2)(B) shall apply to hospitals located in urban areas, as well as in rural areas,

(C) subsection (d)(3) shall apply, and

(D) subsection (g) shall apply.

(f) LIMITATION ON FEDERAL FINANCIAL PARTICIPATION.—

(1) IN GENERAL.—Payment under section 1903(a) shall not be made to a State with respect to any payment adjustment made under this section for hospitals in a State for quarters in a fiscal year in excess of the disproportionate share hospital (in this subsection referred to as “DSH”) allotment for the State for the fiscal year, as specified in paragraphs (2), (3), and (7).

(2) STATE DSH ALLOTMENTS FOR FISCAL YEARS 1998 THROUGH 2002.—Subject to paragraph (4), the DSH allotment for a State for each fiscal year during the period beginning with fiscal year 1998 and ending with fiscal year 2002 is determined in accordance with the following table:

State or District	DSH Allotment (in millions of dollars)				
	FY 98	FY 99	FY 00	FY 01	FY 02
Alabama	293	269	248	246	246
Alaska	10	10	10	9	9
Arizona	81	81	81	81	81
Arkansas	2	2	2	2	2
California	1,085	1,068	986	931	877
Colorado	93	85	79	74	74
Connecticut	200	194	164	160	160
Delaware	4	4	4	4	4

State or District	DSH Allotment (in millions of dollars)				
	FY 98	FY 99	FY 00	FY 01	FY 02
District of Columbia	23	23	49	49	49
Florida	207	203	197	188	160
Georgia	253	248	241	228	215
Hawaii	0	0	0	0	0
Idaho	1	1	1	1	1
Illinois	203	199	193	182	172
Indiana	201	197	191	181	171
Iowa	8	8	8	8	8
Kansas	51	49	42	36	33
Kentucky	137	134	130	123	116
Louisiana	880	795	713	658	631
Maine	103	99	84	84	84
Maryland	72	70	68	64	61
Massachusetts	288	282	273	259	244
Michigan	249	244	237	224	212
Minnesota	16	16	33	33	33
Mississippi	143	141	136	129	122
Missouri	436	423	379	379	379
Montana	0.2	0.2	0.2	0.2	0.2
Nebraska	5	5	5	5	5
Nevada	37	37	37	37	37
New Hampshire	140	136	130	130	130
New Jersey	600	582	515	515	515
New Mexico	5	5	9	9	9
New York	1,512	1,482	1,436	1,361	1,285
North Carolina	278	272	264	250	236
North Dakota	1	1	1	1	1
Ohio	382	374	363	344	325
Oklahoma	16	16	16	16	16
Oregon	20	20	20	20	20
Pennsylvania	529	518	502	476	449
Rhode Island	62	60	58	55	52
South Carolina	313	303	262	262	262
South Dakota	1	1	1	1	1
Tennessee	0	0	0	0	0
Texas	979	950	806	765	765
Utah	3	3	3	3	3
Vermont	18	18	18	18	18
Virginia	70	68	66	63	59
Washington	174	171	166	157	148
West Virginia	64	63	61	58	54
Wisconsin	7	7	7	7	7
Wyoming	0	0	0.1	0.1	0.1

(3) STATE DSH ALLOTMENTS FOR FISCAL YEAR 2003 AND THEREAFTER.—

(A) IN GENERAL.—Except as provided in paragraphs (6), (7), and (8) and subparagraph (E), the DSH allotment for any State for fiscal year 2003 and each succeeding fiscal year is equal to the DSH allotment for the State for the preceding fiscal year under paragraph (2) or this paragraph, increased, subject to subparagraphs (B) and (C) and paragraph (5), by the percentage change in the consumer price index for all urban consumers (all items; U.S. city average), for the previous fiscal year.

(B) LIMITATION.—The DSH allotment for a State shall not be increased under subparagraph (A) for a fiscal year to the extent that such an increase would result in the DSH allotment for the year exceeding the greater of—

(i) the DSH allotment for the previous year, or

(ii) 12 percent of the total amount of expenditures under the State plan for medical assistance during the fiscal year.

(C) SPECIAL, TEMPORARY INCREASE IN ALLOTMENTS ON A ONE-TIME, NON-CUMULATIVE BASIS.—The DSH allotment for any State (other than a State with a DSH allotment determined under paragraph (5))—

(i) for fiscal year 2004 is equal to 116 percent of the DSH allotment for the State for fiscal year 2003 under this paragraph, notwithstanding subparagraph (B); and

(ii) for each succeeding fiscal year is equal to the DSH allotment for the State for fiscal year 2004 or, in the case of fiscal years beginning with the fiscal year specified in subparagraph (D) for that State, the DSH allotment for the State for the previous fiscal year increased by the percentage change in the consumer price index for all urban consumers (all items; U.S. city average), for the previous fiscal year.

(D) FISCAL YEAR SPECIFIED.—For purposes of subparagraph (C)(ii), the fiscal year specified in this subparagraph for a State is the first fiscal year for which the Secretary estimates that the DSH allotment for that State will equal (or no longer exceed) the DSH allotment for that State under the law as in effect before the date of the enactment of this subparagraph.

(E) TEMPORARY INCREASE IN ALLOTMENTS DURING RECESSION.—

(i) IN GENERAL.—Subject to clause (ii), the DSH allotment for any State—

(I) for fiscal year 2009 is equal to 102.5 percent of the DSH allotment that would be determined under this paragraph for the State for fiscal year 2009 without application of this subparagraph, notwithstanding subparagraphs (B) and (C);

(II) for fiscal year 2010 is equal to 102.5 percent of the DSH allotment for the State for fiscal year 2009, as determined under subclause (I); and

(III) for each succeeding fiscal year is equal to the DSH allotment for the State under this paragraph determined without applying subclauses (I) and (II).

(ii) APPLICATION.—Clause (i) shall not apply to a State for a year in the case that the DSH allotment for such State for such year under this paragraph determined without applying clause (i) would grow higher than the DSH allotment specified under clause (i) for the State for such year.

(4) SPECIAL RULE FOR FISCAL YEARS 2001 AND 2002.—

(A) IN GENERAL.—Notwithstanding paragraph (2), the DSH allotment for any State for—

(i) fiscal year 2001, shall be the DSH allotment determined under paragraph (2) for fiscal year 2000 increased, subject to subparagraph (B) and paragraph (5), by the percentage change in the consumer price

index for all urban consumers (all items; U.S. city average) for fiscal year 2000; and

(ii) fiscal year 2002, shall be the DSH allotment determined under clause (i) increased, subject to subparagraph (B) and paragraph (5), by the percentage change in the consumer price index for all urban consumers (all items; U.S. city average) for fiscal year 2001.

(B) LIMITATION.—Subparagraph (B) of paragraph (3) shall apply to subparagraph (A) of this paragraph in the same manner as that subparagraph (B) applies to paragraph (3)(A).

(C) NO APPLICATION TO ALLOTMENTS AFTER FISCAL YEAR 2002.—The DSH allotment for any State for fiscal year 2003 or any succeeding fiscal year shall be determined under paragraph (3) without regard to the DSH allotments determined under subparagraph (A) of this paragraph.

(5) SPECIAL RULE FOR LOW DSH STATES.—

(A) FOR FISCAL YEARS 2001 THROUGH 2003 FOR EXTREMELY LOW DSH STATES.—In the case of a State in which the total expenditures under the State plan (including Federal and State shares) for disproportionate share hospital adjustments under this section for fiscal year 1999, as reported to the Administrator of the Health Care Financing Administration as of August 31, 2000, is greater than 0 but less than 1 percent of the State's total amount of expenditures under the State plan for medical assistance during the fiscal year, the DSH allotment for fiscal year 2001 shall be increased to 1 percent of the State's total amount of expenditures under such plan for such assistance during such fiscal year. In subsequent fiscal years before fiscal year 2004, such increased allotment is subject to an increase for inflation as provided in paragraph (3)(A).

(B) FOR FISCAL YEAR 2004 AND SUBSEQUENT FISCAL YEARS.—In the case of a State in which the total expenditures under the State plan (including Federal and State shares) for disproportionate share hospital adjustments under this section for fiscal year 2000, as reported to the Administrator of the Centers for Medicare & Medicaid Services as of August 31, 2003, is greater than 0 but less than 3 percent of the State's total amount of expenditures under the State plan for medical assistance during the fiscal year, the DSH allotment for the State with respect to—

(i) fiscal year 2004 shall be the DSH allotment for the State for fiscal year 2003 increased by 16 percent;

(ii) each succeeding fiscal year before fiscal year 2009 shall be the DSH allotment for the State for the previous fiscal year increased by 16 percent; and

(iii) fiscal year 2009 and any subsequent fiscal year, shall be the DSH allotment for the State for the previous year subject to an increase for inflation as provided in paragraph (3)(A).

(6) ALLOTMENT ADJUSTMENTS.—

(A) TENNESSEE.—

(i) IN GENERAL.—Only with respect to fiscal year 2007, the DSH allotment for Tennessee for such fiscal year, notwithstanding the table set forth in paragraph (2) or the terms of the TennCare Demonstration Project in effect for the State, shall be the greater of—

(I) the amount that the Secretary determines is equal to the Federal medical assistance percentage component attributable to disproportionate share hospital payment adjustments for the demonstration year ending in 2006 that is reflected in the budget neutrality provision of the TennCare Demonstration Project; and

(II) \$280,000,000.

Only with respect to fiscal years 2008, 2009, 2010, and 2011, the DSH allotment for Tennessee for the fiscal year, notwithstanding such table or terms, shall be the amount specified in the previous sentence for fiscal year 2007. Only with respect to fiscal year 2012 for the period ending on December 31, 2011, the DSH allotment for Tennessee for such portion of the fiscal year, notwithstanding such table or terms, shall be $\frac{1}{4}$ of the amount specified in the first sentence for fiscal year 2007.

(ii) LIMITATION ON AMOUNT OF PAYMENT ADJUSTMENTS ELIGIBLE FOR FEDERAL FINANCIAL PARTICIPATION.—Payment under section 1903(a) shall not be made to Tennessee with respect to the aggregate amount of any payment adjustments made under this section for hospitals in the State for fiscal year 2007, 2008, 2009, 2010, 2011, or for period in fiscal year 2012 described in clause (i) that is in excess of 30 percent of the DSH allotment for the State for such fiscal year or period determined pursuant to clause (i).

(iii) STATE PLAN AMENDMENT.—The Secretary shall permit Tennessee to submit an amendment to its State plan under this title that describes the methodology to be used by the State to identify and make payments to disproportionate share hospitals, including children's hospitals and institutions for mental diseases or other mental health facilities. The Secretary may not approve such plan amendment unless the methodology described in the amendment is consistent with the requirements under this section for making payment adjustments to disproportionate share hospitals. For purposes of demonstrating budget neutrality under the TennCare Demonstration Project, payment adjustments made pursuant to a State plan amendment approved in accordance with this subparagraph shall be considered expenditures under such project.

(iv) OFFSET OF FEDERAL SHARE OF PAYMENT ADJUSTMENTS FOR FISCAL YEARS 2007 THROUGH 2011 AND THE FIRST CALENDAR QUARTER OF FISCAL YEAR 2012 AGAINST ESSENTIAL ACCESS HOSPITAL SUPPLEMENTAL POOL PAY-

MENTS UNDER THE TENNCARE DEMONSTRATION PROJECT.—

(I) The total amount of Essential Access Hospital supplemental pool payments that may be made under the TennCare Demonstration Project for fiscal year 2007, 2008, 2009, 2010, 2011, or for a period in fiscal year 2012 described in clause (i) shall be reduced on a dollar for dollar basis by the amount of any payments made under section 1903(a) to Tennessee with respect to payment adjustments made under this section for hospitals in the State for such fiscal year or period.

(II) The sum of the total amount of payments made under section 1903(a) to Tennessee with respect to payment adjustments made under this section for hospitals in the State for fiscal year 2007, 2008, 2009, 2010, 2011, or for a period in fiscal year 2012 described in clause (i) and the total amount of Essential Access Hospital supplemental pool payments made under the TennCare Demonstration Project for such fiscal year or period shall not exceed the State's DSH allotment for such fiscal or period year established under clause (i).

(v) ALLOTMENT FOR 2D, 3RD, AND 4TH QUARTERS OF FISCAL YEAR 2012 AND FOR FISCAL YEAR 2013.—Notwithstanding the table set forth in paragraph (2):

(I) 2D, 3RD, AND 4TH QUARTERS OF FISCAL YEAR 2012.—In the case of a State that has a DSH allotment of \$0 for the 2d, 3rd, and 4th quarters of fiscal year 2012, the DSH allotment shall be \$47,200,000 for such quarters.

(II) FISCAL YEAR 2013.—In the case of a State that has a DSH allotment of \$0 for fiscal year 2013, the DSH allotment shall be \$53,100,000 for such fiscal year.

(vi) ALLOTMENT FOR FISCAL YEARS 2015 THROUGH 2025.—Notwithstanding any other provision of this subsection, any other provision of law, or the terms of the TennCare Demonstration Project in effect for the State, the DSH allotment for Tennessee for fiscal year 2015, and for each fiscal year thereafter through fiscal year 2025, shall be \$53,100,000 for each such fiscal year.

(B) HAWAII.—

(i) IN GENERAL.—Only with respect to each of fiscal years 2007 through 2011, the DSH allotment for Hawaii for such fiscal year, notwithstanding the table set forth in paragraph (2), shall be \$10,000,000. Only with respect to fiscal year 2012 for the period ending on December 31, 2011, the DSH allotment for Hawaii for such portion of the fiscal year, notwithstanding the table set forth in paragraph (2), shall be \$2,500,000.

(ii) STATE PLAN AMENDMENT.—The Secretary shall permit Hawaii to submit an amendment to its State

plan under this title that describes the methodology to be used by the State to identify and make payments to disproportionate share hospitals, including children's hospitals and institutions for mental diseases or other mental health facilities. The Secretary may not approve such plan amendment unless the methodology described in the amendment is consistent with the requirements under this section for making payment adjustments to disproportionate share hospitals.

(iii) ALLOTMENT FOR 2D, 3RD, AND 4TH QUARTER OF FISCAL YEAR 2012, FISCAL YEAR 2013, AND SUCCEEDING FISCAL YEARS.—Notwithstanding the table set forth in paragraph (2):

(I) 2D, 3RD, AND 4TH QUARTER OF FISCAL YEAR 2012.—The DSH allotment for Hawaii for the 2d, 3rd, and 4th quarters of fiscal year 2012 shall be \$7,500,000.

(II) TREATMENT AS A LOW-DSH STATE FOR FISCAL YEAR 2013 AND SUCCEEDING FISCAL YEARS.—With respect to fiscal year 2013, and each fiscal year thereafter, the DSH allotment for Hawaii shall be increased in the same manner as allotments for low DSH States are increased for such fiscal year under clause (iii) of paragraph (5)(B).

(III) CERTAIN HOSPITAL PAYMENTS.—The Secretary may not impose a limitation on the total amount of payments made to hospitals under the QUEST section 1115 Demonstration Project except to the extent that such limitation is necessary to ensure that a hospital does not receive payments in excess of the amounts described in subsection (g), or as necessary to ensure that such payments under the waiver and such payments pursuant to the allotment provided in this clause do not, in the aggregate in any year, exceed the amount that the Secretary determines is equal to the Federal medical assistance percentage component attributable to disproportionate share hospital payment adjustments for such year that is reflected in the budget neutrality provision of the QUEST Demonstration Project.

(7) MEDICAID DSH REDUCTIONS.—

(A) REDUCTIONS.—

(i) IN GENERAL.—For each of fiscal years 2018 through 2025 the Secretary shall effect the following reductions:

(I) REDUCTION IN DSH ALLOTMENTS.—The Secretary shall reduce DSH allotments to States in the amount specified under the DSH health reform methodology under subparagraph (B) for the State for the fiscal year.

(II) REDUCTIONS IN PAYMENTS.—The Secretary shall reduce payments to States under section 1903(a) for each calendar quarter in the fiscal year, in the manner specified in clause (iii), in an

amount equal to $\frac{1}{4}$ of the DSH allotment reduction under subclause (I) for the State for the fiscal year.

(ii) AGGREGATE REDUCTIONS.—The aggregate reductions in DSH allotments for all States under clause (i)(I) shall be equal to—

- [(I) \$2,000,000,000 for fiscal year 2018;]
- [(II)] (I) \$3,000,000,000 for fiscal year 2019;
- [(III)] (II) \$4,000,000,000 for fiscal year 2020;
- [(IV)] (III) \$5,000,000,000 for fiscal year 2021;
- [(V)] (IV) \$6,000,000,000 for fiscal year 2022;
- [(VI)] (V) \$7,000,000,000 for fiscal year 2023;
- [(VII)] (VI) \$8,000,000,000 for fiscal year 2024;
- [and]
- [(VIII)] (VII) \$8,000,000,000 for fiscal year 2025[.];
- (VIII) \$8,000,000,000 for fiscal year 2026; and
- (IX) \$8,000,000,000 for fiscal year 2027.

(iii) MANNER OF PAYMENT REDUCTION.—The amount of the payment reduction under clause (i)(II) for a State for a quarter shall be deemed an overpayment to the State under this title to be disallowed against the State’s regular quarterly draw for all spending under section 1903(d)(2). Such a disallowance is not subject to a reconsideration under subsections (d) and (e) of section 1116.

(iv) DEFINITION.—In this paragraph, the term “State” means the 50 States and the District of Columbia.

(v) DISTRIBUTION OF AGGREGATE REDUCTIONS.—The Secretary shall distribute the aggregate reductions under clause (ii) among States in accordance with subparagraph (B).

(B) DSH HEALTH REFORM METHODOLOGY.—The Secretary shall carry out subparagraph (A) through use of a DSH Health Reform methodology that meets the following requirements:

(i) The methodology imposes the largest percentage reductions on the States that—

(I) have the lowest percentages of uninsured individuals (determined on the basis of data from the Bureau of the Census, audited hospital cost reports, and other information likely to yield accurate data) during the most recent year for which such data are available; or

(II) do not target their DSH payments on—

(aa) hospitals with high volumes of Medicaid inpatients (as defined in subsection (b)(1)(A)); and

(bb) hospitals that have high levels of uncompensated care (excluding bad debt).

(ii) The methodology imposes a smaller percentage reduction on low DSH States described in paragraph (5)(B).

(iii) The methodology takes into account the extent to which the DSH allotment for a State was included in the budget neutrality calculation for a coverage expansion approved under section 1115 as of July 31, 2009.

(8) CALCULATION OF DSH ALLOTMENTS AFTER REDUCTIONS PERIOD.—The DSH allotment for a State for fiscal years after fiscal year 2025 shall be calculated under paragraph (3) without regard to paragraph (7).

(9) DEFINITION OF STATE.—In this subsection, the term “State” means the 50 States and the District of Columbia.

(g) LIMIT ON AMOUNT OF PAYMENT TO HOSPITAL.—

(1) AMOUNT OF ADJUSTMENT SUBJECT TO UNCOMPENSATED COSTS.—

(A) IN GENERAL.—A payment adjustment during a fiscal year shall not be considered to be consistent with subsection (c) with respect to a hospital if the payment adjustment exceeds the costs incurred during the year of furnishing hospital services (as determined by the Secretary and net of payments under this title, other than under this section, and by uninsured patients) by the hospital to individuals who either are eligible for medical assistance under the State plan or have no health insurance (or other source of third party coverage) for services provided during the year. For purposes of the preceding sentence, payments made to a hospital for services provided to indigent patients made by a State or a unit of local government within a State shall not be considered to be a source of third party payment.

(B) LIMIT TO PUBLIC HOSPITALS DURING TRANSITION PERIOD.—With respect to payment adjustments during a State fiscal year that begins before January 1, 1995, subparagraph (A) shall apply only to hospitals owned or operated by a State (or by an instrumentality or a unit of government within a State).

(C) MODIFICATIONS FOR PRIVATE HOSPITALS.—With respect to hospitals that are not owned or operated by a State (or by an instrumentality or a unit of government within a State), the Secretary may make such modifications to the manner in which the limitation on payment adjustments is applied to such hospitals as the Secretary considers appropriate.

(2) ADDITIONAL AMOUNT DURING TRANSITION PERIOD FOR CERTAIN HOSPITALS WITH HIGH DISPROPORTIONATE SHARE.—

(A) IN GENERAL.—In the case of a hospital with high disproportionate share (as defined in subparagraph (B)), a payment adjustment during a State fiscal year that begins before January 1, 1995, shall be considered consistent with subsection (c) if the payment adjustment does not exceed 200 percent of the costs of furnishing hospital services described in paragraph (1)(A) during the year, but only if the Governor of the State certifies to the satisfaction of the Secretary that the hospital’s applicable minimum amount is used for health services during the year. In determining the amount that is used for such services during a year,

there shall be excluded any amounts received under the Public Health Service Act, title V, title XVIII, or from third party payors (not including the State plan under this title) that are used for providing such services during the year.

(B) HOSPITALS WITH HIGH DISPROPORTIONATE SHARE DEFINED.—In subparagraph (A), a hospital is a “hospital with high disproportionate share” if—

(i) the hospital is owned or operated by a State (or by an instrumentality or a unit of government within a State); and

(ii) the hospital—

(I) meets the requirement described in subsection (b)(1)(A), or

(II) has the largest number of inpatient days attributable to individuals entitled to benefits under the State plan of any hospital in such State for the previous State fiscal year.

(C) APPLICABLE MINIMUM AMOUNT DEFINED.—In subparagraph (A), the “applicable minimum amount” for a hospital for a fiscal year is equal to the difference between the amount of the hospital’s payment adjustment for the fiscal year and the costs to the hospital of furnishing hospital services described in paragraph (1)(A) during the fiscal year.

(h) LIMITATION ON CERTAIN STATE DSH EXPENDITURES.—

(1) IN GENERAL.—Payment under section 1903(a) shall not be made to a State with respect to any payment adjustments made under this section for quarters in a fiscal year (beginning with fiscal year 1998) to institutions for mental diseases or other mental health facilities, to the extent the aggregate of such adjustments in the fiscal year exceeds the lesser of the following:

(A) 1995 IMD DSH PAYMENT ADJUSTMENTS.—The total State DSH expenditures that are attributable to fiscal year 1995 for payments to institutions for mental diseases and other mental health facilities (based on reporting data specified by the State on HCFA Form 64 as mental health DSH, and as approved by the Secretary).

(B) APPLICABLE PERCENTAGE OF 1995 TOTAL DSH PAYMENT ALLOTMENT.—The amount of such payment adjustments which are equal to the applicable percentage of the Federal share of payment adjustments made to hospitals in the State under subsection (c) that are attributable to the 1995 DSH allotment for the State for payments to institutions for mental diseases and other mental health facilities (based on reporting data specified by the State on HCFA Form 64 as mental health DSH, and as approved by the Secretary).

(2) APPLICABLE PERCENTAGE.—

(A) IN GENERAL.—For purposes of paragraph (1), the applicable percentage with respect to—

(i) each of fiscal years 1998, 1999, and 2000, is the percentage determined under subparagraph (B); or

(ii) a succeeding fiscal year is the lesser of the percentage determined under subparagraph (B) or the following percentage:

(I) For fiscal year 2001, 50 percent.

(II) For fiscal year 2002, 40 percent.

(III) For each succeeding fiscal year, 33 percent.

(B) 1995 PERCENTAGE.—The percentage determined under this subparagraph is the ratio (determined as a percentage) of—

(i) the Federal share of payment adjustments made to hospitals in the State under subsection (c) that are attributable to the 1995 DSH allotment for the State (as reported by the State not later than January 1, 1997, on HCFA Form 64, and as approved by the Secretary) for payments to institutions for mental diseases and other mental health facilities, to

(ii) the State 1995 DSH spending amount.

(C) STATE 1995 DSH SPENDING AMOUNT.—For purposes of subparagraph (B)(ii), the “State 1995 DSH spending amount”, with respect to a State, is the Federal medical assistance percentage (for fiscal year 1995) of the payment adjustments made under subsection (c) under the State plan that are attributable to the fiscal year 1995 DSH allotment for the State (as reported by the State not later than January 1, 1997, on HCFA Form 64, and as approved by the Secretary).

(i) REQUIREMENT FOR DIRECT PAYMENT.—

(1) IN GENERAL.—No payment may be made under section 1903(a)(1) with respect to a payment adjustment made under this section, for services furnished by a hospital on or after October 1, 1997, with respect to individuals eligible for medical assistance under the State plan who are enrolled with a managed care entity (as defined in section 1932(a)(1)(B)) or under any other managed care arrangement unless a payment, equal to the amount of the payment adjustment—

(A) is made directly to the hospital by the State; and

(B) is not used to determine the amount of a prepaid capitation payment under the State plan to the entity or arrangement with respect to such individuals.

(2) EXCEPTION FOR CURRENT ARRANGEMENTS.—Paragraph (1) shall not apply to a payment adjustment provided pursuant to a payment arrangement in effect on July 1, 1997.

(j) ANNUAL REPORTS AND OTHER REQUIREMENTS REGARDING PAYMENT ADJUSTMENTS.—With respect to fiscal year 2004 and each fiscal year thereafter, the Secretary shall require a State, as a condition of receiving a payment under section 1903(a)(1) with respect to a payment adjustment made under this section, to do the following:

(1) REPORT.—The State shall submit an annual report that includes the following:

(A) An identification of each disproportionate share hospital that received a payment adjustment under this section for the preceding fiscal year and the amount of the payment adjustment made to such hospital for the preceding fiscal year.

(B) Such other information as the Secretary determines necessary to ensure the appropriateness of the payment adjustments made under this section for the preceding fiscal year.

(2) INDEPENDENT CERTIFIED AUDIT.—The State shall annually submit to the Secretary an independent certified audit that verifies each of the following:

(A) The extent to which hospitals in the State have reduced their uncompensated care costs to reflect the total amount of claimed expenditures made under this section.

(B) Payments under this section to hospitals that comply with the requirements of subsection (g).

(C) Only the uncompensated care costs of providing inpatient hospital and outpatient hospital services to individuals described in paragraph (1)(A) of such subsection are included in the calculation of the hospital-specific limits under such subsection.

(D) The State included all payments under this title, including supplemental payments, in the calculation of such hospital-specific limits.

(E) The State has separately documented and retained a record of all of its costs under this title, claimed expenditures under this title, uninsured costs in determining payment adjustments under this section, and any payments made on behalf of the uninsured from payment adjustments under this section.

* * * * *

MEDICAID INTEGRITY PROGRAM

SEC. 1936. (a) IN GENERAL.—There is hereby established the Medicaid Integrity Program (in this section referred to as the “Program”) under which the Secretary shall promote the integrity of the program under this title by entering into contracts in accordance with this section with eligible entities, or otherwise, to carry out the activities described in subsection (b).

(b) ACTIVITIES DESCRIBED.—Activities described in this subsection are as follows:

(1) Review of the actions of individuals or entities furnishing items or services (whether on a fee-for-service, risk, or other basis) for which payment may be made under a State plan approved under this title (or under any waiver of such plan approved under section 1115) to determine whether fraud, waste, or abuse has occurred, is likely to occur, or whether such actions have any potential for resulting in an expenditure of funds under this title in a manner which is not intended under the provisions of this title.

(2) Audit of claims for payment for items or services furnished, or administrative services rendered, under a State plan under this title, including—

(A) cost reports;

(B) consulting contracts; and

(C) risk contracts under section 1903(m).

(3) Identification of overpayments to individuals or entities receiving Federal funds under this title.

(4) Education or training, including at such national, State, or regional conferences as the Secretary may establish, of State or local officers, employees, or independent contractors responsible for the administration or the supervision of the administration of the State plan under this title, providers of services, managed care entities, beneficiaries, and other individuals with respect to payment integrity **[and quality of care]**, *quality of care, and the liability of responsible third parties (as defined in section 1902(nn))*.

(c) ELIGIBLE ENTITY AND CONTRACTING REQUIREMENTS.—

(1) IN GENERAL.—An entity is eligible to enter into a contract under the Program to carry out any of the activities described in subsection (b) if the entity satisfies the requirements of paragraphs (2) and (3).

(2) ELIGIBILITY REQUIREMENTS.—The requirements of this paragraph are the following:

(A) The entity has demonstrated capability to carry out the activities described in subsection (b).

(B) In carrying out such activities, the entity agrees to cooperate with the Inspector General of the Department of Health and Human Services, the Attorney General, and other law enforcement agencies, as appropriate, in the investigation and deterrence of fraud and abuse in relation to this title and in other cases arising out of such activities.

(C) The entity complies with such conflict of interest standards as are generally applicable to Federal acquisition and procurement.

(D) The entity agrees to provide the Secretary and the Inspector General of the Department of Health and Human Services with such performance statistics (including the number and amount of overpayments recovered, the number of fraud referrals, and the return on investment of such activities by the entity) as the Secretary or the Inspector General may request.

(E) The entity meets such other requirements as the Secretary may impose.

(3) CONTRACTING REQUIREMENTS.—The entity has contracted with the Secretary in accordance with such procedures as the Secretary shall by regulation establish, except that such procedures shall include the following:

(A) Procedures for identifying, evaluating, and resolving organizational conflicts of interest that are generally applicable to Federal acquisition and procurement.

(B) Competitive procedures to be used—

(i) when entering into new contracts under this section;

(ii) when entering into contracts that may result in the elimination of responsibilities under section 202(b) of the Health Insurance Portability and Accountability Act of 1996; and

(iii) at any other time considered appropriate by the Secretary.

(C) Procedures under which a contract under this section may be renewed without regard to any provision of law re-

quiring competition if the contractor has met or exceeded the performance requirements established in the current contract.

The Secretary may enter into such contracts without regard to final rules having been promulgated.

(4) LIMITATION ON CONTRACTOR LIABILITY.—The Secretary shall by regulation provide for the limitation of a contractor's liability for actions taken to carry out a contract under the Program, and such regulation shall, to the extent the Secretary finds appropriate, employ the same or comparable standards and other substantive and procedural provisions as are contained in section 1157.

(d) COMPREHENSIVE PLAN FOR PROGRAM INTEGRITY.—

(1) 5-YEAR PLAN.—With respect to the 5-fiscal year period beginning with fiscal year 2006, and each such 5-fiscal year period that begins thereafter, the Secretary shall establish a comprehensive plan for ensuring the integrity of the program established under this title by combatting fraud, waste, and abuse.

(2) CONSULTATION.—Each 5-fiscal year plan established under paragraph (1) shall be developed by the Secretary in consultation with the Attorney General, the Director of the Federal Bureau of Investigation, the Comptroller General of the United States, the Inspector General of the Department of Health and Human Services, and State officials with responsibility for controlling provider fraud and abuse under State plans under this title.

(e) APPROPRIATION.—

(1) IN GENERAL.—Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated to carry out the Medicaid Integrity Program under this section (including the costs of equipment, salaries and benefits, and travel and training), without further appropriation—

(A) for fiscal year 2006, \$5,000,000;

(B) for each of fiscal years 2007 and 2008, \$50,000,000;

(C) for each of fiscal years 2009 and 2010, \$75,000,000;

and

(D) for each fiscal year after fiscal year 2010, the amount appropriated under this paragraph for the previous fiscal year, increased by the percentage increase in the consumer price index for all urban consumers (all items; United States city average) over the previous year.

(2) AVAILABILITY; AUTHORITY FOR USE OF FUNDS.—

(A) AVAILABILITY.—Amounts appropriated pursuant to paragraph (1) shall remain available until expended.

(B) AUTHORITY FOR USE OF FUNDS FOR TRANSPORTATION AND TRAVEL EXPENSES FOR ATTENDEES AT EDUCATION, TRAINING, OR CONSULTATIVE ACTIVITIES.—

(i) IN GENERAL.—The Secretary may use amounts appropriated pursuant to paragraph (1) to pay for transportation and the travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business, of individuals de-

scribed in subsection (b)(4) who attend education, training, or consultative activities conducted under the authority of that subsection.

(ii) PUBLIC DISCLOSURE.—The Secretary shall make available on a website of the Centers for Medicare & Medicaid Services that is accessible to the public—

(I) the total amount of funds expended for each conference conducted under the authority of subsection (b)(4); and

(II) the amount of funds expended for each such conference that were for transportation and for travel expenses.

(3) INCREASE IN CMS STAFFING DEVOTED TO PROTECTING MEDICAID PROGRAM INTEGRITY.—From the amounts appropriated under paragraph (1), the Secretary shall increase by 100, or such number as determined necessary by the Secretary to carry out the Program, the number of full-time equivalent employees whose duties consist solely of protecting the integrity of the Medicaid program established under this section by providing effective support and assistance to States to combat provider fraud and abuse.

(4) EVALUATIONS.—The Secretary shall conduct evaluations of eligible entities which the Secretary contracts with under the Program not less frequently than every 3 years.

(5) ANNUAL REPORT.—Not later than 180 days after the end of each fiscal year (beginning with fiscal year 2006), the Secretary shall submit a report to Congress which identifies—

(A) the use of funds appropriated pursuant to paragraph (1); and

(B) the effectiveness of the use of such funds.

(f) *THIRD PARTY LIABILITY TRAINING.*—*With respect to education or training activities carried out pursuant to subsection (b)(4) with respect to the liability of responsible third parties (as defined in section 1902(nn) for payment for items and services furnished under State plans (or under waivers of such plans)) under this title, the Secretary shall—*

(1) publish (and update on an annual basis) on the public Internet website of the Centers for Medicare & Medicaid Services a dedicated Internet page containing best practices to be used in assessing such liability;

(2) monitor efforts to assess such liability and analyze the challenges posed by that assessment;

(3) distribute to State agencies administering the State plan under this title information related to such efforts and challenges; and

(4) provide guidance to such State agencies with respect to State oversight of efforts under a medicaid managed care plan under section 1903(m) or 1932 to assess such liability.

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TITLE XXI—STATE CHILDREN'S HEALTH INSURANCE PROGRAM

* * * * *

SEC. 2104. ALLOTMENTS.

(a) APPROPRIATION; TOTAL ALLOTMENT.—For the purpose of providing allotments to States under this section, subject to subsection (d), there is appropriated, out of any money in the Treasury not otherwise appropriated—

- (1) for fiscal year 1998, \$4,295,000,000;
- (2) for fiscal year 1999, \$4,275,000,000;
- (3) for fiscal year 2000, \$4,275,000,000;
- (4) for fiscal year 2001, \$4,275,000,000;
- (5) for fiscal year 2002, \$3,150,000,000;
- (6) for fiscal year 2003, \$3,150,000,000;
- (7) for fiscal year 2004, \$3,150,000,000;
- (8) for fiscal year 2005, \$4,050,000,000;
- (9) for fiscal year 2006, \$4,050,000,000;
- (10) for fiscal year 2007, \$5,000,000,000;
- (11) for fiscal year 2008, \$5,000,000,000.
- (12) for fiscal year 2009, \$10,562,000,000;
- (13) for fiscal year 2010, \$12,520,000,000;
- (14) for fiscal year 2011, \$13,459,000,000;
- (15) for fiscal year 2012, \$14,982,000,000;
- (16) for fiscal year 2013, \$17,406,000,000;
- (17) for fiscal year 2014, \$19,147,000,000;
- (18) for fiscal year 2015, for purposes of making 2 semi-annual allotments—
 - (A) \$2,850,000,000 for the period beginning on October 1, 2014, and ending on March 31, 2015, and
 - (B) \$2,850,000,000 for the period beginning on April 1, 2015, and ending on September 30, 2015;
- (19) for fiscal year 2016, \$19,300,000,000; **[and]**
- (20) for fiscal year 2017, for purposes of making 2 semi-annual allotments—
 - (A) \$2,850,000,000 for the period beginning on October 1, 2016, and ending on March 31, 2017; and
 - (B) \$2,850,000,000 for the period beginning on April 1, 2017, and ending on September 30, 2017**[.]**;
- (21) for fiscal year 2018, \$21,500,000,000;
- (22) for fiscal year 2019, \$22,600,000,000;
- (23) for fiscal year 2020, \$23,700,000,000;
- (24) for fiscal year 2021, \$24,800,000,000; and
- (25) for fiscal year 2022, for purposes of making 2 semi-annual allotments—
 - (A) \$2,850,000,000 for the period beginning on October 1, 2021, and ending on March 31, 2022; and
 - (B) \$2,850,000,000 for the period beginning on April 1, 2022, and ending on September 30, 2022.

(b) ALLOTMENTS TO 50 STATES AND DISTRICT OF COLUMBIA.—

(1) IN GENERAL.—Subject to paragraph (4) and subsections (d) and (m), of the amount available for allotment under subsection (a) for a fiscal year, reduced by the amount of allotments made under subsection (c) (determined without regard to paragraph (4) thereof) for the fiscal year, the Secretary shall allot to each State (other than a State described in such subsection) with a State child health plan approved under this title the same proportion as the ratio of—

(A) the product of (i) the number of children described in paragraph (2) for the State for the fiscal year and (ii) the State cost factor for that State (established under paragraph (3)); to

(B) the sum of the products computed under subparagraph (A).

(2) NUMBER OF CHILDREN.—

(A) IN GENERAL.—The number of children described in this paragraph for a State for—

(i) each of fiscal years 1998 and 1999 is equal to the number of low-income children in the State with no health insurance coverage for the fiscal year;

(ii) fiscal year 2000 is equal to—

(I) 75 percent of the number of low-income children in the State for the fiscal year with no health insurance coverage, plus

(II) 25 percent of the number of low-income children in the State for the fiscal year; and

(iii) each succeeding fiscal year is equal to—

(I) 50 percent of the number of low-income children in the State for the fiscal year with no health insurance coverage, plus

(II) 50 percent of the number of low-income children in the State for the fiscal year.

(B) DETERMINATION OF NUMBER OF CHILDREN.—For purposes of subparagraph (A), a determination of the number of low-income children (and of such children who have no health insurance coverage) for a State for a fiscal year shall be made on the basis of the arithmetic average of the number of such children, as reported and defined in the 3 most recent March supplements to the Current Population Survey of the Bureau of the Census before the beginning of the calendar year in which such fiscal year begins.

(3) ADJUSTMENT FOR GEOGRAPHIC VARIATIONS IN HEALTH COSTS.—

(A) IN GENERAL.—For purposes of paragraph (1)(A)(ii), the “State cost factor” for a State for a fiscal year equal to the sum of—

(i) 0.15, and

(ii) 0.85 multiplied by the ratio of—

(I) the annual average wages per employee for the State for such year (as determined under subparagraph (B)), to

(II) the annual average wages per employee for the 50 States and the District of Columbia.

(B) ANNUAL AVERAGE WAGES PER EMPLOYEE.—For purposes of subparagraph (A), the “annual average wages per employee” for a State, or for all the States, for a fiscal year is equal to the average of the annual wages per employee for the State or for the 50 States and the District of Columbia for employees in the health services industry (SIC code 8000), as reported by the Bureau of Labor Statistics of the Department of Labor for each of the most recent 3 years before the beginning of the calendar year in which such fiscal year begins.

(4) FLOORS AND CEILINGS IN STATE ALLOTMENTS.—

(A) IN GENERAL.—The proportion of the allotment under this subsection for a subsection (b) State (as defined in subparagraph (D)) for fiscal year 2000 and each fiscal year thereafter shall be subject to the following floors and ceilings:

(i) FLOOR OF \$2,000,000.—A floor equal to \$2,000,000 divided by the total of the amount available under this subsection for all such allotments for the fiscal year.

(ii) ANNUAL FLOOR OF 10 PERCENT BELOW PRECEDING FISCAL YEAR'S PROPORTION.—A floor of 90 percent of the proportion for the State for the preceding fiscal year.

(iii) CUMULATIVE FLOOR OF 30 PERCENT BELOW THE FY 1999 PROPORTION.—A floor of 70 percent of the proportion for the State for fiscal year 1999.

(iv) CUMULATIVE CEILING OF 45 PERCENT ABOVE FY 1999 PROPORTION.—A ceiling of 145 percent of the proportion for the State for fiscal year 1999.

(B) RECONCILIATION.—

(i) ELIMINATION OF ANY DEFICIT BY ESTABLISHING A PERCENTAGE INCREASE CEILING FOR STATES WITH HIGHEST ANNUAL PERCENTAGE INCREASES.—To the extent that the application of subparagraph (A) would result in the sum of the proportions of the allotments for all subsection (b) States exceeding 1.0, the Secretary shall establish a maximum percentage increase in such proportions for all subsection (b) States for the fiscal year in a manner so that such sum equals 1.0.

(ii) ALLOCATION OF SURPLUS THROUGH PRO RATA INCREASE.—To the extent that the application of subparagraph (A) would result in the sum of the proportions of the allotments for all subsection (b) States being less than 1.0, the proportions of such allotments (as computed before the application of floors under clauses (i), (ii), and (iii) of subparagraph (A)) for all subsection (b) States shall be increased in a pro rata manner (but not to exceed the ceiling established under subparagraph (A)(iv)) so that (after the application of such floors and ceiling) such sum equals 1.0.

(C) CONSTRUCTION.—This paragraph shall not be construed as applying to (or taking into account) amounts of allotments redistributed under subsection (f).

(D) DEFINITIONS.—In this paragraph:

(i) PROPORTION OF ALLOTMENT.—The term “proportion” means, with respect to the allotment of a subsection (b) State for a fiscal year, the amount of the allotment of such State under this subsection for the fiscal year divided by the total of the amount available under this subsection for all such allotments for the fiscal year.

(ii) SUBSECTION (b) STATE.—The term “subsection (b) State” means one of the 50 States or the District of Columbia.

(c) ALLOTMENTS TO TERRITORIES.—

(1) IN GENERAL.—Of the amount available for allotment under subsection (a) for a fiscal year, subject to subsections (d) and (m)(5), the Secretary shall allot 0.25 percent among each of the commonwealths and territories described in paragraph (3) in the same proportion as the percentage specified in paragraph (2) for such commonwealth or territory bears to the sum of such percentages for all such commonwealths or territories so described.

(2) PERCENTAGE.—The percentage specified in this paragraph for—

- (A) Puerto Rico is 91.6 percent,
- (B) Guam is 3.5 percent,
- (C) the Virgin Islands is 2.6 percent,
- (D) American Samoa is 1.2 percent, and
- (E) the Northern Mariana Islands is 1.1 percent.

(3) COMMONWEALTHS AND TERRITORIES.—A commonwealth or territory described in this paragraph is any of the following if it has a State child health plan approved under this title:

- (A) Puerto Rico.
- (B) Guam.
- (C) The Virgin Islands.
- (D) American Samoa.
- (E) The Northern Mariana Islands.

(4) ADDITIONAL ALLOTMENT.—

(A) IN GENERAL.—In addition to the allotment under paragraph (1), the Secretary shall allot each commonwealth and territory described in paragraph (3) the applicable percentage specified in paragraph (2) of the amount appropriated under subparagraph (B).

(B) APPROPRIATIONS.—For purposes of providing allotments pursuant to subparagraph (A), there is appropriated, out of any money in the Treasury not otherwise appropriated \$32,000,000 for fiscal year 1999, \$34,200,000 for each of fiscal years 2000 and 2001, \$25,200,000 for each of fiscal years 2002 through 2004, \$32,400,000 for each of fiscal years 2005 and 2006, and \$40,000,000 for each of fiscal years 2007 through 2009.

(d) ADDITIONAL ALLOTMENTS TO ELIMINATE FUNDING SHORTFALLS.—

(1) APPROPRIATION; ALLOTMENT AUTHORITY.—For the purpose of providing additional allotments to shortfall States described in paragraph (2), there is appropriated, out of any money in the Treasury not otherwise appropriated, \$283,000,000 for fiscal year 2006.

(2) SHORTFALL STATES DESCRIBED.—For purposes of paragraph (1), a shortfall State described in this paragraph is a State with a State child health plan approved under this title for which the Secretary estimates, on the basis of the most recent data available to the Secretary as of December 16, 2005, that the projected expenditures under such plan for such State for fiscal year 2006 will exceed the sum of—

- (A) the amount of the State's allotments for each of fiscal years 2004 and 2005 that will not be expended by the end of fiscal year 2005;

(B) the amount, if any, that is to be redistributed to the State during fiscal year 2006 in accordance with subsection (f); and

(C) the amount of the State's allotment for fiscal year 2006.

(3) ALLOTMENTS.—In addition to the allotments provided under subsections (b) and (c), subject to paragraph (4), of the amount available for the additional allotments under paragraph (1) for fiscal year 2006, the Secretary shall allot—

(A) to each shortfall State described in paragraph (2) such amount as the Secretary determines will eliminate the estimated shortfall described in such paragraph for the State; and

(B) to each commonwealth or territory described in subsection (c)(3), the same proportion as the proportion of the commonwealth's or territory's allotment under subsection (c) (determined without regard to subsection (f)) to 1.05 percent of the amount appropriated under paragraph (1).

(4) USE OF ADDITIONAL ALLOTMENT.—Additional allotments provided under this subsection are only available for amounts expended under a State plan approved under this title for child health assistance for targeted low-income children.

(5) 1-YEAR AVAILABILITY; NO REDISTRIBUTION OF UNEXPENDED ADDITIONAL ALLOTMENTS.—Notwithstanding subsections (e) and (f), amounts allotted to a State pursuant to this subsection for fiscal year 2006 shall only remain available for expenditure by the State through September 30, 2006. Any amounts of such allotments that remain unexpended as of such date shall not be subject to redistribution under subsection (f) and shall revert to the Treasury on October 1, 2006.

(e) AVAILABILITY OF AMOUNTS ALLOTTED.—

(1) IN GENERAL.—Except as provided in paragraph (2), amounts allotted to a State pursuant to this section—

(A) for each of fiscal years 1998 through 2008, shall remain available for expenditure by the State through the end of the second succeeding fiscal year; and

(B) for fiscal year 2009 and each fiscal year thereafter, shall remain available for expenditure by the State through the end of the succeeding fiscal year.

(2) AVAILABILITY OF AMOUNTS REDISTRIBUTED.—Amounts redistributed to a State under subsection (f) shall be available for expenditure by the State through the end of the fiscal year in which they are redistributed.

(f) PROCEDURE FOR REDISTRIBUTION OF UNUSED ALLOTMENTS.—

(1) IN GENERAL.—The Secretary shall determine an appropriate procedure for redistribution of allotments from States that were provided allotments under this section for a fiscal year but that do not expend all of the amount of such allotments during the period in which such allotments are available for expenditure under subsection (e), to States that the Secretary determines with respect to the fiscal year for which unused allotments are available for redistribution under this subsection, are shortfall States described in paragraph (2) for such fiscal year, but not to exceed the amount of the shortfall de-

scribed in paragraph (2)(A) for each such State (as may be adjusted under paragraph (2)(C)).

(2) SHORTFALL STATES DESCRIBED.—

(A) IN GENERAL.—For purposes of paragraph (1), with respect to a fiscal year, a shortfall State described in this subparagraph is a State with a State child health plan approved under this title for which the Secretary estimates on the basis of the most recent data available to the Secretary, that the projected expenditures under such plan for the State for the fiscal year will exceed the sum of—

(i) the amount of the State's allotments for any preceding fiscal years that remains available for expenditure and that will not be expended by the end of the immediately preceding fiscal year;

(ii) the amount (if any) of the child enrollment contingency fund payment under subsection (n); and

(iii) the amount of the State's allotment for the fiscal year.

(B) PRORATION RULE.—If the amounts available for redistribution under paragraph (1) for a fiscal year are less than the total amounts of the estimated shortfalls determined for the year under subparagraph (A), the amount to be redistributed under such paragraph for each shortfall State shall be reduced proportionally.

(C) RETROSPECTIVE ADJUSTMENT.—The Secretary may adjust the estimates and determinations made under paragraph (1) and this paragraph with respect to a fiscal year as necessary on the basis of the amounts reported by States not later than November 30 of the succeeding fiscal year, as approved by the Secretary.

(g) RULE FOR REDISTRIBUTION AND EXTENDED AVAILABILITY OF FISCAL YEARS 1998, 1999, 2000, AND 2001 ALLOTMENTS.—

(1) AMOUNT REDISTRIBUTED.—

(A) IN GENERAL.—In the case of a State that expends all of its allotment under subsection (b) or (c) for fiscal year 1998 by the end of fiscal year 2000, or for fiscal year 1999 by the end of fiscal year 2001, or for fiscal year 2000 by the end of fiscal year 2002, or for fiscal year 2001 by the end of fiscal year 2003, the Secretary shall redistribute to the State under subsection (f) (from the fiscal year 1998, 1999, 2000, or 2001 allotments of other States, respectively, as determined by the application of paragraphs (2) and (3) with respect to the respective fiscal year) the following amount:

(i) STATE.—In the case of one of the 50 States or the District of Columbia, with respect to—

(I) the fiscal year 1998 allotment, the amount by which the State's expenditures under this title in fiscal years 1998, 1999, and 2000 exceed the State's allotment for fiscal year 1998 under subsection (b);

(II) the fiscal year 1999 allotment, the amount by which the State's expenditures under this title in fiscal years 1999, 2000, and 2001 exceed the

State's allotment for fiscal year 1999 under subsection (b);

(III) the fiscal year 2000 allotment, the amount specified in subparagraph (C)(i) (less the total of the amounts under clause (ii) for such fiscal year), multiplied by the ratio of the amount specified in subparagraph (C)(ii) for the State to the amount specified in subparagraph (C)(iii); or

(IV) the fiscal year 2001 allotment, the amount specified in subparagraph (D)(i) (less the total of the amounts under clause (ii) for such fiscal year), multiplied by the ratio of the amount specified in subparagraph (D)(ii) for the State to the amount specified in subparagraph (D)(iii).

(ii) TERRITORY.—In the case of a commonwealth or territory described in subsection (c)(3), an amount that bears the same ratio to 1.05 percent of the total amount described in paragraph (2)(B)(i)(I) as the ratio of the commonwealth's or territory's fiscal year 1998, 1999, 2000, or 2001 allotment under subsection (c) (as the case may be) bears to the total of all such allotments for such fiscal year under such subsection.

(B) EXPENDITURE RULES.—An amount redistributed to a State under this paragraph—

(i) shall not be included in the determination of the State's allotment for any fiscal year under this section;

(ii) notwithstanding subsection (e), with respect to fiscal year 1998, 1999, or 2000, shall remain available for expenditure by the State through the end of fiscal year 2004;

(iii) notwithstanding subsection (e), with respect to fiscal year 2001, shall remain available for expenditure by the State through the end of fiscal year 2005; and

(iv) shall be counted as being expended with respect to a fiscal year allotment in accordance with applicable regulations of the Secretary.

(C) AMOUNTS USED IN COMPUTING REDISTRIBUTIONS FOR FISCAL YEAR 2000.—For purposes of subparagraph (A)(i)(III)—

(i) the amount specified in this clause is the amount specified in paragraph (2)(B)(i)(I) for fiscal year 2000, less the total amount remaining available pursuant to paragraph (2)(A)(iii);

(ii) the amount specified in this clause for a State is the amount by which the State's expenditures under this title in fiscal years 2000, 2001, and 2002 exceed the State's allotment for fiscal year 2000 under subsection (b); and

(iii) the amount specified in this clause is the sum, for all States entitled to a redistribution under subparagraph (A) from the allotments for fiscal year 2000, of the amounts specified in clause (ii).

(D) AMOUNTS USED IN COMPUTING REDISTRIBUTIONS FOR FISCAL YEAR 2001.—For purposes of subparagraph (A)(i)(IV)—

(i) the amount specified in this clause is the amount specified in paragraph (2)(B)(i)(I) for fiscal year 2001, less the total amount remaining available pursuant to paragraph (2)(A)(iv);

(ii) the amount specified in this clause for a State is the amount by which the State's expenditures under this title in fiscal years 2001, 2002, and 2003 exceed the State's allotment for fiscal year 2001 under subsection (b); and

(iii) the amount specified in this clause is the sum, for all States entitled to a redistribution under subparagraph (A) from the allotments for fiscal year 2001, of the amounts specified in clause (ii).

(2) EXTENSION OF AVAILABILITY OF PORTION OF UNEXPENDED FISCAL YEARS 1998 THROUGH 2001 ALLOTMENTS.—

(A) IN GENERAL.—Notwithstanding subsection (e):

(i) FISCAL YEAR 1998 ALLOTMENT.—Of the amounts allotted to a State pursuant to this section for fiscal year 1998 that were not expended by the State by the end of fiscal year 2000, the amount specified in subparagraph (B) for fiscal year 1998 for such State shall remain available for expenditure by the State through the end of fiscal year 2004.

(ii) FISCAL YEAR 1999 ALLOTMENT.—Of the amounts allotted to a State pursuant to this subsection for fiscal year 1999 that were not expended by the State by the end of fiscal year 2001, the amount specified in subparagraph (B) for fiscal year 1999 for such State shall remain available for expenditure by the State through the end of fiscal year 2004.

(iii) FISCAL YEAR 2000 ALLOTMENT.—Of the amounts allotted to a State pursuant to this section for fiscal year 2000 that were not expended by the State by the end of fiscal year 2002, 50 percent of that amount shall remain available for expenditure by the State through the end of fiscal year 2004.

(iv) FISCAL YEAR 2001 ALLOTMENT.—Of the amounts allotted to a State pursuant to this section for fiscal year 2001 that were not expended by the State by the end of fiscal year 2003, 50 percent of that amount shall remain available for expenditure by the State through the end of fiscal year 2005.

(B) AMOUNT REMAINING AVAILABLE FOR EXPENDITURE.—The amount specified in this subparagraph for a State for a fiscal year is equal to—

(i) the amount by which (I) the total amount available for redistribution under subsection (f) from the allotments for that fiscal year, exceeds (II) the total amounts redistributed under paragraph (1) for that fiscal year; multiplied by

(ii) the ratio of the amount of such State's unexpended allotment for that fiscal year to the total amount described in clause (i)(I) for that fiscal year.

(C) USE OF UP TO 10 PERCENT OF RETAINED 1998 ALLOTMENTS FOR OUTREACH ACTIVITIES.—Notwithstanding section 2105(c)(2)(A), with respect to any State described in subparagraph (A)(i), the State may use up to 10 percent of the amount specified in subparagraph (B) for fiscal year 1998 for expenditures for outreach activities approved by the Secretary.

(3) DETERMINATION OF AMOUNTS.—For purposes of calculating the amounts described in paragraphs (1) and (2) relating to the allotment for fiscal year 1998, fiscal year 1999, fiscal year 2000, or fiscal year 2001, the Secretary shall use the amounts reported by the States not later than December 15, 2000, November 30, 2001, November 30, 2002, or November 30, 2003, respectively, on HCFA Form 64 or HCFA Form 21 or CMS Form 64 or CMS Form 21, as the case may be, as approved by the Secretary.

(h) SPECIAL RULES TO ADDRESS FISCAL YEAR 2007 SHORTFALLS.—

(1) REDISTRIBUTION OF UNUSED FISCAL YEAR 2004 ALLOTMENTS.—

(A) IN GENERAL.—Notwithstanding subsection (f) and subject to subparagraphs (C) and (D), with respect to months beginning during fiscal year 2007, the Secretary shall provide for a redistribution under such subsection from the allotments for fiscal year 2004 under subsection (b) that are not expended by the end of fiscal year 2006, to a shortfall State described in subparagraph (B), such amount as the Secretary determines will eliminate the estimated shortfall described in such subparagraph for such State for the month.

(B) SHORTFALL STATE DESCRIBED.—For purposes of this paragraph, a shortfall State described in this subparagraph is a State with a State child health plan approved under this title for which the Secretary estimates, on a monthly basis using the most recent data available to the Secretary as of such month, that the projected expenditures under such plan for such State for fiscal year 2007 will exceed the sum of—

(i) the amount of the State's allotments for each of fiscal years 2005 and 2006 that was not expended by the end of fiscal year 2006; and

(ii) the amount of the State's allotment for fiscal year 2007.

(C) FUNDS REDISTRIBUTED IN THE ORDER IN WHICH STATES REALIZE FUNDING SHORTFALLS.—The Secretary shall redistribute the amounts available for redistribution under subparagraph (A) to shortfall States described in subparagraph (B) in the order in which such States realize monthly funding shortfalls under this title for fiscal year 2007. The Secretary shall only make redistributions under this paragraph to the extent that there are unexpended fiscal year 2004 allotments under subsection (b) available for such redistributions.

(D) PRORATION RULE.—If the amounts available for redistribution under subparagraph (A) for a month are less than the total amounts of the estimated shortfalls determined for the month under that subparagraph, the amount computed under such subparagraph for each shortfall State shall be reduced proportionally.

(2) FUNDING PART OF SHORTFALL FOR FISCAL YEAR 2007 THROUGH REDISTRIBUTION OF CERTAIN UNUSED FISCAL YEAR 2005 ALLOTMENTS.—

(A) IN GENERAL.—Subject to subparagraphs (C) and (D) and paragraph (5)(B), with respect to months beginning during fiscal year 2007 after March 31, 2007, the Secretary shall provide for a redistribution under subsection (f) from amounts made available for redistribution under paragraph (3) to each shortfall State described in subparagraph (B), such amount as the Secretary determines will eliminate the estimated shortfall described in such subparagraph for such State for the month.

(B) SHORTFALL STATE DESCRIBED.—For purposes of this paragraph, a shortfall State described in this subparagraph is a State with a State child health plan approved under this title for which the Secretary estimates, on a monthly basis using the most recent data available to the Secretary as of March 31, 2007, that the projected expenditures under such plan for such State for fiscal year 2007 will exceed the sum of—

(i) the amount of the State's allotments for each of fiscal years 2005 and 2006 that was not expended by the end of fiscal year 2006;

(ii) the amount, if any, that is to be redistributed to the State in accordance with paragraph (1); and

(iii) the amount of the State's allotment for fiscal year 2007.

(C) FUNDS REDISTRIBUTED IN THE ORDER IN WHICH STATES REALIZE FUNDING SHORTFALLS.—The Secretary shall redistribute the amounts available for redistribution under subparagraph (A) to shortfall States described in subparagraph (B) in the order in which such States realize monthly funding shortfalls under this title for fiscal year 2007. The Secretary shall only make redistributions under this paragraph to the extent that such amounts are available for such redistributions.

(D) PRORATION RULE.—If the amounts available for redistribution under paragraph (3) for a month are less than the total amounts of the estimated shortfalls determined for the month under subparagraph (A), the amount computed under such subparagraph for each shortfall State shall be reduced proportionally.

(3) TREATMENT OF CERTAIN STATES WITH FISCAL YEAR 2005 ALLOTMENTS UNEXPENDED AT THE END OF THE FIRST HALF OF FISCAL YEAR 2007.—

(A) IDENTIFICATION OF STATES.—The Secretary, on the basis of the most recent data available to the Secretary as of March 31, 2007—

(i) shall identify those States that received an allotment for fiscal year 2005 under subsection (b) which have not expended all of such allotment by March 31, 2007; and

(ii) for each such State shall estimate—

(I) the portion of such allotment that was not so expended by such date; and

(II) whether the State is described in subparagraph (B).

(B) STATES WITH FUNDS IN EXCESS OF 200 PERCENT OF NEED.—A State described in this subparagraph is a State for which the Secretary determines, on the basis of the most recent data available to the Secretary as of March 31, 2007, that the total of all available allotments under this title to the State as of such date, is at least equal to 200 percent of the total projected expenditures under this title for the State for fiscal year 2007.

(C) REDISTRIBUTION AND LIMITATION ON AVAILABILITY OF PORTION OF UNUSED ALLOTMENTS FOR CERTAIN STATES.—

(i) IN GENERAL.—In the case of a State identified under subparagraph (A)(i) that is also described in subparagraph (B), notwithstanding subsection (e), the applicable amount described in clause (ii) shall not be available for expenditure by the State on or after April 1, 2007, and shall be redistributed in accordance with paragraph (2).

(ii) APPLICABLE AMOUNT.—For purposes of clause (i), the applicable amount described in this clause is the lesser of—

(I) 50 percent of the amount described in subparagraph (A)(i)(I); or

(II) \$20,000,000.

(4) ADDITIONAL AMOUNTS TO ELIMINATE REMAINDER OF FISCAL YEAR 2007 FUNDING SHORTFALLS.—

(A) IN GENERAL.—From the amounts provided in advance in appropriations Acts, the Secretary shall allot to each remaining shortfall State described in subparagraph (B) such amount as the Secretary determines will eliminate the estimated shortfall described in such subparagraph for the State for fiscal year 2007.

(B) REMAINING SHORTFALL STATE DESCRIBED.—For purposes of subparagraph (A), a remaining shortfall State is a State with a State child health plan approved under this title for which the Secretary estimates, on the basis of the most recent data available to the Secretary as of the date of the enactment of this paragraph, that the projected Federal expenditures under such plan for the State for fiscal year 2007 will exceed the sum of—

(i) the amount of the State's allotments for each of fiscal years 2005 and 2006 that will not be expended by the end of fiscal year 2006;

(ii) the amount of the State's allotment for fiscal year 2007; and

(iii) the amounts, if any, that are to be redistributed to the State during fiscal year 2007 in accordance with paragraphs (1) and (2).

(5) RETROSPECTIVE ADJUSTMENT.—

(A) IN GENERAL.—The Secretary may adjust the estimates and determinations made under paragraphs (1), (2), (3), and (4) as necessary on the basis of the amounts reported by States not later than November 30, 2007, on CMS Form 64 or CMS Form 21, as the case may be and as approved by the Secretary, but in no case may the applicable amount described in paragraph (3)(C)(ii) exceed the amount determined by the Secretary on the basis of the most recent data available to the Secretary as of March 31, 2007.

(B) FUNDING OF ANY RETROSPECTIVE ADJUSTMENTS ONLY FROM UNEXPENDED 2005 ALLOTMENTS.—Notwithstanding subsections (e) and (f), to the extent the Secretary determines it necessary to adjust the estimates and determinations made for purposes of paragraphs (1), (2), and (3), the Secretary may use only the allotments for fiscal year 2005 under subsection (b) that remain unexpended through the end of fiscal year 2007 for providing any additional amounts to States described in paragraph (2)(B) (without regard to whether such unexpended allotments are from States described in paragraph (3)(B)).

(C) RULES OF CONSTRUCTION.—Nothing in this subsection shall be construed as—

(i) authorizing the Secretary to use the allotments for fiscal year 2006 or 2007 under subsection (b) of States described in paragraph (3)(B) to provide additional amounts to States described in paragraph (2)(B) for purposes of eliminating the funding shortfall for such States for fiscal year 2007; or

(ii) limiting the authority of the Secretary to redistribute the allotments for fiscal year 2005 under subsection (b) that remain unexpended through the end of fiscal year 2007 and are available for redistribution under subsection (f) after the application of subparagraph (B).

(6) 1-YEAR AVAILABILITY; NO FURTHER REDISTRIBUTION.—Notwithstanding subsections (e) and (f), amounts redistributed or allotted to a State pursuant to this subsection for fiscal year 2007 shall only remain available for expenditure by the State through September 30, 2007, and any amounts of such redistributions or allotments that remain unexpended as of such date, shall not be subject to redistribution under subsection (f). Nothing in the preceding sentence shall be construed as limiting the ability of the Secretary to adjust the determinations made under paragraphs (1), (2), (3), and (4) in accordance with paragraph (5).

(7) DEFINITION OF STATE.—For purposes of this subsection, the term “State” means a State that receives an allotment for fiscal year 2007 under subsection (b).

(i) REDISTRIBUTION OF UNUSED FISCAL YEAR 2005 ALLOTMENTS TO STATES WITH ESTIMATED FUNDING SHORTFALLS FOR FISCAL YEAR 2008.—

(1) IN GENERAL.—Notwithstanding subsection (f) and subject to paragraphs (3) and (4), with respect to months beginning during fiscal year 2008, the Secretary shall provide for a redistribution under such subsection from the allotments for fiscal year 2005 under subsection (b) that are not expended by the end of fiscal year 2007, to a fiscal year 2008 shortfall State described in paragraph (2), such amount as the Secretary determines will eliminate the estimated shortfall described in such paragraph for such State for the month.

(2) FISCAL YEAR 2008 SHORTFALL STATE DESCRIBED.—A fiscal year 2008 shortfall State described in this paragraph is a State with a State child health plan approved under this title for which the Secretary estimates, on a monthly basis using the most recent data available to the Secretary as of such month, that the projected expenditures under such plan for such State for fiscal year 2008 will exceed the sum of—

(A) the amount of the State's allotments for each of fiscal years 2006 and 2007 that was not expended by the end of fiscal year 2007; and

(B) the amount of the State's allotment for fiscal year 2008.

(3) FUNDS REDISTRIBUTED IN THE ORDER IN WHICH STATES REALIZE FUNDING SHORTFALLS.—The Secretary shall redistribute the amounts available for redistribution under paragraph (1) to fiscal year 2008 shortfall States described in paragraph (2) in the order in which such States realize monthly funding shortfalls under this title for fiscal year 2008. The Secretary shall only make redistributions under this subsection to the extent that there are unexpended fiscal year 2005 allotments under subsection (b) available for such redistributions.

(4) PRORATION RULE.—If the amounts available for redistribution under paragraph (1) are less than the total amounts of the estimated shortfalls determined for the month under that paragraph, the amount computed under such paragraph for each fiscal year 2008 shortfall State for the month shall be reduced proportionally.

(5) RETROSPECTIVE ADJUSTMENT.—The Secretary may adjust the estimates and determinations made to carry out this subsection as necessary on the basis of the amounts reported by States not later than November 30, 2007, on CMS Form 64 or CMS Form 21, as the case may be, and as approved by the Secretary.

(6) 1-YEAR AVAILABILITY; NO FURTHER REDISTRIBUTION.—Notwithstanding subsections (e) and (f), amounts redistributed to a State pursuant to this subsection for fiscal year 2008 shall only remain available for expenditure by the State through September 30, 2008, and any amounts of such redistributions that remain unexpended as of such date, shall not be subject to redistribution under subsection (f).

(j) ADDITIONAL ALLOTMENTS TO ELIMINATE FUNDING SHORTFALLS FOR FISCAL YEAR 2008.—

(1) APPROPRIATION; ALLOTMENT AUTHORITY.—For the purpose of providing additional allotments described in subparagraphs (A) and (B) of paragraph (3), there is appropriated, out of any money in the Treasury not otherwise appropriated, such sums as may be necessary, not to exceed \$1,600,000,000 for fiscal year 2008.

(2) SHORTFALL STATES DESCRIBED.—For purposes of paragraph (3), a shortfall State described in this paragraph is a State with a State child health plan approved under this title for which the Secretary estimates, on the basis of the most recent data available to the Secretary as of November 30, 2007, that the Federal share amount of the projected expenditures under such plan for such State for fiscal year 2008 will exceed the sum of—

(A) the amount of the State's allotments for each of fiscal years 2006 and 2007 that will not be expended by the end of fiscal year 2007;

(B) the amount, if any, that is to be redistributed to the State during fiscal year 2008 in accordance with subsection (i); and

(C) the amount of the State's allotment for fiscal year 2008.

(3) ALLOTMENTS.—In addition to the allotments provided under subsections (b) and (c), subject to paragraph (4), of the amount available for the additional allotments under paragraph (1) for fiscal year 2008, the Secretary shall allot—

(A) to each shortfall State described in paragraph (2) not described in subparagraph (B), such amount as the Secretary determines will eliminate the estimated shortfall described in such paragraph for the State; and

(B) to each commonwealth or territory described in subsection (c)(3), an amount equal to the percentage specified in subsection (c)(2) for the commonwealth or territory multiplied by 1.05 percent of the sum of the amounts determined for each shortfall State under subparagraph (A).

(4) PRORATION RULE.—If the amounts available for additional allotments under paragraph (1) are less than the total of the amounts determined under subparagraphs (A) and (B) of paragraph (3), the amounts computed under such subparagraphs shall be reduced proportionally.

(5) RETROSPECTIVE ADJUSTMENT.—The Secretary may adjust the estimates and determinations made to carry out this subsection as necessary on the basis of the amounts reported by States not later than November 30, 2008, on CMS Form 64 or CMS Form 21, as the case may be, and as approved by the Secretary.

(6) ONE-YEAR AVAILABILITY; NO REDISTRIBUTION OF UNEXPENDED ADDITIONAL ALLOTMENTS.—Notwithstanding subsections (e) and (f), amounts allotted to a State pursuant to this subsection for fiscal year 2008, subject to paragraph (5), shall only remain available for expenditure by the State through September 30, 2008. Any amounts of such allotments that remain unexpended as of such date shall not be subject to redistribution under subsection (f).

(k) REDISTRIBUTION OF UNUSED FISCAL YEAR 2006 ALLOTMENTS TO STATES WITH ESTIMATED FUNDING SHORTFALLS DURING FISCAL YEAR 2009.—

(1) IN GENERAL.—Notwithstanding subsection (f) and subject to paragraphs (3) and (4), with respect to months beginning during fiscal year 2009, the Secretary shall provide for a redistribution under such subsection from the allotments for fiscal year 2006 under subsection (b) that are not expended by the end of fiscal year 2008, to a fiscal year 2009 shortfall State described in paragraph (2), such amount as the Secretary determines will eliminate the estimated shortfall described in such paragraph for such State for the month.

(2) FISCAL YEAR 2009 SHORTFALL STATE DESCRIBED.—A fiscal year 2009 shortfall State described in this paragraph is a State with a State child health plan approved under this title for which the Secretary estimates, on a monthly basis using the most recent data available to the Secretary as of such month, that the Federal share amount of the projected expenditures under such plan for such State for the first 2 quarters of fiscal year 2009 will exceed the sum of—

(A) the amount of the State's allotments for each of fiscal years 2007 and 2008 that was not expended by the end of fiscal year 2008; and

(B) the amount of the State's allotment for fiscal year 2009.

(3) FUNDS REDISTRIBUTED IN THE ORDER IN WHICH STATES REALIZE FUNDING SHORTFALLS.—The Secretary shall redistribute the amounts available for redistribution under paragraph (1) to fiscal year 2009 shortfall States described in paragraph (2) in the order in which such States realize monthly funding shortfalls under this title for fiscal year 2009. The Secretary shall only make redistributions under this subsection to the extent that there are unexpended fiscal year 2006 allotments under subsection (b) available for such redistributions.

(4) PRORATION RULE.—If the amounts available for redistribution under paragraph (1) are less than the total amounts of the estimated shortfalls determined for the month under that paragraph, the amount computed under such paragraph for each fiscal year 2009 shortfall State for the month shall be reduced proportionally.

(5) RETROSPECTIVE ADJUSTMENT.—The Secretary may adjust the estimates and determinations made to carry out this subsection as necessary on the basis of the amounts reported by States not later than May 31, 2009, on CMS Form 64 or CMS Form 21, as the case may be, and as approved by the Secretary.

(6) AVAILABILITY; NO FURTHER REDISTRIBUTION.—Notwithstanding subsections (e) and (f), amounts redistributed to a State pursuant to this subsection for fiscal year 2009 shall only remain available for expenditure by the State through September 30, 2009, and any amounts of such redistributions that remain unexpended as of such date, shall not be subject to redistribution under subsection (f).

(l) ADDITIONAL ALLOTMENTS TO ELIMINATE FUNDING SHORTFALLS FOR THE FIRST 2 QUARTERS OF FISCAL YEAR 2009.—

(1) APPROPRIATION; ALLOTMENT AUTHORITY.—For the purpose of providing additional allotments described in subparagraphs (A) and (B) of paragraph (3), there is appropriated, out of any money in the Treasury not otherwise appropriated, such sums as may be necessary, not to exceed \$275,000,000 for the first 2 quarters of fiscal year 2009.

(2) SHORTFALL STATES DESCRIBED.—For purposes of paragraph (3), a shortfall State described in this paragraph is a State with a State child health plan approved under this title for which the Secretary estimates, on the basis of the most recent data available to the Secretary, that the Federal share amount of the projected expenditures under such plan for such State for the first 2 quarters of fiscal year 2009 will exceed the sum of—

(A) the amount of the State's allotments for each of fiscal years 2007 and 2008 that will not be expended by the end of fiscal year 2008;

(B) the amount, if any, that is to be redistributed to the State during fiscal year 2009 in accordance with subsection (k); and

(C) the amount of the State's allotment for fiscal year 2009.

(3) ALLOTMENTS.—In addition to the allotments provided under subsections (b) and (c), subject to paragraph (4), of the amount available for the additional allotments under paragraph (1) for the first 2 quarters of fiscal year 2009, the Secretary shall allot—

(A) to each shortfall State described in paragraph (2) not described in subparagraph (B) such amount as the Secretary determines will eliminate the estimated shortfall described in such paragraph for the State; and

(B) to each commonwealth or territory described in subsection (c)(3), an amount equal to the percentage specified in subsection (c)(2) for the commonwealth or territory multiplied by 1.05 percent of the sum of the amounts determined for each shortfall State under subparagraph (A).

(4) PRORATION RULE.—If the amounts available for additional allotments under paragraph (1) are less than the total of the amounts determined under subparagraphs (A) and (B) of paragraph (3), the amounts computed under such subparagraphs shall be reduced proportionally.

(5) RETROSPECTIVE ADJUSTMENT.—The Secretary may adjust the estimates and determinations made to carry out this subsection as necessary on the basis of the amounts reported by States not later than May 31, 2009, on CMS Form 64 or CMS Form 21, as the case may be, and as approved by the Secretary.

(6) AVAILABILITY; NO REDISTRIBUTION OF UNEXPENDED ADDITIONAL ALLOTMENTS.—Notwithstanding subsections (e) and (f), amounts allotted to a State pursuant to this subsection for fiscal year 2009, subject to paragraph (5), shall only remain available for expenditure by the State through March 31, 2009. Any amounts of such allotments that remain unexpended as of such date shall not be subject to redistribution under subsection (f).

(m) ALLOTMENTS FOR FISCAL YEARS 2009 AND THEREAFTER.—

(1) FOR FISCAL YEAR 2009.—

(A) FOR THE 50 STATES AND THE DISTRICT OF COLUMBIA.—Subject to the succeeding provisions of this paragraph and paragraph (5), the Secretary shall allot for fiscal year 2009 from the amount made available under subsection (a)(12), to each of the 50 States and the District of Columbia 110 percent of the highest of the following amounts for such State or District:

(i) The total Federal payments to the State under this title for fiscal year 2008, multiplied by the allotment increase factor determined under paragraph (6) for fiscal year 2009.

(ii) The amount allotted to the State for fiscal year 2008 under subsection (b), multiplied by the allotment increase factor determined under paragraph (6) for fiscal year 2009.

(iii) The projected total Federal payments to the State under this title for fiscal year 2009, as determined on the basis of the February 2009 projections certified by the State to the Secretary by not later than March 31, 2009.

(B) FOR THE COMMONWEALTHS AND TERRITORIES.—Subject to the succeeding provisions of this paragraph and paragraph (5), the Secretary shall allot for fiscal year 2009 from the amount made available under subsection (a)(12) to each of the commonwealths and territories described in subsection (c)(3) an amount equal to the highest amount of Federal payments to the commonwealth or territory under this title for any fiscal year occurring during the period of fiscal years 1999 through 2008, multiplied by the allotment increase factor determined under paragraph (6) for fiscal year 2009, except that subparagraph (B) thereof shall be applied by substituting “the United States” for “the State”.

(C) ADJUSTMENT FOR QUALIFYING STATES.—In the case of a qualifying State described in paragraph (2) of section 2105(g), the Secretary shall permit the State to submit a revised projection described in subparagraph (A)(iii) in order to take into account changes in such projections attributable to the application of paragraph (4) of such section.

(2) FOR FISCAL YEARS 2010 **THROUGH 2016** *THROUGH 2022*.—

(A) IN GENERAL.—Subject to paragraphs (4) and (6), from the amount made available under paragraphs (13) through (15) of subsection (a) for each of fiscal years 2010 through 2012, respectively, the Secretary shall compute a State allotment for each State (including the District of Columbia and each commonwealth and territory) for each such fiscal year as follows:

(i) GROWTH FACTOR UPDATE FOR FISCAL YEAR 2010.—For fiscal year 2010, the allotment of the State is equal to the sum of—

(I) the amount of the State allotment under paragraph (1) for fiscal year 2009; and

(II) the amount of any payments made to the State under subsection (k), (l), or (n) for fiscal year 2009, multiplied by **the allotment increase factor under paragraph (5)** *the allotment increase factor under paragraph (6)* for fiscal year 2010.

(ii) REBASING IN FISCAL YEAR 2011.—For fiscal year 2011, the allotment of the State is equal to the Federal payments to the State that are attributable to (and countable towards) the total amount of allotments available under this section to the State in fiscal year 2010 (including payments made to the State under subsection (n) for fiscal year 2010 as well as amounts redistributed to the State in fiscal year 2010), multiplied by **the allotment increase factor under paragraph (5)** *the allotment increase factor under paragraph (6)* for fiscal year 2011.

(iii) GROWTH FACTOR UPDATE FOR FISCAL YEAR 2012.—For fiscal year 2012, the allotment of the State is equal to the sum of—

(I) the amount of the State allotment under clause (ii) for fiscal year 2011; and

(II) the amount of any payments made to the State under subsection (n) for fiscal year 2011, multiplied by **the allotment increase factor under paragraph (5)** *the allotment increase factor under paragraph (6)* for fiscal year 2012.

(B) FISCAL YEAR 2013 AND EACH SUCCEEDING FISCAL YEAR.—Subject to paragraphs (5) and (7), from the amount made available under paragraphs (16) through **[(19)] (24)** of subsection (a) for fiscal year 2013 and each succeeding fiscal year, respectively, the Secretary shall compute a State allotment for each State (including the District of Columbia and each commonwealth and territory) for each such fiscal year as follows:

(i) REBASING IN FISCAL YEAR 2013 AND EACH SUCCEEDING ODD-NUMBERED FISCAL YEAR.—For fiscal year 2013 and each succeeding odd-numbered fiscal year (other than fiscal years 2015 and 2017), the allotment of the State is equal to the Federal payments to the State that are attributable to (and countable toward) the total amount of allotments available under this section to the State in the preceding fiscal year (including payments made to the State under subsection (n) for such preceding fiscal year as well as amounts redistributed to the State in such preceding fiscal year), multiplied by the allotment increase factor under paragraph (6) for such odd-numbered fiscal year.

(ii) GROWTH FACTOR UPDATE FOR FISCAL YEAR 2014 AND EACH SUCCEEDING EVEN-NUMBERED FISCAL YEAR.—Except as provided in clauses (iii) and (iv), for fiscal year 2014 and each succeeding even-numbered fiscal year (*other than fiscal year 2022*), the allotment of the State is equal to the sum of—

(I) the amount of the State allotment under clause (i) (*or, in the case of fiscal year 2018, under paragraph (4)*) for the preceding fiscal year; and

(II) the amount of any payments made to the State under subsection (n) for such preceding fiscal year,

multiplied by the allotment increase factor under paragraph (6) for such even-numbered fiscal year.

(iii) SPECIAL RULE FOR 2016.—For fiscal year 2016, the allotment of the State is equal to the Federal payments to the State that are attributable to (and countable toward) the total amount of allotments available under this section to the State in the preceding fiscal year (including payments made to the State under subsection (n) for such preceding fiscal year as well as amounts redistributed to the State in such preceding fiscal year), but determined as if the last two sentences of section 2105(b) were in effect in such preceding fiscal year and then multiplying the result by the allotment increase factor under paragraph (6) for fiscal year 2016.

(iv) REDUCTION IN 2018.—For fiscal year 2018, with respect to the allotment of the State for fiscal year 2017, any amounts of such allotment that remain available for expenditure by the State in fiscal year 2018 shall be reduced by one-third.

(3) FOR FISCAL YEAR 2015.—

(A) FIRST HALF.—Subject to paragraphs (5) and (7), from the amount made available under subparagraph (A) of paragraph (18) of subsection (a) for the semi-annual period described in such paragraph, increased by the amount of the appropriation for such period under section 108 of the Children's Health Insurance Program Reauthorization Act of 2009, the Secretary shall compute a State allotment for each State (including the District of Columbia and each commonwealth and territory) for such semi-annual period in an amount equal to the first half ratio (described in subparagraph (D)) of the amount described in subparagraph (C).

(B) SECOND HALF.—Subject to paragraphs (5) and (7), from the amount made available under subparagraph (B) of paragraph (18) of subsection (a) for the semi-annual period described in such paragraph, the Secretary shall compute a State allotment for each State (including the District of Columbia and each commonwealth and territory) for such semi-annual period in an amount equal to the amount made available under such subparagraph, multiplied by the ratio of—

(i) the amount of the allotment to such State under subparagraph (A); to

(ii) the total of the amount of all of the allotments made available under such subparagraph.

(C) FULL YEAR AMOUNT BASED ON REBASED AMOUNT.—The amount described in this subparagraph for a State is equal to the Federal payments to the State that are attrib-

utable to (and countable towards) the total amount of allotments available under this section to the State in fiscal year 2014 (including payments made to the State under subsection (n) for fiscal year 2014 as well as amounts redistributed to the State in fiscal year 2014), multiplied by the allotment increase factor under paragraph (6) for fiscal year 2015.

(D) FIRST HALF RATIO.—The first half ratio described in this subparagraph is the ratio of—

(i) the sum of—

(I) the amount made available under subsection (a)(18)(A); and

(II) the amount of the appropriation for such period under section 108 of the Children’s Health Insurance Program Reauthorization Act of 2009; to

(ii) the sum of the—

(I) amount described in clause (i); and

(II) the amount made available under subsection (a)(18)(B).

(4) FOR FISCAL YEAR 2017.—

(A) FIRST HALF.—Subject to paragraphs (5) and (7), from the amount made available under subparagraph (A) of paragraph (20) of subsection (a) for the semi-annual period described in such paragraph, increased by the amount of the appropriation for such period under section 301(b)(3) of the Medicare Access and CHIP Reauthorization Act of 2015, the Secretary shall compute a State allotment for each State (including the District of Columbia and each commonwealth and territory) for such semi-annual period in an amount equal to the first half ratio (described in subparagraph (D)) of the amount described in subparagraph (C).

(B) SECOND HALF.—Subject to paragraphs (5) and (7), from the amount made available under subparagraph (B) of paragraph (20) of subsection (a) for the semi-annual period described in such paragraph, the Secretary shall compute a State allotment for each State (including the District of Columbia and each commonwealth and territory) for such semi-annual period in an amount equal to the amount made available under such subparagraph, multiplied by the ratio of—

(i) the amount of the allotment to such State under subparagraph (A); to

(ii) the total of the amount of all of the allotments made available under such subparagraph.

(C) FULL YEAR AMOUNT BASED ON REBASED AMOUNT.—The amount described in this subparagraph for a State is equal to the Federal payments to the State that are attributable to (and countable towards) the total amount of allotments available under this section to the State in fiscal year 2016 (including payments made to the State under subsection (n) for fiscal year 2016 as well as amounts redistributed to the State in fiscal year 2016), multiplied by the allotment increase factor under paragraph (6) for fiscal year 2017.

(D) FIRST HALF RATIO.—The first half ratio described in this subparagraph is the ratio of—

(i) the sum of—

(I) the amount made available under subsection (a)(20)(A); and

(II) the amount of the appropriation for such period under section 301(b)(3) of the Medicare Access and CHIP Reauthorization Act of 2015; to

(ii) the sum of the—

(I) amount described in clause (i); and

(II) the amount made available under subsection (a)(20)(B).

(5) PRORATION RULE.—If, after the application of this subsection without regard to this paragraph, the sum of the allotments determined under paragraph (1), (2), (3), ~~or (4)~~ (4), ~~or (10)~~ for a fiscal year (or, in the case of fiscal year 2015 ~~or 2017~~, 2017, ~~or 2022~~, for a semi-annual period in such fiscal year) exceeds the amount available under subsection (a) for such fiscal year or period, the Secretary shall reduce each allotment for any State under such paragraph for such fiscal year or period on a proportional basis.

(6) ALLOTMENT INCREASE FACTOR.—The allotment increase factor under this paragraph for a fiscal year is equal to the product of the following:

(A) PER CAPITA HEALTH CARE GROWTH FACTOR.—1 plus the percentage increase in the projected per capita amount of National Health Expenditures from the calendar year in which the previous fiscal year ends to the calendar year in which the fiscal year involved ends, as most recently published by the Secretary before the beginning of the fiscal year.

(B) CHILD POPULATION GROWTH FACTOR.—1 plus the percentage increase (if any) in the population of children in the State from July 1 in the previous fiscal year to July 1 in the fiscal year involved, as determined by the Secretary based on the most recent published estimates of the Bureau of the Census before the beginning of the fiscal year involved, plus 1 percentage point.

(7) INCREASE IN ALLOTMENT TO ACCOUNT FOR APPROVED PROGRAM EXPANSIONS.—In the case of one of the 50 States or the District of Columbia that—

(A) has submitted to the Secretary, and has approved by the Secretary, a State plan amendment or waiver request relating to an expansion of eligibility for children or benefits under this title that becomes effective for a fiscal year (beginning with fiscal year 2010 and ending with fiscal year ~~2017~~ 2022); and

(B) has submitted to the Secretary, before the August 31 preceding the beginning of the fiscal year *(or, in the case of fiscal year 2018, by not later than the date that is 60 days after the date of the enactment of the HEALTHY KIDS Act of 2017)*, a request for an expansion allotment adjustment under this paragraph for such fiscal year that specifies—

(i) the additional expenditures that are attributable to the eligibility or benefit expansion provided under the amendment or waiver described in subparagraph (A), as certified by the State and submitted to the Secretary by not later than August 31 preceding the beginning of the fiscal year; and

(ii) the extent to which such additional expenditures are projected to exceed the allotment of the State or District for the year,

subject to paragraph (5), the amount of the allotment of the State or District under this subsection for such fiscal year shall be increased by the excess amount described in subparagraph (B)(i). A State or District may only obtain an increase under this paragraph for an allotment for fiscal year 2010, fiscal year 2012, fiscal year 2014, **[or fiscal year 2016]** *fiscal year 2016, fiscal year 2018, fiscal year 2020, or fiscal year 2022.*

(8) **ADJUSTMENT OF FISCAL YEAR 2010 ALLOTMENTS TO ACCOUNT FOR CHANGES IN PROJECTED SPENDING FOR CERTAIN PREVIOUSLY APPROVED EXPANSION PROGRAMS.**—For purposes of recalculating the fiscal year 2010 allotment, in the case of one of the 50 States or the District of Columbia that has an approved State plan amendment effective January 1, 2006, to provide child health assistance through the provision of benefits under the State plan under title XIX for children from birth through age 5 whose family income does not exceed 200 percent of the poverty line, the Secretary shall increase the allotment by an amount that would be equal to the Federal share of expenditures that would have been claimed at the enhanced FMAP rate rather than the Federal medical assistance percentage matching rate for such population.

(9) **AVAILABILITY OF AMOUNTS FOR SEMI-ANNUAL PERIODS IN **[FISCAL YEARS 2015 AND 2017]** CERTAIN FISCAL YEARS.**—Each semi-annual allotment made under paragraph (3) **[or (4)], (4), or (10)** for a period in fiscal year 2015 **[or fiscal year 2017], 2017, or 2022** shall remain available for expenditure under this title for periods after the end of such fiscal year in the same manner as if the allotment had been made available for the entire fiscal year.

(10) **FOR FISCAL YEAR 2022.**—

(A) **FIRST HALF.**—Subject to paragraphs (5) and (7), from the amount made available under subparagraph (A) of paragraph (25) of subsection (a) for the semi-annual period described in such subparagraph, increased by the amount of the appropriation for such period under section 101(b)(3) of the *HEALTHY KIDS Act*, the Secretary shall compute a State allotment for each State (including the District of Columbia and each commonwealth and territory) for such semi-annual period in an amount equal to the first half ratio (described in subparagraph (D)) of the amount described in subparagraph (C).

(B) **SECOND HALF.**—Subject to paragraphs (5) and (7), from the amount made available under subparagraph (B) of paragraph (25) of subsection (a) for the semi-annual period described in such subparagraph, the Secretary shall compute a State allotment for each State (including the

District of Columbia and each commonwealth and territory) for such semi-annual period in an amount equal to the amount made available under such subparagraph, multiplied by the ratio of—

(i) the amount of the allotment to such State under subparagraph (A); to

(ii) the total of the amount of all of the allotments made available under such subparagraph.

(C) FULL YEAR AMOUNT BASED ON GROWTH FACTOR UPDATED AMOUNT.—*The amount described in this subparagraph for a State is equal to the sum of—*

(i) the amount of the State allotment for fiscal year 2021 determined under paragraph (2)(B)(i); and

(ii) the amount of any payments made to the State under subsection (n) for fiscal year 2021, multiplied by the allotment increase factor under paragraph (6) for fiscal year 2022.

(D) FIRST HALF RATIO.—*The first half ratio described in this subparagraph is the ratio of—*

(i) the sum of—

(I) the amount made available under subsection (a)(25)(A); and

(II) the amount of the appropriation for such period under section 101(b)(3) of the HEALTHY KIDS Act; to

(ii) the sum of—

(I) the amount described in clause (i); and

(II) the amount made available under subsection (a)(25)(B).

(n) CHILD ENROLLMENT CONTINGENCY FUND.—

(1) ESTABLISHMENT.—There is hereby established in the Treasury of the United States a fund which shall be known as the “Child Enrollment Contingency Fund” (in this subsection referred to as the “Fund”). Amounts in the Fund shall be available without further appropriations for payments under this subsection.

(2) DEPOSITS INTO FUND.—

(A) INITIAL AND SUBSEQUENT APPROPRIATIONS.—Subject to subparagraphs (B) and (D), out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated to the Fund—

(i) for fiscal year 2009, an amount equal to 20 percent of the amount made available under paragraph (12) of subsection (a) for the fiscal year; and

(ii) for each of fiscal years [2010, 2011, 2012, 2013, 2014, and 2016] 2010 through 2014, 2016, and 2018 through 2021 (and for each of the semi-annual allotment periods for [fiscal year 2015 and fiscal year 2017] fiscal years 2015, 2017, and 2022), such sums as are necessary for making payments to eligible States for such fiscal year or period, but not in excess of the aggregate cap described in subparagraph (B).

(B) AGGREGATE CAP.—The total amount available for payment from the Fund for each of fiscal years [2010, 2011, 2012, 2013, 2014, and 2016] 2010 through 2014,

2016, and 2018 through 2021 (and for each of the semi-annual allotment periods for **■**fiscal year 2015 and fiscal year 2017**■** *fiscal years 2015, 2017, and 2022*), taking into account deposits made under subparagraph (C), shall not exceed 20 percent of the amount made available under subsection (a) for the fiscal year or period.

(C) INVESTMENT OF FUND.—The Secretary of the Treasury shall invest, in interest bearing securities of the United States, such currently available portions of the Fund as are not immediately required for payments from the Fund. The income derived from these investments constitutes a part of the Fund.

(D) AVAILABILITY OF EXCESS FUNDS FOR PERFORMANCE BONUSES.—Any amounts in excess of the aggregate cap described in subparagraph (B) for a fiscal year or period shall be made available for purposes of carrying out section 2105(a)(3) for any succeeding fiscal year and the Secretary of the Treasury shall reduce the amount in the Fund by the amount so made available.

(3) CHILD ENROLLMENT CONTINGENCY FUND PAYMENTS.—

(A) IN GENERAL.—If a State's expenditures under this title in any of fiscal years 2009 through 2014, fiscal year 2016, **■**or a semi-annual allotment period for fiscal year 2015 or 2017**■** *or in any of fiscal years 2018 through 2021 (or a semi-annual allotment period for fiscal year 2015, 2017, or 2022)*, exceed the total amount of allotments available under this section to the State in the fiscal year or period (determined without regard to any redistribution it receives under subsection (f) that is available for expenditure during such fiscal year or period, but including any carryover from a previous fiscal year) and if the average monthly unduplicated number of children enrolled under the State plan under this title (including children receiving health care coverage through funds under this title pursuant to a waiver under section 1115) during such fiscal year or period exceeds its target average number of such enrollees (as determined under subparagraph (B)) for that fiscal year or period, subject to subparagraph (D), the Secretary shall pay to the State from the Fund an amount equal to the product of—

- (i) the amount by which such average monthly case-load exceeds such target number of enrollees; and
- (ii) the projected per capita expenditures under the State child health plan (as determined under subparagraph (C) for the fiscal year), multiplied by the enhanced FMAP (as defined in section 2105(b)) for the State and fiscal year involved (or in which the period occurs).

(B) TARGET AVERAGE NUMBER OF CHILD ENROLLEES.—In this paragraph, the target average number of child enrollees for a State—

- (i) for fiscal year 2009 is equal to the monthly average unduplicated number of children enrolled in the State child health plan under this title (including such children receiving health care coverage through funds

under this title pursuant to a waiver under section 1115) during fiscal year 2008 increased by the population growth for children in that State for the year ending on June 30, 2007 (as estimated by the Bureau of the Census) plus 1 percentage point; or

(ii) for a subsequent fiscal year (or semi-annual period occurring in a fiscal year) is equal to the target average number of child enrollees for the State for the previous fiscal year increased by the child population growth factor described in subsection (m)(6)(B) for the State for the prior fiscal year.

(C) PROJECTED PER CAPITA EXPENDITURES.—For purposes of subparagraph (A)(ii), the projected per capita expenditures under a State child health plan—

(i) for fiscal year 2009 is equal to the average per capita expenditures (including both State and Federal financial participation) under such plan for the targeted low-income children counted in the average monthly caseload for purposes of this paragraph during fiscal year 2008, increased by the annual percentage increase in the projected per capita amount of National Health Expenditures (as estimated by the Secretary) for 2009; or

(ii) for a subsequent fiscal year (or semi-annual period occurring in a fiscal year) is equal to the projected per capita expenditures under such plan for the previous fiscal year (as determined under clause (i) or this clause) increased by the annual percentage increase in the projected per capita amount of National Health Expenditures (as estimated by the Secretary) for the year in which such subsequent fiscal year ends.

(D) PRORATION RULE.—If the amounts available for payment from the Fund for a fiscal year or period are less than the total amount of payments determined under subparagraph (A) for the fiscal year or period, the amount to be paid under such subparagraph to each eligible State shall be reduced proportionally.

(E) TIMELY PAYMENT; RECONCILIATION.—Payment under this paragraph for a fiscal year or period shall be made before the end of the fiscal year or period based upon the most recent data for expenditures and enrollment and the provisions of subsection (e) of section 2105 shall apply to payments under this subsection in the same manner as they apply to payments under such section.

(F) CONTINUED REPORTING.—For purposes of this paragraph and subsection (f), the State shall submit to the Secretary the State's projected Federal expenditures, even if the amount of such expenditures exceeds the total amount of allotments available to the State in such fiscal year or period.

(G) APPLICATION TO COMMONWEALTHS AND TERRITORIES.—No payment shall be made under this paragraph to a commonwealth or territory described in subsection (c)(3) until such time as the Secretary determines that there are in effect methods, satisfactory to the Secretary,

for the collection and reporting of reliable data regarding the enrollment of children described in subparagraphs (A) and (B) in order to accurately determine the commonwealth's or territory's eligibility for, and amount of payment, under this paragraph.

SEC. 2105. PAYMENTS TO STATES.

(a) **PAYMENTS.**—

(1) **IN GENERAL.**—Subject to the succeeding provisions of this section, the Secretary shall pay to each State with a plan approved under this title, from its allotment under section 2104, an amount for each quarter equal to the enhanced FMAP (or, in the case of expenditures described in subparagraph (D)(iv), the higher of 75 percent or the sum of the enhanced FMAP plus 5 percentage points) of expenditures in the quarter—

(A) for child health assistance under the plan for targeted low-income children in the form of providing medical assistance for which payment is made on the basis of an enhanced FMAP under the fourth sentence of section 1905(b);

(B)

(C) for child health assistance under the plan for targeted low-income children in the form of providing health benefits coverage that meets the requirements of section 2103; and

(D) only to the extent permitted consistent with subsection (c)—

(i) for payment for other child health assistance for targeted low-income children;

(ii) for expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children);

(iii) for expenditures for outreach activities as provided in section 2102(c)(1) under the plan;

(iv) for translation or interpretation services in connection with the enrollment of, retention of, and use of services under this title by, individuals for whom English is not their primary language (as found necessary by the Secretary for the proper and efficient administration of the State plan); and

(v) for other reasonable costs incurred by the State to administer the plan.

(2) **ORDER OF PAYMENTS.**—Payments under paragraph (1) from a State's allotment shall be made in the following order:

(A) First, for expenditures for items described in paragraph (1)(A).

(B) Second, for expenditures for items described in paragraph (1)(B).

(C) Third, for expenditures for items described in paragraph (1)(C).

(D) Fourth, for expenditures for items described in paragraph (1)(D).

(3) **PERFORMANCE BONUS PAYMENT TO OFFSET ADDITIONAL MEDICAID AND CHIP CHILD ENROLLMENT COSTS RESULTING FROM ENROLLMENT AND RETENTION EFFORTS.**—

(A) IN GENERAL.—In addition to the payments made under paragraph (1), for each fiscal year (beginning with fiscal year 2009 and ending with fiscal year 2013), the Secretary shall pay from amounts made available under subparagraph (E), to each State that meets the condition under paragraph (4) for the fiscal year, an amount equal to the amount described in subparagraph (B) for the State and fiscal year. The payment under this paragraph shall be made, to a State for a fiscal year, as a single payment not later than the last day of the first calendar quarter of the following fiscal year.

(B) AMOUNT FOR ABOVE BASELINE MEDICAID CHILD ENROLLMENT COSTS.—Subject to subparagraph (E), the amount described in this subparagraph for a State for a fiscal year is equal to the sum of the following amounts:

(i) FIRST TIER ABOVE BASELINE MEDICAID ENROLLEES.—An amount equal to the number of first tier above baseline child enrollees (as determined under subparagraph (C)(i)) under title XIX for the State and fiscal year, multiplied by 15 percent of the projected per capita State Medicaid expenditures (as determined under subparagraph (D)) for the State and fiscal year under title XIX.

(ii) SECOND TIER ABOVE BASELINE MEDICAID ENROLLEES.—An amount equal to the number of second tier above baseline child enrollees (as determined under subparagraph (C)(ii)) under title XIX for the State and fiscal year, multiplied by 62.5 percent of the projected per capita State Medicaid expenditures (as determined under subparagraph (D)) for the State and fiscal year under title XIX.

(C) NUMBER OF FIRST AND SECOND TIER ABOVE BASELINE CHILD ENROLLEES; BASELINE NUMBER OF CHILD ENROLLEES.—For purposes of this paragraph:

(i) FIRST TIER ABOVE BASELINE CHILD ENROLLEES.—The number of first tier above baseline child enrollees for a State for a fiscal year under title XIX is equal to the number (if any, as determined by the Secretary) by which—

(I) the monthly average unduplicated number of qualifying children (as defined in subparagraph (F)) enrolled during the fiscal year under the State plan under title XIX; exceeds

(II) the baseline number of enrollees described in clause (iii) for the State and fiscal year under title XIX;

but not to exceed 10 percent of the baseline number of enrollees described in subclause (II).

(ii) SECOND TIER ABOVE BASELINE CHILD ENROLLEES.—The number of second tier above baseline child enrollees for a State for a fiscal year under title XIX is equal to the number (if any, as determined by the Secretary) by which—

(I) the monthly average unduplicated number of qualifying children (as defined in subparagraph

(F)) enrolled during the fiscal year under title XIX as described in clause (i)(I); exceeds

(II) the sum of the baseline number of child enrollees described in clause (iii) for the State and fiscal year under title XIX, as described in clause (i)(II), and the maximum number of first tier above baseline child enrollees for the State and fiscal year under title XIX, as determined under clause (i).

(iii) **BASELINE NUMBER OF CHILD ENROLLEES.**—Subject to subparagraph (H), the baseline number of child enrollees for a State under title XIX—

(I) for fiscal year 2009 is equal to the monthly average unduplicated number of qualifying children enrolled in the State plan under title XIX during fiscal year 2007 increased by the population growth for children in that State from 2007 to 2008 (as estimated by the Bureau of the Census) plus 4 percentage points, and further increased by the population growth for children in that State from 2008 to 2009 (as estimated by the Bureau of the Census) plus 4 percentage points;

(II) for each of fiscal years 2010, 2011, and 2012, is equal to the baseline number of child enrollees for the State for the previous fiscal year under title XIX, increased by the population growth for children in that State from the calendar year in which the respective fiscal year begins to the succeeding calendar year (as estimated by the Bureau of the Census) plus 3.5 percentage points;

(III) for each of fiscal years 2013, 2014, and 2015, is equal to the baseline number of child enrollees for the State for the previous fiscal year under title XIX, increased by the population growth for children in that State from the calendar year in which the respective fiscal year begins to the succeeding calendar year (as estimated by the Bureau of the Census) plus 3 percentage points; and

(IV) for a subsequent fiscal year is equal to the baseline number of child enrollees for the State for the previous fiscal year under title XIX, increased by the population growth for children in that State from the calendar year in which the fiscal year involved begins to the succeeding calendar year (as estimated by the Bureau of the Census) plus 2 percentage points.

(D) **PROJECTED PER CAPITA STATE MEDICAID EXPENDITURES.**—For purposes of subparagraph (B), the projected per capita State Medicaid expenditures for a State and fiscal year under title XIX is equal to the average per capita expenditures (including both State and Federal financial participation) for children under the State plan under such title, including under waivers but not including such chil-

dren eligible for assistance by virtue of the receipt of benefits under title XVI, for the most recent fiscal year for which actual data are available (as determined by the Secretary), increased (for each subsequent fiscal year up to and including the fiscal year involved) by the annual percentage increase in per capita amount of National Health Expenditures (as estimated by the Secretary) for the calendar year in which the respective subsequent fiscal year ends and multiplied by a State matching percentage equal to 100 percent minus the Federal medical assistance percentage (as defined in section 1905(b)) for the fiscal year involved.

(E) AMOUNTS AVAILABLE FOR PAYMENTS.—

(i) INITIAL APPROPRIATION.—Out of any money in the Treasury not otherwise appropriated, there are appropriated \$3,225,000,000 for fiscal year 2009 for making payments under this paragraph, to be available until expended.

(ii) TRANSFERS.—Notwithstanding any other provision of this title, the following amounts shall also be available, without fiscal year limitation, for making payments under this paragraph:

(I) UNOBLIGATED NATIONAL ALLOTMENT.—

(aa) FISCAL YEARS 2009 THROUGH 2012.—As of December 31 of fiscal year 2009, and as of December 31 of each succeeding fiscal year through fiscal year 2012, the portion, if any, of the amount appropriated under subsection (a) for such fiscal year that is unobligated for allotment to a State under subsection (m) for such fiscal year or set aside under subsection (a)(3) or (b)(2) of section 2111 for such fiscal year.

(bb) FIRST HALF OF FISCAL YEAR 2013.—As of December 31 of fiscal year 2013, the portion, if any, of the sum of the amounts appropriated under subsection (a)(16)(A) and under section 108 of the Children's Health Insurance Reauthorization Act of 2009 for the period beginning on October 1, 2012, and ending on March 31, 2013, that is unobligated for allotment to a State under subsection (m) for such fiscal year or set aside under subsection (b)(2) of section 2111 for such fiscal year.

(cc) SECOND HALF OF FISCAL YEAR 2013.—As of June 30 of fiscal year 2013, the portion, if any, of the amount appropriated under subsection (a)(16)(B) for the period beginning on April 1, 2013, and ending on September 30, 2013, that is unobligated for allotment to a State under subsection (m) for such fiscal year or set aside under subsection (b)(2) of section 2111 for such fiscal year.

(II) UNEXPENDED ALLOTMENTS NOT USED FOR REDISTRIBUTION.—As of November 15 of each of

fiscal years 2010 through 2013, the total amount of allotments made to States under section 2104 for the second preceding fiscal year (third preceding fiscal year in the case of the fiscal year 2006, 2007, and 2008 allotments) that is not expended or redistributed under section 2104(f) during the period in which such allotments are available for obligation.

(III) EXCESS CHILD ENROLLMENT CONTINGENCY FUNDS.—As of October 1 of each of fiscal years 2010 through 2013, any amount in excess of the aggregate cap applicable to the Child Enrollment Contingency Fund for the fiscal year under section 2104(n).

(iii) PROPORTIONAL REDUCTION.—If the sum of the amounts otherwise payable under this paragraph for a fiscal year exceeds the amount available for the fiscal year under this subparagraph, the amount to be paid under this paragraph to each State shall be reduced proportionally.

(F) QUALIFYING CHILDREN DEFINED.—

(i) IN GENERAL.—For purposes of this subsection, subject to clauses (ii) and (iii), the term “qualifying children” means children who meet the eligibility criteria (including income, categorical eligibility, age, and immigration status criteria) in effect as of July 1, 2008, for enrollment under title XIX, taking into account criteria applied as of such date under title XIX pursuant to a waiver under section 1115.

(ii) LIMITATION.—A child described in clause (i) who is provided medical assistance during a presumptive eligibility period under section 1920A shall be considered to be a “qualifying child” only if the child is determined to be eligible for medical assistance under title XIX.

(iii) EXCLUSION.—Such term does not include any children for whom the State has made an election to provide medical assistance under paragraph (4) of section 1903(v) or any children enrolled on or after October 1, 2013.

(G) APPLICATION TO COMMONWEALTHS AND TERRITORIES.—The provisions of subparagraph (G) of section 2104(n)(3) shall apply with respect to payment under this paragraph in the same manner as such provisions apply to payment under such section.

(H) APPLICATION TO STATES THAT IMPLEMENT A MEDICAID EXPANSION FOR CHILDREN AFTER FISCAL YEAR 2008.—In the case of a State that provides coverage under section 115 of the Children’s Health Insurance Program Reauthorization Act of 2009 for any fiscal year after fiscal year 2008—

(i) any child enrolled in the State plan under title XIX through the application of such an election shall be disregarded from the determination for the State of the monthly average unduplicated number of quali-

fying children enrolled in such plan during the first 3 fiscal years in which such an election is in effect; and

(ii) in determining the baseline number of child enrollees for the State for any fiscal year subsequent to such first 3 fiscal years, the baseline number of child enrollees for the State under title XIX for the third of such fiscal years shall be the monthly average unduplicated number of qualifying children enrolled in the State plan under title XIX for such third fiscal year.

(4) ENROLLMENT AND RETENTION PROVISIONS FOR CHILDREN.—For purposes of paragraph (3)(A), a State meets the condition of this paragraph for a fiscal year if it is implementing at least 5 of the following enrollment and retention provisions (treating each subparagraph as a separate enrollment and retention provision) throughout the entire fiscal year:

(A) CONTINUOUS ELIGIBILITY.—The State has elected the option of continuous eligibility for a full 12 months for all children described in section 1902(e)(12) under title XIX under 19 years of age, as well as applying such policy under its State child health plan under this title.

(B) LIBERALIZATION OF ASSET REQUIREMENTS.—The State meets the requirement specified in either of the following clauses:

(i) ELIMINATION OF ASSET TEST.—The State does not apply any asset or resource test for eligibility for children under title XIX or this title.

(ii) ADMINISTRATIVE VERIFICATION OF ASSETS.—The State—

(I) permits a parent or caretaker relative who is applying on behalf of a child for medical assistance under title XIX or child health assistance under this title to declare and certify by signature under penalty of perjury information relating to family assets for purposes of determining and re-determining financial eligibility; and

(II) takes steps to verify assets through means other than by requiring documentation from parents and applicants except in individual cases of discrepancies or where otherwise justified.

(C) ELIMINATION OF IN-PERSON INTERVIEW REQUIREMENT.—The State does not require an application of a child for medical assistance under title XIX (or for child health assistance under this title), including an application for renewal of such assistance, to be made in person nor does the State require a face-to-face interview, unless there are discrepancies or individual circumstances justifying an in-person application or face-to-face interview.

(D) USE OF JOINT APPLICATION FOR MEDICAID AND CHIP.—The application form and supplemental forms (if any) and information verification process is the same for purposes of establishing and renewing eligibility for children for medical assistance under title XIX and child health assistance under this title.

(E) AUTOMATIC RENEWAL (USE OF ADMINISTRATIVE RENEWAL).—

(i) IN GENERAL.—The State provides, in the case of renewal of a child's eligibility for medical assistance under title XIX or child health assistance under this title, a pre-printed form completed by the State based on the information available to the State and notice to the parent or caretaker relative of the child that eligibility of the child will be renewed and continued based on such information unless the State is provided other information. Nothing in this clause shall be construed as preventing a State from verifying, through electronic and other means, the information so provided.

(ii) SATISFACTION THROUGH DEMONSTRATED USE OF EX PARTE PROCESS.—A State shall be treated as satisfying the requirement of clause (i) if renewal of eligibility of children under title XIX or this title is determined without any requirement for an in-person interview, unless sufficient information is not in the State's possession and cannot be acquired from other sources (including other State agencies) without the participation of the applicant or the applicant's parent or caretaker relative.

(F) PRESUMPTIVE ELIGIBILITY FOR CHILDREN.—The State is implementing section 1920A under title XIX as well as, pursuant to section 2107(e)(1), under this title.

(G) EXPRESS LANE.—The State is implementing the option described in section 1902(e)(13) under title XIX as well as, pursuant to section 2107(e)(1), under this title.

(H) PREMIUM ASSISTANCE SUBSIDIES.—The State is implementing the option of providing premium assistance subsidies under section 2105(c)(10) or section 1906A.

(b) ENHANCED FMAP.—For purposes of subsection (a), the "enhanced FMAP", for a State for a fiscal year, is equal to the Federal medical assistance percentage (as defined in the first sentence of section 1905(b)) for the State increased by a number of percentage points equal to 30 percent of the number of percentage points by which (1) such Federal medical assistance percentage for the State, is less than (2) 100 percent; but in no case shall the enhanced FMAP for a State exceed 85 percent. Notwithstanding the preceding sentence, during the period that begins on October 1, 2015, and ends on September 30, 2019, the enhanced FMAP determined for a State for a fiscal year (or for any portion of a fiscal year occurring during such period) shall be increased by 23 percentage points, *and during the period that begins on October 1, 2019, and ends on September 30, 2020, the enhanced FMAP determined for a State for a fiscal year (or for any portion of a fiscal year occurring during such period) shall be increased by 11.5 percentage points* but in no case shall exceed 100 percent. The increase in the enhanced FMAP under the preceding sentence shall not apply with respect to determining the payment to a State under subsection (a)(1) for expenditures described in subparagraph (D)(iv), paragraphs (8), (9), (11) of subsection (c), or clause (4) of the first sentence of section 1905(b).

(c) LIMITATION ON CERTAIN PAYMENTS FOR CERTAIN EXPENDITURES.—

(1) GENERAL LIMITATIONS.—Funds provided to a State under this title shall only be used to carry out the purposes of this title (as described in section 2101) and may not include coverage of a nonpregnant childless adult, and any health insurance coverage provided with such funds may include coverage of abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. For purposes of the preceding sentence, a caretaker relative (as such term is defined for purposes of carrying out section 1931) shall not be considered a childless adult.

(2) LIMITATION ON EXPENDITURES NOT USED FOR MEDICAID OR HEALTH INSURANCE ASSISTANCE.—

(A) IN GENERAL.—Except as provided in this paragraph, the amount of payment that may be made under subsection (a) for a fiscal year for expenditures for items described in paragraph (1)(D) of such subsection shall not exceed 10 percent of the total amount of expenditures for which payment is made under subparagraphs (A), (C), and (D) of paragraph (1) of such subsection.

(B) WAIVER AUTHORIZED FOR COST-EFFECTIVE ALTERNATIVE.—The limitation under subparagraph (A) on expenditures for items described in subsection (a)(1)(D) shall not apply to the extent that a State establishes to the satisfaction of the Secretary that—

(i) coverage provided to targeted low-income children through such expenditures meets the requirements of section 2103;

(ii) the cost of such coverage is not greater, on an average per child basis, than the cost of coverage that would otherwise be provided under section 2103; and

(iii) such coverage is provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under section 1886(d)(5)(F) or 1923.

(C) NONAPPLICATION TO CERTAIN EXPENDITURES.—The limitation under subparagraph (A) shall not apply with respect to the following expenditures:

(i) EXPENDITURES TO INCREASE OUTREACH TO, AND THE ENROLLMENT OF, INDIAN CHILDREN UNDER THIS TITLE AND TITLE XIX.—Expenditures for outreach activities to families of Indian children likely to be eligible for child health assistance under the plan or medical assistance under the State plan under title XIX (or under a waiver of such plan), to inform such families of the availability of, and to assist them in enrolling their children in, such plans, including such activities conducted under grants, contracts, or agreements entered into under section 1139(a).

(ii) EXPENDITURES TO COMPLY WITH CITIZENSHIP OR NATIONALITY VERIFICATION REQUIREMENTS.—Expenditures necessary for the State to comply with paragraph (9)(A).

(iii) EXPENDITURES FOR OUTREACH TO INCREASE THE ENROLLMENT OF CHILDREN UNDER THIS TITLE AND TITLE XIX THROUGH PREMIUM ASSISTANCE SUBSIDIES.—Expenditures for outreach activities to families of children likely to be eligible for premium assistance subsidies in accordance with paragraph (2)(B), (3), or (10), or a waiver approved under section 1115, to inform such families of the availability of, and to assist them in enrolling their children in, such subsidies, and to employers likely to provide qualified employer-sponsored coverage (as defined in subparagraph (B) of such paragraph), but not to exceed an amount equal to 1.25 percent of the maximum amount permitted to be expended under subparagraph (A) for items described in subsection (a)(1)(D).

(iv) PAYMENT ERROR RATE MEASUREMENT (PERM) EXPENDITURES.—Expenditures related to the administration of the payment error rate measurement (PERM) requirements applicable to the State child health plan in accordance with the Improper Payments Information Act of 2002 and parts 431 and 457 of title 42, Code of Federal Regulations (or any related or successor guidance or regulations).

(3) WAIVER FOR PURCHASE OF FAMILY COVERAGE.—Payment may be made to a State under subsection (a)(1) for the purchase of family coverage under a group health plan or health insurance coverage that includes coverage of targeted low-income children only if the State establishes to the satisfaction of the Secretary that—

(A) purchase of such coverage is cost-effective relative to—

(i) the amount of expenditures under the State child health plan, including administrative expenditures, that the State would have made to provide comparable coverage of the targeted low-income child involved or the family involved (as applicable); or

(ii) the aggregate amount of expenditures that the State would have made under the State child health plan, including administrative expenditures, for providing coverage under such plan for all such children or families; and

(B) such coverage shall not be provided if it would otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage.

(4) USE OF NON-FEDERAL FUNDS FOR STATE MATCHING REQUIREMENT.—Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of non-Federal contributions required under subsection (a).

(5) OFFSET OF RECEIPTS ATTRIBUTABLE TO PREMIUMS AND OTHER COST-SHARING.—For purposes of subsection (a), the amount of the expenditures under the plan shall be reduced by

the amount of any premiums and other cost-sharing received by the State.

(6) PREVENTION OF DUPLICATIVE PAYMENTS.—

(A) OTHER HEALTH PLANS.—No payment shall be made to a State under this section for expenditures for child health assistance provided for a targeted low-income child under its plan 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 child health assistance under the plan.

(B) OTHER FEDERAL GOVERNMENTAL PROGRAMS.—Except as provided in subparagraph (A) or (B) of subsection (a)(1) or any other provision of law, no payment shall be made to a State under this section for expenditures for child health assistance provided for a targeted low-income child under its plan to the extent that payment has been made or can reasonably be expected to be made promptly (as determined in accordance with regulations) under any other federally operated or financed health care insurance program, other than an insurance program operated or financed by the Indian Health Service, as identified by the Secretary. For purposes of this paragraph, rules similar to the rules for overpayments under section 1903(d)(2) shall apply.

(7) LIMITATION ON PAYMENT FOR ABORTIONS.—

(A) IN GENERAL.—Payment shall not be made to a State under this section for any amount expended under the State plan to pay for any abortion or to assist in the purchase, in whole or in part, of health benefit coverage that includes coverage of abortion.

(B) EXCEPTION.—Subparagraph (A) shall not apply to an abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.

(C) RULE OF CONSTRUCTION.—Nothing in this section shall be construed as affecting the expenditure by a State, locality, or private person or entity of State, local, or private funds (other than funds expended under the State plan) for any abortion or for health benefits coverage that includes coverage of abortion.

(8) LIMITATION ON MATCHING RATE FOR EXPENDITURES FOR CHILD HEALTH ASSISTANCE PROVIDED TO CHILDREN WHOSE EFFECTIVE FAMILY INCOME EXCEEDS 300 PERCENT OF THE POVERTY LINE.—

(A) FMAP APPLIED TO EXPENDITURES.—Except as provided in subparagraph (B), for fiscal years beginning with fiscal year 2009, the Federal medical assistance percentage (as determined under section 1905(b) without regard to clause (4) of such section) shall be substituted for the enhanced FMAP under subsection (a)(1) with respect to any

expenditures for providing child health assistance or health benefits coverage for a targeted low-income child whose effective family income would exceed 300 percent of the poverty line but for the application of a general exclusion of a block of income that is not determined by type of expense or type of income.

(B) EXCEPTION.—Subparagraph (A) shall not apply to any State that, on the date of enactment of the Children’s Health Insurance Program Reauthorization Act of 2009, has an approved State plan amendment or waiver to provide, or has enacted a State law to submit a State plan amendment to provide, expenditures described in such subparagraph under the State child health plan.

(9) CITIZENSHIP DOCUMENTATION REQUIREMENTS.—

(A) IN GENERAL.—No payment may be made under this section with respect to an individual who has, or is, declared to be a citizen or national of the United States for purposes of establishing eligibility under this title unless the State meets the requirements of section 1902(a)(46)(B) with respect to the individual.

(B) ENHANCED PAYMENTS.—Notwithstanding subsection (b), the enhanced FMAP with respect to payments under subsection (a) for expenditures described in clause (i) or (ii) of section 1903(a)(3)(G) necessary to comply with subparagraph (A) shall in no event be less than 90 percent and 75 percent, respectively.

(10) STATE OPTION TO OFFER PREMIUM ASSISTANCE.—

(A) IN GENERAL.—A State may elect to offer a premium assistance subsidy (as defined in subparagraph (C)) for qualified employer-sponsored coverage (as defined in subparagraph (B)) to all targeted low-income children who are eligible for child health assistance under the plan and have access to such coverage in accordance with the requirements of this paragraph if the offering of such a subsidy is cost-effective, as defined for purposes of paragraph (3)(A). No subsidy shall be provided to a targeted low-income child under this paragraph unless the child (or the child’s parent) voluntarily elects to receive such a subsidy. A State may not require such an election as a condition of receipt of child health assistance.

(B) QUALIFIED EMPLOYER-SPONSORED COVERAGE.—

(i) IN GENERAL.—Subject to clause (ii), in this paragraph, the term “qualified employer-sponsored coverage” means a group health plan or health insurance coverage offered through an employer—

(I) that qualifies as creditable coverage as a group health plan under section 2701(c)(1) of the Public Health Service Act;

(II) for which the employer contribution toward any premium for such coverage is at least 40 percent; and

(III) that is offered to all individuals in a manner that would be considered a nondiscriminatory eligibility classification for purposes of paragraph (3)(A)(ii) of section 105(h) of the Internal Revenue

Code of 1986 (but determined without regard to clause (i) of subparagraph (B) of such paragraph).

(ii) EXCEPTION.—Such term does not include coverage consisting of—

(I) benefits provided under a health flexible spending arrangement (as defined in section 106(c)(2) of the Internal Revenue Code of 1986); or

(II) a high deductible health plan (as defined in section 223(c)(2) of such Code), without regard to whether the plan is purchased in conjunction with a health savings account (as defined under section 223(d) of such Code).

(C) PREMIUM ASSISTANCE SUBSIDY.—

(i) IN GENERAL.—In this paragraph, the term “premium assistance subsidy” means, with respect to a targeted low-income child, the amount equal to the difference between the employee contribution required for enrollment only of the employee under qualified employer-sponsored coverage and the employee contribution required for enrollment of the employee and the child in such coverage, less any applicable premium cost-sharing applied under the State child health plan (subject to the limitations imposed under section 2103(e), including the requirement to count the total amount of the employee contribution required for enrollment of the employee and the child in such coverage toward the annual aggregate cost-sharing limit applied under paragraph (3)(B) of such section).

(ii) STATE PAYMENT OPTION.—A State may provide a premium assistance subsidy either as reimbursement to an employee for out-of-pocket expenditures or, subject to clause (iii), directly to the employee’s employer.

(iii) EMPLOYER OPT-OUT.—An employer may notify a State that it elects to opt-out of being directly paid a premium assistance subsidy on behalf of an employee. In the event of such a notification, an employer shall withhold the total amount of the employee contribution required for enrollment of the employee and the child in the qualified employer-sponsored coverage and the State shall pay the premium assistance subsidy directly to the employee.

(iv) TREATMENT AS CHILD HEALTH ASSISTANCE.—Expenditures for the provision of premium assistance subsidies shall be considered child health assistance described in paragraph (1)(C) of subsection (a) for purposes of making payments under that subsection.

(D) APPLICATION OF SECONDARY PAYOR RULES.—The State shall be a secondary payor for any items or services provided under the qualified employer-sponsored coverage for which the State provides child health assistance under the State child health plan.

(E) REQUIREMENT TO PROVIDE SUPPLEMENTAL COVERAGE FOR BENEFITS AND COST-SHARING PROTECTION PROVIDED UNDER THE STATE CHILD HEALTH PLAN.—

(i) IN GENERAL.—Notwithstanding section 2110(b)(1)(C), the State shall provide for each targeted low-income child enrolled in qualified employer-sponsored coverage, supplemental coverage consisting of—

(I) items or services that are not covered, or are only partially covered, under the qualified employer-sponsored coverage; and

(II) cost-sharing protection consistent with section 2103(e).

(ii) RECORD KEEPING REQUIREMENTS.—For purposes of carrying out clause (i), a State may elect to directly pay out-of-pocket expenditures for cost-sharing imposed under the qualified employer-sponsored coverage and collect or not collect all or any portion of such expenditures from the parent of the child.

(F) APPLICATION OF WAITING PERIOD IMPOSED UNDER THE STATE.—Any waiting period imposed under the State child health plan prior to the provision of child health assistance to a targeted low-income child under the State plan shall apply to the same extent to the provision of a premium assistance subsidy for the child under this paragraph.

(G) OPT-OUT PERMITTED FOR ANY MONTH.—A State shall establish a process for permitting the parent of a targeted low-income child receiving a premium assistance subsidy to disenroll the child from the qualified employer-sponsored coverage and enroll the child in, and receive child health assistance under, the State child health plan, effective on the first day of any month for which the child is eligible for such assistance and in a manner that ensures continuity of coverage for the child.

(H) APPLICATION TO PARENTS.—If a State provides child health assistance or health benefits coverage to parents of a targeted low-income child in accordance with section 2111(b), the State may elect to offer a premium assistance subsidy to a parent of a targeted low-income child who is eligible for such a subsidy under this paragraph in the same manner as the State offers such a subsidy for the enrollment of the child in qualified employer-sponsored coverage, except that—

(i) the amount of the premium assistance subsidy shall be increased to take into account the cost of the enrollment of the parent in the qualified employer-sponsored coverage or, at the option of the State if the State determines it cost-effective, the cost of the enrollment of the child's family in such coverage; and

(ii) any reference in this paragraph to a child is deemed to include a reference to the parent or, if applicable under clause (i), the family of the child.

(I) ADDITIONAL STATE OPTION FOR PROVIDING PREMIUM ASSISTANCE.—

(i) IN GENERAL.—A State may establish an employer-family premium assistance purchasing pool for employers with less than 250 employees who have at least 1 employee who is a pregnant woman eligible for assistance under the State child health plan (including

through the application of an option described in section 2112(f) or a member of a family with at least 1 targeted low-income child and to provide a premium assistance subsidy under this paragraph for enrollment in coverage made available through such pool.

(ii) ACCESS TO CHOICE OF COVERAGE.—A State that elects the option under clause (i) shall identify and offer access to not less than 2 private health plans that are health benefits coverage that is equivalent to the benefits coverage in a benchmark benefit package described in section 2103(b) or benchmark-equivalent coverage that meets the requirements of section 2103(a)(2) for employees described in clause (i).

(iii) CLARIFICATION OF PAYMENT FOR ADMINISTRATIVE EXPENDITURES.—Nothing in this subparagraph shall be construed as permitting payment under this section for administrative expenditures attributable to the establishment or operation of such pool, except to the extent that such payment would otherwise be permitted under this title.

(J) NO EFFECT ON PREMIUM ASSISTANCE WAIVER PROGRAMS.—Nothing in this paragraph shall be construed as limiting the authority of a State to offer premium assistance under section 1906 or 1906A, a waiver described in paragraph (2)(B) or (3), a waiver approved under section 1115, or other authority in effect prior to the date of enactment of the Children’s Health Insurance Program Reauthorization Act of 2009.

(K) NOTICE OF AVAILABILITY.—If a State elects to provide premium assistance subsidies in accordance with this paragraph, the State shall—

(i) include on any application or enrollment form for child health assistance a notice of the availability of premium assistance subsidies for the enrollment of targeted low-income children in qualified employer-sponsored coverage;

(ii) provide, as part of the application and enrollment process under the State child health plan, information describing the availability of such subsidies and how to elect to obtain such a subsidy; and

(iii) establish such other procedures as the State determines necessary to ensure that parents are fully informed of the choices for receiving child health assistance under the State child health plan or through the receipt of premium assistance subsidies.

(L) APPLICATION TO QUALIFIED EMPLOYER-SPONSORED BENCHMARK COVERAGE.—If a group health plan or health insurance coverage offered through an employer is certified by an actuary as health benefits coverage that is equivalent to the benefits coverage in a benchmark benefit package described in section 2103(b) or benchmark-equivalent coverage that meets the requirements of section 2103(a)(2), the State may provide premium assistance subsidies for enrollment of targeted low-income children in such group health plan or health insurance coverage in the same man-

ner as such subsidies are provided under this paragraph for enrollment in qualified employer-sponsored coverage, but without regard to the requirement to provide supplemental coverage for benefits and cost-sharing protection provided under the State child health plan under subparagraph (E).

(M) COORDINATION WITH MEDICAID.—In the case of a targeted low-income child who receives child health assistance through a State plan under title XIX and who voluntarily elects to receive a premium assistance subsidy under this section, the provisions of section 1906A shall apply and shall supersede any other provisions of this paragraph that are inconsistent with such section.

(11) ENHANCED PAYMENTS.—Notwithstanding subsection (b), the enhanced FMAP with respect to payments under subsection (a) for expenditures related to the administration of the payment error rate measurement (PERM) requirements applicable to the State child health plan in accordance with the Improper Payments Information Act of 2002 and parts 431 and 457 of title 42, Code of Federal Regulations (or any related or successor guidance or regulations) shall in no event be less than 90 percent.

(d) MAINTENANCE OF EFFORT.—

(1) IN MEDICAID ELIGIBILITY STANDARDS.—No payment may be made under subsection (a) with respect to child health assistance provided under a State child health plan if the State adopts income and resource standards and methodologies for purposes of determining a child's eligibility for medical assistance under the State plan under title XIX that are more restrictive than those applied as of June 1, 1997, except as required under section 1902(e)(14).

(2) IN AMOUNTS OF PAYMENT EXPENDED FOR CERTAIN STATE-FUNDED HEALTH INSURANCE PROGRAMS FOR CHILDREN.—

(A) IN GENERAL.—The amount of the allotment for a State in a fiscal year (beginning with fiscal year 1999) shall be reduced by the amount by which—

- (i) the total of the State children's health insurance expenditures in the preceding fiscal year, is less than
- (ii) the total of such expenditures in fiscal year 1996.

(B) STATE CHILDREN'S HEALTH INSURANCE EXPENDITURES.—The term "State children's health insurance expenditures" means the following:

- (i) The State share of expenditures under this title.
- (ii) The State share of expenditures under title XIX that are attributable to an enhanced FMAP under the fourth sentence of section 1905(b).
- (iii) State expenditures under health benefits coverage under an existing comprehensive State-based program, described in section 2103(d).

(3) CONTINUATION OF ELIGIBILITY STANDARDS FOR CHILDREN [UNTIL OCTOBER 1, 2019] THROUGH SEPTEMBER 30, 2022.—

(A) IN GENERAL.—During the period that begins on the date of enactment of the Patient Protection and Affordable Care Act and ends on September 30, [2019] 2022, as a condition of receiving payments under section 1903(a), a

State shall not have in effect eligibility standards, methodologies, or procedures under its State child health plan (including any waiver under such plan) for children (including children provided medical assistance for which payment is made under section 2105(a)(1)(A)) that are more restrictive than the eligibility standards, methodologies, or procedures, respectively, under such plan (or waiver) as in effect on the date of enactment of that Act. [The preceding sentence shall not be construed as preventing a State during such period] *During the period that begins on October 1, 2019, and ends on September 30, 2022, the preceding sentence shall only apply with respect to children in families whose income does not exceed 300 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved. The preceding sentences shall not be construed as preventing a State during any such periods from—*

(i) applying eligibility standards, methodologies, or procedures for children under the State child health plan or under any waiver of the plan that are less restrictive than the eligibility standards, methodologies, or procedures, respectively, for children under the plan or waiver that are in effect on the date of enactment of such Act;

(ii) after September 30, 2015, enrolling children eligible to be targeted low-income children under the State child health plan in a qualified health plan that has been certified by the Secretary under subparagraph (C); or

(iii) imposing a limitation described in section 2112(b)(7) for a fiscal year in order to limit expenditures under the State child health plan to those for which Federal financial participation is available under this section for the fiscal year.

(B) ASSURANCE OF EXCHANGE COVERAGE FOR TARGETED LOW-INCOME CHILDREN UNABLE TO BE PROVIDED CHILD HEALTH ASSISTANCE AS A RESULT OF FUNDING SHORTFALLS.—In the event that allotments provided under section 2104 are insufficient to provide coverage to all children who are eligible to be targeted low-income children under the State child health plan under this title, a State shall establish procedures to ensure that such children are screened for eligibility for medical assistance under the State plan under title XIX or a waiver of that plan and, if found eligible, enrolled in such plan or a waiver. In the case of such children who, as a result of such screening, are determined to not be eligible for medical assistance under the State plan or a waiver under title XIX, the State shall establish procedures to ensure that the children are enrolled in a qualified health plan that has been certified by the Secretary under subparagraph (C) and is offered through an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act. For purposes of eligibility for premium assistance for the purchase of a qualified health plan under section 36B

of the Internal Revenue Code of 1986 and reduced cost-sharing under section 1402 of the Patient Protection and Affordable Care Act, children described in the preceding sentence shall be deemed to be ineligible for coverage under the State child health plan.

(C) CERTIFICATION OF COMPARABILITY OF PEDIATRIC COVERAGE OFFERED BY QUALIFIED HEALTH PLANS.—With respect to each State, the Secretary, not later than April 1, 2015, shall review the benefits offered for children and the cost-sharing imposed with respect to such benefits by qualified health plans offered through an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act and shall certify those plans that offer benefits for children and impose cost-sharing with respect to such benefits that the Secretary determines are at least comparable to the benefits offered and cost-sharing protections provided under the State child health plan.

(e) ADVANCE PAYMENT; RETROSPECTIVE ADJUSTMENT.—The Secretary may make payments under this section for each quarter on the basis of advance estimates of expenditures submitted by the State and such other investigation as the Secretary may find necessary, and may reduce or increase the payments as necessary to adjust for any overpayment or underpayment for prior quarters.

(f) FLEXIBILITY IN SUBMITTAL OF CLAIMS.—Nothing in this section or subsections (e) and (f) of section 2104 shall be construed as preventing a State from claiming as expenditures in the quarter expenditures that were incurred in a previous quarter.

(g) AUTHORITY FOR QUALIFYING STATES TO USE CERTAIN FUNDS FOR MEDICAID EXPENDITURES.—

(1) STATE OPTION.—

(A) IN GENERAL.—Notwithstanding any other provision of law, subject to paragraph (4), a qualifying State (as defined in paragraph (2)) may elect to use not more than 20 percent of any allotment under section 2104 for fiscal year 1998, 1999, 2000, 2001, 2004, 2005, 2006, 2007, or 2008 (insofar as it is available under subsections (e) and (g) of such section) for payments under title XIX in accordance with subparagraph (B), instead of for expenditures under this title.

(B) PAYMENTS TO STATES.—

(i) IN GENERAL.—In the case of a qualifying State that has elected the option described in subparagraph (A), subject to the availability of funds under such subparagraph with respect to the State, the Secretary shall pay the State an amount each quarter equal to the additional amount that would have been paid to the State under title XIX with respect to expenditures described in clause (ii) if the enhanced FMAP (as determined under subsection (b)) had been substituted for the Federal medical assistance percentage (as defined in section 1905(b)).

(ii) EXPENDITURES DESCRIBED.—For purposes of this subparagraph, the expenditures described in this clause are expenditures, made after the date of the en-

actment of this subsection and during the period in which funds are available to the qualifying State for use under subparagraph (A), for medical assistance under title XIX to individuals who have not attained age 19 and whose family income exceeds 150 percent of the poverty line.

(iii) NO IMPACT ON DETERMINATION OF BUDGET NEUTRALITY FOR WAIVERS.—In the case of a qualifying State that uses amounts paid under this subsection for expenditures described in clause (ii) that are incurred under a waiver approved for the State, any budget neutrality determinations with respect to such waiver shall be determined without regard to such amounts paid.

(2) QUALIFYING STATE.—In this subsection, the term “qualifying State” means a State that, on and after April 15, 1997, has an income eligibility standard that is at least 184 percent of the poverty line with respect to any 1 or more categories of children (other than infants) who are eligible for medical assistance under section 1902(a)(10)(A) or, in the case of a State that has a statewide waiver in effect under section 1115 with respect to title XIX that was first implemented on August 1, 1994, or July 1, 1995, has an income eligibility standard under such waiver for children that is at least 185 percent of the poverty line, or, in the case of a State that has a statewide waiver in effect under section 1115 with respect to title XIX that was first implemented on January 1, 1994, has an income eligibility standard under such waiver for children who lack health insurance that is at least 185 percent of the poverty line, or, in the case of a State that had a statewide waiver in effect under section 1115 with respect to title XIX that was first implemented on October 1, 1993, had an income eligibility standard under such waiver for children that was at least 185 percent of the poverty line and on and after July 1, 1998, has an income eligibility standard for children under section 1902(a)(10)(A) or a statewide waiver in effect under section 1115 with respect to title XIX that is at least 185 percent of the poverty line.

(3) CONSTRUCTION.—Nothing in paragraphs (1) and (2) shall be construed as modifying the requirements applicable to States implementing State child health plans under this title.

(4) OPTION FOR ALLOTMENTS FOR FISCAL YEARS 2009 [THROUGH 2017] THROUGH 2022.—

(A) PAYMENT OF ENHANCED PORTION OF MATCHING RATE FOR CERTAIN EXPENDITURES.—In the case of expenditures described in subparagraph (B), a qualifying State (as defined in paragraph (2)) may elect to be paid from the State’s allotment made under section 2104 for any of fiscal years 2009 through [2017] 2022 (insofar as the allotment is available to the State under subsections (e) and (m) of such section) an amount each quarter equal to the additional amount that would have been paid to the State under title XIX with respect to such expenditures if the enhanced FMAP (as determined under subsection (b)) had been substituted for the Federal medical assistance percentage (as defined in section 1905(b)).

(B) EXPENDITURES DESCRIBED.—For purposes of subparagraph (A), the expenditures described in this subparagraph are expenditures made after the date of the enactment of this paragraph and during the period in which funds are available to the qualifying State for use under subparagraph (A), for the provision of medical assistance to individuals residing in the State who are eligible for medical assistance under the State plan under title XIX or under a waiver of such plan and who have not attained age 19 (or, if a State has so elected under the State plan under title XIX, age 20 or 21), and whose family income equals or exceeds 133 percent of the poverty line but does not exceed the Medicaid applicable income level.

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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)(25) (relating to third party liability).*

[(B)] (C) Section 1902(a)(39) (relating to termination of participation of certain providers).

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

[(D)] (E) Section 1902(a)(72) (relating to limiting FQHC contracting for provision of dental services).

[(E)] (F) Section 1902(a)(73) (relating to requiring certain States to seek advice from designees of Indian Health Programs and Urban Indian Organizations).

[(F)] (G) Subsections (a)(77) and (kk) of section 1902 (relating to provider and supplier screening, oversight, and reporting requirements).

[(G)] (H) 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).

[(H)] (I) Section 1902(e)(14) (relating to income determined using modified adjusted gross income and household income).

[(I)] (J) Section 1902(bb) (relating to payment for services provided by Federally-qualified health centers and rural health clinics).

[(J)] (K) Section 1902(ff) (relating to disregard of certain property for purposes of making eligibility determinations).

[(K)] (L) Paragraphs (2), (16), and (17) of section 1903(i) (relating to limitations on payment).

[(L)] (M) Section 1903(m)(3) (relating to limitation on payment with respect to managed care).

[(M)] (N) 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.

[(N)] (O) Section 1903(w) (relating to limitations on provider taxes and donations).

[(O)] (P) Section 1920A (relating to presumptive eligibility for children).

[(P)] (Q) Subsections (a)(2)(C) (relating to Indian enrollment), (d)(5) (relating to contract requirement 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.

[(Q)] (R) Section 1942 (relating to authorization to receive data directly relevant to eligibility determinations).

[(R)] (S) 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.

(g) USE OF BLENDED RISK POOLS.—

(1) *IN GENERAL.*—*Nothing in this title (or any other provision of Federal law) shall be construed as preventing a State from considering children enrolled in a qualified CHIP look-alike program and children enrolled in a State child health plan under this title (or a waiver of such plan) as members of a single risk pool.*

(2) *QUALIFIED CHIP LOOK-ALIKE PROGRAM.*—*In this subsection, the term “qualified CHIP look-alike program” means a State program—*

(A) under which children who are under the age of 19 and are not eligible to receive medical assistance under title XIX or child health assistance under this title may purchase coverage through the State that provides benefits that are at least identical to the benefits provided under the

State child health plan under this title (or a waiver of such plan); and

(B) that is funded exclusively through non-Federal funds, including funds received by the State in the form of premiums for the purchase of such coverage.

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SEC. 2113. GRANTS TO IMPROVE OUTREACH AND ENROLLMENT.

(a) OUTREACH AND ENROLLMENT GRANTS; NATIONAL CAMPAIGN.—

(1) IN GENERAL.—From the amounts appropriated under subsection (g), subject to paragraph (2), the Secretary shall award grants to eligible entities during the period of fiscal years 2009 through ~~2017~~ 2022 to conduct outreach and enrollment efforts that are designed to increase the enrollment and participation of eligible children under this title and title XIX.

(2) TEN PERCENT SET ASIDE FOR NATIONAL ENROLLMENT CAMPAIGN.—An amount equal to 10 percent of such amounts shall be used by the Secretary for expenditures during such period to carry out a national enrollment campaign in accordance with subsection (h).

(b) PRIORITY FOR AWARD OF GRANTS.—

(1) IN GENERAL.—In awarding grants under subsection (a), the Secretary shall give priority to eligible entities that—

(A) propose to target geographic areas with high rates of—

(i) eligible but unenrolled children, including such children who reside in rural areas; or

(ii) racial and ethnic minorities and health disparity populations, including those proposals that address cultural and linguistic barriers to enrollment; and

(B) submit the most demonstrable evidence required under paragraphs (1) and (2) of subsection (c).

(2) TEN PERCENT SET ASIDE FOR OUTREACH TO INDIAN CHILDREN.—An amount equal to 10 percent of the funds appropriated under subsection (g) shall be used by the Secretary to award grants to Indian Health Service providers and urban Indian organizations receiving funds under title V of the Indian Health Care Improvement Act (25 U.S.C. 1651 et seq.) for outreach to, and enrollment of, children who are Indians.

(c) APPLICATION.—An eligible entity that desires to receive a grant under subsection (a) shall submit an application to the Secretary in such form and manner, and containing such information, as the Secretary may decide. Such application shall include—

(1) evidence demonstrating that the entity includes members who have access to, and credibility with, ethnic or low-income populations in the communities in which activities funded under the grant are to be conducted;

(2) evidence demonstrating that the entity has the ability to address barriers to enrollment, such as lack of awareness of eligibility, stigma concerns and punitive fears associated with receipt of benefits, and other cultural barriers to applying for and receiving child health assistance or medical assistance;

(3) specific quality or outcomes performance measures to evaluate the effectiveness of activities funded by a grant awarded under this section; and

- (4) an assurance that the eligible entity shall—
 - (A) conduct an assessment of the effectiveness of such activities against the performance measures;
 - (B) cooperate with the collection and reporting of enrollment data and other information in order for the Secretary to conduct such assessments; and
 - (C) in the case of an eligible entity that is not the State, provide the State with enrollment data and other information as necessary for the State to make necessary projections of eligible children and pregnant women.
- (d) DISSEMINATION OF ENROLLMENT DATA AND INFORMATION DETERMINED FROM EFFECTIVENESS ASSESSMENTS; ANNUAL REPORT.—The Secretary shall—
 - (1) make publicly available the enrollment data and information collected and reported in accordance with subsection (c)(4)(B); and
 - (2) submit an annual report to Congress on the outreach and enrollment activities conducted with funds appropriated under this section.
- (e) MAINTENANCE OF EFFORT FOR STATES AWARDED GRANTS; NO MATCH REQUIRED FOR ANY ELIGIBLE ENTITY AWARDED A GRANT.—
 - (1) STATE MAINTENANCE OF EFFORT.—In the case of a State that is awarded a grant under this section, the State share of funds expended for outreach and enrollment activities under the State child health plan shall not be less than the State share of such funds expended in the fiscal year preceding the first fiscal year for which the grant is awarded.
 - (2) NO MATCHING REQUIREMENT.—No eligible entity awarded a grant under subsection (a) shall be required to provide any matching funds as a condition for receiving the grant.
- (f) DEFINITIONS.—In this section:
 - (1) ELIGIBLE ENTITY.—The term “eligible entity” means any of the following:
 - (A) A State with an approved child health plan under this title.
 - (B) A local government.
 - (C) An Indian tribe or tribal consortium, a tribal organization, an urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act (25 U.S.C. 1651 et seq.), or an Indian Health Service provider.
 - (D) A Federal health safety net organization.
 - (E) A national, State, local, or community-based public or nonprofit private organization, including organizations that use community health workers or community-based doula programs.
 - (F) A faith-based organization or consortia, to the extent that a grant awarded to such an entity is consistent with the requirements of section 1955 of the Public Health Service Act (42 U.S.C. 300x–65) relating to a grant award to nongovernmental entities.
 - (G) An elementary or secondary school.
 - (H) *Parent mentors*.
 - (2) FEDERAL HEALTH SAFETY NET ORGANIZATION.—The term “Federal health safety net organization” means—

(A) a Federally-qualified health center (as defined in section 1905(l)(2)(B));

(B) a hospital defined as a disproportionate share hospital for purposes of section 1923;

(C) a covered entity described in section 340B(a)(4) of the Public Health Service Act (42 U.S.C. 256b(a)(4)); and

(D) any other entity or consortium that serves children under a federally funded program, including the special supplemental nutrition program for women, infants, and children (WIC) established under section 17 of the Child Nutrition Act of 1966 (42 U.S.C. 1786), the Head Start and Early Head Start programs under the Head Start Act (42 U.S.C. 9801 et seq.), the school lunch program established under the Richard B. Russell National School Lunch Act, and an elementary or secondary school.

(3) INDIANS; INDIAN TRIBE; TRIBAL ORGANIZATION; URBAN INDIAN ORGANIZATION.—The terms “Indian”, “Indian tribe”, “tribal organization”, and “urban Indian organization” have the meanings given such terms in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

(4) COMMUNITY HEALTH WORKER.—The term “community health worker” means an individual who promotes health or nutrition within the community in which the individual resides—

(A) by serving as a liaison between communities and health care agencies;

(B) by providing guidance and social assistance to community residents;

(C) by enhancing community residents’ ability to effectively communicate with health care providers;

(D) by providing culturally and linguistically appropriate health or nutrition education;

(E) by advocating for individual and community health or nutrition needs; and

(F) by providing referral and followup services.

(5) PARENT MENTOR.—*The term “parent mentor” means an individual who—*

(A) is a parent or guardian of at least one child who is an eligible child under this title or title XIX; and

(B) is trained to assist families with children who have no health insurance coverage with respect to improving the social determinants of the health of such children, including by providing—

(i) education about health insurance coverage, including, with respect to obtaining such coverage, eligibility criteria and application and renewal processes;

(ii) assistance with completing and submitting applications for health insurance coverage;

(iii) a liaison between families and representatives of State plans under title XIX or State child health plans under this title;

(iv) guidance on identifying medical and dental homes and community pharmacies for children; and

(v) assistance and referrals to successfully address social determinants of children's health, including poverty, food insufficiency, and housing.

(g) APPROPRIATION.—There is appropriated, out of any money in the Treasury not otherwise appropriated, \$140,000,000 for the period of fiscal years 2009 through 2015 [and \$40,000,000], \$40,000,000 for the period of fiscal years 2016 and 2017, and \$100,000,000 for the period of fiscal years 2018 through 2022, for the purpose of awarding grants under this section. Amounts appropriated and paid under the authority of this section shall be in addition to amounts appropriated under section 2104 and paid to States in accordance with section 2105, including with respect to expenditures for outreach activities in accordance with subsections (a)(1)(D)(iii) and (c)(2)(C) of that section.

(h) NATIONAL ENROLLMENT CAMPAIGN.—From the amounts made available under subsection (a)(2), the Secretary shall develop and implement a national enrollment campaign to improve the enrollment of underserved child populations in the programs established under this title and title XIX. Such campaign may include—

(1) the establishment of partnerships with the Secretary of Education and the Secretary of Agriculture to develop national campaigns to link the eligibility and enrollment systems for the assistance programs each Secretary administers that often serve the same children;

(2) the integration of information about the programs established under this title and title XIX in public health awareness campaigns administered by the Secretary;

(3) increased financial and technical support for enrollment hotlines maintained by the Secretary to ensure that all States participate in such hotlines;

(4) the establishment of joint public awareness outreach initiatives with the Secretary of Education and the Secretary of Labor regarding the importance of health insurance to building strong communities and the economy;

(5) the development of special outreach materials for Native Americans or for individuals with limited English proficiency; and

(6) such other outreach initiatives as the Secretary determines would increase public awareness of the programs under this title and title XIX.

INTERNAL REVENUE CODE OF 1986

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Subtitle D—Miscellaneous Excise Taxes

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CHAPTER 48—MAINTENANCE OF MINIMUM ESSENTIAL COVERAGE

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SEC. 5000A. REQUIREMENT TO MAINTAIN MINIMUM ESSENTIAL COVERAGE.

(a) **REQUIREMENT TO MAINTAIN MINIMUM ESSENTIAL COVERAGE.**—An applicable individual shall for each month beginning after 2013 ensure that the individual, and any dependent of the individual who is an applicable individual, is covered under minimum essential coverage for such month.

(b) **SHARED RESPONSIBILITY PAYMENT.**—

(1) **IN GENERAL.**—If a taxpayer who is an applicable individual, or an applicable individual for whom the taxpayer is liable under paragraph (3), fails to meet the requirement of subsection (a) for 1 or more months, then, except as provided in subsection (e), there is hereby imposed on the taxpayer a penalty with respect to such failures in the amount determined under subsection (c).

(2) **INCLUSION WITH RETURN.**—Any penalty imposed by this section with respect to any month shall be included with a taxpayer's return under chapter 1 for the taxable year which includes such month.

(3) **PAYMENT OF PENALTY.**—If an individual with respect to whom a penalty is imposed by this section for any month—

(A) is a dependent (as defined in section 152) of another taxpayer for the other taxpayer's taxable year including such month, such other taxpayer shall be liable for such penalty, or

(B) files a joint return for the taxable year including such month, such individual and the spouse of such individual shall be jointly liable for such penalty.

(c) **AMOUNT OF PENALTY.**—

(1) **IN GENERAL.**—The amount of the penalty imposed by this section on any taxpayer for any taxable year with respect to failures described in subsection (b)(1) shall be equal to the lesser of—

(A) the sum of the monthly penalty amounts determined under paragraph (2) for months in the taxable year during which 1 or more such failures occurred, or

(B) an amount equal to the national average premium for qualified health plans which have a bronze level of coverage, provide coverage for the applicable family size involved, and are offered through Exchanges for plan years beginning in the calendar year with or within which the taxable year ends.

(2) **MONTHLY PENALTY AMOUNTS.**—For purposes of paragraph (1)(A), the monthly penalty amount with respect to any taxpayer for any month during which any failure described in subsection (b)(1) occurred is an amount equal to $\frac{1}{12}$ of the greater of the following amounts:

(A) **FLAT DOLLAR AMOUNT.**—An amount equal to the lesser of—

(i) the sum of the applicable dollar amounts for all individuals with respect to whom such failure occurred during such month, or

(ii) 300 percent of the applicable dollar amount (determined without regard to paragraph (3)(C)) for the

calendar year with or within which the taxable year ends.

(B) PERCENTAGE OF INCOME.—An amount equal to the following percentage of the excess of the taxpayer's household income for the taxable year over the amount of gross income specified in section 6012(a)(1) with respect to the taxpayer for the taxable year:

- (i) 1.0 percent for taxable years beginning in 2014.
- (ii) 2.0 percent for taxable years beginning in 2015.
- (iii) 2.5 percent for taxable years beginning after 2015.

(3) APPLICABLE DOLLAR AMOUNT.—For purposes of paragraph (1)—

(A) IN GENERAL.—Except as provided in subparagraphs (B) and (C), the applicable dollar amount is \$695.

(B) PHASE IN.—The applicable dollar amount is \$95 for 2014 and \$325 for 2015.

(C) SPECIAL RULE FOR INDIVIDUALS UNDER AGE 18.—If an applicable individual has not attained the age of 18 as of the beginning of a month, the applicable dollar amount with respect to such individual for the month shall be equal to one-half of the applicable dollar amount for the calendar year in which the month occurs.

(D) INDEXING OF AMOUNT.—In the case of any calendar year beginning after 2016, the applicable dollar amount shall be equal to \$695, increased by an amount equal to—

- (i) \$695, multiplied by
- (ii) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year, determined by substituting “calendar year 2015” for “calendar year 1992” in subparagraph (B) thereof.

If the amount of any increase under clause (i) is not a multiple of \$50, such increase shall be rounded to the next lowest multiple of \$50.

(4) TERMS RELATING TO INCOME AND FAMILIES.—For purposes of this section—

(A) FAMILY SIZE.—The family size involved with respect to any taxpayer shall be equal to the number of individuals for whom the taxpayer is allowed a deduction under section 151 (relating to allowance of deduction for personal exemptions) for the taxable year.

(B) HOUSEHOLD INCOME.—The term “household income” means, with respect to any taxpayer for any taxable year, an amount equal to the sum of—

- (i) the modified adjusted gross income of the taxpayer, plus
- (ii) the aggregate modified adjusted gross incomes of all other individuals who—

(I) were taken into account in determining the taxpayer's family size under paragraph (1), and

(II) were required to file a return of tax imposed by section 1 for the taxable year.

(C) MODIFIED ADJUSTED GROSS INCOME.—The term “modified adjusted gross income” means adjusted gross income increased by—

- (i) any amount excluded from gross income under section 911, and
 - (ii) any amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax.
- (d) APPLICABLE INDIVIDUAL.—For purposes of this section—
 - (1) IN GENERAL.—The term “applicable individual” means, with respect to any month, an individual other than an individual described in paragraph (2), (3), or (4).
 - (2) RELIGIOUS EXEMPTIONS.—
 - (A) RELIGIOUS CONSCIENCE EXEMPTION.—Such term shall not include any individual for any month if such individual has in effect an exemption under section 1311(d)(4)(H) of the Patient Protection and Affordable Care Act which certifies that such individual is—
 - (i) a member of a recognized religious sect or division thereof which is described in section 1402(g)(1), and
 - (ii) an adherent of established tenets or teachings of such sect or division as described in such section.
 - (B) HEALTH CARE SHARING MINISTRY.—
 - (i) IN GENERAL.—Such term shall not include any individual for any month if such individual is a member of a health care sharing ministry for the month.
 - (ii) HEALTH CARE SHARING MINISTRY.—The term “health care sharing ministry” means an organization—
 - (I) which is described in section 501(c)(3) and is exempt from taxation under section 501(a),
 - (II) members of which share a common set of ethical or religious beliefs and share medical expenses among members in accordance with those beliefs and without regard to the State in which a member resides or is employed,
 - (III) members of which retain membership even after they develop a medical condition,
 - (IV) which (or a predecessor of which) has been in existence at all times since December 31, 1999, and medical expenses of its members have been shared continuously and without interruption since at least December 31, 1999, and
 - (V) which conducts an annual audit which is performed by an independent certified public accounting firm in accordance with generally accepted accounting principles and which is made available to the public upon request.
 - (3) INDIVIDUALS NOT LAWFULLY PRESENT.—Such term shall not include an individual for any month if for the month the individual is not a citizen or national of the United States or an alien lawfully present in the United States.
 - (4) INCARCERATED INDIVIDUALS.—Such term shall not include an individual for any month if for the month the individual is incarcerated, other than incarceration pending the disposition of charges.

(e) EXEMPTIONS.—No penalty shall be imposed under subsection (a) with respect to—

(1) INDIVIDUALS WHO CANNOT AFFORD COVERAGE.—

(A) IN GENERAL.—Any applicable individual for any month if the applicable individual's required contribution (determined on an annual basis) for coverage for the month exceeds 8 percent of such individual's household income for the taxable year described in section 1412(b)(1)(B) of the Patient Protection and Affordable Care Act. For purposes of applying this subparagraph, the taxpayer's household income shall be increased by any exclusion from gross income for any portion of the required contribution made through a salary reduction arrangement.

(B) REQUIRED CONTRIBUTION.—For purposes of this paragraph, the term “required contribution” means—

(i) in the case of an individual eligible to purchase minimum essential coverage consisting of coverage through an eligible-employer-sponsored plan, the portion of the annual premium which would be paid by the individual (without regard to whether paid through salary reduction or otherwise) for self-only coverage, or

(ii) in the case of an individual eligible only to purchase minimum essential coverage described in subsection (f)(1)(C), the annual premium for the lowest cost bronze plan available in the individual market through the Exchange in the State in the rating area in which the individual resides (without regard to whether the individual purchased a qualified health plan through the Exchange), reduced by the amount of the credit allowable under section 36B for the taxable year (determined as if the individual was covered by a qualified health plan offered through the Exchange for the entire taxable year).

(C) SPECIAL RULES FOR INDIVIDUALS RELATED TO EMPLOYEES.—For purposes of subparagraph (B)(i), if an applicable individual is eligible for minimum essential coverage through an employer by reason of a relationship to an employee, the determination under subparagraph (A) shall be made by reference to required contribution of the employee.

(D) INDEXING.—In the case of plan years beginning in any calendar year after 2014, subparagraph (A) shall be applied by substituting for “8 percent” the percentage the Secretary of Health and Human Services determines reflects the excess of the rate of premium growth between the preceding calendar year and 2013 over the rate of income growth for such period.

(2) TAXPAYERS WITH INCOME BELOW FILING THRESHOLD.—Any applicable individual for any month during a calendar year if the individual's household income for the taxable year described in section 1412(b)(1)(B) of the Patient Protection and Affordable Care Act is the amount of gross income specified in section 6012(a)(1) with respect to the taxpayer.

(3) MEMBERS OF INDIAN TRIBES.—Any applicable individual for any month during which the individual is a member of an Indian tribe (as defined in section 45A(c)(6)).

(4) MONTHS DURING SHORT COVERAGE GAPS.—

(A) IN GENERAL.—Any month the last day of which occurred during a period in which the applicable individual was not covered by minimum essential coverage for a continuous period of less than 3 months.

(B) SPECIAL RULES.—For purposes of applying this paragraph—

(i) the length of a continuous period shall be determined without regard to the calendar years in which months in such period occur,

(ii) if a continuous period is greater than the period allowed under subparagraph (A), no exception shall be provided under this paragraph for any month in the period, and

(iii) if there is more than 1 continuous period described in subparagraph (A) covering months in a calendar year, the exception provided by this paragraph shall only apply to months in the first of such periods.

The Secretary shall prescribe rules for the collection of the penalty imposed by this section in cases where continuous periods include months in more than 1 taxable year.

(5) HARDSHIPS.—Any applicable individual who for any month is determined by the Secretary of Health and Human Services under section 1311(d)(4)(H) to have suffered a hardship with respect to the capability to obtain coverage under a qualified health plan.

(f) MINIMUM ESSENTIAL COVERAGE.—For purposes of this section—

(1) IN GENERAL.—The term “minimum essential coverage” means any of the following:

(A) GOVERNMENT SPONSORED PROGRAMS.—Coverage under—

(i) the Medicare program under part A of title XVIII of the Social Security Act,

(ii) the Medicaid program under title XIX of the Social Security Act,

(iii) the CHIP program under title XXI of the Social Security Act or under a qualified CHIP look-alike program (as defined in section 2107(g) of the Social Security Act),

(iv) medical coverage under chapter 55 of title 10, United States Code, including coverage under the TRICARE program;

(v) a health care program under chapter 17 or 18 of title 38, United States Code, as determined by the Secretary of Veterans Affairs, in coordination with the Secretary of Health and Human Services and the Secretary,

(vi) a health plan under section 2504(e) of title 22, United States Code (relating to Peace Corps volunteers); or

(vii) the Nonappropriated Fund Health Benefits Program of the Department of Defense, established under section 349 of the National Defense Authorization Act for Fiscal Year 1995 (Public Law 103-337; 10 U.S.C. 1587 note).

(B) EMPLOYER-SPONSORED PLAN.—Coverage under an eligible employer-sponsored plan.

(C) PLANS IN THE INDIVIDUAL MARKET.—Coverage under a health plan offered in the individual market within a State.

(D) GRANDFATHERED HEALTH PLAN.—Coverage under a grandfathered health plan.

(E) OTHER COVERAGE.—Such other health benefits coverage, such as a State health benefits risk pool, as the Secretary of Health and Human Services, in coordination with the Secretary, recognizes for purposes of this subsection.

(2) ELIGIBLE EMPLOYER-SPONSORED PLAN.—The term “eligible employer-sponsored plan” means, with respect to any employee, a group health plan or group health insurance coverage offered by an employer to the employee which is—

(A) a governmental plan (within the meaning of section 2791(d)(8) of the Public Health Service Act), or

(B) any other plan or coverage offered in the small or large group market within a State.

Such term shall include a grandfathered health plan described in paragraph (1)(D) offered in a group market.

(3) EXCEPTED BENEFITS NOT TREATED AS MINIMUM ESSENTIAL COVERAGE.—The term “minimum essential coverage” shall not include health insurance coverage which consists of coverage of excepted benefits—

(A) described in paragraph (1) of subsection (c) of section 2791 of the Public Health Service Act; or

(B) described in paragraph (2), (3), or (4) of such subsection if the benefits are provided under a separate policy, certificate, or contract of insurance.

(4) INDIVIDUALS RESIDING OUTSIDE UNITED STATES OR RESIDENTS OF TERRITORIES.—Any applicable individual shall be treated as having minimum essential coverage for any month—

(A) if such month occurs during any period described in subparagraph (A) or (B) of section 911(d)(1) which is applicable to the individual, or

(B) if such individual is a bona fide resident of any possession of the United States (as determined under section 937(a)) for such month.

(5) INSURANCE-RELATED TERMS.—Any term used in this section which is also used in title I of the Patient Protection and Affordable Care Act shall have the same meaning as when used in such title.

(g) ADMINISTRATION AND PROCEDURE.—

(1) IN GENERAL.—The penalty provided by this section shall be paid upon notice and demand by the Secretary, and except as provided in paragraph (2), shall be assessed and collected in the same manner as an assessable penalty under subchapter B of chapter 68.

(2) SPECIAL RULES.—Notwithstanding any other provision of law—

(A) WAIVER OF CRIMINAL PENALTIES.—In the case of any failure by a taxpayer to timely pay any penalty imposed by this section, such taxpayer shall not be subject to any criminal prosecution or penalty with respect to such failure.

(B) LIMITATIONS ON LIENS AND LEVIES.—The Secretary shall not—

(i) file notice of lien with respect to any property of a taxpayer by reason of any failure to pay the penalty imposed by this section, or

(ii) levy on any such property with respect to such failure.

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BIPARTISAN BUDGET ACT OF 2013

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DIVISION A—BIPARTISAN BUDGET AGREEMENT

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TITLE II—PREVENTION OF WASTE, FRAUD, AND ABUSE

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SEC. 202. STRENGTHENING MEDICAID THIRD-PARTY LIABILITY.

(a) PAYMENT FOR PRENATAL AND PREVENTIVE PEDIATRIC CARE AND IN CASES INVOLVING MEDICAL SUPPORT.—Section 1902(a)(25) of the Social Security Act (42 U.S.C. 1396a(a)(25)) is amended—

(1) in subparagraph (E)(i), by inserting before the semicolon at the end the following: “, except that the State may, if the State determines doing so is cost-effective and will not adversely affect access to care, only make such payment if a third party so liable has not made payment within 90 days after the date the provider of such services has initially submitted a claim to such third party for payment for such services”; and

(2) in subparagraph (F)(i), by striking “30 days after such services are furnished” and inserting “90 days after the date the provider of such services has initially submitted a claim to such third party for payment for such services, except that the State may make such payment within 30 days after such date if the State determines doing so is cost-effective and necessary to ensure access to care.”.

(b) RECOVERY OF MEDICAID EXPENDITURES FROM BENEFICIARY LIABILITY SETTLEMENTS.—

(1) STATE PLAN REQUIREMENTS.—Section 1902(a)(25) of the Social Security Act (42 U.S.C. 1396a(a)(25)) is amended—

(A) in subparagraph (B), by striking “to the extent of such legal liability”; and

(B) in subparagraph (H), by striking “payment by any other party for such health care items or services” and inserting “any payments by such third party”.

(2) ASSIGNMENT OF RIGHTS OF PAYMENT.—Section 1912(a)(1)(A) of such Act (42 U.S.C. 1396k(a)(1)(A)) is amended by striking “payment for medical care from any third party” and inserting “any payment from a third party that has a legal liability to pay for care and services available under the plan”.

(3) LIENS.—Section 1917(a)(1)(A) of such Act (42 U.S.C. 1396p(a)(1)(A)) is amended to read as follows:

“(A) pursuant to—

“(i) the judgment of a court on account of benefits incorrectly paid on behalf of such individual, or

“(ii) rights acquired by or assigned to the State in accordance with section 1902(a)(25)(H) or section 1912(a)(1)(A), or”.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on October 1, **[2017]** 2019.

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MINORITY VIEWS

Committee Democrats unanimously oppose H.R. 3921, the “Helping Ensure Access for Little Ones, Toddlers, and Hopeful Youth by Keeping Insurance Delivery Stable Act of 2017”, or the HEALTHY KIDS Act. While we strongly support the policy in the legislation that would provide a robust reauthorization of the Children’s Health Insurance Program (CHIP), we cannot support doing so using the harmful offsets that Republicans have proposed in this bill which undermine the Affordable Care Act (ACA) and our Medicare and Medicaid programs. This legislation offers a false choice—provide health care for some, at the expense of others. Committee Democrats do not support such an approach, and must oppose this legislation.

Committee Democrats are deeply concerned that Congress has allowed funding for the Children’s Health Insurance Program to expire. Since its creation in 1997, the Children’s Health Insurance Program has been a lifeline for 8.9 million children nationwide.¹ Together with Medicaid, CHIP has helped to bring the children’s health coverage rate to an all-time high of more than 95 percent.² Put simply, states deserve the certainty that timely federal financing provides and children deserve the certainty of access to health care. Congress created CHIP to ensure that no American child fell through the cracks of our nation’s health care system. Yet, by wasting months attempting to repeal the ACA instead of working together to reauthorize this important program, Congress has jeopardized the certainty that our states and families need and deserve. Now, states are taking steps to wind down their CHIP programs, actively putting millions of children and pregnant women at risk.³

Committee Democrats urge Republicans to join together to reauthorize the CHIP program immediately with responsible offsets that do not harm coverage for others.

THE MINORITY MEMBERS OPPOSE POLICIES THAT WOULD CUT OR RESTRICT ACCESS TO HEALTH COVERAGE FOR MEDICARE AND MEDICAID BENEFICIARIES

The minority members oppose paying for the reauthorization of CHIP with a policy that shifts additional costs onto seniors that rely on the Medicare program. The majority’s proposal to add addi-

¹ Kaiser Family Foundation. *Total Number of Children Ever Enrolled in CHIP Annually*. (Feb. 2017) (<https://www.kff.org/other/state-indicator/annual-chip-enrollment/?currentTimeframe=sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>).

² Georgetown University Health Policy Institute, Center for Children and Families, *Children’s Health Coverage Rate Now at Historic High of 95 Percent* (Nov. 2016) (<https://ccf.georgetown.edu/wp-content/uploads/2016/11/Kids-ACS-update-11-02-1.pdf>).

³ National Academy for State Health Policy. *Increasing Urgency for States on Congressional Action for CHIP*. (Aug. 2017) (<http://nashp.org/increasing-urgency-for-states-on-congressional-action-for-chip/>).

tional income-related premiums in the Medicare Part B and Part D programs will hurt seniors and undermine the Medicare program, by encouraging high-income beneficiaries to drop out. This in turn could affect the risk pool, resulting in higher premiums for seniors who remain in the Medicare program. The minority notes that high-income seniors already pay more for Part B and Part D premiums, and are being asked to pay 80 percent of the average per capita cost of Medicare Part B and D coverage beginning in 2018. Asking these seniors to now pay 100 percent of the costs of coverage before the new premium increases go into effect is unfair and inappropriate. Additionally, Democrats oppose additional income-related premiums because they undermine the universality of the Medicare program, paving the way for additional policies that we oppose—such as efforts to convert Medicare into a premium support or voucher program.

The HEALTHY KIDS Act also includes a policy to offset the costs of enacting the legislation that would change how lump sums are calculated for purposes of eligibility in the Medicaid program. Specifically, under the legislation a state would be required to count such sums for purposes of determining eligibility for coverage:

- For amounts less than \$80,000, in the month in which the lump sum was received;
- Over a period of two months, if the amount is at least \$80,000 but less than \$90,000;
- Over a period of three months, if the amount is at least \$90,000 but less than \$100,000; and
- Over an additional one-month period for each increment of \$10,000 received, up to a period of 120 months.

This policy essentially “locks out” very low-income individuals from coverage for receiving lump sum payments that are not large enough in the majority of cases to realistically move such individuals out of poverty permanently. Thus, this policy derives its savings primarily from churning individuals off of Medicaid coverage for varying periods of time.

Furthermore, the ACA created a streamlined approach to determining eligibility for Medicaid, CHIP and both the premium tax credits (PTCs) and cost-sharing subsidies (CSRs) that help people afford coverage. To accomplish this, the ACA redefined the way that Medicaid counts income, and eliminated the asset test for most beneficiaries in order to align Medicaid rules with the definition of income that is used in the tax code and hence is used to determine eligibility for the ACA’s premium tax credits. This revision in Medicaid eligibility rules was essential to coordinate Medicaid with Marketplace coverage. Assets are counted, but simply in a different way. This provision would undermine the streamlined, coordinated eligibility approach the ACA established and would add additional administrative burden to states.

Finally, the minority members have concerns with certain provisions in the HEALTHY KIDS Act that would, under the guise of strengthening Medicaid third party liability rules, result in delayed payment to prenatal and pediatric care providers, potentially impacting access to care for children and pregnant women. Democrats are not willing to risk even the potential of a barrier to prenatal and pediatric well-child care. For more than thirty years Congress

has held two general exceptions with respect to Medicaid third party liability rules:

- If the claim is for prenatal care or for preventive pediatric care, including services under Medicaid's early and periodic screening, diagnosis, and testing (EPSDT) benefit; and
- If the claim is for Medicaid services provided to any child on whose behalf child support enforcement is being carried out, if the third party liability in question is derived from the parent whose obligation to pay child support is being enforced and the third party has not paid within 30 days of services being provided.

In these situations only, a state must pay providers for care provided first, and recover payments from any relevant third party after. These protections were put in place in recognition of the very special circumstances surrounding such beneficiaries, the overwhelming need and volume of children and pregnant women in the Medicaid program, and the catastrophic consequences should such providers leave the Medicaid program or restrict their availability to take new Medicaid patients.

The Bipartisan Budget Act of 2013 (Budget Act) weakened these protections slightly, by allowing states to hold payments for 90 days in such instances. Recognizing this misguided policy, Congress, on a bipartisan basis, has delayed this provision twice, first in the Protecting Access to Medicare Act of 2014 and most recently in the Medicare Access and CHIP Reauthorization Act of 2015. The HEALTHY KIDS Act would delay the Budget Act changes to these protections once again for two years, but then subsequently remove them entirely. Democrats are strongly concerned about the potential creation of barriers to care for highly vulnerable populations; as such, we cannot support an outright repeal of these protections.

THE MINORITY MEMBERS OPPOSE POLICIES THAT ARE INADEQUATE
AND FAIL TO ADDRESS OUR NATION'S HEALTH NEEDS

The HEALTHY KIDS Act includes two additional policies that Democrats believe are inadequate.

First, the legislation proposes to eliminate a scheduled \$2 billion cut in FY 2017 to Medicaid's Disproportionate Share Payments (DSH) made to safety net hospitals. The legislation would offset the elimination of this cut by adding \$8 billion in cuts for both the years 2026 and 2027.

The minority members appreciate the Majority's recognition of the significant financial hardship that would be caused by such a cut to safety net providers. However, the Majority's policy would leave an even greater \$3 billion cut in place, which is scheduled to take effect in less than one year in FY 2018, and would further add an additional \$16 billion in cuts to the later half of the budget window. This is not responsible policy. Congress should eliminate two years of the scheduled DSH cuts at a minimum in order to provide safety net hospitals with the operational certainty that they need while Congress comes to an agreement regarding a permanent solution for the remaining schedule of Medicaid DSH cuts.

The HEALTHY KIDS Act, as amended, also includes a provision intended to provide additional Medicaid dollars to the Puerto Rico and United States Virgin Islands (USVI) territories. This provision

is wholly insufficient to meet the needs of both territories given the recent and catastrophic hurricanes. Hurricanes Irma and Maria made landfall on September 6, 2017 and September 20, 2017, respectively, causing massive power outages, flooding and structural damage in both Puerto Rico and the USVI. A significant proportion of the population has Medicaid health insurance in both territories, and the need will only grow as people struggle to rebuild their lives. Significant infrastructure needs are also present for both programs.

Unfortunately, the territories cannot respond to the needs of their citizens because they are statutorily required to operate under a capped Medicaid program with a lower Federal Medical Assistance Percentage (FMAP) than the mainland states. The HEALTHY KIDS Act proposes to increase the growth rate of the base annual funding ceiling amount by 1 percent for a period of two years. The legislation would also allow for a one time influx of \$880 million, with an additional \$120 million available with the requirement of majority approval by Puerto Rico's Control Board, plus a commitment that Puerto Rico will use the dollars for reducing fraud, reducing excessive spending, improving availability of data or improving quality. The legislation would also increase the fraud detection and medical personnel review matching rate from 75 percent to 90 percent.

The HEALTHY KIDS Act provision is not acceptable because it is not enough funding to meet the need, and more importantly, does not address fundamental financing issues. Specifically, the \$1 billion in funds is not enough to address Puerto Rico's Medicaid needs over two years, the length the provision contemplates, even at pre-hurricane circumstances. Furthermore, the policy does not address the already low (55 percent) matching rate for Puerto Rico and the USVI. Puerto Rico and the USVI cannot maintain their share of the costs when considering both the increased demand and the collapse of revenue, which will only exacerbate and lengthen challenges to recovery. In 2005, Congress allowed for full federal financing for expanded Medicaid for Hurricane Katrina Victims through the Deficit Reduction Act of 2005. Hurricane Irma and Maria have caused unprecedented damage to Puerto Rico and USVI, with substantial financial and human costs. Committee Democrats believe Congress should undertake, at the very least, similar coordinated efforts to protect the health and lives of Medicaid beneficiaries living in Puerto Rico and the USVI. This provision does not go far enough to address the needs of these individuals.

FRANK PALLONE, JR.,
Ranking Member.

GENE GREEN,
Ranking Member, Subcommittee on Health.